

## Introduction: purpose of discussion, who's on the panel

### Rebecca Harris

Kia ora and welcome everyone. Thank you for joining us for this discussion. In October last year, 2024, bpac<sup>nz</sup> published the main resources in our series on the ACC Recovery at Work Initiative. This was the comprehensive guide and quick Reference summary - we call that B-QuiCK, and since then we've added other activities to help reinforce learning, including a case study that follows through two practical scenarios, a peer group discussion that can be used in groups or for individual reflection. And we've got a clinical audit for you to do as well. The aim of these resources is to familiarise general practitioners and other primary care clinicians with the Recovery at Work programme and to provide information and tools to help navigate some of the more challenging aspects of managing patients back into the workplace while they recover from an injury. During the development of these resources, we realised that we still had questions, and after we started publishing them, it was evident that our primary care audience had questions too.

So, we've got together a panel of ACC representatives who have kindly agreed to talk with us today to clarify and expand on some aspects of the Recovery at Work programme. To prepare for the discussion, we invited a group of ten primary care specialists, so that includes general practitioners, urgent care clinicians and nurse practitioners, to participate in a written interview. We asked them about their experiences with the Recovery at Work programme and the common threads from their responses will be used to inform and direct our panel discussion today. Their input has been absolutely essential, and we are really grateful for their contribution. We'll put up a list of who was involved so they can be acknowledged. So, thank you.

Right, so there's no better place to start than at the beginning. So, let's do a round of introductions. I'm Rebecca Harris. I'm the editor of all the publications we produce here at bpac<sup>nz</sup>. I'm a medical writer and I manage the Publications Team. I've been with bpac<sup>nz</sup> for a number of years now, so I'm very familiar with everything that we do here. Quality is really important to me and also being evidence-based, but what's most important is that our guidance is always grounded in that pragmatic, real world primary care context. There's a lot of information out there, so we are really grateful for all of you who continue to trust in what we do and read and engage with our resources.

### Sharyn Willis

Hi, I'm Sharyn Willis. I'm a part-time GP in Dunedin, and I work halftime for bpac<sup>nz</sup> as the senior clinical advisor. Like Rebecca, I've been here for quite a while. I'm looking forward to finding out a bit more about the ins and outs of the Recovery at Work programme and how I can apply that to my clinical practice, and help others do the same along the way. I think when some of the changes started with the Recovery at Work programme, I found it quite hard to explain things to my patients, but I know that I'm getting better at doing that now, so interesting to see how we go.

### Merian Graham (3:07):

Kia ora, ko Merian Graham tōku ingoa. I'm ACC's Portfolio Manager for general practice nursing and dental services. I've been working at ACC for close to ten years now in multiple different roles. But prior to this, I have a background in working at a multidisciplinary, pain management clinic in Canada. And my experience working in that pain management clinic really made me appreciate that if we don't get a client's journey on the right track right from the start, that it can cause significant delays in their recovery and cause some onward harm to them, their employers, the community, and their whānau. So, I'm very passionate about this space and very grateful to be able to speak to everyone today.

### **Maartje Lyons**

Kia ora koutou, ko Maartje tōku ingoa. I'm a clinical advice manager here at ACC. I've been here for a number of years now, but my background is as a GP with a special interest in occupational medicine, and I'm really passionate about the role that work plays in ensuring the health of our patients.

### **Angela Keen**

Kia ora. Ko Angela tōku ingoa. I am a relationship manager here at ACC, and I'm happy to admit I've been here 21 years, and I have worked the vast majority of that time with New Zealand employers. I also, you know, to coin a cliché, I'm really passionate about this space. I'm an old occupational therapist, so, absolutely believe in the power of purposeful activity in terms of people's wellbeing and ability to engage in their communities. Working with New Zealand employers, our focus over the last couple of years in particular has been in this space, i.e. recovery at work. And we are doing a lot to raise awareness around the benefits of recovery at work and why it's so critical for them in their business to support and manage their injured employees to come back to work as soon as is possible. In 2024, the cost of injury in New Zealand was articulated in a report. We paid two and a half billion dollars in costs of weekly compensation, which represents 18 million days of lost productivity due to injury. And that was paid out to just over 162,000 injured people. So, the impact of this is absolutely enormous and can't be overstated, and I'm really happy to be here today to talk to you about the employer experience with regards to the Recovery at Work programme.

### **Shaun Westhead**

Kia ora tātou, ko Sean Westhead tōku ingoa. I'm one of the portfolio managers here at ACC looking after our community assessment and rehabilitation services, which includes vocational rehab. I've been here at ACC for 12 years in various roles, but prior to working here, I was a physiotherapist and worked in the vocational rehab setting as well.

### **Geoff Mercer**

Kia ora, my name's Geoff Mercer. I'm an engagement and performance manager. Lots of syllables, but essentially it's a relationship manager and for me in particular, I'm the sole relationship manager for all of the vocational rehab providers, that work for ACC. So, I've been at ACC for four years. In my previous life I was a physio and I did my postgrad in voc. and I was a voc. provider, and also I was a national clinical lead for one of the voc. rehab companies. So, I've

spent a lot of time, having some great conversations with GPs to help drive really great outcomes for your patients.

## **Background: defining the three types of work capacity for medical certificates**

### **Rebecca Harris**

Okay, let's start with a little bit of background on the Recovery at Work programme. So, returning to work after an injury is a key component of the recovery process. We know that spending too much time off work can be detrimental to a person's long-term outcomes. Medicines must be prescribed at the right dose and for the right duration. So, in the same way, time off work must also be, but to prescribe a medicine, you have to have a good understanding of the indications, and which medicine is appropriate for which patient. So, the same goes for selecting the right type of medical certification. The definitions of each type of medical certification have evolved over time, and some clinicians may not be completely familiar with what the current criteria are. So, a key shift in thinking is that the clinician's role is to focus on the functional capacity of the patient and to identify any limitations rather than considering whether there are any specific tasks they can do at work. What we are seeing is that too many people are being automatically signed off work when they actually still do have functional capacities. So, let's ask one of our panel members to explain the three types of medical certification.

### **Merian Graham**

ACC revised our medical certification definitions, and these were released in February, 2023. The aim of doing that was to encourage a system that supports patients to recover at work at the level suitable of their injury. So, as Rebecca has mentioned, there are three different ACC medical certification categories for patients. The first one is, is fully fit, pretty self-explanatory, but this means that the patient is able to undertake all their full pre-injury job duties and hours. Then we have fit for selected work. Basically, fit for selected work means that your patient is able to engage in active rehabilitation and some form of work. And sometimes that might mean that there's support that is required. So, for example, it's not just light duties as we used to kind of talk about.

It could be modified duties, alternative hours, workplace modifications, or gradual re-entry into the workplace. So, there's a lot more options than just that light duties. The final criteria is fully unfit. So, for fully unfit, it's quite specific. So, the individual is either admitted to hospital or confined to bed. They may require quarantine due to infection risk of their injury, and the nature of their job doesn't allow them to work remotely. Or even with supports and adjustments, the client, poses a health and safety risk to themselves, their colleagues or the public if they were to go back to work. So based on that criteria for fully unfit, there is an understanding or a level of expectation that most injuries would not require this level of certification. We would expect that the majority of clients would actually have the ability to engage in some form of activity or some form of work. It might be modified as we talked about

before, and it's important that we be quite clear on those restrictions. But what we are seeing is that currently of all our weekly compensation claims, we've got about two-thirds of the injuries that require weekly comp are of low complexity, so sprains and strains, and close to 60% of all the med certs are signed off as fully unfit, which doesn't really meet that criteria that I just mentioned. So that's of a concern for us.

### **Sharyn Willis**

Just in terms of when you're saying that the majority of people are fit for selected work and very few will be fully unfit based on those criteria, now are we talking just about ACC 18s here, or is this the person who's had quite a severe injury and is basically incapable of working for a few days or maybe up to a week, which might be covered on the initial ACC 45? And then might transition to selected duties after that? Just trying to get my head around where we're sort of talking about at this stage.

### **Merian Graham**

That's a great question. So, the stats that I provided, um, earlier are for subsequent med certs, so for the ACC 18. So, we know that currently 60 to 70% of the subsequent med certs are signed off still as fully unfit. And as I mentioned, we know that two-thirds of our current weekly compensation claims are for soft tissue injuries. When I quote those statistics, we've already taken out patients that have a serious injury because we know obviously that can skew those stats. We've already removed those types of injuries from those stats. When we look at the ACC 45 statistics, we see that an even higher ratio of medical certification that is signed off fully unfit. Does that answer your question?

### **Sharyn Willis**

Yes, that's really helpful. Thanks. And I think that probably is a good way to set the scene when we're talking about this whole process.

## **Aligning clinical assessment with medical certification**

### **Rebecca Harris**

So, we are now going to move on to discuss some themes that emerged in our interview with our primary care expert group. So, the first topic was about aligning clinical assessment with medical certification. Overall, the group felt confident in their understanding of key factors that influence return to work following injury. However, issues were identified around how information from clinical assessments aligned with medical certification in some circumstances. Many of the group members said that patients are often reluctant to be designated as fit for selected work, and they say things like "there's no light duties at work", or, "my boss won't let me do this". And then this then complicates discussions about work capability. And many patients still don't understand or accept that fit for selected work certification doesn't mean that they have to immediately return to their full levels of work. They're worried that if there's no suitable alternative duties, that they won't be eligible for compensation. And there needs to

be a significant mindset shift from people thinking that they have to stay home to recover and that working will make their injury worse. The new normal needs to be to focus on how to work safely with an injury, and that people generally shouldn't be off on ACC for long periods of time unless they really are completely unable to work. So, Sharyn has some questions from the panel.

### Managing expectations from patients and employers

**Sharyn Willis** What can clinicians do in situations where a patient has quite a different perspective, or expectation about their ability to work than the clinician has. Any tips or things that can assist the clinician with that scenario?

#### **Maartje Lyons**

Absolutely that's a real challenge that I think everyone can relate to. I think we've all been in those situations where those conversations come up. I think the key thing is that getting certification right and setting those recovery expectations from the beginning is in the very best interest, of your patients. And GPs and primary care clinicians play a key role in helping your patients to recover at work and return to their everyday activities as soon as possible. As we've already talked about, the reality is that most patients with low complexity injuries will be able to be certified as fit for selected work. And we've also already mentioned the myths out there about what that means for patients. And I actually think that's often those myths about certification that make those conversations really challenging. And that's also what makes those conversations so valuable because the conversation has the potential to significantly influence your patient's recovery from injury and return back to work and normal life. We know that there's strong evidence that shows that work can be a valuable part of recovery and rehabilitation, and this is a really important message that we should be sharing with our patients. Getting back to work's good for your patient's own health, keeps them engaged with their employer and colleagues, and it's good for their whānau and their community. And that part of the conversation is so critical for your patients and for their return to work.

### Busting myths: financial entitlements and alternative duties while on “fit for selected work”

**(Maartje cont.)** Merian, patients and clinicians often mistakenly think their patient needs to be certified as fully fit to receive financial entitlements from ACC?

#### **Merian Graham**

Yes, we do hear that very frequently Maartje and so, really good for us to address that in today's session. So, it's really important and we want to be really clear that your patient will still get paid regardless of if they're certified fully unfit or fit for selected. And actual fact, if a person is signed off as fit for selected work and they're able to complete some of their duties, they actually have an opportunity to earn up to a hundred percent of their pre-injury earnings. Under a fully unfit medical certificate they are capped at 80%. How that kind of works is the

employer will pay for either the time or the percentage of productivity that the client is able to complete on the work site and ACC will top them up the rest. So, there's a real benefit there for patients to be signed off as fit for selected. The other thing that we hear quite frequently that a client will be signed off for selected and they'll go to their employer and there's no alternative duties available based on what's written on that med cert. And so, the employer or the client will feel that they need to go back to their primary care provider and have that med cert changed back from fit for selected to fully unfit in order to receive weekly compensation. And we just want to be really, really clear that that is also untrue and we would not expect that if you have signed your patient off as fit for selected work, it actually doesn't matter what duties are available. That is your medical and clinical opinion of how that person has presented with the injury that they have. That still stands true regardless of what is available out there. And again, they will still get paid regardless. I think that's really important when we're having these challenging conversations that we really start to bust that myth because we don't want people unnecessarily presenting back to primary care providers just to have a med cert changed. I think we can all agree that that's not very a valuable use of a very busy primary care provider's time. So, we've created some resources over the years in conjunction with the sector and we've been working quite closely with the medical council.

### **Maartje Lyons**

There's a fantastic resource called "How to Choose the Right Medical Certification for your patient", and this one's probably my favourite. It's a one-page flow chart that you can print out. You can have it sitting on your desk and you can go through it as you discuss with your patient what you're thinking about certification. It's a really good visual aid to use this will help your patients understand that fit for selected duties might be the right certification for them. And it is a great way to frame that conversation around what that means and why that's what you're thinking. It helps you frame a conversation about all the good things about engaging in work if suitable work is available in their workplace. And you can also address some of those myths about certifications such as that one about the financial support - what happens if an employer doesn't have suitable work, that they will then still receive financial support that doesn't really matter. And being certified fit for selected work means that they can be actively engaged in rehabilitation. It's also a really good opportunity I find to discuss some of those wider recovery expectations with your patient. There's also another really helpful handout that I think is great. And this one is about explaining a fit for selected medical certificate. It's really great to give to your patient because they can share this with their employer. As Merian just said, it's, it's those situations where patients go away with a fit for selected work med cert and they're feeling quite happy about that, and then their employer sends them back for a fully unfit med certificate. Having this handout helps your patient have that conversation with your employer.

### **Choosing the correct injury code on the initial ACC45**

### **Sharyn Willis**

Can I just go sideways for a little minute and thinking about the initial ACC 45 form, because that has a flow on effect to the ACC 18s as well. Sometimes we find selecting an injury code can

be a bit challenging. So, have you any guidance about things we should be doing when choosing an injury code or other tips when completing these initial injury forms?

**Maartje Lyons**

I can definitely relate to the frustration of not being able to find the right code when you're trying to complete a form. It's a really annoying thing to happen and it feels like it takes up a lot of time sometimes, but those accurate injury codes do help ACC assess claims efficiently and ensure that your patients receive the right support. So, it is really helpful for both your patient and for ACC if you can find the right code. If you can't find it though, I'd say don't panic, choose the best one and add a free text comment with a diagnosis that you can't find the code for, and that will be picked up when the certificate comes through. So that's always an option. Also, remember, you can always add or update a diagnosis later, and that can be done via the change of diagnosis form in your PMS or by popping it on a separate ACC 18 certificate. So worst case scenario, if you can't find it at the time or you want to change it, you can make that adjustment down the track.

**Sharyn Willis**

Yeah, and I think that's probably good for us to realise, because often I still see, you know, ankle sprain that turned out to be ankle fracture, but it's not been updated or lumbar sprain, which turned out to be a significant disc prolapse and still isn't updated on the ACC 18. So, I think it's a good thing for us to remember. We should actively update those to the correct diagnosis to make it easier for everyone and so that you guys can judge better what kind of help the patient might need. So, those are good points. And you also mentioned the free text box. Now, just on a practical basis, you mean the wee box at the bottom below the diagnosis codes?

**Maartje Lyons**

Exactly. Yeah, that's exactly what I mean. Yeah, you can just jump in there, type in, be as accurate as you can. Leave the code out and just type in what you think the diagnosis is. And then we'll take the hard work of finding the code.

**Sharyn Willis**

That's good to know, because sometimes you type in those boxes and you think, hmm, does anyone ever read this? Okay. That's good to know.

**Maartje Lyons**

We definitely do.

**Assessing injury and functional capacity when you can't "see" the dysfunction**

**Sharyn Willis**

Right, can we just talk a little bit about, assessing injuries and assessing functional capacities? So, it's obviously much clearer when there are obvious physical signs or impairments, but how

can you reasonably assess a work capacity if you can't actually sort of see the dysfunction? How do you objectively assess something subjective that the patient's telling you, like pain or fatigue or limited concentration and arrive at a the right direction for working out time off work or limitations to duties?

### **Maartje Lyons**

I think that's a really good question, Sharyn, and I think it's something a lot of people feel uncomfortable about because of that perception of it being very subjective, but actually, certification for someone who has mental injuries in many respects is the same as assessing certification for a physical injury. You want to think about the same things, you want to think about the person's ability, what your patient can safely do cognitively and physically, what the diagnosis is, what treatment they're having, what their tolerance is at the moment in terms of work hours, travel, tasks that they do, the environment that they might be exposed to in terms of work and risks, and in particular, things that your patient shouldn't do to keep themselves and others safe, or if there's activities or situations that constitute a risk to your patient. Sometimes there's mitigations you need to think about as well, like reducing hours shift work, taking breaks.

I find that for mental injuries, cognitive symptoms such as poor concentration, the effects of poor sleep, fatigue, for someone who's got PTSD, it might be triggers and flashbacks. The predictability of those things, side effects of medications, might be particularly relevant and that might mean that certain work environments, safety critical things or shift work might not be suitable. Sometimes I think as a GP or a primary care clinician, you might feel that you don't have the right information available to you to make a decision about those things. Someone might be seeing a provider external to your practice for some of their treatment, and you may not have the information at hand at the time of certification. And I think that adds a layer of complexity and uncertainty when you are that certifying provider. I think in that case, you can seek help through either a vocational medical advice request or a VMA, or a vocational rehabilitation review, a VRR, for which you can refer directly yourself or ACC can make a referral if you let ACC know your concerns on either the ACC 18 certificate or by email or phone call. So, if you don't have the right information, I think it's really important that you feel able to communicate that to ACC.

### **The level of information to include on the ACC45 or ACC18**

#### **Sharyn Willis**

So, being quite specific about, for example, risks, when you're assessing work capacity is pretty important. Is it then important to include those risks in free text on the form so that you guys know what we are thinking and what boundaries we're working within for that patient?

#### **Maartje Lyons**

Absolutely. I think at the end of the day, you're the person with the most information about your patient and we rely entirely on the information that we receive from you. So, it is useful to

put as much information as you can. If you think there are specific things, specific risks that you are aware of, absolutely share them. That's really helpful from our perspective and it really helps the team who are supporting your patient in terms of their rehabilitation and the workplace as well. I would say you can't provide too much information.

### **Angela Keen**

And I'll jump in just to agree with Maartje to say that employers are just looking for as much information as they can on that medical certificate. So, if you can be as specific as possible around what your concerns are and what needs to be accommodated from a return to work perspective, the employers will love that, so don't hesitate.

### **Sharyn Willis**

Sometimes...I suppose it depends on the PMS and which form you're using, but sometimes the free text boxes aren't very large, and you have to write in shorthand. I know that the ones we use it, it tends to be a wee bit that way. So, yeah, I guess that's where contacting you guys via an email could be useful.

### **Maartje Lyons**

I would add that it's important to be cognisant of what you write on an ACC 18 or 45 in terms of certification. I think it's really important to be transparent and do that in a shared way with your patient so that they know what's on that certificate. Because if the employer sees the information on there, that can cause challenges if there's information the patient didn't want to disclose to their employer. So, this is just something to be mindful of. It's great to put detail, but make sure that your patient knows what detail that you are including on that certificate.

## **Special circumstances**

### **Rebecca Harris**

Let's move on now to think about when a patient has particular circumstances that seem more difficult to fit into the recovery at work framework, or they're having difficulties with their employer about medical certification, sometimes it's hard for the clinician to know what to do in this situation. So, our expert primary care group had some questions here that Sharyn's going to take us through.

### **Approaching medical certification and injury cover if the injured person is self-employed or the employer**

### **Sharyn Willis**

One of the things they asked is what happens in situations where the injured person is the employer or is, self-employed, should the approach be different? The key question I am wanting to ask is there any specific advice that ACC would give to self-employed people with work limitations? How do they then look at covering the cost of someone to do their job for their business if they're unable to do that?

## **Angela Keen**

A couple of good questions, actually, it's sort of two parts, so I'll have a have a go at answering that for you. Certainly, you've asked the question about is our approach at ACC any different to self-employed people or employers as opposed to perhaps an injured worker? And the short answer is no, it's not any different at all. The conversation about recovery at work and the support services and entitlements that are available to a self-employed person, or an employer are largely the same as for anybody else. The only difference really being around the weekly compensation component, which can be a little bit more complicated for self-employed people or shareholder employees. But my advice to primary care practitioners is just to encourage their injured patient to talk to ACC as soon as possible about their need for financial assistance so that they can understand exactly what they're entitled to. I mean, it's going to be a little bit late for a GP to talk to a person about whether they have cover plus extra, for example, which is a product that self-employed people can pick up whereby they actually agree with ACC about the level of weekly compensation cover that they will be paid in the event of being incapacitated for work. And that's paid right through until a person is fully fit for work. So, no abatement applies, but it's a little too late if they don't have that cover at the time of injury. So maybe not something that you would ask about afterwards, but certainly the primary message is the same. Just ask your patient to get in touch with ACC ASAP to talk about what their entitlements might be from a financial perspective.

And I just want to say too, that as a general rule, self-employed people are pretty motivated with regards to getting back to work given that they are the engine that powers their business and their income and replacement costs. And it's great that GPs are concerned about that and that's obviously something that a patient might bring up, but certainly that's a conversation to be had with their insurance advisor. And there should be income protection, and those kinds of things involved as well. But certainly, get in touch with ACC early to talk about what financial support is available and just be assured that the vocational pathway is the same for a self-employed person as it is for anybody else.

## **The “My ACC” mobile application and the reintroduction of one-on-one case management**

### **Sharyn Willis**

We sort of see a lot that patients tend to sit back and wait for ACC to contact them. And I suppose maybe we should be encouraging the person to contact ACC as you say, early and get things on board. So just on a practical basis, at what stage does your “My ACC” mobile phone app kick in and is that offered to every person with an injury or how does that work?

### **Angela Keen**

So “My ACC” is available immediately to those clients who have, it looks like they're going to need entitlements in order to support their recovery journey where we have a verified mobile phone number or email address on file at the time of the injury. Those invitations are sent out automatically, but also our case owners do offer that support to our injured people. We talk about registering for My ACC and they'll be sent a registration code to be able to register onto

that platform. And My ACC is amazing. There's a lot of things that injured people can do for themselves in terms of asking for support at the time that they need it rather than waiting for ACC.

But I mean, there is some good news in this in terms of ACC has moved back to a model of one-to-one claim management, where an injured person needs to receive weekly compensation for a period of time. So they will have a single point of contact who will be in touch with them early on in the claim to be able to establish what is their situation with regards to their injury, what are their support needs and what they can expect from ACC and beginning that conversation about recovery and recovery at work and what they might need to support them through that. So, we've moved back to that model of one-to-one. So, there's a lot more support early on in the piece in terms of recovery and expectations are set very early on about what they can expect from ACC, support that's available from ACC, which also includes that digital platform that you are speaking about.

## **Managing long-term claimants and financial challenges**

### **Sharyn Willis**

Can we talk a little bit in general about, anyone who's off work for a long time. How does that alter the approach. From our end, we find that sometimes these people struggle with some financial challenges. There's a widespread myth out there that ACC covers the full cost of appointments, for example, and other aspects of rehab and things. And I know you guys provide a lot of care, but patients often quite shocked to find they're still paying significant amounts of money and that makes life challenging for them. So, I'm just, I guess wanting to talk a little bit about support services for those people and how we can help with that and how, how you can help from your end.

### **Angela Keen**

Where the rehabilitation goal is to return to work, same job, same employer, the focus will very much be on vocational rehabilitation, physical rehabilitation to support that goal. So, as long as that takes, that's what we are doing. In situations where an injured person might leave their employment, they resign, or the employer terminates their employment, then there is potential for ACC to take a different track in terms of the rehab outcome. That might be looking at vocational independence, which is a long process where we determine what the person is able to do whilst still carrying a lingering incapacity as a result of an injury. Or we will manage the claim through providing support, through vocational rehab or physical rehabilitation to the point where we determine that the ongoing incapacity isn't related to the covered injury anymore, whereby the support would stop or we would determine that the person is able to carry out those pre-injury duties even though they don't have that job to go back to and support stops at that point. So, there are sort of several pathways to take with this. So, the same job, same employer is very focused on vocational rehabilitation, return to work, working with the employer, working with the injured person and a provider, potentially like a stay at work provider, for example, to facilitate that as long as that might take. But when they lose

their job or they resign, or it becomes clear that they can't return to that job based on the incapacity, there are other avenues that ACC takes.

### **Merian Graham**

Can I just add to what Angela has mentioned as well is you talked about, you know, if someone's in financial hardship and they're finding it hard to kind of cover the costs of treatment and rehab and things like that. What we suggest in this situation is, again, making sure that the patient reaches out to ACC. Obviously we don't want cost to be a barrier to recovery. So, it's really important for them to reach out to us to see what kind of supports are available. That's typically done on a case-by-case basis. But we absolutely encourage people to reach out to us.

### **Angela Keen**

I guess it's another way that the primary care provider can talk to the person about the benefits of being at work is around that financial stability, like being able to earn a hundred percent of their pre-injury income by being back at work in some capacity during their recovery. So that's another incentive that drives that behaviour around being back at work on an alternate duties plan, modified duties, or a gradual return to work plan. It's all good stuff from a financial point of view, but certainly just reinforcing Merian's point to ask, you know, ACC can't help if we don't know if that problem exists. And certainly, we are very keen to knock down any barriers that are in the way of people getting back to work, as soon as possible.

## **Enabling recovery at work through ACC and employer collaboration: stay at work assessment, resource pack for employers**

### **Sharyn Willis**

Can you just talk us through a bit about how ACC collaborates with employers to ensure that they can accommodate work modifications or restrictions or shorter hours?

### **Angela Keen**

Well, can I just first go back to that really fabulous, good news, which is all about the fact that ACC has moved back to the one-to-one case management models for anybody who's in receipt of weekly compensation for a period of time. So, we are intervening earlier. We are having conversations with clients really early about the benefits of recovery at work and talking through what are the opportunities at work. We also have that same conversation with the injured persons employer. So, these are called welcome conversations. We have one with the client to establish what their situation is, what their pre-injury work is, how they're going, what support they're getting, and then we have that same conversation with the injured person's employer. So, this is what's making a real difference, in our ability to get people back to work, is actually having those conversations really early with employers to establish firstly that they have obligations. Whether the employer has expertise, willingness, confidence in that area. And if they don't, we offer support services. So there's a stay at work assessment, which we are

really happy to put in place whereby an occupational therapist or a physiotherapist comes into the business and identifies pre-injury duties, the demands of those, looks at the person's functional capability, their diagnosis and their expected recovery, and develops a plan based on all of those things about what that person can be doing at work and then presents that to the GP for sign off or if there is a fit for selected work, just making sure that all of those tasks and things fit in with what the GP would want to have restricted at the beginning of that process. At that conversation, the employer can raise concerns about their ability to accommodate somebody, and our people get a really good feel for whether an employer is on board or not.

So, another thing that we have done in recent times is develop a recovery at work resource pack for employers, which talk about the benefits of recovery at work, why it's important that they participate and how to participate. So in the same way that you've developed resources for your GP community and your primary care community, we've developed the same for employers around how to have conversations with injured people about how they can support them with their recovery at work, how to modify duties, how to think about changing the environment, whether they can change their hours or the days that they work, the work cadence, that type of stuff. So, giving them some really good steer about how to do that. Also, how to develop a recovery at work plan. So, we've given them templates, this is how you can fill one of these things in and how weekly compensation works. So, in tandem, so we are working at your end of things in terms of educating you about the benefits of recovery at work and how to make that happen, but we're also telling employers how to make that happen too.

What we find is that the employee goes to the primary care person for their injury and they come out with a fully unfit for work medical certificate when there are opportunities in the workplace. So, it's about just making sure that we've got that communication going right from the 'get go', which enables that selected work medical certificate to be written as early as possible so that recovery at work can be undertaken. Employers can also self-refer for a stay at work assessment too. So, if ACC hasn't referred, if you haven't thought that would be a useful thing to do and referred yourself, then the employer can do it.

## **Complex cases and removing barriers to recovery**

### **Rebecca Harris**

So, another common theme from our primary care group is that while the system functions well in straightforward cases, it becomes problematic in others where, and I quote, "it's obvious that the patient is off work for many different reasons, and any connection to an accident is tenuous at best". So, navigating these complicated cases can be time consuming leading to, and again, I quote, "a strong incentive for doctors to just sign it and save themselves a very long and difficult consultation."

## **Support from ACC when the "going gets tough"**

So if a clinician finds that a lot of time during the consultation is taken up by just listening to and reassuring the patient about their concerns with the ACC process rather than actually addressing their injury, is there any team or service within ACC that the patient can be referred to so that the clinician can just continue to concentrate on the clinical aspects of the case?

### **Maartje Lyons**

Absolutely. I think we're all conscious that everybody has a limited amount of time. So, if you do have a patient who is concerned about ACC processes that is separate to the clinical reasons that you're seeing the patient for, ACC does have a navigation service. So, you can encourage your patient to connect with ACC and link in with the ACC navigation service to address any concerns that they have. They can also reach out to their case manager. So don't hesitate to redirect them to ACC for the support and clarification they might need around some of those process issues.

### **How to get in touch with ACC**

#### **Sharyn Willis**

What's the best practical way for clinicians to contact ACC if they have questions about a person's case. On the bottom of the ACC 18, there's a wee button that says ACC to contact me or something. Is that the best way to just tick that or have you got a better way?

#### **Angela Keen**

There are four ways. First of all, using, using that little tick box in in your medical certificate, you can also do a free text in terms of additional support needs to be discussed. You can call the contact centre on 0800 101 996 with your patient's details handy. You might wait five to seven minutes, and I know that's a long time in a GPs world, but you will be put through to the case owner. There's voicemail capability now has been lit up again. So that means you can leave voicemail saying...my name is, I'm ringing about this client, date of birth, claim number, please call me on such and such a date at such and such a time, I want to talk about X, Y, and Z. That's an excellent way of getting a case owner to call you back to talk about your specific problems. Now that we have also gone back to one-to-one case management, the injured person may well know who's managing their claim and have their contact details -just ask them for that. And then the last one is, if there's a stay at work provider involved, you can talk to them, and they can raise your concerns with either ACC or the employer or the injured person and just work as that liaison.

### **Early contact with ACC is recommended in complex cases, including chronic pain**

#### **Sharyn Willis**

For a case that has become quite complex, any tips for helping us manage those cases? Are there pathways for early referral into further services or should we only do that once we've sort of exhausted all measures in primary care? At what stage does ACC want the input into those complex cases?

### **Shaun Westhead**

We can support clients with treatment, whether it's in primary care referral through to specialists or specialised services. So probably the best thing to do is let us know what your client's injury related need is and we can help look for the appropriate supports and things to support them back to work in independence and around those complex injury needs.

### **Sharyn Willis**

Just thinking about someone who's got chronic pain, post-injury, it's often a reason for someone staying off work for some time, and often hard to assess. And we may have covered a little bit of this earlier, but any other specific advice you could give clinicians in terms of the right certification for patients, if the physical sort of aspects of their injury have resolved, but they still say that pain is preventing them from returning to work?

### **Shaun Westhead**

So again, I think this is one to let us know about. We do have supports in place for clients who have got persistent pain and we can look to see whether or not those services are appropriate for those clients. And those services, they also link through to, things like our recovery at work and help supporting them to become independent in work and other areas.

### **Maartje Lyons**

Can I add in there, I think as a GP or a primary care clinician, you know, you're very in tune with your patient and I think when you start to see barriers like pain becoming a persisting problem and you're starting to see those flags that that particular patient might struggle for longer than you might have expected for a certain injury, I think flag that early to us. I think that the earlier we can get those supports in place for that particular patient, the better. So don't think that you need to wait a certain time before you bring it to someone's attention. I think as soon as you get that sense for that particular patient, reach out and let us know.

## **Vocation rehabilitation services**

### **Rebecca Harris**

So, when we asked our primary care group about vocational rehabilitation services, there were varying degrees of familiarity amongst the group. Some regularly referred patients, whereas others were less certain about the range of available services, the eligibility criteria and the referral pathways. And some group members highlighted difficulties in co-ordinating care between general practice and service providers. So, we have a few questions about the vocational rehabilitation services.

## **Explaining the role of vocation rehabilitation services**

### **Sharyn Willis**

Firstly, can you tell us just a bit about what vocational rehab services are all about?

### **Shaun Westhead**

Our vocational rehabilitation services are supports from allied health vocational practitioners, psychologists, and medical practitioners to support clients achieve a return to work outcome. Could be their pre-injury job with their current employer or with a new employer, or it could be if their work is deemed to be not medically sustainable. ACC can engage a vocational rehab service to support the client gaining vocational independence in an alternative sustainable work type. So, an example of that is a builder who may not be able to go back to building. If they've got experience in that area, we may be able to do some retraining to help them transition to a role such as a quantity surveyor or something like that.

### **Sharyn Willis**

So, do you find there are any particular groups of patients who benefit most or is it injury specific or a mixed bag?

### **Shaun Westhead**

I think when there is a challenge with that person getting back to their pre-injury role, then putting a referral through to a vocational rehabilitation service will help them get back into work.

## **Refer patients to a vocation rehabilitation service as soon as issues are identified**

### **Sharyn Willis**

So, are there any set times when a referral should be considered, or just immediately when you start to realise things are going a bit slower than you might've expected, the person's struggling to return to their full duties? I suppose that would trigger it.

### **Geoff Mercer**

It is definitely an art, not a science. There's no kind of date or kind of timeframe that you can give. So, the majority of patients that are in receipt of weekly comp don't actually get a return to work programme. Most of them get back without it. So that's probably important to note. Especially the case if you've got a motivated patient, you guys know your patients, motivated employer, you can be pretty sure that person's getting back to work. But a referral for voc. rehab could be considered when your nose twitches that there's barriers preventing that timely return to work. So, it could be when you are expecting your patient to be back at work, but their progress has stalled for some reason.

Providers are great at being your eyes and ears on the ground at the workplace, eyeballing everything, the client, the employer, and giving you some great information, in terms of how to progress that patient's progress. Another indication, something that I saw in my time as a voc. rehab, is when there's, what's pretty clear to you as the GP, there's a communication breakdown between your patient and their employer. That's a kind of significant flag there that things might go a little bit pear shaped. So, questions that you could ask, because often a patient will say they're motivated to go back to work, so words can be useful, but actions

usually speak louder than words. So if you're asking them when was the last time you popped into the workplace, you know, that connectedness, or when was the last time you spoke to your employer, that actually helps create a bit of a picture in terms of are there barriers going on there that's preventing your patient getting back into the workplace?

So, it's definitely specific to every patient. If it's a regular patient, if you've got the luxury of working in a practice where you know your patients quite well, you might actually know immediately on the onset of injury, this person will benefit from having someone like a provider out there at the workplace. But essentially, as soon as those barriers are identified though, and you can't resolve the barriers with the time you've got in the clinic educating your patient, then definitely consider it. And as a GP you can just fire it off and voc. providers are sitting willing and very capable of doing that work for you.

## **Vocation rehabilitation service availability nationwide**

### **Sharyn Willis**

In an urban area there's obviously lots of services available, but can we think a bit more about rural settings where vocational rehab services might not be readily available? Can practices offer or co-ordinate their own services if there aren't any available, or what would be the plan there?

### **Shaun Westhead**

We've got contracted suppliers nationally, so we should have coverage. So, check out our website or Health Pathways to find out who provides these services in your local area. But absolutely, if you've got the time and ability to support your clients achieve that return-to-work outcome, do so, that's fantastic. But again, if you believe they need additional supports or assessments, make a referral, our voc. rehab services suppliers will be able to assess the client's work, their ability and capacity, complete their duties, alternative duties, make contact with the employer and ensure that that person can make a safe and sustainable return to work.

### **Sharyn Willis**

So, thinking just beyond vocational rehabilitation itself, any other ACC-mediated pathways or programmes that clinicians should be aware of that we haven't already touched on?

### **Shaun Westhead**

We can offer lots of supports to clients. And so, again, I think this is a great place to make contact with us. So let us know what the injury related needs are, and what supports that client requires and we can assist them connect with those different services.

## **Collaboration between vocation rehabilitation service providers and general practice**

### **Sharyn Willis**

If a referral's made, have you got any tips for how clinicians can better collaborate with the providers to continue to support patient outcomes?

**Geoff Mercer**

So, the good news is providers are telling us that they're willing and able and really want to engage with you. They've identified that the inability to connect with the GP is actually a pretty significant barrier for getting people back to work. My time as a provider, again, it was absolute gold dust to have those open communication channels with GPs, especially for those curlier situations, I guess. So, voc. providers who are working on ACC contracts it's actually a contractual requirement to engage with the certifier, which more often than not is the GP, sometimes it's a specialist. They need you guys to agree to the return to work plan and then sign it off. So, they need to be communicating with you when recovery's progressing well. Probably the most efficient form for everyone is just email, maybe a phone call if you've got the luxury again, which 10 years ago was the case, maybe not so much now. But when rehab has stalled, and or there's a difference of opinion perhaps between yourself and the voc. provider or maybe a specialist and yourself and the provider, the best thing to do there is a case conference where you can get everyone together in the same room, have your patient, the voc. provider, and yourself and you can overcome the barriers just to ensure the most effective pathway is developed to go forward.

**Sharyn Willis**

Sounds ideal, but not sure where I'm going to fit that in my day!

**Compensation for case conferences is available to primary care clinicians**

**Merian Graham**

If I can just comment on that as well. We acknowledge that primary care providers are obviously extremely busy, but one of the things that we can set up with those case conferences is we can pay for your time to participate. So, if a case conference is required, either the stay at work provider can get in touch with ACC or you can get in touch with ACC directly and we can just set up a purchase order to cover that time to attend the case conference. Not many GPs know about that, and so it's just important that we do get that out there.

**Sharyn Willis**

That's good to know.

**ACC concussion programme – referring the right people, aligning with recovery at work**

**Rebecca Harris**

So, interestingly, when we posed questions to our primary care expert group, we didn't specifically ask about managing patients with concussion, but this was a topic that was almost universally raised. Many of the group members had really positive feedback about concussion services, but some raised concerns about whether filtering patients into the service could actually ultimately result in delays in recovery from some of the people. One group member said, "there are people who I feel are not helping themselves by malingering or staying off work much longer than necessary".

### **Sharyn Willis**

Could you just tell us a little bit about how the ACC concussion programme works and how does that align with the recovery at work programme?

### **Shaun Westhead**

We've got a specialised concussion service that is to support our clients who are at risk of delayed recovery from concussion. And so this service supports our people with all aspects of their concussion, but also includes supports with returning to work and engaging in work. So that's a new component of the service and it's to connect people back with their employment and also with a vocational rehab service provider if that is quite a complex process. And so, bringing some real integration and collaboration between our providers.

### **Sharyn Willis**

So, do you think the right patients are being referred at the right time to the programmes? Should we be more selective about who's referred? And ultimately how do we stop people being in the system for too long?

### **Shaun Westhead**

I think many people recover from concussion without too much intervention. And then there are others who require a lot of support. And so, we don't want to cause harm to our clients by creating beliefs about about their injury. That may not be true, but we also don't want to cause harm by missing the diagnosis or not providing enough care or support. And so, what we would say to GPs is we'd encourage early monitoring around people's symptoms in that primary care setting. And if they identify risks of delayed recovery or people whose symptoms aren't improving, then making a referral through to our concussion services is an ideal next step. If people have red flags, you know, send them through to the emergency department for further assessment and for those things to be ruled out. There are lots of useful tools as well that are available out there to GPs to help support their decision making. So, there's some great information on the bpac website, as well as things like the brain injury screening tool, which is really useful to help make decisions about where to refer people for their next sort of episode of care.

## **Final remarks and sum-up**

## **Rebecca Harris**

Okay. So, I think we might just move on now to the final part of our discussion and conclude with some final remarks.

## **Importance of primary care to ACC**

### **Merian Graham**

I've had the privilege of working with the primary care sector for over five years now, and it's really important that the sector knows that you are of strategic importance to ACC, you're the main entry point into this scheme. I think that you account for approximately 60% of the claims that do get lodged within ACC, and you are also the key referral gateway to specialists in other rehabilitation services. Primary care providers sign off the majority of the work certificates and as we've mentioned throughout this entire session is those are really, really quite key interactions for ACC. They can either put the hand brake on recovery, or they can support an early reintegration into the workplace. We know that ACC clients see primary care clinicians about 2 million appointments per year. That's quite significant. And primary care providers fill out about 45,000 med certs per month, which is huge.

We do want to acknowledge that primary care is currently under significant strain driven by workforce shortages. We know that there's a high rate of primary care providers that are due to retire over the next five to 10 years. There's uncertain financial sustainability, increasing patient complexity, due to an ageing population and multiple comorbidities. And we also know that there's an increased percentage of practices with closed books for new enrolments, which can make it hard to get access to a GP to even get into the system. And we know that there's high reports of practitioner burnout and a growing administrative load. We also want to acknowledge that historically we probably haven't done enough as an organisation to enable primary care to be able to work efficiently and effectively with us. And this can impact on what you're able to do in regards to supporting your clients, in particular with recovering at work and making sure that they get the right services at the right time. We also know that we do contribute to some of that admin burden. And so that's something that we really do need to start to be looking at.

As we've touched on a little bit earlier, our current rehabilitation rates and weekly conversation costs are not where they should be and they've actually been trending in the wrong direction for the last 10 years. We know that more people are going on to weekly compensation than they were 10 years ago. And when they do go on to weekly compensation, they're on for much longer. This is really important for ACC because it indicates that people aren't recovering with the same injuries for the same time period that they did previously. And so there's obviously multiple factors that influence that. But as we've all kind of talked about here, it is really important if we are putting the patient right at the centre of recovery, that we are minimising any delays in getting them back into their everyday lives, which includes work and their activities of daily living. We also know, and I've kind of touched based on this, that at the same time that our rehab performance is decreasing significantly, we know that we've got a high percentage of claims receiving weekly compensation that are for those low complex injuries. I think we've got about 66% of our current weekly comp claims are with soft tissue injuries. And,

as I've touched on before, a lot of these are receiving fully unfit med certs. So, we really just ask people to take the time during that interaction to really kind of think about the, you know, the criteria that we've talked about and the impact that that med cert does have on their recovery.

For all these reasons, we now as an organisation, our current focus is to work with the health sector and commission for services and find new ways of being able to work better together with you as a primary care sector, and us to improve these recovery outcomes.

We need to do this not only to ensure that we're not causing any harm to patients but also ensuring that there's sustainability for you and for us. An example of what we've done recently is we've set up a primary care external reference group and this group is made up of clinicians all around the motu from different parts of primary care and our objective with this group is to provide some guidance and potential solutions to help us improve the rehab outcomes for our clients, especially those that are accessing primary care services. And things that are coming up, which we have mentioned in this session already today, is the med cert forms. They can be quite difficult to fill out, sometimes there's not a lot of room in the free text box, for example. Sometimes it's hard to communicate with ACC. We are exploring all these pain points with this group and trying to come up with solutions of how we can make it better into the future. So, watch this space. We will be providing regular updates, but I think it's a quite an exciting time, especially, you know, working with the primary care sector that we are actively engaging to try and make it easier for you guys to do what you do best.

### **Employers want to help**

#### **Angela Keen**

Can I just give one final plug for the employer community? Having worked really closely with employers for the last 20 years, it's just the, there is a real desire to work with their injured employees to help support recovery at work. And the fit for selected work medical certificate is the golden ticket to enabling everybody to work together to make that happen. So please do remember it's not on you to determine whether there are alternative duties or whether a person can be accommodated back at work. That is the work of ACC and the employer and the injured employee and potentially a stay at work provider to work that out. So, you're focused on the stuff that you do best and allow us to support that recovery at work through that fit for selected work medical certificate, the employer community will thank you for it.

### **Feedback and certificate of accreditation**

#### **Rebecca Harris**

Well, I'd just like to thank everyone for participating in this really valuable discussion today. I think we've delved into the topics and hopefully have explained some of the tricky areas and concepts. If anyone listening still does have any questions, please get in touch with us and we'll pass these on and get some answers for you. For those of you who are interested, we are offering a certificate of accreditation for reading and engaging in our full series of recovery at work resources. So be sure you check out that link below. So, thank you again to all of our panel members here today and our expert primary care group who so generously provided the questions. Primary care is under a lot of pressure at the moment and things can be tough out

there. So, we hope that what we've provided here for you can help in some way to make it least one of your jobs a little easier. Thank you everyone.