



Jupiter

The case management approach adopted to deliver rehabilitation could be the main cause of many of its performance limitations, argues **Matthew Beard**

In search of confidence

THE rehabilitation industry has grown significantly over the past five years, with insurers and lawyers embracing the theory of rehabilitation for the benefit of individuals who are unfortunate enough to suffer physical injuries.

However, most insurers and claims handlers are still not convinced of the merits of engaging with rehabilitation providers. There is an emerging attitude that engaging with rehabilitation only serves to layer cost and elongate claims. Why is this?

It is undeniable that rehabilitating an injured person and helping them return to work safely, in a claims environment, should be of huge benefit. The key to effective rehabilitation is its ability to affect clinical change over and above 'natural' recovery or through the provision of routinely available clinical services - and it is here that limitations of the current rehabilitation market are most apparent.

Multi-disciplinary skills

A commonly seen injury within the rehabilitative industry is a fractured tibia. The clinical management of this condition requires a combination of professions and disciplines from acute care, surgical care, post-operative care and longer term therapy. From the outset and for a significant period thereafter, a patient suffering this condition would have encountered and continued to be under the care of medical and surgical professionals. Only at later non-acute stages would this patient then encounter physiotherapy and then occupational therapy - if the latter is necessary at all.

Clinical treatment, therefore, demands a multi-disciplinary skill set - based on objective examinations and investigations tailored to the individual, which consider the

injury, past medical history and social circumstance.

But the majority of UK rehabilitation providers only offer a linear case management approach: meaning a physiotherapist, occupational therapist or nurse solely manages a case through the entire treatment process. This approach does not mirror the actual clinical delivery of treatment by a multi-disciplinary team. Thus the case manager is forced to operate outside their clinical scope of practice on issues not related to their immediate profession. This would not be acceptable within a clinical setting so why is it permissible in the rehabilitation market?

Limited clinical change

The ability to affect and influence clinical change through the case management model is strictly limited as there is not an adequate clinical skill set to do so. The unavoidable clinical consequence of this approach is that the case manager is forced to 'monitor' the treatment of others as they do not have the qualification or experience to have a credible clinical influence outside their discipline.

And the problems do not stop here. Further limitations are demonstrated throughout the diagnostic and prognostic process, which are the domain of the medical profession. This is particularly prevalent where the injury is non-routine or if there is a lack of clear diagnosis or prognosis.

On an individual case basis, this model produces expensive management and treatment programmes that are routinely recommended on the basis of subjective patient-led information, rather than objective clinical fact. This can expose insurers to patients justifying unnecessary approaches that may have a direct bearing on increasing

a subsequent claim. Furthermore, the clinical quality of the treatment programmes is routinely limited to therapy and overlooks invasive (operative) options, which a doctor is required to make.

The practical difficulties encountered by the case management process are numerous. Having established that the case manager is forced to monitor the work of others, this process also involves significant clinical liaison - problematic, in itself. For example, busy NHS orthopaedic consultants place a low priority on responding to a case manager who may be a nurse - potentially stalling the rehabilitative timeframe.

The most worrying aspect in terms of clinical objectivity is that this approach does not routinely obtain the patient's GP and hospital notes - the objective foundation of any patient treatment. The case manager is not always qualified to interpret and report upon the entirety of the notes and certainly not able to officially comment on the diagnosis or prognosis of the injury in a rehabilitative context. Only a doctor is qualified to do this. Unfortunately a GP report is often not enough as it potentially introduces the subjective views and interpretation of the GP alone.

In addition to the barriers to effective clinical intervention, the market also needs to review the costs and processes by which it manages cases. These can be highly expensive and routinely inefficient. For example, you do not need to visit a patient in order to report subjectively on their condition. The current 'initial needs assessment' entertained by the market is entirely subjective and could be performed at a fraction of the cost by telephone. Patients only need to be examined when the clinical features of the case demand it. Furthermore, the examination should be clinically

objective in order to provide additional clinical information that is not available from other objective sources, such as the medical notes.

The theory of case management is predominantly an imported concept from countries where the health care infrastructure is very different from the UK; perhaps it is now proving that this model does not perform in the same way here.

Current moves to regulate and set standards for the rehabilitation industry can only be a good thing. But will this instil confidence in an industry where the vast majority of providers offer services based on processes with so many clinical and delivery limitations?

Taking responsibility

The problems within the rehabilitative industry are, largely, self-generated. The industry has oversold and clinically under-delivered. This is demonstrated by the less than supportive views of some insurers in the recent Post article 'To Hell and Back', (24 July, pp23-24).

It is time for the industry to fundamentally review its structure and clinical delivery. There is a need for the providers to raise the clinical bar in order to meet the demands of treating patients and the commercial demands of their clients. Likewise, insurers and lawyers should expect and demand more from rehabilitation providers in order to drive out complacency and clinical ineffectiveness.

Unless the rehabilitation industry becomes more self-effacing and accepts some hard truths about its performance, there is a very real prospect that insurers will turn their back on it.

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