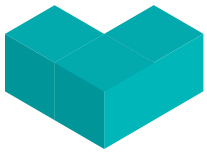
TAKING ACTION

A Best Practice Framework for the
Management of Psychological Claims



ACTION AREA 1

Developing the Management Practices for Psychological Claims

Superfriend®

ABOUT SUPERFRIEND

PROMOTING WORKPLACE MENTAL HEALTH & WELLBEING

SuperFriend is a national health promotion foundation that helps 'all profit to member' superannuation funds to promote and support improved mental health and wellbeing for their members, through the workplace. SuperFriend's mission is to reduce the incidence of suicide and the impact of mental illness on individuals, employers, workplaces, friends and families.

Created by the Industry Funds Forum, an association whose members are the CEOs of Australia's largest industry superannuation funds, SuperFriend collaborates with 'all profit to member' funds, group life insurers and the mental health sector to facilitate targeted workplace mental health initiatives for members of these funds.

SuperFriend's work focuses on the development, promotion and facilitation of information, resources, programs and research about mental health and wellbeing. By improving the understanding of mental health and mental illness in individuals and workplaces, SuperFriend influences the policies and practices that foster mentally healthy, supportive work environments.

We collaborate with a range of organisations, including recognised mental health service providers, to facilitate the delivery of mental health information, initiatives, programs and referral pathways to assist 'all profit to member' superannuation fund members, employers and staff, along with their associated organisations.

For more information about SuperFriend visit us at www.superfriend.com.au.

ACKNOWLEDGEMENTS

The development of this Action Area Guide, the first arising from the **TAKING ACTION** Framework, was led by a representative of the SuperFriend Insurance Reference Group Sub-Committee, Pat Cowley, along with members of the project consulting team, Dr Anne-Marie Feyer and Professor Niki Ellis. Our particular thanks go to Pat, whose dedication, knowledge and input throughout the project has been critical to its success.

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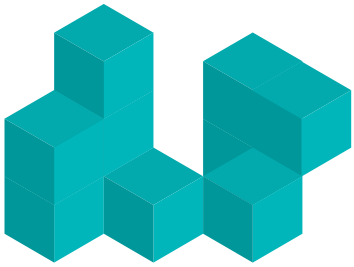


TAKING ACTION FRAMEWORK

FINDING BEST PRACTICE

In 2012, SuperFriend's Insurance Reference Group proposed a project that would enhance understanding of the experience of people on claim and identify ways to improve that experience, particularly for those affected by psychological illness or at risk of developing a psychological illness after a physical injury. The result was **TAKING ACTION:** ***A Best Practice Framework for the Management of Psychological Claims.***

The **TAKING ACTION** Framework provides an overview of the interlinked strategic action areas identified when developing evidence-informed best practices for managing psychological injury claims. Eight key Action Areas were identified:


DEVELOPING THE MANAGEMENT PRACTICES FOR PSYCHOLOGICAL CLAIMS


OPTIMISING CLAIMS MANAGEMENT TEAMS


BRINGING EVIDENCE TO TREATMENT AND REHABILITATION


EFFECTIVE DECISION MAKING SUPPORTED BY ANALYTICS AND AUTOMATION


TAILORED SUPPORT FOR THE PERSON ON CLAIM


TRANSFORMING PRODUCT DESIGN


ENGAGING EMPLOYERS IN STAY AT WORK/RETURN TO WORK


RECORDING PROGRESS

You may notice that the first letter in each of the eight Action Area titles spell out DO BETTER. We believe all organisations can DO BETTER by identifying some priority areas, measuring baseline performance, making changes, measuring performance again, and adjusting action as necessary. Organisations vary in their readiness for change and in their optimal starting point for implementing change. This means that progress towards evidence-informed better–and ultimately best–practice in psychological claims management will occur within a variety of organisational contexts.

To obtain printed copies of the **TAKING ACTION** Framework, please contact SuperFriend. Soft copies of the Framework, including the bibliography from the rapid review of evidence, can also be found on the SuperFriend website at www.superfriend.com.au. The full rapid review of the literature that informed the development of the Framework can be also be found there.

ABOUT THIS DOCUMENT

This document is the first in a series of user-friendly guides that will expand on the Action Areas defined in the **TAKING ACTION** Framework. The aim of this guide is to provide practical advice on HOW better practice in psychological claims management can be achieved through Developing the Management Practices for Psychological Claims. The second in this series of guides, Action Area 2: Optimising Claims Management Teams, will be published later in 2015.

HOW TO USE THIS DOCUMENT

This document should be used in conjunction with the relevant Action Area within the **TAKING ACTION** Framework, which provides research evidence and case studies. Key practice areas have been identified by insurers, informed by the research evidence in the Framework, and for each practice area the following are provided:

- An introduction to the issues, research evidence and innovative practice
- Target – a statement of focus for this practice
- Key components – what best practice should look like
- Examples of relevant actions – examples of how this can be achieved by insurers and their stakeholders.

WHO SHOULD USE THIS DOCUMENT

This guide has been designed to assist claims teams and other staff of organisations across the insurance and personal injury sectors to bring the evidence highlighted in the **TAKING ACTION** Framework to their everyday practices. Improving claims management processes will result in better support for all people on claim, particularly those claims related to psychological illness.

AN INTRODUCTION TO PSYCHOLOGICAL CLAIMS

We can all expect to suffer aches or pains - perhaps a twisted ankle or painful muscle, an infection or some type of food poisoning. It is considered normal and natural for people to sustain some sort of physical injury at various points throughout their life and usually such injuries will heal with time, appropriate care and support. It is important to understand that in many ways psychological illness is no different to physical illness – however, the journey to recovery is often more complex.

Similarly, psychological claims tend to be inherently more difficult or complex than claims for physical injuries or illness, partly because the symptoms and treatments for various psychological illnesses can vary from individual to individual. Two individuals may share the same 'diagnosis' but the way in which it impacts the individual, the recovery period, and the appropriate treatment may differ significantly. In contrast, physical injuries and illnesses tend to be more predictable and consistent in terms of symptoms and treatment. The root cause for, and contributing factors of, psychological illness may also not be entirely clear, and often it is a combination of factors that can lead to psychological illness. Relapses are common, and various life events can have a cumulative impact on individuals' psychological functioning.

Psychological illness claims can also occur in the form of a secondary claim cause, as the psychological impact of a physical injury can materialise. It can often be this secondary claim cause that prevents or limits individuals from returning to work, rather than the primary physical injury, and so the motivational and psychological impacts must be considered and explored to support individuals in maintaining or returning to work.

Despite knowing more about psychological health than ever, it can be easy to fall into the trap of not understanding something that you can't see. Psychological injuries are not tangible in the way that physical injuries are, and from a workplace and claims context, it is often a culmination of psychosocial factors that impact on an individual's ability to restore normal psychological functioning, including returning to work.

Psychological illness can often lead individuals to feel a lack of control over their circumstances as well as a sense of helplessness, which creates further harm to individuals' psychological wellbeing. From a claims management perspective then, it is important to understand and accept these differences and use good management practices to help individuals feel empowered and supported. Depending on the nature and severity of the specific psychological illness and associated psychosocial factors, it may be difficult to determine an expected timeframe for recovery and, in some cases, a focus on return to work may not be appropriate.

THE CASE FOR CHANGE

Despite the inherent complexity of psychological claims, there are components of service and claim management highlighted in this Action Area guide which are extremely simple and easy to incorporate individually. When added together they present an opportunity to provide a much improved customer experience and enable the greatest chance of successful outcomes for all parties involved.

For the Person on Claim it will mean a smoother and more tailored experience, quicker payment of benefit, and access to support. The Person on Claim is likely to be less anxious about the process and feel like a stakeholder involved in their own future.

For the insurer it will mean reduced claim costs, more efficient processes, happier, more capable assessors and great customer feedback. It will also mean fulfilling a higher purpose as insurers, which is to help people with financial support when the policy terms are met and also help people to get back to a productive life where this is possible.

For the superannuation fund and employer, it will mean that premiums are more likely to be kept at a manageable level and as a result, the cost for financial protection will be more sustainable over the longer term.

DO BETTER

Part of building a framework around best practice involves looking at customer feedback and then looking to improve the process for the Person on Claim, and as a result achieving the best outcomes for all involved. The following stories demonstrate the distress and frustration that can be experienced by superannuation fund members when making a claim related to psychological illness.

"I found the whole process confusing. Where to begin? I didn't even know for ages that I could make a claim through my super fund for the time I needed off work because of my depression. Then when I found out I could, the claim form was hard to understand, especially the way I was feeling, and I couldn't work out what to send back to the insurer. I didn't even know why the information was being asked for and there was no-one I could ask for help. I couldn't think and it was a long time before I could get the forms done.

After I eventually returned the forms I was constantly trying to understand what was happening next but no-one wanted to speak to me, no one called me and I had to chase them and do all the legwork. This was really hard for me and made me feel really helpless.

I was never allowed to speak to the actual insurance company person and it seemed that the person I did speak to didn't understand what was happening. There were delays in them calling me back while they found out from the insurer what was happening. Then when they did call back they hadn't resolved my actual question! They didn't understand what I was actually asking so they had to try again. How would you feel in this situation?"

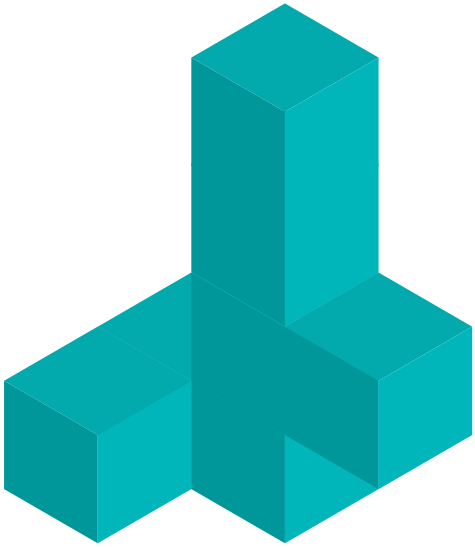
Customer 1

"It was such a hotchpotch of bad service. It took ages to pay the claim whilst I tried to prove I was disabled enough and I wasn't kept informed about what was happening and why. The claim assessors changed and I had to keep explaining my situation. That made my anxiety and stress levels even worse, as it made me relive all the things that had led me to this terrible point in my life.

I could tell from their tone that the second assessor had no empathy for what I was going through, I felt like a number going through their system, there was no individual consideration. Even when the claim was paid I had to get forms completed by my doctor every single month, even though the insurer knew my medical treatment plan and that it was going to take a long time for me to get better – six months or more the doctor said.

I felt like I was alone, I had no support to help me try and get back to work. I wasn't really sure my doctor was the right person either and it would have been good to have some help getting better medical advice. I think the whole process made it more difficult for me and actually made me worse."

Customer 2



BEST PRACTICE IN DEVELOPING THE MANAGEMENT PRACTICES FOR PSYCHOLOGICAL CLAIMS

Drawing on the evidence in the **TAKING ACTION** Framework, five key practices were identified for this Action Area:

1. Initiate action or intervene as early as possible
2. Have logical and clear processes
3. Tailor the claim management activities to the person's individual situation
4. Collaborate with stakeholders
5. Ensure outcome focussed decision making.

PRACTICE 1

EARLY INTERVENTION

Every piece of research we know of shows the earlier we act to assist a person with psychological problems, the better. Research clearly indicates that the earlier the diagnosis and treatment for a mental health condition or any condition, the better the outcome for the person. The longer individuals are absent or out of work, the more likely they are to experience anxiety and depression. National and international return-to-work statistics consistently show that the longer a person is off work, the less likely they are to return to work.

The case for the benefit of supporting a return to some form of work as early as possible is clear, even if it is reduced hours or duties initially. It also makes sense to encourage people to remain physically and socially active, as a pre-cursor to returning to work.

However, early intervention is particularly problematic in the Group Life Insurance sector. Within the Australian context there are particular factors that currently inhibit the ability of insurers to intervene early, including:

- Notification date for psychological illness claims is too late for early intervention. Customers with psychological illnesses are often not seen within the 6–12 week window identified as the optimal therapeutic window for early intervention. This can be because employers with Group Insurance wait too long to advise their insurer that an employee is absent from work due to psychological illness
- Superannuation fund members are sometimes not aware that they have disability insurance cover
- Poor co-ordination between the Superannuation Fund administration and the insurance systems.

On the other hand, early intervention at all points in the insured person's journey, including the claims journey, is best practice.

In other words, 'early' should be seen as a relative term, which includes:

- Developing an understanding of the person's condition and the treatment being provided as soon as possible, to enable the insurer to be more pro-active in assisting with their claim and their eventual return to work
- Claims management processes for facilitating engagement with the Superannuation Fund, the Employer and the Member early in relation to work absences
- Prompt access to professional medical review and rehabilitation support experts.

TARGET

Initiate action as early as possible across the entire claims process and life of the claim.

KEY COMPONENTS

- Processes which recognise that the early activities and stages of a claim can be very influential
- Processes that respond to claims with a view to supporting early return to work

- Processes that support prompt access to expert health, legal or financial advice
- Processes that support prompt gathering of required information
- Processes that support prompt communication with the Person on Claim's employer to discuss Stay at Work (SAW), Return To Work (RTW), modified/ partial duties and absence management.

Acting early can avoid having the Person on Claim reach a mindset that is ingrained in disability:

- *Where their view of themselves has changed from worker to disabled*
- *Where their beliefs and behaviours move from those that support normal daily activity to ones which reinforce their disability.*

EXAMPLES OF RELEVANT ACTIONS

- Develop processes that provide for assessment and response to illness related time off work, irrespective of whether waiting period criteria have been met. This strategy will be particularly beneficial when there is a realistic prospect of supporting a timely recovery
- Develop approaches for early identification of claims with particular risk profiles to allow earlier and more appropriate targeting of strategies. Incoming claims can be screened against claim duration risk factors to highlight which claims have a high likelihood of exceeding RTW duration. These claims can then be triaged to the most appropriate assessor with early guidance on the observed risk factors and what supports might be used to assist the person to recover and return to work
- Take a pro-active approach to early contact in the claims management process. Some insurers engage nurses to visit the Person on Claim to complete forms and do an on-the-spot assessment; other insurers have specialised teams who take the information needed to assess the claim over the phone
- Develop and maintain communication with the Person on Claim's employer to discuss SAW, RTW, modified/partial duties and absence management (e.g. keeping job available)
- Proactively assist employers to establish best practice SAW, RTW processes. That is, allowing a return to work to occur in a safe and controlled environment, initially on a reduced hours of work or reduced duties basis for a set amount of time to allow a graded return to normal duties. An 'all or nothing' approach to work should only be necessary in a minority of occupation types. Graded return to work is particularly important when encouragement is needed to return to work, for example, to overcome anxieties about work or manage fatigue from out of work deconditioning (see Action Area 7: Engaging Employers in SAW/RTW)
- Proactively encourage employers to report likely claims early. Ideally insurers should receive the earliest possible notification of an employee who has been absent from work due to illness for more than 14 days where ongoing absence is likely
- Develop reporting and advice protocols between Insurers and Superannuation Funds to agree on co-ordination of reporting, assessing and managing claims. Of particular importance is notification by the Fund of a possible claim within a month of illness or injury, irrespective of the policy waiting period. The Fund and Insurer should have processes that allow a possible claim to be initiated and reviewed quickly (see Action Area 5: Tailored Support for the Person on Claim.)

PRACTICE 2

LOGICAL AND CLEAR PROCESSES

The Australian and international evidence indicates that the claims process is difficult for People on Claim, and it is not perceived as transparent and easily understood, especially for someone not at their best psychologically and/or physically. Common sub-optimal practices include:

- *Lack of a proactive approach by Claims Managers – focussed on process not on good outcomes*
- *Poor telephone manner or communication skills of the Claims Manager*
- *Claims and injury management activity occurring in isolation*
- *Ambiguous and overly technical communication and forms*
- *A focus on eligibility monopolising rehabilitation resources and delaying access to treatment and rehabilitation programs.*

These sub-optimal practices reflect a focus of processes around the claim, rather than the Person on Claim. In Group Disability Insurance, disability assessors manage claims for employees of companies and members of superannuation funds. It has been traditional for the assessor to have no direct contact with the individual experiencing the illness. Consequently, a claim review form might be sent every month and payment not released until it is returned, all without contact with the Person on Claim, and irrespective of their disability level, their personal circumstances and so forth. A third party between the Person on Claim and Insurer creates delays and miscommunication, reduces effective claim management and leads to dissatisfaction from the Person on Claim.

In contrast, best practice is based on a much more person-centered approach. In such an approach, all aspects of procedures, documentation, communication, benefit processing and activities are focused on the experience and outcomes of the Person on Claim. Best practice claims management process is characterised by people-focused principles to guide the entire claims management process, from the functions of claims management teams through to the business systems that support them at the organisational level, and from lodgement through initial contact, assessment, treatment and payment/ benefits. In practical terms, these principles are evident in processes that:

- Build rapport and show empathy from the start of the claims process
- Are transparent regarding what the person can and cannot claim, with clear expectation setting about what the claim process will be like for the Person on Claim
- Gather required information in a timely fashion accompanied by explanations of purpose
- Are clear about what the process is, what action is required and from whom, estimated timeframes, and who to contact.

TARGET

Customer-centred processes: Procedures, documentation, communication, benefit processing and activities are focused on the experiences and outcomes of the People on Claim.

KEY COMPONENTS

- The claims process is focused on the experience and outcome of the Person on Claim
- All involved in the management of the claim are well-informed about the Person on Claim's situation from initial assessment and throughout the life of the claim
- The Person on Claim understands the process and likely time frames for management of the claim and their part in the process
- The Claims Manager provides a continuous single point of contact for the Person on Claim throughout the claims process
- The Person on Claim understands that the claim process is to provide support for SAW or RTW
- The Person on Claim is empowered and motivated to make evidence-based and informed decisions that promote wellbeing, including early intervention, treatment and rehabilitation, and RTW.

EXAMPLES OF RELEVANT ACTIONS

- Develop processes for comprehensive initial assessment and claim duration planning. As with any new disability claim, the Insurer should look to gather as much relevant information about the Person on Claim's situation as possible from the very start of the claim and then make decisions promptly about disability and liability
- Develop processes for gathering medical information for the claim assessment. The General Practitioner should be approached to establish the build-up to the illness, as documented in the clinical notes. If there has been more than one General Practitioner involved, then the notes relating to the history of the condition should be gained from each doctor. If there is a treating Psychiatrist and/or Clincal Psychologist and the treatment or prognosis are unclear, then they should be approached for information. If there is no treating Psychiatrist or Clincal Psychologist then the assessor should consider instructing an Independent Medical Assessment and the clinical notes obtained can then be provided to a Psychiatrist for review
- Develop processes for gathering employer information for the claim assessment. At the initial assessment the assessor should understand what discussions with the employer have so far taken place regarding a RTW strategy. If this is unclear, consideration should be given to contacting the employer from the very first assessment to verify the employer's understanding of the situation and to also ask the employer how open they are to assisting a return to work

Initial questions to the employer could include:

- *Can you confirm the daily duties of (insured person's name) job role and the percentage splits of these duties?*
- *Do you have any expectation of when (insured person's name) will return to work?*
- *Please can you confirm what your understanding is of (insured person's name) absence from work and the cause of this?*
- *Are you open to (insured person's name) returning to work? (on a graduated basis initially?)*
- *Have you arranged to have a discussion with (insured person's name) to discuss their employment situation?*

- Establish protocols and expectations that Claims Managers will have direct and regular communication with the Person on Claim at claim lodgement and proactively through the life of the claim. The assessor should try and build a relationship over the telephone with the Person on Claim. Regular (as appropriate) contact will also help the person feel secure and less anxious about what is happening and also reduce their need to seek updates. A single point of contact also means the Person on Claim does not have to keep explaining their history to different assessors. To ensure quality control, develop communication protocols for communication with the Person on Claim that describe:
  - the desired style of contact
  - critical milestone and turning points at which face to face or telephone contact should be made

Customer insight:

Customer feedback from people who have gone through the claim process has highlighted that the process feels easier when they can talk directly to the person managing their claim. Conversely no communication or multiple communication points leads to dissatisfaction.

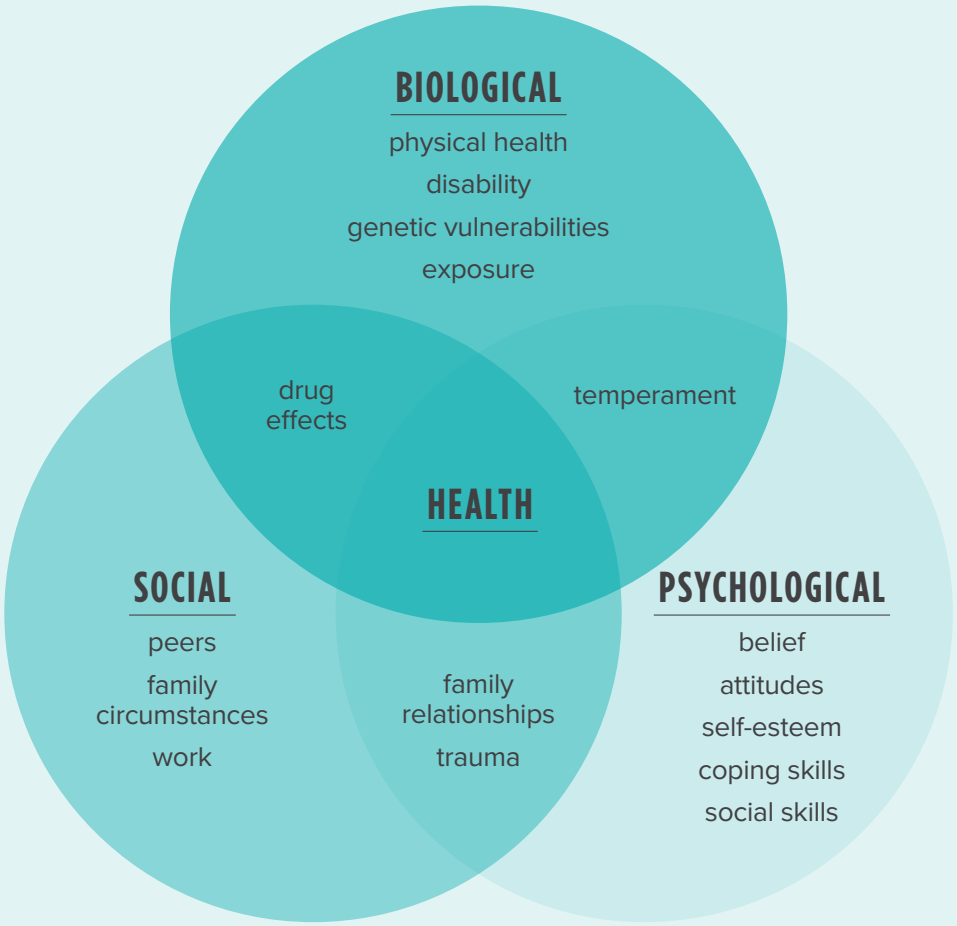
- Consider offering different methods of claim submission. To support the person making the claim some claims teams are capturing information face to face or over the phone and typing this onto the claim form and other teams are providing online claim forms to allow the information to be typed onto the form with attachment of uploaded documents for quick claim submission. Consider allowing the Person on Claim to communicate through a family member or support person if preferred by the Person on Claim
- Develop communication/correspondence to the Person on Claim that includes a description of the roles of the Insurer, Superannuation Fund, Employer and a third party administrator if relevant. This includes a clear description of the internal and external process for dispute management
- Ensure claim documentation and reporting forms for Persons on Claim are written in plain English, and that there is appropriate consideration of the needs of culturally and linguistically diverse groups. For example, support available to people from Non-English Speaking Backgrounds [NESB]
- Review the number of reports required of People on Claim with a view to removing reports not directly focused on positive outcomes: ability rather than disability, psychological wellbeing and RTW
- Develop protocols to optimise medical treatment and return to work support. For example, by using a clinical specialist to provide a medical review in a timely fashion. If a person has been disabled from work for more than 3 months with no clear recovery or return to work date, then in most cases it would be reasonable to believe the condition is serious enough to warrant referral to a Consultant Psychiatrist
- Empower People on Claim with RTW support. Often after a sustained period of time off work a strong feeling of detachment grows and sometimes people don't know how to return to work. They may have lost contact with their networks or employer and will perhaps have lost confidence in their ability to work. Where appropriate, the insurer can access rehabilitation providers to help the person return to work. Such services can support job seeking, or help align employer expectations and doctor opinions with the Person on Claim's expectations, and enable a more supportive and gradual return to work.

PRACTICE 3

TAILOR THE CLAIM MANAGEMENT ACTIVITIES TO THE PERSON'S INDIVIDUAL SITUATION

Current best practice claims management is based on a biopsychosocial model. The biopsychosocial approach starts from the premise that aside from biological influences, disability is also affected by social and environmental factors and by perceptions and beliefs. This approach takes an holistic view of disability and has an holistic focus on the treatment and management of psychological illness.

THE BIOPSYCHOSOCIAL MODEL



The biopsychosocial approach is used to help understand the Person on Claim and identify any barriers to required outcomes. It should guide the determination of appropriate support, including treatment and rehabilitation, which should be tailored to the Person on Claim.

Non-biological reasons for not working are many and varied. They can include:

- Beliefs about own age and ability to work or pass a job interview
- Resentment, blaming others and not seeking a positive outcome
- Job satisfaction, motivation, boring and repetitive work, being passed over for promotion
- Personality, low self-confidence
- Conflict in the workplace, harassment, bullying
- Family situation such as caring for children, caring for an unwell family member
- Having no job to return to and a poor local employment market
- Better financial security claiming insurance benefit than when working
- A preference to avoid work
- Travel difficulties
- Ongoing unsettled litigation or compensation claims
- Poor medical treatment and avoidance of receiving a psychological illness diagnosis
- Believing that a full recovery or total absence from pain needs to occur to allow a return to work
- Fear of re-injury and avoidance behaviour, believing that work is unhealthy or damaging.

The claim assessor should establish the root causes of the condition being experienced and the reason for the claim. Why has the condition stopped the person from working at this specific time? What was it that led to the decision to stop work at the point it happened and not earlier?

TARGET

Right support/intervention for the Person on Claim, and tailored to their individual needs.

KEY COMPONENTS

- Psychological claims are considered in an holistic way, based on the biopsychosocial model which recognises that disability cannot be understood by biomedical influences alone
- The Claims Manager takes an holistic approach to understanding all the barriers to RTW
- The Claims Manager takes an holistic approach to support recovery and wellness
- Claims processes recognise that recovery can vary significantly from person to person
- There is a focus on supporting access to appropriate treatment.

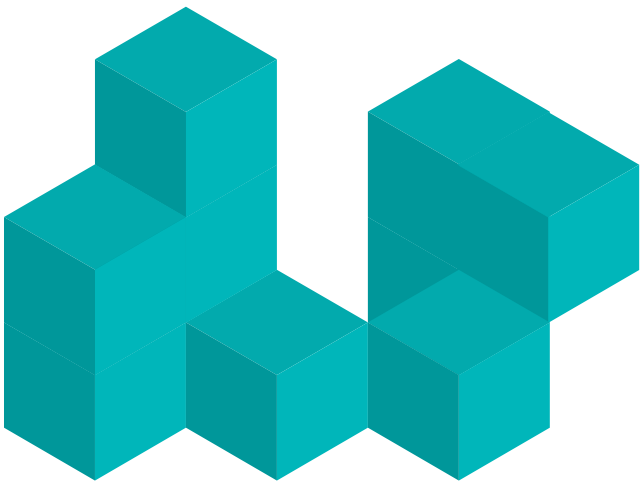
EXAMPLES OF RELEVANT ACTIONS

- Establish a systematic biopsychosocial approach to understanding the Person on Claim, their abilities and identifying any issues that might prevent recovery or RTW
- Apply analytics to assess likely escalation of physical ill-health claims into secondary psychological claims (see Action Area 4: Effective Decision-Making Supported by Analytics and Automation)
- Establish processes to ensure information is gathered from relevant stakeholders in a way that is tailored to the Person on Claim's unique situation. For example, if a person is an in-patient at hospital for the next three months, then the review action should involve gaining an update

at the end of this course of treatment without the need for monthly review forms in the meantime. Income Protection payments should be scheduled for monthly release in the meantime, without the need for additional documentation

- Develop reporting and advice protocols between Claims Managers and other specialist support units within the organisation that enable Claims Managers to obtain prompt access to expert health, legal or financial advice. Use case conferencing internally as well as externally
- Establish protocols that encourage the involvement of the Employer in RTW plans and intervention
- Ensure that the output of the biopsychosocial screening process is utilised as a basis for evidence-based intervention matched to the Person on Claim's needs (see Action Area 3: Bringing Evidence to Treatment and Rehabilitation)
- Ensure medical reports that claims teams request about the treatment and recovery of the Person on Claim take an holistic view of health.

Note: It is likely that a move from a biomedical model to a biopsychosocial model by an Insurer will mean changes to product design, actuarial analysis and provider management, as well as to claims management and staff training.



PRACTICE 4

COLLABORATION WITH STAKEHOLDERS

A broad range of influential stakeholders are involved in psychological claims, including Superannuation Funds, Employers, Claims Managers, Medical Practitioners and Rehabilitation Providers. Their influence is well researched. The evidence indicates that an employee's relationship with their employer/ manager is a key determinant of their satisfaction and engagement with work. Their satisfaction and engagement with work is, in turn, a key determinant of motivation to return to work. Similarly, we know that the recovery and return-to-work expectations of the Person on Claim are significantly influenced by the expectations of their medical and rehabilitation providers.

People who are confident they will find work or return to work are more likely to do so and the highest predictors of return to work success are 'intention to return to work' and 'job availability'. This means if a person isn't confident they will return to or find work then the likelihood of a return to work drastically reduces. If a Person on Claim is confident that they will return to work then there is a better chance that they will.

The assessor should be a RTW advocate. As RTW advocates, claims assessors need to understand the importance of breaking down barriers related to perception and stereotypes. This is where using telephone and face-to-face discussions with the treating General Practitioner, Person on Claim and Employer can be important. It should be confirmed that work is a healthy activity and returning to appropriate work should not cause psychological or physical risk to the Person on Claim or their co-workers. RTW should generally form part of the treatment plan from GPs, Consultants and Therapists.

To be a successful advocate, the assessor needs to ensure that all parties involved in the claim – including the Person on Claim – are aligned regarding recovery expectations and a RTW plan. Stakeholder management to achieve alignment to support the Person on Claim is a critical path activity throughout the life of a claim.
Key questions to consider include:

- Will the GP phone the Employer to discuss return to work?
- Will the Employer phone the GP to discuss return to work?
- Will someone else bring both parties together to support the patient's return to work?
- Should this be an occupational therapist, independent doctor, or is it the job of the assessor or rehabilitation adviser?

Treating doctors are an important stakeholder in managing claims. In many cases the GP will have been the Person on Claim's doctor for many years and built up a close and familiar relationship. They are an important influence. They should not be placed in the position of deciding whether a financial benefit is awarded or not, nor do they want to. Claims assessors can reasonably expect a treating doctor to provide information on:

- What is the diagnosis?
- What is the treatment? Is it evidence based?
- What is it that the Person on Claim can and can't do?
- What are their job duties?
- What is the employer attitude to RTW?

Decisions about disability and liability reside with the insurer.

Best practice claims management relies on good communication and proactive collaboration with and between key stakeholders, with the aim of providing consistent support for the Person on Claim. It also relies on the assessor understanding how the Person on Claim views their medical condition and how they view their occupation.

If the assessor does not understand how the Person on Claim feels about their manager and work environment then they are blind to one of the most relevant parts of the RTW assessment.

TARGET

Advocate and work towards return to work and align stakeholders.

KEY COMPONENTS

- RTW factors and confidence levels are understood
- Communication with and between stakeholders is facilitated
- Stakeholder expectations are aligned
- Productive stakeholder relationships are brokered to support the Person on Claim
- There is collaboration between all stakeholders with clearly defined areas of responsibility
- The Person on Claim has ownership of the outcomes of the claims process and there is a sense of joint obligation with the Insurer/ Superannuation Fund
- The Claims Manager is empowered by access to information, enabling them to be accountable for brokerage of stakeholder relationships to support the Person on Claim.

EXAMPLES OF RELEVANT ACTIONS

- Ensure the initial claim form design includes questions about any discussions on RTW that have already occurred with the employer
- Develop and maintain communication with the Person on Claim's employer to discuss SAW, RTW, modified/partial duties and absence management (e.g. keeping job available, see Action Area 7: Engaging with Employers in SAW and RTW)
- Develop reporting and advice protocols between Claims Managers and other specialist support units within the organisation that enable Claims Managers to obtain prompt access to expert health, legal or financial advice
- Develop guidelines for conducting case conferencing with all stakeholders, including face-to-face meetings, and involving care givers and support networks
- Establish communication lines directly between the Claims Manager and the external treating practitioner
- Ensure review forms required of treating practitioners have a focus on RTW and ability, rather than disability. Consider using the ***National Clinical Framework (2012)*** overview of best practice treatment for compensable clients (available on most compensation authority websites) in developing a health services quality mechanism. This has been developed to guide the delivery of best practice health services in the context of personal injury insurance
- Ensure all documentation required to be completed by stakeholders is user-friendly and fit for purpose, to help cultivate productive relationships
- Develop guidelines for referral for external parties ensuring referral documentation contains relevant information (e.g. risks identified) and asks for relevant information that will inform the claim or rehabilitation intervention.

PRACTICE 5

OUTCOME FOCUSED DECISION-MAKING

The Australian and international evidence indicates that the claims management process is dominated by a focus on process, at the expense of a focus on outcomes. Decision-making has therefore been more driven by process milestones (for example, turnaround times, eligibility, monthly forms and so forth), rather than by goals related to the Person on Claim (for example, recovery, return to work, wellness support). Given the dynamic and individual nature of recovery, outcomes need to be monitored, goals need to be reviewed and plans need to be revised. For the claims management process to support outcome-focused decision-making, it needs to be dynamic, informed and proactive.

Some claims team have adopted control reports which provide insight into which claims have travelled beyond the expected return to work date or other measured claim factors. This allows Claim Managers to be aware of the claims that aren't travelling as expected, or claim outcome focussed activities that were expected to be completed by the assessor that have not yet been undertaken. It is expected that in the future tracking progress against norms and reporting variation will be automated (see Action Area 4: Effective decision making supported by analytics and automation).

Return to work as an outcome, and points along the trajectory of the claim to achieving it, should feature prominently in planning and discussions with all stakeholders from the outset. A significant body of research indicates that employment is good for mental health and wellbeing and that lack of work is detrimental to health. The health benefits of good work include:

- Community and social inclusion
- Feelings of self-worth arising from contribution to society and family
- A way to structure time productively
- Financial security
- Physical activity.

Conversely, the effects of long-term worklessness include:

- Loss of self-esteem
- Reduced role in the community and reduced social participation
- Relationship strain with family and friends
- Increasing exclusion from employment opportunities
- Increased psychological and physical ill health
- Increased health-risk behaviours, for example weight gain and alcohol use.

Staying at work, or returning to work as soon as possible, is good for health and wellbeing – whether it is on reduced hours in the usual job, or on modified or alternative duties. There are two important areas to consider in decisions about the return to work, however: the abilities of the Person on Claim, and the appropriateness and quality of the work they are returning to. The key point is to include a strong focus on return to good work as an outcome throughout disability assessment, planning and management, with discussions

about return to work with the Person on Claim and all relevant stakeholders.

It can be expected that if customer outcomes improve, improvement in outcomes for the Insurer, Superannuation Fund and Employer will follow. This is not just win:win, it is win:win:win:win.

TARGET

The claims and rehabilitation strategy is focused on Customer-centred outcomes, is established early, and is regularly reviewed.

KEY COMPONENTS

- A focus on outcomes drives the claims management process from the outset
- The rehabilitation and claims management strategy recognises that progress towards outcomes is dynamic
- Outcomes-focused strategies are established early
- Progress, or lack of it, with the claim management direction is tracked and reviewed/updated regularly.

EXAMPLES OF RELEVANT ACTIONS

Establish a review and evaluation cycle that is based on events and timeframes along the claim pathway. Ensure it has clearly defined processes for internal escalation and review, and it includes mechanisms to evaluate claim and rehabilitation interventions to ensure they remain appropriate (see Action Area 4: Effective Decision-making Supported by Analytics and Automation).

- Develop claim form to focus more on what the person can do, including RTW, and not just what the person cannot do
- Limit the role of GPs to providing information on:
  - Diagnosis
  - Symptoms as described by the patient
  - Dates of consultation
  - What was discussed at the consultations relevant to the claim
  - Treatment history and response to treatment
  - Planned treatment
  - Whether RTW has been discussed with the patient and what they said.

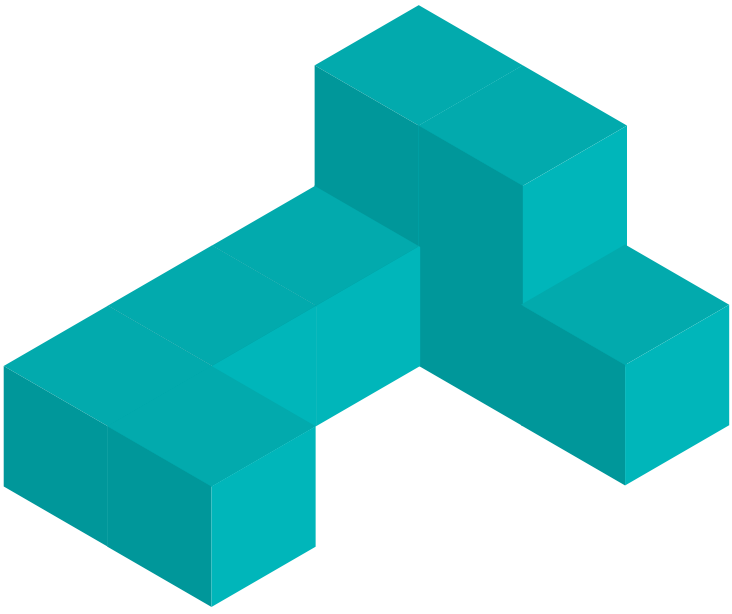
Analytics can support person-centred, outcome focused decision making

Analysis of claims experience for particular claim types can establish the percentage of claim acceptance for each claim type and the reasons why claims were not accepted. By analysing claims experience in this way the team can identify which claims typically would and would not be accepted on the basis of experience. Claims that experience indicates would be paid can then be paid sooner rather than later.

- Enable the claim to be paid quickly, at least for a limited period. The goal of this strategy is to take the issue of how disabled the person claiming benefit is 'off the table'. Achieving the strategy may vary:
  - One approach may be to consider including in claim conditions a provisional acceptance of mental health claims to expedite early intervention, treatment and rehabilitation (see Framework Action Area 6: Transforming Product Design)
  - Alternatively, a 'provisional acceptance' approach may be applied on a claim by claim basis, where all parties agree that a particular claim can be accepted for a defined period of time, based on agreed decision-making criteria. Examples include where disability can be accepted for a period of time but further information is needed to confirm disability after that period

  - Another example may be one where the quantum of monthly benefit can be reasonably approximated. In such cases all parties agree to insurance payment for a set period at an agreed amount during which time the appropriate financial evidence is obtained, with adjustment for underpayment or overpayment after the recalculation

- Ensure that expected outcomes are documented and defined for Claims Managers and other internal staff. These criteria should be linked to Claims Manager accountability and responsibility (see Framework Action Area 4: Effective Decision-making Supported by Analytics and Automation)
- Establish the expectation and protocols to support each Person on Claim having a documented claim and rehabilitation strategy with agreed outcomes
- Require RTW plans and strategies to have agreed goals, agreed review points, expected timeframes for RTW and address any identified barriers
- Ensure that the effectiveness of a claims or rehabilitation intervention is regularly assessed and progress towards goals recorded and communicated to the Person on Claim
- Establish an outcomes-based performance management system for claims team key external providers. This will help evaluate their strengths and weaknesses and facilitate feedback to improve quality and results (see Framework Action Area 3: Bringing Evidence to Treatment and Rehabilitation)
- Establish an outcomes-based provider management framework for rehabilitation providers. Such providers will usually have the skills to challenge long held negative beliefs, perceptions or attitudes that the Person on Claim has with a view to changing them into positive beliefs and actions (see Framework Action Area 3: Bringing Evidence to Treatment and Rehabilitation).



MEASUREMENT

OUTCOMES ARE MULTIDIMENSIONAL AND OCCUR IN AT LEAST FOUR OUTCOME SPACES:

- *Person on Claim/Member outcomes (e.g. health and social outcomes, RTW)*
- *Insurer outcomes (e.g. improved claims KPIs; cost-effectiveness of interventions and RTW programs)*
- *Superannuation Fund outcomes (premiums)*
- *Employer outcomes (e.g. worker productivity, workplace adjustment costs).*

Improvements in Customer outcomes are likely to be followed by improvements in outcomes for Insurers, Superannuation Funds and Employers.

The **TAKING ACTION** Framework proposes a continuous improvement approach to implementing best practice in psychological claims management (see Action Area 8: Recording Progress).

INSURER OUTCOMES

Outcomes directly related to claims will continue to be important and will need to be continually assessed. However performance measurement for claims management teams should take a balanced score-card approach and include:

- communication and relationships
- assessment and risk identification
- planning for RTW
- implementation of services
- monitoring and review
- dispute resolution.

Other outcomes for the Insurer may include:

- Reduction in the number of days between lodgement and eligibility decision
- Proportion with RTW eligibility requiring support that agree to participate in RTW rehabilitation
- Number with an appropriate RTW/ Rehabilitation plan in place
- Proportion with sustainable recovery/RTW
- Reduced average claims duration
- Disputation level
- Number of GP/Employer case conferences.

CUSTOMER OUTCOMES

- Customer satisfaction improved
- RTW work outcomes improved
- Customer perception of communication: proactive, timely, responsive, collaborative.

WHAT NEXT?

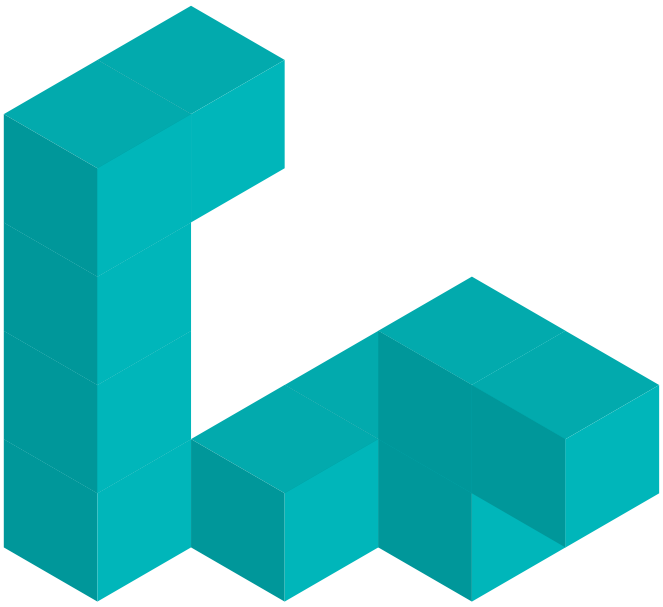
There is significant scope to improve the management of psychological claims in Australia, drawing on national and international research evidence and case studies of innovation. Some of the lessons learned apply specifically to providing support to people with psychological illness, but most relate to all claims. Their implementation should see a reduction in the occurrence of psychological complications in People on Claim for chronic physical injury and illness, as occurs so frequently now.

Best practice requires a rethink in claims management practices, with a clearer focus on outcomes. Current practice is dominated by process, with process becoming an end in itself.

The focus of this Action Area guide was Developing the Management Practices for Psychological Claims. Five practices were addressed:

- Early Intervention, with a focus on SAW or RTW, providing work is appropriate
- Logical and clear processes that are Customer-centric
- Support provided that is tailored to the reality of Person on Claim's individual situation (not just their diagnosis), is evidence-based, and appears to be moving the Person on Claim towards agreed outcomes
- Collaboration with stakeholders to ensure agreement on desired outcomes and alignment of effort, including the Person on Claim and their family, the Employer, the treating doctor and the Superannuation Fund
- Outcome measurement – expected outcomes are defined and adjusted based on experience, outcomes are measured, Claims Managers and external providers are held accountable for outcomes.

With the support of the **TAKING ACTION** Framework and the Action Area Guides being developed, Insurers and other stakeholders are encouraged to take a continuous improvement approach to adopting best practice in the management of psychological claims. The first letter in each of the eight Action Area titles spell out DO BETTER. We believe all organisations can DO BETTER by identifying some priority areas, measuring baseline performance, making changes, measuring performance again, and adjusting action as necessary.



APPENDIX 1: A GUIDE TO THE INITIAL TELEPHONE CONTACT

A typical initial tele-interview will focus on establishing a timeline of events and a timeline of the person's functional ability and beliefs. The call should be prepared for in advance and the assessor should think through the possible replies to the questions asked and then the ongoing line of questioning.

At the start of the call the assessor should explain that the initial call can be quite long, as it helps gain a full picture of what has happened. Questions for an income protection phone assessment can include:

Medical, functional and occupational situation

Focus on Capacity and Function

- What does your doctor/specialist say about your illness? (and future treatment) What do they say about you maintaining/ returning to work?
- Tell me about your job, what were your regular daily duties? What were the duties you found most stressful/challenging? What duties do you find you are most confident/comfortable with?
- Talk me through what a typical day and week looks like for you at the moment (get a detailed breakdown of what the person can and cannot do – focusing on the 'can do' as much as possible: waking & sleeping time, eating habits, cooking, cleaning, driving, time in and out of house, shopping, seeing friends or family, activities)?

Motivation

- What are your thoughts about returning to work?
- Your specialist has indicated you should be able to return to work around...how do you feel about this?
- Can you see yourself returning to work? When? How/who with?
- What would help you return to work?
- Is your job available for you to return to?

Stakeholder alignment

- What has your employer (and doctor) said about you returning to work?

Financial (Income Protection cover)

- We've calculated your earnings prior to illness as xxx. Does this sound correct?
- How have you managed financially during your time off work?
- Do you have any other insurance that you might claim on?

- Have you made a workers compensation or CTP claim?
- Do you have any other income that you haven't mentioned?

Barriers to returning to work

- What non-medical support have you had since your disability? (from family, friends, and work?)
- Are there any work-related factors that you feel may impact on your psychological condition?
- Is there anything that we haven't already talked about that is causing you difficulty at the moment or that may make a return to work difficult for you?

The claim assessor can help understand the Person on Claim's thoughts about returning to work by asking the following questions:

- Did you enjoy your work? What about it did you like/dislike?
- What aspects of your work do you find cause you greater stress?
- Was your workplace healthy? Tell me what it is about your workplace that means they are healthy/unhealthy?
- What was/is your manager like?
- Does your workplace support your return to work?
- Have you discussed return to work with your employer?
- Are there any work supports available to you to assist you with returning to work?

CONCLUDE THE CALL BY

Highlighting what will happen next, set expectations and get buy in from the Person on Claim, helping to gather additional information where needed. Summarise information succinctly so that it is not overwhelming for the Person on Claim. Be clear about any steps the Person on Claim may need to take in order to further process the claim.

Explaining what will happen when there's a return to work and how any partial income protection benefit payments work. Check for the Person on Claim's understanding by asking them to state back their understanding of next steps. If memory deficiency may be a problem indicate that you will provide the information in writing.

TONE OF VOICE

It is important to make sure the Person on Claim does not feel like they are being interrogated. One way to do this is to use a warm and friendly tone of voice and ask open questions to encourage discussion. Paraphrasing what the Person on Claim is saying also helps them feel heard. Use appropriate empathy to help develop rapport. Rephrase questions to avoid asking 'why', as this can create a greater sense of interrogation and judgement.

FURTHER DO'S AND DON'TS

Actively listen – After asking an open questions (which invites the person to talk), just listen to the Person on Claim so that you fully take on the information they are providing you. Demonstrate that you are listening by displaying minimal encouragers ("mmm hmm", "yes", "uh huh" – i.e. verbal nods), paraphrasing and reflecting.

Demonstrate empathy – Indicate to the Person on Claim that you understand what they are experiencing without saying that you understand. Identify the emotion that they are demonstrating and reflect this back to them.

Clarify information – If what the Person on Claim has just advised you is unclear, ask questions to clarify. Use open questions to probe for further information. Ask specific questions to clarify certain points – "When you say xyz... I understand you to mean... Is that what you mean?"

Recognise and accept differences – Each claim will likely be different, as is different people's ability to cope and capacity to deal with various hardship. This is particularly the case for psychological claims, where the same diagnosis can manifest in very different ways from

individual to individual. Likewise, each of us has different ways of organising ourselves, relating to others, gathering and using information and making decisions. Be mindful and accepting of these differences.

Defer judgement – Avoid interrupting and allow the Person on Claim to finish what they are saying. Avoid interrupting with counter-arguments. State your response only after you have listened.

Summarise to close – Keep summaries succinct and simple. The initial call can involve a lot of information and can be overwhelming for People on Claim. Offer to write information down, check for their understanding, and make any next steps very clear.

DISCLAIMER

*The **TAKING ACTION** Framework and Action Area Guides:*

- *Should be considered as a guide to best practice and recognises that there may be exceptions to the best practices noted. For that reason it should only be used as a guide and there may be reasons why the application of a point of best practice may not be appropriate to follow for a particular situation or organisation*
- *May be amended from time to time based on interpretation of legislation and best practice*
- *Does not take precedence over the terms of a Life Insurance policy or contract and does not create legal rights.*

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