Rehabilitation Research Review™

Making Education Easy

Issue 44 – 2018

In this issue:

Abbreviations used in this issue
ACC = Accident Compensation Corporation
RTW = return-to-work
SCI = spinal cord injury
TBI = traumatic brain injury

Rehabilitation Counsellors are tertiary qualified allied health professionals who work with individuals with disability, injury or social disadvantage, along with their families, organisations and other health professionals, to deliver work, life and career solutions. The core skills and expertise of Rehabilitation Counsellors include: vocational assessment, job placement support, and career development; rehabilitation and return-to-work services; workplace disability prevention and management.

Welcome to issue 44 of Rehabilitation Research Review.

In this issue, commentary covers two broad topics. The first is a range of papers exploring return-to-work processes across a range of populations, including a large population-based study exploring patterns and predictors of return to work following major trauma. The second focuses on topics relevant to leadership, structures and processes in rehabilitation, including one paper providing guidance on leadership and governance of health-related rehabilitation services. The last paper in this issue is a message from the World Health Organisation emphasising that rehabilitation is part of universal health coverage and should be incorporated into the package of essential services, along with prevention, promotion, treatment and palliation.

I hope that you find the research in this issue useful in your practice and I welcome your comments and feedback.

Kind regards,

Associate Professor Nicola Kayes
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Perceptions of breast cancer survivors on the supporting practices of their supervisors in the return-to-work process: A qualitative descriptive study

Authors: Caron M et al.

Summary: This Canadian investigation explored the perceptions of breast cancer survivors on the practices put in place by their supervisors to support them during their RTW process. Ten breast cancer survivors who had returned to work after treatment and were still at work more than 18 months later participated in semi-structured interviews, which were audio recorded and transcribed for qualitative thematic content analysis using a semi-open codification framework. Participants identified three main practices put in place by their supervisors that they perceived as particularly helpful during the RTW process. The first was maintaining communication during their period of absence. The second was working with them to structure the RTW process before the actual return. The third was allowing the women flexibility in the work schedule for a certain period, particularly at the beginning of the RTW process. The women also identified an omission in practice that could be perceived as a barrier: the lack of follow-up from supervisors over time.

Comment: In NZ, we have a world-class system in ACC. Of course, any system that has the size and complexity of ACC has its strengths and limitations. Nonetheless, as a general rule, ACC means that NZers who experience traumatic injury benefit from access to early, targeted and coordinated vocational rehabilitation. The same is not true for those who experience non-traumatic illness in NZ. Vocational rehabilitation services for them are far more limited (if they exist at all). This is despite there being many illnesses such as multiple sclerosis, stroke, and cancer (the focus of this study), which impact work ability for working age adults living with their consequences. As such, successful reengagement with work relies heavily on having good organisational structures to support RTW and having committed individuals within those organisations to provide the necessary support. In this study, the focus is on supervisor support practices for breast cancer survivors. The findings offer useful insight into what the survivors found useful for supporting their RTW (such as ongoing communication during work absence, proactive planning for RTW, and flexibility in work schedule) as well as what was missing (such as recognition of the enduring process of RTW and therefore the need for active follow-up beyond the early transition processes). These findings are potentially applicable across a wider range of settings and contexts and resonate with existing evidence for effective RTW practices in the broader vocational rehabilitation field.

Reference: J Occup Rehabil. 2018;28(1):89-96

Abstract

Are wait lists inevitable in subacute ambulatory and community health services? A qualitative analysis

Authors: Harding KE et al.

Summary: This qualitative study involved 26 managers and team leaders of ambulatory and community-based health services from a large metropolitan health service, in Victoria, Australia, about their perceptions of factors that contribute to wait times for their services. Coding of the interviews revealed four major themes. Three themes related to reasons and factors contributing to increased wait time for services (inefficiencies in intake and scheduling processes; service disruptions due to human resource issues; and a high demand for services). A fourth theme was the acceptance of wait list time among services; meeting key performance indicators (KPIs) were often seen as sufficient.

Comment: While this research was undertaken in Australia, we have the same wait list issues in NZ. It is not uncommon for people to have a lengthy wait for community-based rehabilitation services post-discharge from inpatient rehabilitation. Patients frequently report feeling abandoned, and the gap in service provision contributes to a loss of gains made in the inpatient setting. The strength of this current study is the active exploration into the perceived source(s) of the problem from the perspectives of clinicians working in the system, leading to the identification of some potentially modifiable organisational level factors that could be the target of quality improvement initiatives. I did find one of the findings particularly interesting though – that is, that there was a general acceptance of current waiting times (so long as they met KPIs and/or were comparable to other similar services)! This appeared to result in a lack of impetus to question the status quo. There are of course any number of reasons why people respond in this way. Indeed, it may be a reflection of a perceived powerlessness to initiate change. However, if we were all just happy to maintain status quo – because everyone else is doing the same, or because it 'is just the way we do it' (something I hear often) and good enough is good enough – then we would never advance. I would argue that these are the very things we ought to be actively and explicitly attending to and advocating for their change.

Reference: Aust Health Rev. 2018;42(1):93-9
Abstract

Independent commentary by Associate Professor Nicola Kayes

Associate Professor Nicola Kayes is Director of the Centre for Person Centred Research at Auckland University of Technology. **For full bio CLICK HERE**

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Promoting good policy for leadership and governance of health related rehabilitation: a realist synthesis

Authors: McVeigh J et al.

Summary: These researchers sought to formulate guidance on principles of policy for leadership and governance of health-related rehabilitation services, so that these policies and services will fit the requirements of any given context according to its structure, systems and resources. The researchers were particularly interested in less resourced settings. The researchers undertook a systematic search and realist synthesis of literature. A Delphi survey involving 18 expert stakeholders refined and triangulated findings from the realist synthesis. Several broad principles emerged throughout formulation of recommendations: participation of persons with disabilities in policy processes to improve programme responsiveness, efficiency, effectiveness, and sustainability, and to strengthen service-user self-determination and satisfaction; collection of disaggregated disability statistics to support political momentum, decision-making of policymakers, evaluation, accountability, and equitable allocation of resources; explicit promotion in policies of access to services for all subgroups of persons with disabilities and service-users to support equitable and accessible services; robust inter-sectoral coordination to cultivate coherent mandates across governmental departments regarding service provision; and 'institutionalising' programmes by aligning them with pre-existing Ministerial models of healthcare to support programme sustainability.

Comment: This is a really interesting read – both for those of you working in rehabilitation leadership and governance roles and for rehabilitation researchers who need convincing of the potential role that realist methodologies have to play in advancing knowledge in rehabilitation. While the focus of this paper is on synthesising evidence regarding good policy-related leadership and governance in less resourced settings, I would argue the findings are relevant in a diversity of settings and contexts. The key take home messages are important – for example, arguing (amongst other things) for involving service users in policy processes, provision of robust data, and inter-sectoral coordination. We might want to consider to what extent we currently actively manage these things to optimise our impact on policy. While some of these things feel outside of our control at the coalface, there are things we can contribute. For example, the authors argue that robust data can "instigate political momentum". This is worth thinking about the next time we are wondering about the value of outcomes data collection in practice. We might consider: To what extent do we want to contribute to raising awareness regarding the impact of rehabilitation with policymakers in NZ? And: How might we capitalise on our existing data collection processes to optimise our impact on policy and practice in our field?

Reference: Global Health. 2016;12(1):49
Abstract

The experience of seeking, gaining and maintaining employment after traumatic spinal cord injury and the vocational pathways involved

Authors: Hilton G et al.

Summary: These researchers sought to understand the experience and pathway of persons seeking and gaining paid employment outcome after traumatic SCI in the state of Victoria, Australia. Thirty-one participants were recruited and allocated into 1 of 3 employment outcome groups: Group A, participants who had stable and durable employment; Group B, those who were in unstable employment (i.e. they had work arrangements that were precarious, temporary, casual, or contract employment); and Group C, participants who had not had any form of paid work for ≥6 months. The study researchers used the quantitative data to construct a vocational map to demonstrate the similarities and differences in pre- and post-injury pathways taken by participants in each group. The most common pathway identified was from study and work pre-injury to stable employment post-injury. Interpretive phenomenological analysis identified four super-ordinate themes from participant interview data: expectations about employment after SCI; comprehension and navigation of systems and rights; the impact of worker identity on motivating employment; and the importance of social supports and their contribution to employment outcomes.

Comment: This research was carried out in Victoria, Australia, where their workers compensation scheme is somewhat comparable to our ACC (albeit more limited in scope in terms of entitlement and cover). It is offers a useful insight into the experiences of persons with SCI in terms of their employment trajectories comparing and contrasting the experiences across three groups (stable, unstable, and without employment). I do, however, offer some caution when reading and interpreting the findings. There is a thread through the findings of the notion that those that were in stable employment were more positive in their expectations and had managed to somehow overcome adversity – implying that one's personality or their personal response in the face of adversity played a large role in their employment success. This may well be the case. However, I worry that this interpretation of findings leads us to put responsibility entirely on the patient as the maker of their success, and in doing so we may miss the opportunity to critically reflect on how health systems and services can play a role in building capability and providing opportunities to optimise the likelihood for success. Certainly, this paper goes on to discuss the role of the system and social supports (including the positive role that peer support played) in enabling successful re-engagement in stable employment. I suggest this is where we should focus our energy.

Reference: Work. 2018;59(1):67-84
Abstract

Patterns and predictors of return to work after major trauma: A prospective, population-based registry study

Authors: Collie A et al.

Summary: These researchers obtained data from the Victorian State Trauma Registry to identify 1,086 working-age individuals who were in paid employment or full-time education before injury and surveyed them all by telephone interview at 6, 12, 24, 36, and 48 months post-injury. Just over half of the respondents (51.6%) recorded early and sustained RTW after injury. RTW was delayed in an additional 15.5% and a further 13.3% failed RTW. One in 5 (19.7%) did not RTW. Using multivariate multinomial logistic regression to assess predictors of RTW patterns, the researchers found that compared with early sustained RTW, delayed and no RTW were predicted by employment in a manual occupation and injury in a motor vehicle accident. Older age and receiving compensation predicted both failed and no RTW patterns. Preinjury disability was an additional predictor of failed RTW. Presence of comorbidity was an additional predictor of no RTW.

Comment: There is often an over-simplification of RTW outcomes in health research and practice, with the dichotomous outcome of RTW (or not) captured at a single point in time, frequently adopted as a primary indicator of successful RTW. The aims of this study recognise the need to look deeper and over a longer period of time – in this case, over a four-year period following trauma. There are many findings of interest and so the full paper is worth a read if you are working in a vocational rehabilitation context. If you do, I encourage you to look at it with a critical eye when interpreting findings, as it is easy to skip over the descriptive detail without really critically reflecting on the practice implications. There are a number of points I would like to pick up on but don't have room! So, I will begrudgingly focus on one – the presence of comorbidities was associated with *no RTW* and pre-injury disability was associated with greater likelihood of a *failed RTW*. There is ongoing debate regarding the extent to which compensation systems contribute funding to manage the impact of pre-existing conditions on RTW outcomes, frequently resulting in lengthy negotiations regarding entitlement. This raises two concerns for me. First, in focusing on entitlement we may miss the opportunity to look for, develop and implement more effective intervention frameworks that address multimorbidity as critical to outcome. Second, research reports disparities in education, health and employment outcomes for disabled people, which may be further exacerbated following trauma. As such, disabled people may benefit from a more targeted and nuanced approach that is built on the premise of self-continuity between pre- and post-injury. The reality is – comorbidities and pre-existing conditions are repeatedly identified as having an impact on RTW outcomes. As such, the long-term cost of not doing something is likely to be far greater than a targeted investment up front.

Reference: Ann Surg. 2018 Jan 16. [Epub ahead of print]
Abstract

Effects of acute-postacute continuity on community discharge and 30-day rehospitalization following inpatient rehabilitation

Authors: Graham JE et al.

Summary: This US analysis of national Medicare enrolment, claims and assessment data included 541,097 patients discharged from 1,156 inpatient rehabilitation facilities (IRFs) in 2010 and 2011. The researchers examined the effects of facility-level acute-post-acute continuity on probability of community discharge and 30-day rehospitalisation following inpatient rehabilitation. Facility-level continuity was calculated as the percentages of patients in IRFs who were admitted from each contributing acute care hospital. Patients were categorised as either low continuity (<26% from the same hospital that discharged the patient), medium continuity (26–75% from the same hospital), or high continuity (>75% from the same hospital). Medicare beneficiaries in hospital-based rehabilitation units were more likely to be referred from a high-contributing hospital compared to those in freestanding facilities. Notably, multivariate analysis revealed a significantly stronger association between higher acute-post-acute continuity and desirable outcomes in freestanding rehabilitation facilities than in hospital-based units.

Comment: A finding that comes through repeatedly in our research at the Centre for Person Centred Research is the problematic nature of key transition points across the rehabilitation trajectory. Transitioning from service to service, from inpatient to community, from young person to working age to older adult represent key tipping points in the client journey. The current study used a fairly crude measure of facility-level continuity (i.e. the % of people admitted to inpatient rehabilitation facility from the same hospital) to explore impact on outcomes (specifically community discharge and 30-day rehospitalisation). This was based on the assumption that more exclusive referral patterns would contribute to better communication and more consistency in care processes across care settings. Arguably, this assumption is somewhat contestable and needs unpacking. However, the findings highlight that in principle greater continuity was associated with higher likelihood of community discharge and reduced likelihood of 30-day rehospitalisation. These findings support a growing body of evidence regarding the urgent need to develop strategies for improved coordination and continuity. The transitions work led by the TBI pathways collaborative (involving ACC and a range of TBI providers in the northern region) is a great example of work that is being undertaken to tackle this issue in NZ. I look forward to seeing their learning expanded to other populations and contexts.

Reference: Health Serv Res. 2017;52(5):1631-46
Abstract

Application of the theoretical domains framework and the behaviour change wheel to understand physicians' behaviors and behavior change in using temporary work modifications for return to work: A qualitative study

Authors: Horppu U et al.

Summary: These researchers held interviews and focus group discussions with 15 occupational physicians (OPs), seeking to understand physicians' behaviours related to applying temporary work modifications (TWMs) for RTW that could be targeted in future interventions. Responses were coded using the theoretical domains framework (TDF) and the Behaviour Change Wheel (BCW). The analysis identified 3 key behaviours that OPs engage in when using TWMs to support staying at work/RTW: (1) initiating the process during consultation with the employee; (2) making recommendations to the workplace; and (3) following up the work modification process. The researchers found that OP behaviours were influenced by several factors related to personal capability and motivation, and opportunities provided by the physical and social environment. Capability comprised relevant knowledge and skills related to applying TWMs, remembering to initiate TWMS and monitor the process, and being accustomed to reflective practice. Opportunity comprised physical resources (e.g., time, predefined procedures, and availability of modified work at companies), and social pressure from stakeholders. Motivation comprised conceptions of a proper OP role, confidence to carry out TWMs, personal RTW-related goals, beliefs about the outcomes of one's actions, feedback received from earlier cases, and feelings related to applying TWMs. OPs' perceived means to target these identified factors were linked to the following BCW intervention functions: education, training, persuasion, enablement, and environmental restructuring.

Comment: I was drawn to this paper as the research draws on the Theoretical Domains Framework (TDF) and the Behaviour Change Wheel (BCW) to explore in depth the behaviour of occupational physicians when recommending temporary work modifications. The TDF and BCW are now well recognised amongst behavioural science colleagues, so it is great to see them being applied more readily in the rehabilitation context. There are a number of papers describing the range of work that has led to their development – a recent and helpful paper for those who want to explore further can be found at https://implementationscience.biomedcentral.com/articles/10.1186/s13012-017-0605-9. Very simply, they are based on the COM-B model, which argues that behaviour (B) is a function of capability (C), opportunity (O), and motivation (M). The result is an insightful reflection on the barriers expressed by occupation physicians across each of the three domains e.g. knowing when, why, how, and under what circumstances temporary work modification would be indicated (capability); availability of work modifications in the workplace (opportunity); and conceptualisation of one's role as an occupational physician (motivation). Michie and colleagues (responsible for the development of COM-B and related frameworks) refer to this in-depth analysis as a behavioural diagnosis. The strength of this approach is that, just as is the case in medical diagnosis, once you know what is going on, you are in a much better position to develop more targeted interventions to support behavioural change.

Reference: J Occup Rehabil. 2018;28(1):135-46
Abstract

Predictors of return-to-work in patients with chronic musculoskeletal pain: A randomized clinical trial

Authors: Brendbekken R et al.

Summary: This assessment investigated how a multidisciplinary intervention programme, pain, work-related factors and health, including anxiety/depression and beliefs, impact upon RTW for patients taking sick leave due to musculoskeletal pain. The study randomised 284 such patients to either a multidisciplinary intervention programme (n=141), or to a less resource-demanding brief intervention (n=143). RTW by 3 months was associated with a multidisciplinary intervention programme (OR2.7; 95% CI,1.1 to 6.9), the factor "belief that work was cause of the pain" (OR2.2; 95% CI,1.1 to 4.3), anxiety and depression (OR0.5; 95% CI,0.2 to 0.98), and by an interaction between the multidisciplinary intervention and perceived support at work (OR0.3; 95% CI,0.1 to 0.9). At 12 months, only duration of sick leave at baseline was associated with RTW (OR0.6; 95% CI,0.5 to 0.8).

Comment: The authors of this paper highlight an important distinction between research exploring the effectiveness of RTW interventions and research identifying predictors of RTW – pointing to a gap in evidence regarding predictors of effect of a multidisciplinary intervention on RTW. They argue that a better understanding of this will enable a more targeted approach to intervention selection potentially enhancing the likelihood of effectiveness as well as contributing to smarter resource allocation. The results are interesting, though perhaps unsurprising to those working with people off work due to musculoskeletal pain and in the context of existing evidence. However, the focus on predictors of treatment effect is a useful approach, while keeping in mind that one is limited to what is observable and measurable when selecting possible predictor variables. Being clear, however, on which subgroups are most likely to benefit from a given intervention also highlights populations less well served by existing approaches and, therefore, where we need to focus our energy next.

Reference: J Rehabil Med. 2018;50(2):193-9
Abstract

Time spent reading this publication has been approved for CME for Royal New Zealand College of General Practitioners (RNZCGP) General Practice Educational Programme Stage 2 (GPEP2) and the Maintenance of Professional Standards (MOPS) purposes, provided that a Learning Reflection Form is completed. Please **CLICK HERE** to download your CPD MOPS Learning Reflection Form. One form per review read would be required.

Time spent reading this publication has been approved for CNE by The College of Nurses Aotearoa (NZ) for RNs and NPs. For more information on how to claim CNE hours please **CLICK HERE**

Investigating the model of community-based case management in the New South Wales Brain Injury Rehabilitation Program: a prospective multicenter study

Authors: Simpson G et al.

Summary: Findings are presented from this investigation into a model of community-based case management based in New South Wales, Australia. The researchers administered a purpose-designed survey to 72 clinicians providing case management within 14 (12 adult and 2 paediatric services) Brain Injury Rehabilitation Program community rehabilitation teams. The 3-part survey explored the organisational context, clinical approach, and case management interventions performed by the clinicians. All services provided a direct service model of case management. The underlying principles were uniform across services (more direct than indirect service provision; with more client-related than administrative-related tasks; more holistic than service-led in defining client needs; with decision making equally directed by staff and clients; and undertaking a more comprehensive versus minimalist range of tasks). Case management interventions included the provision of individual support, family support, advocacy, and community development alongside assessment, monitoring, referral, and liaison tasks. Practices differed very little by age or location.

Comment: Advances in case management (CM) have been hampered by a lack of robust research so it is great to see some research like this coming through. This research captures key aspects of the CM model taken up in a community-based brain injury service as described by staff members working in a CM role within that service. The findings are descriptive and, while interesting, are not in themselves the reason I selected this paper for this Research Review issue. Rather, I selected this paper as the approach taken to describing the CM model highlights the complexity inherent in CM – something I think we can take for granted. The authors of this paper highlight a number of key parameters including the organisational context (e.g. case management only, multidisciplinary, etc.), the approach taken (e.g. direct, case coordination, brokerage, advocacy, etc.), principles underpinning CM (e.g. comprehensive, consumer-led, holistic, etc.), and CM tasks (e.g. referral and liaison, assessment, goal setting, etc.). In rehabilitation in NZ, there are examples of both formal models of CM, such as that provided by ACC, as well as examples of more informal approaches, such as a keyworker role within a clinical team. Regardless, explicit consideration should be given to the aims and purpose of the CM role and what would constitute a good outcome so that it can inform more conscious decision-making regarding the context, approach, principles and tasks embedded in the CM model. It is argued in this paper that this will also support the identification of appropriate measures to capture the impact of the CM model – a necessary step for active and ongoing service development.

Reference: J Head Trauma Rehabil. 2018 Jan 30. [Epub ahead of print]
Abstract

Strengthening health systems to provide rehabilitation services

Authors: Krug E et al.

Summary: This editorial from the World Health Organisation's (WHO's) Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention emphasises the ongoing health and demographic trends that are challenging society worldwide: populations are ageing, and the number of people living with noncommunicable diseases and the consequences of injuries is increasing. Policy-makers need to invest not only in health services that reduce mortality and morbidity, but also in those that improve functioning and consequently well-being, yet rehabilitation services are often underdeveloped, under-resourced and undervalued. The editorial goes on to call for the incorporation of rehabilitation into essential services, along with prevention, promotion, treatment and palliation. Key actions to strengthen rehabilitation services in Member States can include: improving rehabilitation governance and investment; expanding a high-quality rehabilitation workforce; and enhancing rehabilitation data collection.

Comment: I have selected this editorial to highlight in this issue as it talks to some of the global healthcare challenges we are set to face (and are already facing). It comes off the back of the WHO Rehabilitation 2030: Call to Action (http://www.who.int/disabilities/care/rehab-2030/en/). The call to action argues that rehabilitation may be well positioned to respond to contemporary health challenges where increasing numbers of people will be living with the enduring and disabling consequences of injury, illness or age-related conditions; frequently in the context of multimorbidity. However, if we are to rise to this challenge we have some work to do. Projections point to imminent and significant shortages in the rehabilitation workforce where demand will soon exceed resource. In NZ, we already suffer from a shortage of rehabilitation specialist physicians as an example. Similarly, there are a number of misconceptions regarding the nature and role of rehabilitation that we need to dispel. In particular in NZ, there is a lack of recognition regarding the value of rehabilitation by policy-makers. As such, we have much work to do to raise our visibility and demonstrate value. A lot of groundwork was done some years ago culminating in a call for a NZ Rehabilitation Strategy – the WHO Call to Action serves as an excellent opportunity for us to advance this further. It is critical that we stand together on this issue. Watch this space.

Reference: Ann Rehabil Med. 2017;41(2):169-70
Abstract

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www.livestronger.org.nz website is full of advice, information and resources for older people and providers. Under the 'Find a class near you' tab you'll see the list of classes available and how to sign-up to local strength and balance classes or in-home support, if that is appropriate.

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