CLINICAL FRAMEWORK
for the delivery of physiotherapy services to injured workers
The information presented in the Clinical Framework for the Delivery of Physiotherapy Services to Injured Workers is intended for general use only. It should not be viewed as a definitive guide to the law, and should be read in conjunction with the Accident Compensation Act 1985.

Whilst every effort has been made to ensure the accuracy and completeness of this Framework, the advice contained herein may not apply in every circumstance. Accordingly, the Victorian WorkCover Authority cannot be held responsible, and extends no warranties as to:

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This publication is current as at 1 January, 2004 and replaces and supersedes all previous versions of this publication.
I have great pleasure in presenting the Victorian WorkCover Authority’s (VWA) Clinical Framework for the Delivery of Physiotherapy Services to Injured Workers.

The Clinical Framework outlines a set of guiding principles and was developed as an acknowledgement of the absence of a consistent policy framework for the provision of physiotherapy to injured workers. This has created uncertainty for all stakeholders and contributed to poor outcomes for injured workers receiving physiotherapy and the WorkCover scheme.

The development of the Clinical Framework is also a testament to the physiotherapy industry and their leadership within the broad allied health sector. The VWA commends the profession’s willingness to grasp, develop and support such principles that will lead to better health and return to work outcomes for injured workers.

The Clinical Framework reflects the most contemporary approach to the physiotherapy treatment of injured workers and also reflects the VWA’s commitment and support for the Australian Physiotherapy Association’s Position Statement on Clinical Justification & Outcome Measures (2003).

Real success with the introduction of the Clinical Framework will be measured by increased return to work outcomes for injured workers and hence greater benefits for the Victorian community. The physiotherapy profession will also benefit as the framework becomes a platform to promote the continuing quality of services provided to injured workers.

I would like to acknowledge the following individuals and groups who have contributed to the development of the framework:

Paul Coburn, B AppSci [physio], B.Sci [HMS], Clinical Leader, VWA Physiotherapy Advisory Panel
Megan Davidson, PhD, Cert Accup, B AppSci [physio]
Kay Crossley, PhD, Post Grad Dip Physio [research], B AppSci [physio]
VWA Physiotherapy Advisory Panel
Australian Physiotherapy Association Victorian Branch
VWA Agents
Staff of the VWA

I commend the Clinical Framework to you and look forward to working with the physiotherapy profession as we put the principles of the framework into action.

Greg Tweedly
Chief Executive
Victorian WorkCover Authority
Our vision
Workplaces free from injury and disease

Our mission
To work with all Victorians to progressively reduce the incidence, severity and cost to the community of work related injury and disease.

Purpose
The Clinical Framework has been established to:

1. Optimise return to work outcomes
2. Inform physiotherapists of the VWA’s expectations for the management of injured workers
3. Provide a set of guiding principles for the provision of physiotherapy services for workers, physiotherapists, other health professionals and VWA agents
4. Assist in the resolution of disputes.

Aims & Principles
The Clinical Framework aims to optimise the injured worker’s safe and prompt return to work.

Underpinning this aim is a set of principles for the provision of physiotherapy services to injured workers:

1. Measurable treatment effectiveness must be demonstrated
2. A biopsychosocial approach is essential for the management of pain
3. Treatment must focus on empowering the worker to manage their injury
4. Treatment goals must be functional and focused on return to work
5. Treatment must be based on the best evidence available.

Application
This document applies solely to the provision of physiotherapy services to workers within the Victorian Workers’ Compensation Scheme under the Accident Compensation Act 1985.

The Victorian WorkCover Authority (VWA) will work in partnership with all physiotherapists within the Victorian Workers’ Compensation Scheme to promote and apply the principles of the Clinical Framework in the delivery of physiotherapy services to injured workers.
Key messages

1. Treatment effectiveness must be demonstrated using outcome measures
2. When available, use outcome measures that are:
   a. Reliable, valid and sensitive to change
   b. Related to the functional goals of therapy
   c. Based on impairment, activity and participation domains
   d. Relevant to the worker’s injury

Measurement of treatment effectiveness (or outcome) provides workers, physiotherapists, the VWA and its Agents with information on the rate (and direction) of change. For example, is the worker’s function improving, worsening or not changing? This information assists all parties to justify their decisions to continue or change the treatment plan, cease treatment or refer the worker to another health professional.

What to measure

Treatment effectiveness should be measured with one or more standardised outcome measurement tools that are reliable, valid and sensitive to change. At times, physiotherapists may use customized outcome measures in situations where standardised measures are not available.

Outcome measures must be related to the functional goals of therapy and cover the World Health Organisation (WHO) International Classification of Functioning (ICF) domains of impairments, activities and participation [see Table 1]. Impairment based outcome measures (such as range of motion) may be used to track changes within a treatment session and assist in a physiotherapist’s clinical reasoning process. However, since they do not reflect the injured worker’s activity limitations or participation restrictions, impairment measures should not be used in isolation.
### TABLE 1: WHO ICF DOMAINS WITH EXAMPLES OF OUTCOME MEASUREMENT TOOLS

<table>
<thead>
<tr>
<th>FUNCTIONING AND DISABILITY</th>
<th>EXAMPLES OF OUTCOME MEASUREMENT TOOLS</th>
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<tbody>
<tr>
<td>Impairments (problems in body function or structure)</td>
<td>Range of motion (e.g., goniometer); muscle strength (e.g., dynamometer, manual muscle test); pain (e.g., 0-10 numerical rating scale, 10cm visual analogue scale, McGill Pain Questionnaire)</td>
</tr>
<tr>
<td>Activity Limitations (difficulties an individual may have in executing activities) and Participation Restrictions (problems an individual may experience in involvement in life situations)</td>
<td>The Patient-Specific Functional Scale, Oswestry Disability Questionnaire (for low back pain), Neck Disability Index, Lower Extremity Functional Scale, Upper Extremity Functional Index, SF-36 Health Survey (a generic health status questionnaire)</td>
</tr>
</tbody>
</table>

When to measure

Outcome measurements need to be taken regularly to measure the rate and direction of change in the worker’s status. Baseline measurements should be taken prior to commencing treatment, or as early as possible. Re-testing should occur as soon as change could be expected given the worker’s injury and the type of treatment provided (e.g., one week for acute injuries or several weeks for chronic pain). Regular use of outcome measures provides ongoing information about the worker’s status and the effectiveness of the treatment modalities used.

Further information about outcome measurement tools is available on the Chartered Society of Physiotherapists outcome measures database (www.csp.org.uk/).
Key messages

1. Physiotherapists must consider the psychosocial factors that influence the worker's experience of pain.
2. Acute injuries require treatment to minimise pain and enhance tissue healing while promoting early return to work and function.
3. Treatment for chronic pain must be based on a cognitive behavioural approach, focus on return to work and function, address underlying physical impairments and promote selfmanagement.

From the outset of management, the physiotherapist must consider the psychosocial factors that can influence the worker’s experience of pain.

Acute Pain

After an acute injury, physiotherapy treatment focuses on minimising acute pain, enhancing tissue healing and promoting early return to work and normal functional activities.

Chronic Pain

Chronic pain is pain that has persisted for longer than three months. After this time, pain and disability may persist due to the complex relationship between physical and psychosocial factors. Psychosocial factors (such as personality, psychological health, emotions, beliefs, feelings, education, past experiences and present environment) result in a set of cognitions and behaviours that affect the worker’s pain experience. Therefore, while pain may still be the worker’s dominant symptom, it may not be appropriate to continue with treatment options aimed solely at pain relief (e.g., electrotherapy or manual techniques). Physiotherapists need to consider all of the contributing factors when making treatment choices and the effectiveness of treatment options must be regularly assessed [as outlined in Principle One]. Treatment for chronic pain must include:

1. Adopting a cognitive-behavioural approach, which incorporates education, positive reinforcement, pacing and clear collaborative goal setting.
2. Addressing physical impairments that may contribute to the recalcitrant nature of the worker’s pain such as abnormal muscle activity, restricted joint and soft tissue mobility, reduced neuro-motor control and systematic deconditioning.
3. Strategies to improve the ability of the worker to return to work and normal functional activities.
4. Promoting self management (such as ongoing exercise programs).
PRINCIPLE TWO:
A BIOPSYCHOSOCIAL APPROACH IS ESSENTIAL FOR THE MANAGEMENT OF PAIN

It may also be appropriate to make recommendations to the worker’s general practitioner with regards to the referral of a worker to another health professional (such as a psychologist or psychiatrist), pain management clinic, alternative physiotherapy clinic or multidisciplinary team (such as those in the VWA Sprains & Strains Care Model).

Flare Ups
Flare-ups of pain are inevitable with chronic pain and may occur at the same time as increased activity or stress. Physiotherapists need to educate workers to expect flare-ups of pain and provide them with strategies to manage these episodes while continuing their active rehabilitation. Flare-ups settle within a few days to a few weeks but exercise prescription, pacing and goal setting reviews are useful if the flare up persists.
Key messages

1. Information assists the worker to understand their injury and its management, make choices, overcome unhelpful beliefs and modify behaviour
2. Assisting the worker to take control of their pain requires the use of active strategies such as:
   a. Active rehabilitation focusing on functional activities
   b. Avoidance of regular, passive treatment techniques without evidence of ongoing effectiveness
   c. Educating the worker about their rehabilitation

Empowering the worker to be actively involved in their treatment is an important component of effective rehabilitation. This may be achieved through education and strategies to assist the worker to take control of their injury or pain.

Education

Knowledge is integral to promote empowerment, and the physiotherapist should inform the worker about:

a. their expected role in recovery
b. their injury, the expected recovery pathway, treatment goals (short and long-term) and time frames to achieve their treatment goals (as outlined in Principle Four)
c. the impact of failed treatments (where appropriate) and proposed changes that may lead to a successful outcome for the current intervention.

Control

The worker needs to be assisted to take control of their treatment. In order to do this, the physiotherapist needs to be aware of the variety of coping strategies that the worker may be using to cope with their pain. Broadly speaking, individuals may primarily use: (i) active strategies, where they take some responsibility for their pain management; or (ii) passive strategies, which involves withdrawal or passing on of the responsibility for the control of pain to someone else. Passive coping strategies can be highly predictive of chronic disability and pain. If an individual primarily uses passive coping strategies or if the treatment ceases to be effective, then passive, “hands-on” treatments (such as manipulation, mobilisation and massage) must be avoided. These passive strategies promote dependency and result in the worker perceiving that the physiotherapist is in control and responsible for the ongoing management of their injury.
If required, the physiotherapist must assist the individual to use active strategies to control their pain, or to function despite pain. The worker needs to be given confidence to be the key person in the rehabilitation process, to question and drive their management. An active rehabilitation, which integrates clinic-based treatment into functional activities of work and daily living, activity-related goal setting and pacing will assist the worker to manage their pain. In addition, the physiotherapist can promote independence through using a variety of service and delivery modes and by avoiding regular appointment times or drop-in sessions.

**PRINCIPLE THREE:**
TREATMENT MUST FOCUS ON EMPOWERING THE WORKER TO MANAGE THEIR INJURY
TREATMENT GOALS MUST BE FUNCTIONAL AND FOCUSED ON RETURN TO WORK

Key messages
1. Physiotherapy goals must relate to function and return to work
2. SMART therapy goals should be negotiated with the worker
3. Goals must be assessed regularly and a record kept of goal achievement
4. New goals should be formulated as early goals are met or revised

Physiotherapy treatment goals focusing on return to work and function need to be developed in collaboration with the worker. Goals need to be Specific, Measurable, Achievable, Relevant and Timed (SMART).

<table>
<thead>
<tr>
<th>S</th>
<th>SPECIFIC</th>
<th>Names the particular variable of interest [“distance able to walk”, “hours at work on modified duties”, “difficulty driving”]</th>
</tr>
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<tbody>
<tr>
<td>M</td>
<td>MEASURABLE</td>
<td>Has a measurement unit (metres, hours, 0-10 scale)</td>
</tr>
<tr>
<td>A</td>
<td>ACHIEVABLE</td>
<td>Likely to be achieved given the diagnosis and prognosis for the worker’s injury, and environmental constraints</td>
</tr>
<tr>
<td>R</td>
<td>RELEVANT</td>
<td>Relevant / important to worker</td>
</tr>
<tr>
<td>T</td>
<td>TIMED</td>
<td>States timeframe within which the goal is expected to be achieved</td>
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New treatment goals are set as the worker progresses, circumstances change or barriers to return to work are identified.
**PRINCIPLE FOUR:**
TREATMENT GOALS MUST BE FUNCTIONAL AND FOCUSED ON RETURN TO WORK

<table>
<thead>
<tr>
<th>POORLY-CONSTRUCTED TREATMENT GOALS:</th>
<th>SMART GOALS:</th>
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<tbody>
<tr>
<td>To increase sitting endurance</td>
<td>To increase sitting endurance at the desk from 5 to 15 minutes within one week</td>
</tr>
<tr>
<td>To improve driving</td>
<td>To decrease difficulty driving from 8/10 to 5/10 within two weeks (i.e. patient-specific functional scale)</td>
</tr>
<tr>
<td>To increase function</td>
<td>To return to modified work duties for 3-hrs per day within three weeks</td>
</tr>
</tbody>
</table>

**Should all goals be functional?**

In some cases, goals based on impairments may be appropriate. For example in an acute injury, pain reduction may be an appropriate treatment goal.
Key messages

1. Physiotherapists must use the best evidence available to inform their treatment

2. Systematic Reviews, Clinical Practice Guidelines and critically appraised papers/topics provide the most comprehensive information on best research evidence

Physiotherapy treatment must be based on the best evidence available. Evidence Based Practice allows physiotherapists to optimise a worker’s functional and return to work outcomes by:

1. Offering treatment that has the best chance of success, and
2. Avoiding treatment that has the least chance of success.

As with all Evidence Based Practitioners, physiotherapists need to integrate the "best research evidence with clinical expertise and patient values" (Sackett et al, 2000).

Where is the best evidence available?

The most accessible source of research evidence is “pre-appraised” evidence such as systematic reviews, clinical practice guidelines and critically appraised papers and topics. Examples of “pre-appraised” evidence include:

1. The Cochrane Library [http://www.update-software.com/cochrane/] [click on “log on”, then “log on anonymously”]. This is a free site that includes systematic reviews of research evidence.


4. The Australian Journal of Physiotherapy regularly presents critically appraised papers that evaluate high quality research reports.
Any feedback on the content and/or application of the Clinical Framework can be sent to the Allied Health Branch of the Victorian WorkCover Authority or email physiotherapist@workcover.vic.gov.au