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# THE MENTAL HEALTH IMPACTS OF COMPENSATION CLAIM ASSESSMENT PROCESSES

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## ABBREVIATIONS

ADF	Australian Defence Force
AIHW	Australian Institute of Health and Welfare
CSC	Commonwealth Superannuation Corporation
CT&CS	Channel Transformation and Client Strategy
DOD	Department of Defence
DHS	Department of Human Services
DVA	Department of Veterans' Affairs
DRCA	Safety, Rehabilitation and Compensation (Defence Related Claims) Act 1988
ESO	Ex Service Organisation
IL	Initial Liability
IMA	Independent Medical Assessment
ISH	Integrated Support Hub
INCAP	Incapacity
MHC	Mental Health Conditions
MRCA	Military Rehabilitation Compensation Act 2004
NLHC	Non Liability Health Care
PI	Permanent Impairment
PTSD	Post-Traumatic Stress Disorder
RTW	Return To Work
SOPs	Statements of Principles
TTTP	Time Taken To Process
VEA	Veterans Entitlements Act 1986
VCR	Veteran Centric Reform

## EXECUTIVE SUMMARY

Mental health conditions are common among people who have served in the Defence forces, and can have substantial impact on family and social life. The Department of Veterans' Affairs (DVA) operates Australia's compensation and rehabilitation scheme for veterans with health conditions arising from their military service. Multiple recent inquiries and reviews of the DVA support system have identified that the compensation claims assessment process may contribute to the psychological distress and mental health conditions experienced by some veterans, including self-harm and suicide.

In response to the Senate inquiry into suicide in veterans and ex-service personnel, the DVA commissioned Phoenix Australia to provide a report examining the mental health impacts of compensation claims assessment processes on veterans and their families. The DVA subsequently commissioned this study to review the Phoenix report and to further explore potential for DVA actions that may mitigate potential mental health impacts of its compensation claims processes.

The study involved document review, site visits to DVA offices and a targeted literature search and is presented in three sections.

Section one critiques the Phoenix Australia report and presents a summary of additional relevant research evidence, as well as information provided by the DVA, and distils key messages from this evidence. There is a strong evidence base supporting the assertion that compensation claims management processes affect the mental health of people making claims. These effects are not limited to people making claims for mental health conditions, and may also contribute to secondary psychological harm in people making claims for physical conditions.

Compensation claims processes are, to a large extent, modifiable, and there are multiple opportunities to change claims management practices in ways that should, on the weight of evidence, lead to a reduction in the risk of psychological harm arising from involvement in DVA compensation claims processes. The major implementation challenge is to identify which changes are likely to have the greatest net positive impact.

Section two describes the DVA compensation claims process, including recent and proposed reforms and trials, and some important contextual factors affecting claims management processes. The DVA claims process is unique and has evolved within a complex and dynamic system and in response to a complex legislative framework. The factors identified in the academic research literature as being potentially problematic for mental health are evident in the DVA compensation processes. For example claims are largely processed sequentially and handed over between delegates for each step in the claim process, introducing potential for delay and loss of contextual information as the claim progresses, and meaning that veterans (or their representatives) may interact with multiple different claims delegates at any point in time, which some may find confusing and stressful.

The DVA has recently introduced a number of reforms and trials that are addressing some of these issues, for example the development of MyService online lodgment portal which reduces processing time for some major components of the claims process, the Combined Benefits Processing trial which minimizes claim hand-over and has been received positively by veteran's involved, and early access to specialist health care through the Non-Liability Healthcare for veterans with mental health conditions. These are positive initiatives that demonstrate strong awareness of the problematic aspects of the claims management processes and a desire to correct them. Despite these positive initiatives, the claims process retains multiple features that could, for some veterans, contribute to the onset or exacerbation of a mental health condition. These features are targets for modification to mitigate any potentially negative impacts.

Section three describes emerging best practices in personal injury compensation claims management, provides some case examples of good practice from Australian personal injury compensation schemes, and concludes by identifying areas in which action by the DVA should, based on the evidence reviewed, help to mitigate any negative impacts of claims processes on the mental health of veterans.

The past decade has seen a substantial shift in the approach to personal injury claims management in Australia. Best practice is shifting from a liability and cost focused, claims processing model to a health and function focused, client-centred model. Claims processing models are increasingly supported by sophisticated data analytics, for example to auto-segment clients into high and low risk claims management streams and identify

client-specific services and supports. A good practice model summarizing these emerging trends is presented.

There are multiple areas in which DVA could act to adopt these good practices by extending recent reforms and trials, modifying existing claims processes or developing new processes and capabilities. These opportunities include expanding the MyService offering and the Combined Benefits Processing model, introducing an approach to client segmentation that links delegate capability with client complexity, better targeting resources for psychosocial screening to clients most at risk, reforming IMA processes, and developing a client health and wellbeing outcome measurement framework. Many of these require (or would benefit from) improvement in the claims information management system and data analysis capability, though action could be taken in some areas without major changes to the current supporting infrastructure. It was not feasible within the timeframe of this project to provide detailed proposal on specific claims reforms, and thus a high level description of these potential action areas is provided, along with a visual matrix summarizing the author's view of the potential impact on veteran mental health and the difficulty of implementation. Coordination of any claims system reform will be important to ensure that benefits are realised.

In conclusion, there appear to be multiple opportunities for the DVA to introduce further reforms to its compensation claims processing model, in order to mitigate any potential impact on veteran mental health.

## BACKGROUND

Mental health conditions (MHC) are common in ex-military personnel. The DVA funded Transition and Wellbeing Research Program reported that almost three in four transitioned members (ex-service personnel and ADF members who transitioned into the reserves) are estimated to have met criteria for a MHC at some stage in their lifetime [1]. This study also reported that anxiety (46.1%) and alcohol disorders (47.5%) were the most common classes of lifetime disorder among transitioned members, and that one quarter of transitioned ADF members were estimated to have met criteria for posttraumatic stress disorder (PTSD) in their lifetime (24.9%).

In addition this study estimated that 46.4% of transitioned ADF members had experienced a MHC in the previous 12 months, with anxiety disorders (including PTSD) being the most common condition. An estimated 20% of transitioned ADF members were reported to have experienced suicidality, including 2% who had attempted suicide and a further 7.9% who had made a suicide plan. The rate of psychological distress in transitioned ADF (33.1%) was nearly twice that in serving ADF members (18.7%) and nearly three times the rate in the Australian community (12.8%).

A recent report by the Australian Institute of Health and Welfare (AIHW) supports these findings. The age-adjusted incidence of suicide in ex-serving men (veterans) was 18% higher than the rate in all Australian men. Younger veterans appear to be at greater risk. Veterans under the age of 30 had a rate of suicide 2.2 times higher than Australian men the same age for the period 2014-2016 [2]. DVA initial liability claim data provided for this study indicates that there were 18,999 MRCA claims for MHCs between 2014 and 2018, representing 10.8% of all MRCA claims accepted in that 6 year period.

These statistics relate to primary MHC compensation claims under MRCA only and are likely to underestimate the true burden of MHC in the DVA compensation system. There is now evidence from civilian personal injury compensation schemes of a high rate of psychological distress and MHC in people making claims for physical conditions. One study of a Canadian workers making compensation claims for musculoskeletal disorders reported a 12 month cumulative incidence of depressive symptoms of 50% [3]. A recent national study in Australian workers compensation systems reported that 38% of workers making claims for musculoskeletal disorders had moderate or severe psychological distress, and as high as 72% in those who had not yet returned to work and were still involved in the compensation claims process [4].



There is also substantial evidence that compensation claims management practices can affect the mental health of people making claims. While much of the academic research evidence arises from civilian personal injury compensation schemes, there have also been multiple recent Australian reports and inquiries that suggest that these effects are also operating within the DVA compensation and rehabilitation processes. It follows that reform of compensation claims systems and processes present an opportunity to mitigate any potential negative impacts on mental health.

In August 2017 the Senate Foreign Affairs Defence and Trade (FADT) Reference Committee published the report of its inquiry into suicide in veterans and ex-service personnel [5]. The report from this wide-ranging inquiry made 24 recommendations. In response to recommendation 2 of the Senate Inquiry, the Government agreed to commission an independent study into the mental health impacts of compensation claim assessment processes on veterans engaging with the DVA and Commonwealth Superannuation Corporation (CSC).

The DVA commissioned Phoenix Australia to provide a report entitled “Mental health impacts of compensation claims assessment processes on claimants and their families”[6]. The DVA subsequently commissioned this study to review the Phoenix report and to further explore potential for DVA actions that may mitigate potential mental health impacts of its compensation claims processes.

## OBJECTIVE

This report seeks to address the DVA's request for "an independent study into the mental health impact of compensation claims assessment processes on veterans, including advice on how the DVA might mitigate any potential impact on mental health."

Specifically the DVA has requested a study which:

- Critically reviews and annotate the research report on "Mental health impacts of compensation claims assessment processes on claimants and their families"
- Identifies and summarises major findings and gaps in the literature review
- Distils current research and DVA material into key messages
- Understands broadly DVA claims assessment processes, including proposed reforms
- Provides advice to DVA on actions it could take to help mitigate any potential mental health impacts of compensation claim processes, based on leading practice, including for claimants with mental health conditions.

## APPROACH

Three main activities were undertaken to gather evidence and information for this report. These included:

- (1) Document Review, including a critical review of the methods and conclusions of the Phoenix Australia report and the research evidence it references, as well as a range of documents provided by the DVA including government inquiries, workshop notes, media articles;
- (2) Site visits to DVA offices in Melbourne, Canberra and Brisbane including meetings with senior management, claims team leaders and delegates involved in various components of the DVA claims process, demonstrations of claims management processes in operations, and attending presentations on the VCR program; and
- (3) Targeted Literature Search, to identify additional academic or other literature relevant to the report, including for instance case examples of personal injury claims leading practices.

This information is summarized and synthesized in this report, and is presented in three main sections.

Section one contains a critique of the Phoenix Australia report including a summary of its major findings, a review of methods, and description of additional research evidence of relevance. This section also briefly summarises key messages that can be drawn from the existing research evidence regarding the impact of compensation claims processes on mental health, and summarises the material provided by DVA relative to this evidence base.

Section two describes at a high level the DVA compensation claims process, including recent and proposed reforms and trials, and some important contextual factors affecting claims management processes. This section concludes with a summary of the extent to which potentially adverse claims processes (as per the evidence base) appear to be present in the DVA compensation system.

Section three describes emerging best practices in personal injury compensation claims management, provides some case examples of Australian personal injury schemes to illustrate how some of these principles are being implemented in practice. This section concludes by identifying opportunities for action by the DVA that should, based on

evidence, help to mitigate any negative impacts of claims processes on the mental health of veterans.

## SECTION ONE: REVIEW OF EVIDENCE

### SUMMARY OF PHOENIX AUSTRALIA REPORT

#### OVERVIEW

The Phoenix Australia research report was finalised in September 2018. The report aims to “examine the mental health effects of compensation claim processes on claimants and their families in order to guide potential improvements designed to minimise those negative impacts”. The report scope includes examination of the mental health impacts of compensation processes in Australia and internationally. There were two main activities undertaken to compile the report:

- (1) A narrative review of published international research literature on the mental health effects of compensation claims processes on claimants, their partners and families; and
- (2) A desktop study synthesising reports and information provided by the DVA including summaries of workshops, inquiry reports, media reports, policy documents and client engagements.

The report also describes some contextual information to support interpretation of the findings, and outlines some ‘controversies and complexities’ as well as methodological considerations that also provide useful background information for interpreting study findings.

The authors summarise the findings of both the literature review and the desktop study thematically. The themes are described as aspects of the claims process that may have an adverse impact on the psychological health of veterans or their families. There is a high degree of consistency between the themes emerging from the two activities, which can be summarised simply as follows, noting that there are detailed descriptions of these themes in the Phoenix report:

- Complexity of the claims process including difficulty accessing accurate information and delays in claims processing.
- Repeated medical assessments.
- Interpersonal interactions between veterans and claims staff.
- Need to prove the legitimacy of the compensation claim and lack of trust.
- Impact of existing mental health vulnerabilities.
- Importance of veteran support and advocacy during the claims process.

- Access to mental health treatment during process
- Lack of support for partners.

The report also proposes, at a high level, some opportunities for improvement. These include the following suggestions:

- Introduction of screening for pre-existing mental health conditions or other complexities early in the claims process to identify veterans requiring additional support;
- Introduction of a 'complex case management' model that matches case manager / delegate capability and case load to claim complexity;
- Enhancing the capability of claims staff through a program of education and training, including specific training in recognising and addressing psychological health;
- Adopting a multidisciplinary approach to assessment and treatment; and
- Taking a 'client-focussed' approach to claims management.

## METHODOLOGICAL REVIEW

It is not possible to conduct a thorough review of the methodological rigour of the Phoenix Australia report as limited methodological detail is included in the report. The broad approach of a narrative review of research literature supplemented by desktop review of other documents appears at face value to be appropriate given the objectives of the study, the wide range of evidence that was required to be considered and (presumably) a requirement to complete the report within a short time frame.

The literature review includes a range of qualitative and quantitative research studies, literature reviews and other documents. A total of over 70 studies were identified, predominantly Australian, with most being studies of civilian workers' compensation and motor vehicle accident compensation systems, supplemented by some other studies in veterans' populations. The narrative synthesis is described as drawing themes from a subgroup of these identified studies, and using description of individual studies and their findings to illustrate the themes identified. This is a commonly used approach in narrative reviews. The strengths of this narrative approach include the ability to include different types of study designs, conducted in different populations across multiple settings, and to consider a variety of relevant outcomes. The limitations of the approach relate to an inability to draw firm conclusions about any particular populations, systems or outcomes

because of the breadth of information included. That is, the lack of a specific focus means that it is difficult to be specific in findings. There are accepted methods for synthesising findings from disparate literature sources such as those presented. For example the 'Best Evidence Synthesis' method allows the researcher to rate the evidence base on the quantity of evidence, the consistency of effects observed, and the quality of included studies, and this enables stronger conclusions, including potentially practice and policy recommendations, to be drawn from the evidence. One recent and relevant example of this method is in the review of Return to Work (RTW) interventions published by Cullen et al [7]. I also note that the report presents limited information regarding the search strategy and the approach to study screening, data extraction and quality assessment, which are usually considered as important components of research literature reviews.

The desktop study is based on documents provided by DVA which are focused on veterans' compensation in Australia, though documents from compensation schemes in other jurisdictions are also included. The authors present the findings of their desktop study as a series of themes, again using text extracted from the documents to illustrate the major themes and subthemes. The method of identifying and extracting themes from these documents is not described and thus I am unable to comment on the quality or rigour the analysis. I would note that there are standardised methods for document content analysis that may have been used.

In multiple places throughout the report the authors observe that there are challenges in attempting to determine a causal relationship between the two concepts under study: (1) claimant health and (2) compensation claims management practices. One criticism of the report is that the authors approach this question from a classical or 'reductionist' paradigm which requires 'causal' evidence in the form of randomised controlled trials or similar. This approach runs the risk of policy and practice inertia, as such causal evidence is rare in social and health policy settings and thus one can never be confident that attempts to change a particular process or practice will affect outcomes. The authors of the Phoenix report recognise these limitations and make attempts to provide guidance regarding opportunities for the DVA to improve its claims management operations.

An alternative approach to interpreting the research literature, which I believe more accurately reflects both the evidence base and the reality of compensation claims systems, is to view the evidence through a complex systems lens. This approach recognises that the influence of claims management processes on health occurs within a

complex and dynamic system in which there are few unidirectional or even bi-directional relationships. Outcomes such as mental health are mediated through interactions with multiple other factors at the level of the person/veteran, their family, the organisation and the environment [8-10]. I would note that this approach is thus also consistent with the biopsychosocial model of health and disability, which is now a dominant paradigm in health systems research and practice worldwide [11].

Viewing the evidence through a complex systems lens, the presence of a consistent finding of poorer mental health among people making compensation claims (which is clearly evident in the published literature) suggests the need to modify the system in which claims are being determined and managed. Evidence of specific detrimental system effects (which are also evident in the literature) suggest specific system level mechanisms that may be changed to achieve a more positive, or at least less detrimental, mental health outcome.

Perhaps most importantly, taking a systems approach also means that an effective policy and practice response to a particular problem requires more than a single solution, because in systems models problems have many parents, not a single progenitor. An effective response will require a range of coordinated changes at the level of claims policy, claims management practice and service delivery.

Another potential criticism of the report is that it makes very little attempt to consider the research findings in relation to the DVA claims model, though I note that the authors may not have been asked to focus on this aspect.

#### [ADDITIONAL RELEVANT LITERATURE \(GAPS\)](#)

In addition to the research evidence presented in the Phoenix report, there are a number of fields of evidence that are relevant to the topic. An overview of these is provided in the following section, with examples of specific studies. Please note that it was not possible within the timeframe to provide a comprehensive review of each of the following areas, and thus I have used examples of published studies to illustrate the research findings and their relevance for the DVA.

#### **Secondary mental health conditions**

In most personal injury compensation schemes including the DVA scheme, claims for mental health conditions represent a minority (by pure volume) of claims. There are usually a far greater number of claims for physical conditions such as musculoskeletal



disorders (MSD) and traumatic injury. It is now commonly accepted that physical injury can have substantial psychological impacts [12]. Studies have shown that depressive symptoms are common following workplace MSD [13, 14], and more likely in people with occupational injury [15]. Depressive symptoms have been shown to delay return to work and complicate recovery in people with MSD [14].

There is also an emerging body of research in civilian workers' compensation schemes that a large proportion of people making claims for physical conditions also have substantial psychological morbidity. One study of injured Canadian workers reported a 12 month cumulative incidence of depressive symptoms of 50% [3]. A very recent national study of Australian workers compensation schemes reported that 38% of workers making claims for MSD had moderate or severe psychological distress, with the incidence as high as 72% in those who had not yet returned to work and were still involved in the compensation claims process [4]. Only one quarter of these people, who had accepted workers' compensation claims, reported receiving specialist mental health treatment. This important evidence suggests a need for claims management processes to focus not only on people making claims for MHC, but also to have rigorous screening processes to identify psychological stress in people making claims for physical conditions.

### **Procedural fairness and the perception of fault**

Procedural justice concerns the fairness and the transparency of the processes by which decisions are made. Just procedures are characterized by consistency, lack of bias, accuracy, correctability, and voice during decision-making [16]. A study in the Dutch motor vehicle crash compensation system identified a positive correlation between perceptions of procedural justice and quality of life [17], while a study in the Victorian and New South Wales motor vehicle accident compensation systems demonstrated that perceptions of fairness were associated with positive health outcomes 12 and 24 months after injury [18]. Theory of procedural justice has been used to propose alternate approaches to Independent Medical Assessment (IMA) in workers' compensation systems, recognising that current IMA processes may fail to meet some principles of procedural justice [19]. Scales for assessing the perceived justice of benefit processes have been developed and validated in workers' compensation systems [20] and have recently been used in Australian workers' compensation systems to measure client experience [21]. These studies suggest that it is possible to improve the health of applicants and benefit

recipients, and reduce their level of functional disability, by improving compensation processes and procedures.

There is also related research that describes the impact of fault perceptions on recovery in people with compensable conditions. For example a recent cohort study of Victorian orthopaedic trauma patients found that attributing fault to another party following a motor vehicle crash was associated with greater risk of not having resumed employment 12 months after injury [22]. There have been similar findings in studies of mixed trauma cohorts, in which external fault attributions were associated with worse functional recovery and poorer RTW [23, 24]. The authors of these studies describe the fault attributions as perceptions of injustice. One suggested response to these findings has been to pay greater attention to the non-pecuniary needs of people making compensation claims [25], including for instance the potential therapeutic role of apology. Some authors have argued that it is possible for a compensation organisation such as DVA to enact the important elements of an apology, despite not being the party responsible for the injury/condition for which compensation is being claimed. The effective elements of an apology include the acknowledgement of responsibility, the expression of empathy, and the undertaking of action (compensation, prevention). Others have suggested that introducing restorative justice practices as an adjunct to dispute resolution processes in compensation schemes may help to meet non-pecuniary needs [26].

### **System / policy studies**

There are substantial differences in the policy (legislative design) of the DVA compensation scheme and the compensation and benefit schemes from which much of the research evidence arises, including differences in eligibility and benefit design. There are also differences in the population of people making claims under the DVA and these other compensation and benefit schemes, including in the demographics, conditions being claimed and time between condition onset or exposure and claiming. There is an emerging body of evidence that these factors (policy / legislative design and characteristics of the claiming population) have a powerful influence on health and recovery from compensable injury.

For example, one recent study examining mapping factors affecting recovery across three Australian injury compensation schemes described the influence of regulatory and organizational features, as well as individual/personal level factors on psychological and physical health [8]. This study adopted a 'complex systems' approach to describe how the

presence and resolution of health conditions among people with compensable injury occurs within a complex social system that involves people and organisations (actors) within, at a minimum, the person's immediate social/family environment, the healthcare and compensation systems and potentially also the workplace [27].

There are also multiple quasi-experimental studies of large-scale disability / compensation system reforms, which have demonstrated that policy reform can have significant and unanticipated consequences for workers, employers, insurers and others involved in injured worker rehabilitation. For example, analysis of a Dutch disability reform identified that reductions in benefit generosity were associated with adverse effects on life expectancy, particularly for women with low pre-disability earnings [28]. Evaluation of legislative reforms in two Australian workers' compensation systems demonstrated that financial incentives to speed employer injury notification coincided with a slowing in insurer claims processing [29]. Delays in claim processing and decision making have been associated with poorer mental and physical health and slower returns to work [30, 31]. A study of 49 USA workers' compensation systems identified that policy related to provision of medical care, and ability to change medical providers, had a statistically significant impact on duration of work disability [32].

The implication of these studies is that policy and scheme design matter. They can impact client health through the strong influence that policy can exert on the complex system in which recovery from compensable conditions occurs.

### **Client – Claims Manager encounters**

In addition to the Australian qualitative studies cited in the Phoenix report, there are multiple international studies of the impacts and experiences of compensation and benefit claimants in their encounters with claims management personnel. These interpersonal interactions can have a positive or negative association with client outcomes. For example, in a cross-sectional survey-based study of the experiences of long-term sickness absentees in the Swedish social insurance system, Lynoe and colleagues found that absentees perceived positive and respectful encounters with social insurance officers as facilitative of RTW, whereas negative encounters and the perception of being wronged impeded RTW [33]. Nordgren and Soderlund made similar findings in a survey of sickness absentees with heart failure [34].

## **Delays in claims processing**

The Phoenix report makes it clear that delays in claims processing can have a negative impact on the experiences, and potentially the mental health, of compensation clients. The evidence presented is primarily qualitative in nature and/or from the government inquiries and workshops included in the Desktop review. There are also additional studies that demonstrate statistically a link between compensation claim outcomes, including duration of work disability, and time to process claims. For example, Sinnott [35] showed that administrative delays (days of delay to claim decision) within a workers' compensation system was associated with increased odds of developing chronic disability among those with a work-related low back pain. This was evident for people with injury ranging from mild to very severe. Similarly, Cocker et al [31] studied the impact of delays to claim lodgement, decision and provision of first wage replacement on duration of time loss in the state of Victoria, Australia. This study observed that delays to all three were associated with increased odds of reaching 52 weeks of wage replacement. Finally, Gray [36] in a study of eight Australian workers' compensation schemes, demonstrated that claim processing times are associated with the duration of time off work, and further that the magnitude of the relationship between claim processing times and the duration of time off work was as large or larger than that observed for other factors that have been shown to affect duration including injury type, age and jurisdiction.

## **Employer role in recovery and return to work**

Many veterans of working age will have a relationship with an employer at the time they make their DVA compensation claim. The employer may be the DOD or another employer. There is a large body of evidence demonstrating the important role that employers play in the health and rehabilitation of workers with compensable conditions. A number of studies have demonstrated a link between the level and type of support offered by the employer to the worker and their recovery and RTW. The majority of these have noted that greater employer support is associated with better health and functional outcomes [37-42]. Awang et al found that of 9,850 injured workers enrolled in a RTW programme, 94% of those with an employer with a high interest in re-employing them had a successful RTW compared to only 35% with a disinterested employer [43]. In a study of 551 Victorian workers who were surveyed about their support from supervisors and co-workers during the RTW process, there was a positive association between strong supervisor support and sustained RTW [37]. At the same time, some studies suggest that messages relayed by an employer to an

injured worker could also be perceived as pressure to re-enter work and act as an RTW deterrent [44]. A recent Australian study of 2,699 workers receiving workers' compensation benefits found that receiving social support and developing RTW plans were significantly associated with greater likelihood of RTW. When controlled for one another in a single model, post-claim social support had the strongest association with RTW. Return to work planning also significantly and positively associated with RTW.

### **General Practitioners and Mental Health claims**

One notable gap in the Phoenix report relates to the role of General Practitioners (GPs) in the treatment of people making compensation claims for mental health conditions. There is a body of evidence on this topic arising from a series of studies in the Victorian workers' compensation system, which demonstrates the challenges facing GPs in treating compensable patients generally [45-47], and the additional challenges in treating patients with mental health conditions specifically [46]. These studies report that MHC claims were complex to manage because of initial assessment and diagnostic difficulties related to the invisibility of the injury, conflicting medical opinions and the stigma associated with making a MHC claim. Mental illness also developed as a secondary issue in the recovery process.

This field of evidence has led to the development of a set of clinical guidelines for the diagnosis and management of work-related mental health conditions (MHCs) which are currently being reviewed by the RACGP for endorsement [48] and will be trialled across multiple state workers' compensation systems in the coming three years.

### **Trials and Intervention Studies**

Much of the research evidence base in this field is descriptive in nature, using epidemiological or qualitative research methods to identify and describe the relationships between health and compensation processes. However, there are also some examples of interventional research or trials. The Phoenix Australia report cites two examples of intervention trials. One of these involved changing the insurance claims handling practices of an Australian motor vehicle compensation insurer that resulted in some improvements in some health outcomes [49]. The second involved establishing a web-based information and problem solving intervention for Dutch motor vehicle accident claimants which did not affect health but improved the perceived fairness of compensation received [50]. There are multiple other examples of claims management intervention trials in the published literature. For example a retrospective evaluation of policy change in the British Columbia

workers' compensation system demonstrated that the introduction of an expedited surgical payments reduced the duration of time off work by up to three weeks, and that expedited fees reduced surgery wait times [51]. A series of studies in the Washington State workers' compensation system describe the impact of an entirely new claims management model introduced progressively over more than a decade [52, 53]. A study underway in the Norwegian sickness insurance system is testing the effect of Independent Medical Assessment (IMA) versus treatment as usual (without IMA) on return to work [54]. These studies demonstrate that it is possible to improve the health of people making compensation claims through changes to claims management practice and policy. The Washington State example is notable as it describes a 'whole of system' transformation of the compensation claims management system that has produced important positive impacts on health, while also improving the financial sustainability of the compensation scheme.

## KEY MESSAGES FROM EXISTING RESEARCH EVIDENCE

The majority of current evidence base relates to the operation of compensation and benefit systems. At this level the DVA scheme shares many similarities with the civilian personal injury compensation schemes that have been the subject of these studies. For example the claims management practices, approaches to evidence and information gathering, provision of treatment and rehabilitation and communication with clients and their families are similar in the DVA scheme to these other schemes. Much of the existing evidence base in these areas will therefore be relevant and applicable to the DVA.

My assessment of the current state of the research evidence concerning the relationship between compensation claim processes and the health of people making compensation claims can be summarized as follows:

1. Most people who make personal injury compensation claims will recover their health status and return to usual levels of function in a timely fashion.
2. Notwithstanding this, compensation claim processes can have a negative impact on the health of some people making claims for compensation, and the most substantial effects appear to be on mental health.
3. The health and recovery of an individual is a consequence of the interaction between a range of biological, psychological, social, environmental and cultural factors operating at the individual, organizational and systems levels. That is, there

is no single causal factor but rather a multiplicity of factors that influence during claim and post-claim health.

4. One set of important factors for health and recovery are compensation claims processes, and more specifically the interaction between the person making a claim and the claims management organization.
5. Specific aspects of compensation claims processes may be experienced as stressful by as many as one third of clients, and include the following:
  - Slow or delayed decision making.
  - Poor communication with claims organization.
  - Poorly conducted or repeated medical examinations.
  - Having multiple points of contact with claims organisation.
  - In people making claims for mental health conditions, requirements to re-live traumatic experiences.
6. The stress experienced by some people during compensation claim processes can contribute to the onset of, or exacerbation of, mental health conditions.
7. These effects are not limited to people making claims for mental health conditions, and may also affect people making claims for physical conditions.
8. Administrative claims processes may also affect people making compensation claims indirectly, through their effects on other participants in the claims process such as healthcare providers or employers.
9. For example healthcare providers may be reluctant to treat compensation clients due to complex administrative and clinical barriers. This may reduce access to healthcare or make treating practitioners less willing to engage with claims management organizations for assessments, for example, which may in turn delay claims decision making.
10. Claims management processes are to a large extent modifiable and thus present opportunities for implementing changes that can mitigate their impact on health, including mental health.
11. There are relatively few published studies of the impacts of changing claims management processes on the health of compensation system clients, though an

evidence base is emerging. There are multiple studies underway and some claims organizations are trialing new approaches.

12. Policy and legislative design provides a framework within which claims management is delivered and thus places some limits on what is possible operationally. Ultimately, delivery of a 'best practice' model of claims management also requires a best practice policy model.

## SUMMARY OF DVA MATERIAL

The DVA made a range of additional material available for this study. Much of this was reviewed in the Phoenix report and included the following:

- Reports from multiple inquiries into the mental health of veterans including two Senate inquiries [5, 55] and the Dunt report.
- Government submissions and responses to the Senate inquiries and ministerial statements with regard to those inquiries, e.g. [56].
- Reports, including quotes and notes, from engagement activities undertaken with veterans and their families as part of the VCR program, and from delegates arising from engagement fora undertaken from 2016 to 2018.
- A series of reports delivered by a consultant (Enzyme) following a series of 'process improvement workshops' including a list of 'quick win' process, policy and technology improvements agreed through a consensus voting process of workshop participants.
- A selection of media articles related to the Jesse Bird case and recommendations arising from the related report from the joint Defence/DVA inquiry into the case.
- A report from the Victorian Ombudsman's inquiry into workers' compensation claims handling in the Victorian workers' compensation system [57].

In addition the DVA provided further material to the study author for current report, including:

- The 2018 draft report of the Productivity Commission inquiry into the Veterans' support system and the Government submission to the inquiry issues paper [58].
- The 2018 report of the Auditor General into the efficiency of Veterans' service delivery [59].



- The 2018 report of the Transition Taskforce regarding improving the transition experience for veterans [60].
- A range of internal documents including delegate training presentations on client support and complex case management, as well as information about the combined benefits processing trial, stream-lining and straight through processing rules.
- A range of summary statistics and data related to DRCA and MRCA initial liability claims including information on time taken to process (TTTP), recent trends in claims volume and claims management caseload.

The evidence provided by DVA aligns with the existing academic research evidence base and provides an important local context including multiple specific examples of veterans and family member's experiences with the DVA compensation processes. The research evidence suggests that the following factors may contribute to poorer mental health in people making compensation claims:

- Slow and complex administrative processes, potentially leading to delays in treatment and financial distress.
- Poor communication between DVA and veterans and lack of transparency in decision making, contributing to a lack of trust towards the DVA by some parts of the veteran community
- Perception that veterans have the burden of proof and must demonstrate the veracity of their claim
- Challenges in identifying vulnerable veterans and those at risk of self-harm, and consequent limitations in the supports provided to vulnerable veterans

The DVA material also extends the conclusions able to be drawn from the academic literature in two important ways. First, these documents demonstrate that psychological harm does arise in some veterans who have been involved in DVA compensation claims. Second, the documents also demonstrate that while DVA compensation claims processes are unlikely to be the sole cause of psychological ill health in these cases, the consequences may be catastrophic and include multiple reported cases of suicide and self-harm.

Finally, the documents also identify some potential, partial solutions to many of the issues identified. This is perhaps most clear in the reports from the 'process improvement

workshops'. For example the report from the PI workshop (dated Sept 2016) lists 'automatic compensation payments' as the top claims improvement initiative, followed closely by 'radical change around obtaining medical evidence' and 'tighter control on re-assessments', but also notes that there had been little progress on these initiatives at the date of the workshop. If implemented, these activities would address multiple of the issues identified in the research literature and the DVA material, notably the issue of delays in decision making/claims processing and the issue of repeated medical assessments.

The final report (dated May 2017) focuses on 'quick wins' and appears to consolidate the opportunities presented in the prior workshops. This report describes a prioritised list of quick win opportunities including 'doctor's opinion stands' and 'reduce unnecessary and unhelpful correspondence'. Once again, if implemented these would address some of the identified issues including the issue of repeat medical assessments, the perception that veterans need to demonstrate the veracity of their claim, and the issue of communication between DVA and veterans.

In summary the DVA material is highly consistent with the research evidence and provides a useful starting point for identifying short-term solutions.

## CONCLUSION

There is a strong evidence base supporting the assertion that compensation claims management processes affect the mental health of people making claims. The processes identified in the academic research literature as being potentially problematic are also evident in the DVA compensation processes, and there is evidence of these processes contributing to psychological harm in some veterans.

Compensation claims processes are, to a large extent, modifiable, and there are multiple opportunities for modification of claims management practices that should, on the weight of evidence, lead to a reduction in the risk of psychological harm arising from involvement in DVA compensation claims processes. The major implementation challenge is to identify which changes are likely to have the greatest net positive impact.

The remaining sections of this report attempt to address this issue by (1) summarising DVA claims processes and future reforms, (2) identifying good practice claims management practices that seek to promote health and reduce harm; and (3) identifying opportunities for DVA to modify existing practices.

## SECTION TWO: DVA CLAIMS PROCESS

### CURRENT STATE

The DVA supports in excess of 280,000 clients and has an annual expenditure of over \$13 billion, with the vast majority of expenditure funding treatment and rehabilitation (\$5b) and providing income support and compensation benefits (\$7.4b) for veterans and their families [61]. There were approximately 166,000 veterans with accepted claims in 2017/18, including 89,000 with accepted claims under VEA, 53,000 under DRCA and 30,000 under the MRCA [58]. The annual claims processing workload is substantial. In the 2017/18 financial year, the DVA made liability determinations on 44,400 condition claims, processed more than 26,000 permanent impairment payments, made a further 5,700 incapacity payments, and continued to pay nearly 100,000 service pensions.

This support is administered under a policy framework that involves three main pieces of legislation (VEA, DRCA & MRCA), which differ with respect to eligibility, benefits and services, and methods of establishing liability. An overview of the major elements of the current policy framework is provided in Chapter 3 of the recent Productivity Commission draft report [58].

The DVA administrative claims process has evolved to enable the DVA to meet the objectives of this legislative framework. The complexity of the policy framework is reflected in the DVA claims operating model. A high level flow diagram describing the process for claiming compensation and other benefits under the MRCA and DRCA is provided at Figure 1. I note that the process for the VEA claims is simpler and also that the majority of current DVA clients are supported through the VEA. However the number of DRCA and MRCA clients is growing and the greater burden of mental ill health, and increased risk of self-harm and suicide appears to be within these latter two younger cohorts.

Some of the defining features of the DVA claims model are as follows:

- There is a stepped approach, with two main parts. Determination of liability and needs assessment occur in the first part, followed by determination of the relevant claims, payments and supports. Claims processing can occur simultaneously for permanent impairment claims, incapacity payments, and for rehabilitation and other

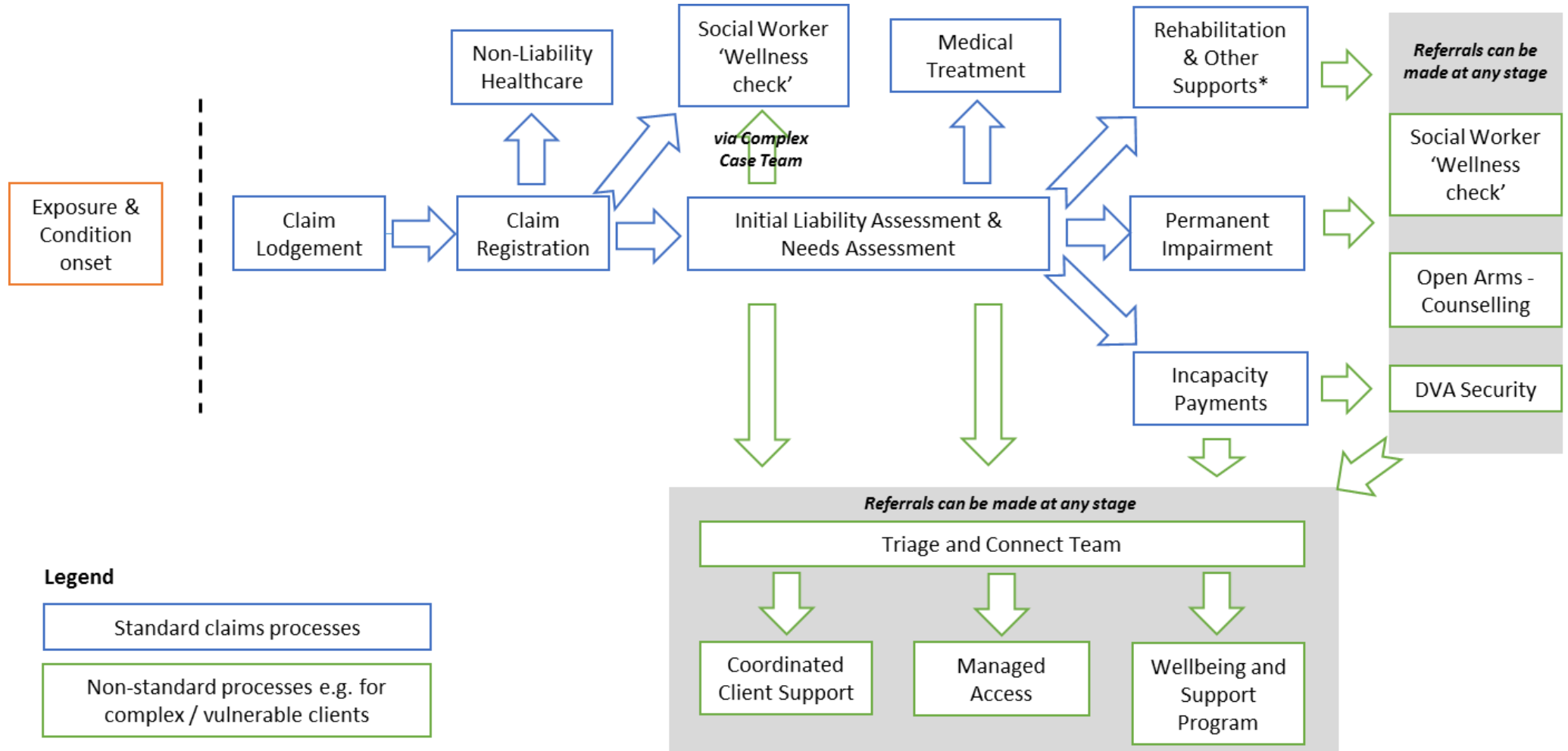
supports. In some cases needs assessment also occurs at the claim registration stage.

- It is claim-based rather than person or veteran-based. This means that each claim made by a veteran is for a separate health condition (injury, disease or illness). It is common for veterans to make multiple claims at a time, and thus also possible for veterans to be involved in multiple stages of the process simultaneously depending on the progress of their various claims.
- Each major component or step in the claims process is performed by a specialist claims team. This means that a single claim is 'handed over' between claims teams and individual delegates on multiple occasions, as the claim progresses through the process. Once a claim passes the needs assessment stage, there may be multiple DVA delegates working on an individual claim if the veteran is seeking access to multiple benefits.
- Each step or component of the process involves some form of evidence gathering by the DVA and a decision. For example to establish liability the DVA requires proof of identity, evidence of service, medical evidence for the claimed condition and demonstration of a causal link between service and the claimed condition. To assess permanent impairment for a claim in which liability has been accepted, the DVA requires further medical evidence to establish the level of impairment and its permanency, and also requests information from the veteran of lifestyle effects of the condition. This, combined with the sequential processing, introduces the potential for requesting similar or the same evidence at multiple stages throughout a claim.
- There are multiple channels for claim lodgment. At present claims can be lodged by completing a paper claim form, over the telephone, or via one of multiple digital channels including the MyAccount, MyService and ESO portals.
- A client can have multiple claims in the system at any one point in time, which may all be at different stages of the process.
- In the vast majority of cases (approximately 90% according to DVA sources), veterans elect to receive Permanent Impairment payments as lump sum amounts rather than as smaller, more regular payments. There is some evidence in the published research literature that this approach, combined with the requirement to

demonstrate impairment to qualify for the lump sum, introduces a perverse incentive to remain sick [62]. Receipt of lump sum benefit payments may also preclude people from accessing other benefit systems, such as social security.

- There is a focus on early access to medical treatment. All veterans with eligible service who have mental health conditions are able to access healthcare prior to liability assessment through the recently extended NLHC model. Early access to healthcare is also available for certain veterans with a limited number of other conditions including Cancer and Pulmonary Tuberculosis. Medical treatment services become available for all other accepted condition claims following initial liability determination.
- The registration of a claim prompts services intended to support early access to social care. This includes that all clients with post-1994 service, as well as clients managed by the Complex Case Team (discussed below), are referred to an in-house team of social workers who undertake a psychosocial 'wellness check' via direct contact with the veteran or their representative. Social workers can refer the client to external services beyond those funded by DVA.

**Figure 1.** High level summary of DVA claims process.



Note: \* Other Supports include housing, attendant care, support for education, appliances etc.

In addition to the standard components of the claims processing model, veterans with complex claims or who are considered at high risk may be referred to one of a number of additional supports and services. This process is supported by a risk screening process undertaken at the claim registration stage, which is the earliest opportunity to identify veterans with more complex needs who may require additional support and services. This is largely a qualitative assessment conducted by the delegate on the basis of information available at the time of registration, though it is aided by a set of risk indicators.

At the IL stage, veterans who have experienced sexual or physical assault, mefloquine claims, some Special Forces claims and MRCA death claims are managed by a Complex Case Team within the Initial Liability Team. This unit has counterparts within the Social Worker team who specialise in managing cases of sexual or physical abuse.

Clients considered complex or at risk can be referred to a number of other supports at any stage throughout the claims process, via the Triage and Connect Team, which has been established as the gatekeepers for internal referrals for complex cases. The triage team may refer the client back to a BAU team, or to one of three other main teams:

- (1) Coordinated Client Support, who help at-risk/vulnerable clients navigate DVA services and ensure needs are met. CCS case coordinators are appointed for a limited time period to assist the client to navigate their DVA entitlements and the claims process and provide links to other external support services. However the CCS does not undertake any claims processing;
- (2) Managed Access, who manage interactions with clients whose behaviours are unreasonable, seeking to address issues and support return of these clients to BAU; and
- (3) Wellbeing and Support Program which is a small-scale, two year trial that uses externally contracted case managers to provide case management services and care coordination to clients with complex needs.

The Triage team also has the option of escalating claims or claims related issues to a cross-departmental group called the Problem-Solving Forum and/or to request consideration of the issue at an Executive meeting. These escalations do not involve case coordination per se, but can be used to find solutions/determine appropriate next steps, which can involve referral to one of the three previous options.

Finally veterans can be referred to Open Arms counselling services or to DVA Security at any point in the process, including by the Triage team. Referrals to Security are made for critical incidents and to manage threats of harm to self, others or property. Veterans are also able to approach Open Arms at any stage and do not need to have a claim with DVA.

The claims operating model that underpins the standard process also has some defining features, including:

- Claim processing is organised in teams. Each team consisting of multiple delegates, a team leader and a subject matter expert. Teams have access to internal medical and other expertise to support claims evaluation and decision making.
- Claims teams are geographically dispersed across the various DVA offices. For example, the team responsible for claim registration is based in Melbourne; teams responsible for initial liability decisions are based in Melbourne and Sydney; incapacity payment teams are based in Adelaide, Brisbane and Perth; and permanent impairment teams are located in Brisbane and Perth.
- For the Initial Liability Assessment and subsequent steps, DVA claims delegates specialize in one of the three Acts. Each claims team will have delegates whose combined expertise covers all of the relevant Acts. This approach has been adopted to enable the DVA to ensure that its delegates have sufficient expertise in a specific part of the policy framework to enable quality decisions to be made.
- The process is supported by a multiple IT / information management systems. In 2017 the DVA introduced the Integrated Support Hub (ISH) as the primary claims management system. However ISH does not currently enable delegates to complete all of the functions required for end-to-end claims management and thus a number of legacy systems are being maintained and used during claims management.
- A number of training and information packages for delegates have been developed to reinforce the supports and services available for complex, at-risk and vulnerable clients. These include information on how to identify vulnerable clients, referral pathways for at-risk clients, procedures for handling critical or emergency phone calls, social workers psychosocial assessments, policy on access to interim PI



compensation, communicating negative decisions to clients, and information on using the Integrated Support Hub (ISH) to trigger supports.

- Decision making regarding initial liability under the MRCA and the VEA are supported by Statements of Principles (SoPs), which are used to establish causal connection between exposures or activities and specific medical conditions. In order for liability to be accepted by the DVA, at least one SoP factor must be met before a medical condition can be found to be related to service. The SoPs are developed and reviewed by the Repatriation Medical Authority (RMA), based on scientific and medical evidence.

## RECENT REFORMS & TRIALS

### VETERAN CENTRIC REFORM

The VCR is a major six year program of work that commenced on 1 July 2017, and has received funding of \$166.6 million (2017/18) and \$111.9m (2018/19) in the first two years. The program includes nine work streams that collectively seek to transform business processes, improve service delivery and redevelop information and communication technology. An overarching objective of the VCR program is to move the DVA to a proactive claims management model from its current reactive approach.

A major focus of the VCR programs is on the digitisation of DVA processes and enabling better use of data and analytics. This is occurring, for instance through the Digital Client Experience Stream. This stream has developed and implemented the MyService digital platform to allow clients to complete claim applications online. The platform also uses a rules-based engine to expedite the initial liability assessment and needs assessment steps using information from Defence's training and service data mapped to the Statements of Principles (SOPs) to immediately determine if claims meet service-related requirements. The MyService portal also collects information for permanent impairment assessment. As at February 2019, over 50,000 clients have been registered through MyService, with over 19,000 claims. Another VCR initiative involves the digitisation of DVA's paper files, with over 232,000 veteran files digitised as at Nov 2018, which reduces the expense and time involved in moving paper between locations.

The primary anticipated benefits of the VCR program are a reduction in the time to process claims resulting in faster access to benefits and services for veterans and their families, and a reduction in the complexity of the claims process resulting in improved experience.

The VCR program is also attempting to increase the number of veterans who are known to the DVA by increasing access via mobile service centres and partnerships with DHS and Defence. This may have the long-term benefit of enabling faster responses to claims as veterans will already be 'known' to the DVA with some information on file at the point of claim.

Another aspect of the VCR program has been the Channel Transformation and Client Strategy (CT&CS). This is a set of activities that has used quantitative and qualitative data to enhance the DVA's understanding of its clients and their needs, and to describe future potential service models. The CT&CS approach has included:

- An exercise in using data to segment the DVA client portfolio by their relationship with Defence and the DVA (serving, transitioning, post-service, family & supporters) and by the complexity of their needs (inactive, low, medium, high). This analysis identified fifteen distinct client segments, and in the process has developed a set of 'complexity indicators' from DVA existing data sources.
- An exercise to develop a better understanding of the service needs, gaps in service, and service 'pain points', of each of the identified client segments. Development of this service interaction model was supported by qualitative data captured through direct engagement with veterans.
- An exercise to define the required capabilities, skills and behaviours of frontline service delivery staff. This identified a set of core skills and capabilities that were consistently reported by existing staff to be required for effective engagement with veterans and job performance. This activity was supported by qualitative data captured directly from DVA staff.

#### OTHER RECENT REFORMS & TRIALS

In addition to the VCR program, the DVA has introduced a number of additional reforms to its standard claims process in recent years that are directly or indirectly related to veterans with mental health conditions, and has been trialling different approaches to claims management. These include:

- Extending Non-Liability Health Care to all mental health conditions, enabling any veteran with at least one day of service to access specialist mental health treatment.

- Enabling interim Permanent Impairment compensation payments to be made to veterans making claims under MRCA. Veterans with PTSD, Anxiety disorder, Depression, Substance use disorder or Alcohol use disorder are able to receive an interim compensation payment if their impairment assessment demonstrates that they have a level of impairment of 10 points or more, but it is not yet stable.
- The “Combined Benefits Processing trial” taking place in the Brisbane and Perth offices. This trial introduced a single team handling the three functions of Initial Liability Assessment, Needs Assessment and Permanent Impairment Assessment, providing a single point of contact for veterans to support them through all three processes (one delegate per Veteran), and combining some of the functions that are required in all three processes, for example a single more comprehensive medical assessment that considers the requirements of IL and PI components. Internal analysis of evaluation survey responses from 33 Veterans who have completed the process suggests that most veterans are satisfied or very satisfied with their experience. Reports from delegates and claims team leaders involved in the trial indicate that claims are being processed more quickly and also that delegates are able to develop a better understanding of veteran’s needs and thus provide more tailored support and services.

## OTHER FACTORS AFFECTING CLAIMS OPERATIONS

The design and operation of the DVA compensation claims model is influenced by a number of important contextual factors. Among these are the legislative framework, the characteristics of the client population, the DVA claims workforce, the use and availability of data and the role of advocates or veteran representatives. It is important to recognise that as well as having a significant impact on current claims operations and performance, these factors may also impact on the ability of DVA to reform its claims operations.

## LEGISLATIVE FRAMEWORK

As noted in multiple of the recent inquiries into the DVA system, and by the DVA itself in its submissions to or responses to these inquiries, the current legislative framework within which the DVA operates is very complex, and creates multiple challenges for the DVA in operating an efficient and effective claims model. The three Acts have different eligibility requirements and provide different benefits and supports through different claims and appeals processes. It is possible for an individual veteran with multiple conditions to have

eligibility under different Acts. As noted by the Productivity Commission in their draft report [58], since World War 1, *“new features have been added, often in an ad hoc manner and/or in response to particular incidents or pressure from veterans’ groups. While a number of the original rationales for elements of the scheme have faded, a political desire to avoid reducing entitlements has meant that governments have not seized opportunities to remove duplication and redundancy. In DVA’s words, the three Acts ‘collectively incorporate almost all of the benefits available to successive generations of veterans over the last 100 years’.”*

The complex legislative framework appears to contribute to at least some of the processes that are having potentially adverse impacts on veteran mental health. For example, again as described by the PC draft report *“One of the consequences of multiple Acts is the need for offsetting of compensation between Acts (to ensure veterans are not over or under compensated). Again, this is confusing for veterans and a source of many complaints to the Commonwealth Ombudsman. Offsetting can also lead to errors in compensation estimates which can have serious consequences for veterans.”*

I note that the PC inquiry has proposed substantial legislative reform to the veterans’ support system. While considering the detail of such reform it beyond the scope of this study, it is important to note the evidence that policy design has a significant impact on claims management processes which subsequently impact on the mental health of veterans. It is also worth re-stating that the research evidence supports the assertion that reform of the claims process to minimize impacts on mental health and promote wellbeing will ultimately also require reform of the legislative and policy framework. Thus one guiding principal for any legislative reform should be to enable implementation of a claims assessment process that maximizes the potential for recovery and minimizes any potentially negative impacts. Policy reform should be informed by the evidence base reviewed in section one of this report.

## CLIENT POPULATION

The population of people claiming benefits from the DVA is unique and differs in multiple respects from people who claim benefits under civilian injury compensation systems such as workers’ compensation or motor vehicle crash compensation schemes. DVA clients have a unique demographic profile, including a large number of dependent females aged 60+ years, and a growing number of young or middle aged male and female veterans. Defence service exposes personnel to a unique set of occupational risk factors and thus

the profile of health conditions in the DVA system differs from that in civilian personal injury compensation systems, including notably a lower barrier to entry for people making claims for MHCs than most civilian schemes, resulting in a greater proportion of clients having claims for mental health conditions.

In the DVA system there are no limits on the time between claim lodgment and the exposure or event that led to condition onset. This means that veterans can lodge a claim for a condition that first became apparent decades earlier, and/or after a long period of time has elapsed since their military service. This can complicate liability determination as it can take a longer period of time to collect service and other records, and can make it more difficult to differentiate service related conditions from other health conditions.

### CLAIMS WORKFORCE

Compensation claims assessment and management is a complex and challenging role. In addition to the administrative challenges, claims management roles often have a significant emotional component, which has been described as the ‘emotional labour’ of claims management roles [63]. These challenges include extra-role commitments, emotional control, stress and balancing tensions arising from differing stakeholder expectations about outcomes related to compensation and health. Studies of civilian personal injury compensation schemes have reported that these challenges contribute to a high turnover of staff, which has flow-on impacts for the claims management organisation related to education and training to ensure role competence, can delay claims processing times, and increases hand-over of claims between claims managers [57].

In recent years the DVA has seen a growth in its claims management workforce, specifically related to DRCA and MRCA initial liability and permanent impairment claims, funded by additional departmental funding in the most recent budget cycles. At the same time there are also indications that the claims mix is shifting. The intake of MRCA and DRCA permanent impairment claims has risen 100% from 5,704 in the six month period July to November 2017 to 11,408 in the period July to November 2018 (unpublished data provided by DVA), whereas the number of VEA clients continue to decline as this population ages[58].

The PC draft report observes that there may be links between these workforce challenges and the quality of DVA claims decisions. The geographic ‘footprint’ of the DVA is substantial and extends beyond Australia with some clients living internationally including in south-east Asia, and many clients living rurally. To accommodate this dispersion DVA

has claims teams in multiple locations across Australia. Each DVA office performs different claims management functions. In practice this results in claims being handed over from one office to another throughout the course of a claim, which may also have an impact on decision making and timeliness of claims processing.

Developing and maintaining an expert compensation claims management workforce is a significant challenge, and one that the DVA clearly faces. The third section of this report makes some comment on a 'best practice' claims model, including reference to the attributes and responsibilities, training and education of claims management staff.

#### AVAILABILITY AND USE OF DATA

Access to data and information about clients is essential for both efficient and effective claims management. Better use of data has underpinned much of the transformational activity in the personal injury compensation and disability benefit sector in Australia over the past decade. The DVA has important data sharing relationships with Defence and the DHS that if operating effectively, would better enable the DVA to better perform its claims management function, and to understand the drivers of poor mental health in compensated veterans. These data sharing relationships have been reviewed in multiple of the recent reports and inquiries into the DVA system, but for completeness I briefly repeat them here.

The DVA has established a Single Access Mechanism (SAM) with Defence that is intended to enable the rapid provision of service information to the DVA to support efficient claims determination. A number of initiatives are underway to improve the exchange of information, including the early registration of serving ADF members with DVA and providing direct access for DVA staff to Defence eHealth records.

DVA uses a number of systems to support its decision-making, which are being progressively integrated and replaced. ISH is hosted by DHS, and DVA also relies on its own back-end systems to support its decision-making.

Improved access to data offers the opportunity to transform claims processes. For example, in the third section of this report I present a case study of data-based claims triage that involves daily data feeds from claims information systems to segment clients into risk categories that are then streamed into tailored claims management pathways.

## ADVOCACY AND CLIENT REPRESENTATION

Veterans can claim benefits directly, representing themselves in their dealings with the DVA, or can enlist the services of an ESO to support them through the claims process. ESOs may lodge claims on behalf of veterans and represent the veteran throughout the claims process. This is a unique representative role that is not replicated by equivalent advocates in other personal injury management systems. There are many hundreds of ESOs and recent reports suggest that there are significant pressures in the ESO community, including a declining number of advocates and the ability of the volunteer advocate workforce to provide expert advice given the complexity of the DVA legislation and claims processes. ESOs play a significant and potentially very influential role in the claims process. As per the role of delegates, their impact on veterans experience and mental health may be significant. I note that the Veterans Advocacy and Support Services Scoping study has delivered a final report to government.

## CLAIMS SYSTEM PERFORMANCE

It is difficult to arrive at an overview of the DVA claims system performance. As noted in the draft report of the Productivity Commission (Chapter 16)[58], there appear to be significant gaps in available data which limit the ability to evaluate claims system performance and its relationship to veteran health and well-being. Further, as noted by DVA in its submission to the PC inquiry, most of the available performance assessments *“have tended to measure delivery (or outputs), rather than effect (or outcomes).”*

Despite these limitations, it is clear that performance is improving in some areas. Claim processing times for MRCA and DRCA permanent impairment decisions have reduced by approximately 50% since 2016 to a median of ~70 days (PC report) while processing times for MRCA and DRCA initial liability decisions have reduced by 10% to 20% in the same period. Further, the rate of dissatisfaction among DVA clients fell from 8% in 2016 to 6% in 2018, although there is a clear age-related effect with younger veterans aged under 45 years much more likely to be dissatisfied, and clients aged 65+ much more likely to be satisfied with the DVA. Among the younger age group the level of dissatisfaction dropped substantially between 2016 and 2018. Recent data suggests that claims volumes are increasing dramatically in some parts of the process.

These metrics suggest that the recent changes to the DVA claims processing system through the VCR program are having a positive impact, however the lack of more comprehensive outcome data makes this difficult to verify. Section three (below) describes an example of a more comprehensive client outcomes measurement framework recently developed in the NSW workers' compensation scheme, as an example of leading practice in this area.

## CLAIMS VOLUME

As already noted, the DVA processes a substantial volume of claims from many thousands of veterans. The number of VEA claims appears to be decreasing as the eligible population ages. In contrast there has been substantial growth in the number of DRCA and MRCA claims in recent years, and this growth has accelerated in the 2017 and 2018 years. Table 1 presents some high level data on the total number of DRCA and MRCA claims lodged between 2013 and 2018, derived from information provided by the DVA.

**Table 1.** MRCA & DRCA claims lodged between 2013 and 2018\*

Year	DRCA		MRCA	
	Number of claims	Percent change from 2013	Number of claims	Percent change from 2013
<b>2013</b>	4,152	-	13,325	-
<b>2014</b>	4,265	2.7	15,927	19.5
<b>2015</b>	5,690	37.0	14,240	6.9
<b>2016</b>	7,421	78.7	18,697	40.3
<b>2017</b>	9,464	127.9	35,369	165.4
<b>2018</b>	23,370	462.9	25,113	88.5

Note: Data shown in Table 1 includes only claims in which the effective data is prior to the lodgement date.

The substantial increase in initial liability claims in the 2017 and 2018 years now appears to be flowing through to the second segment of the DVA claims process. For example, the draft October 2018 Client Benefits National Summary shows that in the four months from July to October 2018 there were 4,935 new MRCA permanent impairment claims, an increase of 114% from the equivalent four month period in 2017. There were 4,769 new DRCA permanent impairment claims lodged in the same period in 2018, an increase of 132% from the equivalent four month period in 2017. The same data summary shows that caseload (number of claims per FTE) has increased for both MRCA and DRCA permanent impairment claims, with an additional 13 MRCA cases per FTE delegate in the period July



to October 2018, an increase of 26%. There were an additional 95 DRCA cases per FTE delegate for the same period, an increase of 151% on the same period for 2017. This increase has been accompanied by an increase in the number of claims processed per FTE, and indicators of the age of claims 'on hand' at Oct 2018 suggest that overall claim age has not yet been impacted and that claims are being processed more rapidly on average.

The DVA provided some data relating to new MRCA condition claims from 2004 to 2018. An extract from this data is shown in Table 2, for the years 2013 to 2018. There were a total of 18,999 new claims for mental health conditions during this 6 year period, representing 10.8% of all new claims lodged. Mental health conditions accounted for 6 of the most common 25 conditions, and the rate of increase in MRCA mental health condition claims was substantial. Claims for depressive disorders increase by 90%, PTSD by 50%, Alcohol use disorder by 97% and Anxiety disorder by 145%. This is consistent with the rate of increase in new claims across many condition types. Note that these data relate to claims for individual conditions, and do not reflect the number of individual veterans making claims, which is likely to be a higher percentage given that many veterans claim for multiple conditions. DVA internal analysis (reported to but not seen by the author) has identified that 32% of DVA clients have either a current or accepted claim for a mental health condition.

**Table 2.** Top 25 MRCA condition claims 2013 to 2018

ICD Body Classification	SOP Description	Number of claims 2013 to 2018	Percent change 2013 to 2018
MSK+I&P	Sprain and strain	8658	24.9
Musculoskeletal	Osteoarthritis	5255	136.0
Nervous System	Tinnitus	5023	127.2
Nervous System	Sensorineural hearing loss	3707	86.7
Musculoskeletal	Lumbar spondylosis	3592	75.0
Musculoskeletal	Rotator cuff syndrome	3192	70.8
MSK+I&P	Fracture	3151	28.8
Mental Disorders	Depressive disorder	2812	90.9
Mental Disorders	Posttraumatic stress disorder	2398	50.0
Musculoskeletal	Shin splints	1597	27.5
Musculoskeletal	Chondromalacia patella	1531	32.4
Musculoskeletal	Joint Instability	1442	122.0
MSK+I&P	Labral tear	1227	4210.0

Musculoskeletal	Intervertebral disc prolapse	1222	-23.2
Mental Disorders	Alcohol use disorder	1208	96.7
Mental Disorders	Adjustment disorder	1043	62.9
MSK+I&P	Acute meniscal tear of the knee	1034	90.0
MSK+I&P	Dislocation	855	-5.5
Musculoskeletal	Plantar fasciitis	722	130.4
Mental Disorders	Erectile dysfunction	708	401.9
Mental Disorders	Anxiety disorder	622	145.5
Injury & Poisoning	Physical injury due to cut or stab or abrasion or laceration	578	-15.4
Musculoskeletal	Patellar tendinopathy	534	103.9
Musculoskeletal	Thoracic spondylosis	531	110.7
Musculoskeletal	Cervical spondylosis	488	25.7

Note: MSK+I&P = Musculoskeletal and Injury and Poisoning

These data demonstrate a substantial recent increase in claim volume under both the DRCA and MRCA schemes, coinciding with the introduction of the VCR program. These new claims are now beginning to flow through the DVA claims process and to have a substantial impact on the caseload in the latter parts of the claims process, although this doesn't yet appear to have impacted time taken to process claims.

## COMMONWEALTH SUPERANNUATION CORPORATION

Some veterans with DVA claims will also be engaged concurrently with claim assessment processes administered by the Commonwealth Superannuation Corporation (CSC). This may include seeking access to invalidity benefits under the life insurance scheme operated by the CSC for ADF members. This cover provides access to invalidity benefits for non-service related injuries and events for people aged under 60 years, and thus complements the service related benefits and age-based pensions provided by the DVA. The CSC life insurance claim assessment process shares many of the features of the DVA and other similar processes, requiring medical evidence to support a claim, and a claim determination step at which a claims manager determines CSC liability for the claim.

CSC indicates that they processed approximately 5000 such claims in 2017, noting that this includes claims from other Commonwealth government agencies such as the DHS, Border Force and the Australian Federal Police. Of these, approximately 45% involved mental health matters. For invalidity claims, this figure rose to over 70% and ADF members account for the majority of these claims. Information provided by the CSC via the

DVA suggests that for some clients the claims process is resolved relatively quickly. For example, in over 40% of cases invalidity pensions for veterans with medical discharge from the ADF are determined on the date of discharge or within two weeks of discharge.

Information provided to the DVA by CSC indicates that they are taking steps to simplify their claims assessment processes and to reduce claims information gathering and decision making times. For example, there are efforts to reduce the reliance on external medical assessment, and to determine a greater proportion of claims based on the medical evidence available from the ADF at the time of claim. A new claims information management system was introduced in late 2018 that has some features to support team-based claims management, meaning that a team manager can access and act on claims being managed by a claims officer if that person is away/on leave. The CSC is also seeking to improve its communication with its clients by reducing the number of written letter templates and re-writing the letters to improve communication. Claims manager training includes a number of modules related to identifying and assisting people with mental health conditions.

As noted in the Phoenix report, for veterans who are concurrently involved in DVA and CSC claims processes, *“it is reasonable to assume that trying to negotiate two systems simultaneously, each with their own specific requirements, will add substantially to the complexity of the process.”* However there is currently a lack of evidence on this client group. Better understanding the population of people making claims through both the DVA and CSC benefit systems may provide valuable information for both the DVA and CSC. By definition, such people are claiming benefits for both service and non-service related conditions, and may thus have a more complex profile of ill health and disability. Mental health conditions appear to be quite prevalent in CSC clients, suggesting that it may be more likely for DVA clients with current, prior or impending mental health condition claims to also claim benefits through the CSC. This group may present a high risk population from a mental health perspective, and it would be valuable to understand the volume of clients going through both processes, their experiences, the types of conditions for which they are claiming benefits, and their psychological and social characteristics, in order to better define and support this group.

## CONCLUSIONS

It is clear that the DVA compensation claims process is unique and has evolved within a complex and dynamic system and in response to a complex legislative framework. This review of the DVA claims process has also revealed that the specific features of claims processes which research evidence observed to be potentially harmful to client mental health also operate within the DVA scheme, and has identified some aspects of the DVA claims process that contribute to these.

For example it is clear that some veterans perceive the DVA scheme to be slow and complex. There are multiple aspects of the claims process that may contribute to this, including that:

- Information needed to determine liability can take a long time to gather when exposure or condition onset was many years prior to claim.
- Claims are processed sequentially and handed over between delegates for each step in the claim process, introducing potential for delay and loss of contextual information as the claim progresses.
- Veterans (or their representatives) may be interacting with multiple different claims delegates at any point in time
- Veterans may have eligibility under multiple Acts which can be confusing for veterans and their representatives

There is also evidence that these effects are not uniform across the population of veterans supported by the DVA. For example with relation to the previous example, these effect may be stronger in veterans who lodge claims on paper claims forms, and are likely to be less evident in veterans using MyService which dramatically reduces claim processing time for IL, Needs Assessment and NLHC components of the claims process.

In summary, the DVA claims processes appear to have multiple features that could, for some veterans, contribute to the onset or exacerbation of a mental health condition. These features are targets for modification to mitigate any potentially negative impacts.

## SECTION THREE: OPPORTUNITIES FOR DVA ACTION

### FEATURES OF A GOOD PRACTICE MODEL

In the past few years there has been a growing interest in developing guidance and support materials for organisations providing insurance based rehabilitation, health and return to work services across sectors such as life insurance, workers' compensation, motor vehicle accident compensation and superannuation. Some examples of these materials that are particularly relevant for the current study include the SuperFriend "Taking Action" Best Practice Framework for the Management of Psychological Claims [64], and the Best Practice Statement on Risk Factor Identification for Return to Work [65].

The Super Friend Framework was developed by a working group of rehabilitation and claims management experts in the Life Insurance industry, guided by a panel of experts from academia, personal injury compensation, occupational rehabilitation and medical specialists. The framework proposes eight areas for strategic action by claims organisations to implement an overarching, evidence-informed best practice approach to the management of psychological claims. These eight action areas span corporate, claims management, healthcare, analytics, engagement and strategic functions of claims organisations, and are underpinned by three 'pillars' which are described as:

1. The philosophy of 'centering the Person on Claim'
2. Acknowledgement that intervention, and hence improvement, can occur at the macro, the meso and the micro level of a system
3. The principle of Continuous Improvement.

The Monash / WorkCover QLD statement on risk factor identification describes an evidence-based approach to identifying and acting on factors that can influence claim outcome, and is designed for a workers' compensation setting. Risk factor identification can be applied for two main purposes: 1. Guide appropriate allocation of resources. The identification of level of expected input (e.g. low, medium or high) can be used to inform triage and the case management model to be applied for a claim. 2. Guide appropriate service delivery, both responsively and proactively. Proactive service delivery aims to address barriers to RTW ahead of time. The statement summarises the evidence base to support claims triage and tailored delivery of supports, and includes guidance on the method and timing of information collection, key enablers of risk factor identification, and provides some case studies to illustrate application.

There is a substantial amount of other evidence regarding good practice in compensation claims management, much of which was referenced in Section One of this report. Based on this evidence and experience working with multiple Australian and international personal injury compensation regulators and insurers, it is possible to identify a list of important trends in personal injury case management. These trends represent emerging ‘good practice’ in that they are being adopted by regulators and insurers seeking to improve and enhance health and work outcomes for their clients. Table 3 includes a summary of these good-practice trends across five domains. I note that many of these best practice trends are consistent with the DVA’s stated approach to service delivery as reported in the 2017/18 Annual Report [61], page 18/19.

**Table 3:** Important trends in good practice for personal injury case management<sup>1</sup>.

<p><b>Strategic Approach</b></p> <p>Customer-centred, taking into account the experiences and outcomes of clients.</p> <p>Co-designed, incorporating key stakeholders in development of operational and service delivery models.</p> <p>Adopt a biopsychosocial model, acknowledging that social and psychological factors have a major impact on client health and require dedicated services and support.</p> <p>Recognition that improving client outcomes (e.g., health, employment) should have positive downstream impacts on financial performance.</p>
<p><b>Service Delivery Model</b></p> <p>Reduction in the amount of information gathered at claim lodgement to that required for initial liability decision making and initial risk screening.</p> <p>Implementation of risk screening / triaging model at claim onset to ‘stream’ clients to appropriately resourced and capable claims staff.</p> <p>For higher risk clients, early-in-claim capture of psychosocial data to identify client specific risks to health and support identification and delivery of services that address those risks.</p> <p>Identification and avoidance of harmful services and assessments that may impair health or delay recovery (e.g., long-term opioid use, medical examination), and</p>

<sup>1</sup> Developed in consultation with Professor Niki Ellis.

wasteful services that may have limited benefit for clients (e.g., unnecessary medical intervention or medical assessment).

Throughout claims life-course, automation of claims assessment processes where possible (straight through processing) typically for low-risk decisions and approvals to both reduce waiting times and enable claims workload management.

Support more rapid access to healthcare and/or introduce provider incentives (or remove disincentives) to reduce waiting times for healthcare delivery.

Enabling clients to self-manage their claim, where appropriate.

Proactive identification and management of outliers through re-assessment of claims progression at specific points in life-course of claim.

Broadening the nature of services that can be funded or supported beyond medical and rehabilitation to include social services (e.g., financial counselling).

Recognition that involvement in disputes can harm health and use of alternative dispute resolution procedures to seek rapid resolution.

### **Claims Operating Model**

Enhance the role of the case manager (delegate) to become a strategic influencer, acknowledging that this requires greater autonomy and responsibility.

Limit potential for 'handover' or 'double-handling' of claims between case managers.

Structure claims teams based on matching claim complexity and case load with case manager experience and expertise.

Provide in-house support for front-line claims staff via access to experienced case managers and medical/healthcare/rehabilitation expertise.

Increase investment in capability/skills development of case managers.

Enhance coordination of client, insurer, health provider, employer actions and services through greater use of communication mechanisms (e.g., case conferencing, shared digital platforms, case managers visiting homes and workplaces).

Where client is work attached, strengthen focus on role of employers to support recovery and health (e.g., work accommodations).

Strengthen third party provider performance management (e.g., healthcare, rehabilitation, employment services) including requirement to demonstrate use of evidence-based services and outcomes measurement.

### **Evaluation and Monitoring**

Performance measurement and benchmarking across a range of client and scheme indicators including client health, client experience, employment, scheme operations, service delivery and financial metrics.

Trial new interventions / services / programs and evaluate these before scaling-up.  
Scale up based on evidence.

Benchmark performance against like compensation schemes and/or against targets jointly established with stakeholders.

### **Cross-sector collaboration**

Cross-government - Identify and manage joint accountabilities for 'flow throughs'; between systems, including through shared KPIs.

Cross-society - Innovation in service delivery with involvement of public, private and not for profit organisations.

In addition to these trends, and to illustrate more clearly how some of these approaches operate in a claims management workflow, it is valuable to consider a high-level claims process for a good-practice model (Figure 2). This also provides a counter-point to the high level DVA claims process described in Figure 1. This model segments the claims process into three main stages, being:

- (1) Lodgement and Segmentation. Increasingly claim lodgement is moving online, with digital lodgement portals (such as the DVA MyService model) replacing paper based claims lodgement. Concurrent with the move to digital lodgement, many organisations are seeking to reduce the amount of information required at lodgement to the minimum required to determine liability, supplemented by some additional data that can support segmentation into risk groups. The digitisation of data collection enables automated (e.g., overnight) analysis of new claims and allocation of these claims to an initial risk category. This process, often referred to as triage or segmentation, streams individual claims into one of multiple claims



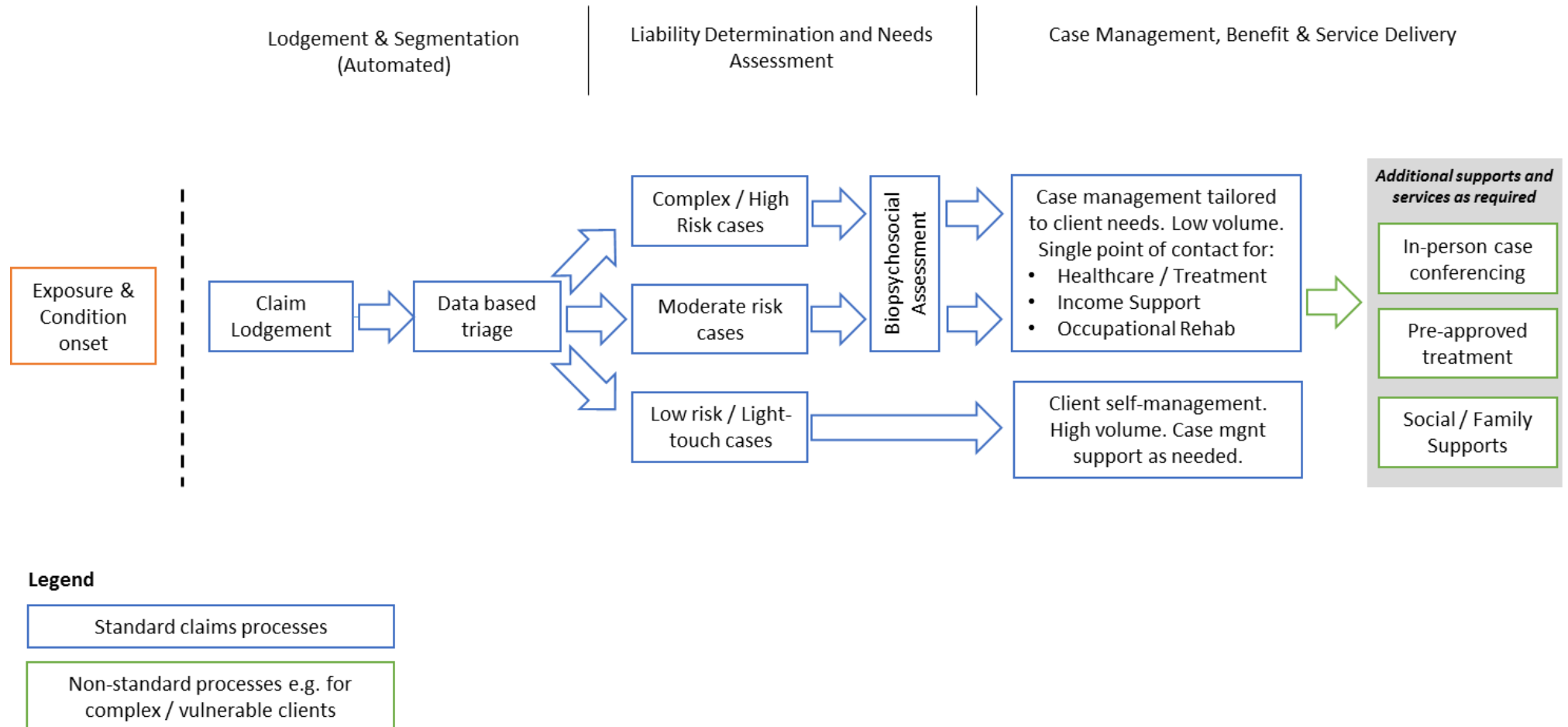
teams where case manager expertise and experience, and case-load, is matched to the 'complexity' of the claim. I would note that digitisation of this process requires well-developed ICT infrastructure and substantial internal analytical capability supported by good access to claims data. There are multiple working examples of this initial process now in operation, for example at WorkCover QLD, in the Transport Accident Commission in the state of Victoria and in the Accident Compensation Corporation of New Zealand. However, it is also possible, and still more common, to implement a 'manual' version of this process in which the segmentation and allocation to risk teams is conducted by a person or a claims team with the specific task of triaging and segmenting new claims rapidly.

- (2) Liability Determination and Needs Assessment. As per the DVA MyService model, it is often possible to determine liability rapidly on the basis of information available at claim lodgement. However, in some cases additional information is required for this decision. This information discovery process may be combined with a needs assessment process in which further information is gathered direct from the client and/or their treating practitioner and/or their employer. Reflecting the evidence base, a biopsychosocial approach to needs assessment is considered best practice. There are now approaches in place that enable this needs assessment to be 'semi-automated' and triggered by the segmentation process, but it is more common for this assessment to be undertaken by a claims manager and to require both direct interaction with the client and/or third parties as well as review of documentary evidence (e.g., claim form and medical certificates). Claims that are triaged into low-risk claims teams are those expected to recover and reach claim resolution without requiring substantial intervention from the claims organisation (often the majority of claims or a substantial proportion), and in these claims the needs assessment is not undertaken, with clients streamed to a 'self-management' approach. Information gathered during the needs assessment of more complex cases is used to identify the specific needs of the client, as per the WorkCover QLD / Monash best practice risk identification model.
- (3) Following completion of needs assessment, claims are managed by a dedicated claims officer who is the single point of contact for decision making regarding access to the range of benefits and services that can be offered or funded by the claims organisation. Complex cases have what is often described as 'active' case

management in which the claims manager has fewer claims to manage, and is able to proactively provide the supports and services identified as being required in the needs assessment process. It is becoming increasingly common to implement a formal stepped-care model in which low-intensity interventions and supports are trialled first, with escalation to more intense or more extensive supports and services as required. Clients in the low-risk teams are allocated to claims teams with higher volumes, who manage claims on an exception basis. This is supported by continuous analysis of this claims portfolio to identify individuals whose claims are not resolving within expected timeframes, or in whom additional risk flags become evident during the course of a claim. These cases may then be transferred to management in a complex case team. Digital / online services enabling self-management are becoming more common, for example by providing an online portal via which a client can submit a medical certificate, or enabling treatment providers to bill the claims organisation rapidly (rather than sending a paper invoice).

Inevitably, some cases require a greater level of support than can be provided in the standard claims teams, and it is common to have methods via which additional supports and services can be provided. There have been multiple trials in recent years of 'face-to-face' or mobile case management for clients with complex needs, involving the claims manager physically visiting the client in their home or work environment, and potentially also engaging treating practitioners in the case conference. It is also increasingly common for claims to have access to pre-approved treatment, or to have expedited approvals for treatment in specific circumstances. Finally it is becoming more common for claims organisations to fund non-traditional services such as financial counselling or family/carer services, reflecting the growing recognition of the importance of psychosocial factors on recovery.

**Figure 2.** High level claims process for a good practice model



Another feature of this model that is not shown in Figure 2, but in which the approach differs from the DVA model, is that it is a “person-based” rather than a “condition-based” claims model. While uncommon, it is possible for an individual to lodge separate claims for multiple conditions in most Australian workers’ compensation schemes. Unless these claims are separated in time, these claims will be aggregated to the person level, and dealt with concurrently throughout the claims process. Finally, there has been growth in claims management organisations investing in the training and education of their claims staff, coinciding with the movement of claims management organisations from a transactional, insurance based approach to client-centred approaches that place greater emphasis health and recovery.

## CASE EXAMPLES

The following case examples are presented to provide brief illustrations of how some Australian personal injury claims organisations are implementing aspects of good practice. Examples have been selected to cover different aspects of the model.

### EARLY CLAIMS TRIAGE & TARGETED SERVICE DELIVERY

WorkCover Queensland is the government insurer for workers’ compensation clients in the state of QLD. The WorkCover Queensland “Recovery Blueprint” trial is using claims data analytics and capture of psychosocial data to support (a) client segmentation into risk groups matched with case manager expertise and experience; and (b) identification and delivery of services and supports that are tailored to the needs of individual clients. The model is underpinned by an evidence base summarized in a best practice statement of risk factor identification for delayed return to work [65].

The model involves three stages that are being rolled out via a trial in the claims management operations of a large segment of WorkCover QLD’s business.

The first stage is an automated analysis of new claims that uses data available at claim lodgment to allocate claims to one of four ‘risk groups’. The two highest risk groups are then allocated to claims teams consisting of more expert / experienced case managers with a lower claims volume, while workers in the lower risk groups are allocated to claims teams with a focus on straight-through processing and a higher claims volume.

The second stage is focused on those claims allocated to the higher-risk groups, in which the case managers capture additional psychosocial data through a set of 10 validated questions that have been shown to predict recovery and return to work outcomes. A high

risk response to any of these 10 questions triggers a further information gathering exercise undertaken by the case manager, capturing data through structured client questionnaires and case managers completing a set of risk indicators on the claims management ICT system.

Finally, the third stage involves a tailored, stepped care service delivery model in which case managers choose from a menu of services, supports and interventions that are matched to the client specific risks identified in the prior step. If these services and supports are exhausted, case managers can escalate to a second set of services and supports.

Underpinning the approach has been a program of education and training for case management staff, and some adjustments to roles and responsibilities. The trial is being evaluated by Monash University. More information is available via the WorkCover QLD website<sup>2</sup>.

Similar models have also been implemented by the Accident Compensation Corporation of New Zealand, the Transport Accident Commission of Victoria, and by some commercial insurers operating across multiple jurisdictions such as Employers Mutual Limited.

## CLIENT OUTCOMES AND EXPERIENCE MEASUREMENT

The State Insurance Regulatory Authority (SIRA) is the regulator for workers' compensation, motor vehicle accident compensation, dust diseases compensation and home and building compensation in the state of New South Wales. The SIRA 2018 strategic plan identifies 'claimant outcomes and experience' measurement as a key focus area. In response, the SIRA workers' compensation branch has developed a client outcomes and experience measurement framework that utilizes a mix of claims data and client survey data to monitor scheme performance across three domains that are linked to the scheme's regulatory and strategic objectives:

- (1) Health. This includes metrics that assess general health, physical health, mental health, and health care use, use of medications, comorbidities and functional impairment.

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<sup>2</sup> <https://www.worksafe.qld.gov.au/about-us/workcover-queensland-research-initiatives/recovery-blueprint>

- (2) Return to Work. This includes metrics of RTW status, durability of RTW, attempts to RTW, duration of work disability, level of work function, offers of suitable duties and RTW self-efficacy.
- (3) Experience. This includes metrics of experience with insurer processes (e.g., claims processing times, satisfaction, perceived fairness), experience with employers (e.g., response to injury, RTW plan development), experience with healthcare providers (e.g., duration of treatment, number of service providers) and personal experience (e.g., financial stress, need for support to navigate the claims process).

The framework was developed by SIRA in consultation with academic and clinical experts, and is being progressively implemented from the 2018 financial year, and supplements the claims processing and financial metrics of scheme performance, and regular reports of its claims operations through a monthly workers compensation system dashboard. Full implementation of the framework will require 2-3 years and is being resourced through a dedicated team within SIRA.

### JOINT MEDICAL EXAMINATION

As described in section one, independent medical examinations are one aspect of the compensation claims process that clients may find stressful and that have been reported to contribute to psychological distress and adverse mental health outcomes.

The Transport Accident Commission (TAC) is the regulator and insurer for the motor vehicle accident compensation system in the state of Victoria. From late 2013 the TAC has introduced a Joint Medical Examination (JME) protocol to reduce the number of medical examinations that its clients were attending, and to improve client experience with the claims process. The JME protocol was developed in consultation with the Australian Lawyers Alliance and the Law Institute of Victoria.

The process essentially involves the TAC and the client's solicitor agreeing to appoint a single examiner to conduct a medical assessment of a client, provides an opportunity for both parties to provide instructions to the examiner, and ensures that both parties receive identical copies of the examination report. The JME guidelines set clear expectations regarding the conduct of examinations by examiners, and of the TAC, the client and their

solicitor. Specific timeframes for organizing examinations and responding to information requests are described to ensure that the examination occurs in a timely manner.

An overview of the process is available at the following website:

[http://www.tac.vic.gov.au/\\_data/assets/pdf\\_file/0007/71494/JME-Process.pdf](http://www.tac.vic.gov.au/_data/assets/pdf_file/0007/71494/JME-Process.pdf)

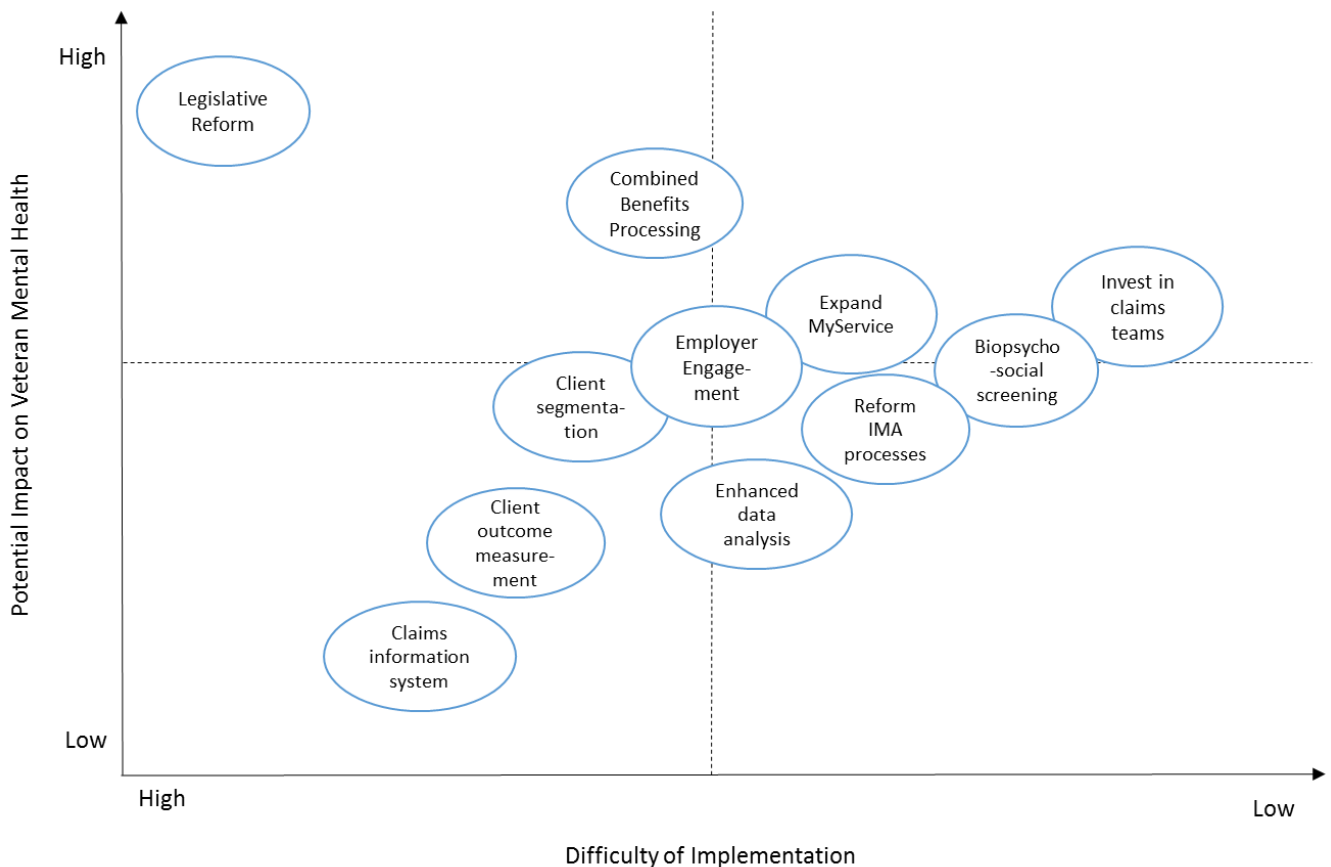
The JME process is the subject of an evaluation by the Australian Centre for Justice Innovation at Monash University.

### POTENTIAL DVA ACTIONS

By comparing the DVA current claims processing model with the academic research evidence, a good practice model of personal injury claims management, and reviewing the findings from a range of reports and inquiries into the DVA system, it is possible to identify multiple areas in which the DVA can take action that may mitigate the potentially negative consequences of compensation claim processes on the mental health of veterans. A summary of these is provided in the following text, along with a brief rationale and where possible observations regarding implementation considerations. Provision of detail about implementation is beyond the scope of this report. With one exception (legislative reform), I have avoided identifying areas that are outside of DVA control and have focused on activities that relate directly to the claims management functions of the DVA. Many of these require (or would benefit from) improvement in the claims information management system and data analysis capability, though action could be taken in some areas without major changes to the current supporting infrastructure. It was not feasible within the timeframe of this project to provide detailed proposal on specific claims reforms, and thus a high level description of these potential action areas is provided,

Figure 3 presents a matrix summarising these areas of potential action, and characterizes these according to the potential to mitigate the impact of claims processes on veteran mental health (y-axis) and the difficulty of implementation (x-axis). Actions in the top right hand quadrant represent those which are least difficult to implement but have substantial potential to mitigate negative impacts on claim processes on veteran mental health, while those in the bottom left quadrant are those that are most difficult to implement and have less potential to impact veteran mental health. The position of the opportunities on the matrix is by necessity a judgement, based on the author's observations of DVA systems and processes, and understanding of the research evidence.

**Figure 3.** Matrix summarizing areas of potential DVA action



### Expand MyService

The MyService portal is a positive development that appears to address, in those veterans using the service, multiple factors that are reported to influence a veteran's experience and mental health. Specifically the service substantially reduces the time taken to process initial liability and needs assessment, and also supports reduced processing times for permanent impairment claims. In addition the service appears to improve/simplify the initial engagement and communication between the DVA and the veteran. Initial feedback suggests that veterans using MyService are more likely to represent themselves in the lodgment process, suggesting that they feel more empowered to participate in the claims process. The increasing usage of MyService by the veteran community is further evidence of its acceptability.

There is potential to expand the MyService offering in order to ensure that these benefits are experienced more broadly across the veteran community. For example, by adding the capability to lodge PI claims through the MyService portal, or by increasing the range of



claims that can be automatically determined without the need for delegate interpretation. There is also opportunity to grow the use of the portal by reducing or removing access to other, generally slower methods of claim lodgment, noting that this would require substantial engagement with the veteran and ESO community as well as further investment in training and education for ESOs in the use of the portal.

There are some risks associated with increasing use of MyService. Since its introduction there has been a growth in the number of MRCA and DRCA claims. One explanation for this is that the lower barrier to entry to the DVA scheme via MyService has encouraged a greater number of veterans to make claims. There is evidence that this increase is impacting on claims processing downstream, as delegate case-loads in MRCA and DRCA increase. Early awareness of claims should, however, allow for earlier intervention by DVA, particularly in relation to medical treatment and other supports, yielding longer term benefits for veterans.

### **Client segmentation**

There are currently a number of ways in which delegates can 'escalate' a claim from routine management to one of a range of additional claims support teams. This process is supported by prompts at registration to consider a number of risk flags, and by some training provided to delegates in complex case identification during an ongoing claim. With few exceptions, these additional support teams supplement but do not replace the role of the delegate, and thus the vast majority of claims are processed through the same pathway, plus or minus additional support. An alternative to this approach is a client segmentation model in which vulnerable veterans or those with complex claims are streamed into a tailored claims management pathway with bespoke services and supports, as per the good practice model. Veterans with less complex claims could be streamed into a 'light-touch' pathway. Case management teams could be organized in a way that matches claim complexity with delegate expertise and experience.

I note that this approach would require modification to existing claims management processes and potentially adaptation of claims information systems. Ideally this triage could be automated using data provided at claim lodgment, as per the WorkCover QLD example described in the case study. However it is also possible to modify some existing processes to achieve this sort of segmentation. For example, some modifications to the existing high risk flags to include methods for delegates to capture additional known risk factors may provide a richer data source for segmentation early in the claim.

In multiple Australian workers' compensation schemes the presence of a mental health condition as the claimed condition, or as a co-morbid condition, is considered sufficient evidence of 'risk' of poor recovery or an extended duration claim that such cases are automatically segmented into a high risk / complex group and managed by a specialist team. These specialist claims team typically include a range of clients including those with MHCs and clients with other vulnerabilities and risk factors, due to the relatively low rate of primary MHC claims in these systems. Analysis of data for claiming patterns provided by the DVA demonstrates that:

- 10.8% of all MRCA new conditions claimed determined during the 2017/18 year (N=5262 conditions) were mental health conditions;
- Of these, the most common conditions claims were Depressive disorders (15.9% of all mental health conditions claimed), PTSD (12.1%), Anxiety disorders (8.2%), Alcohol use disorder (7.8%) and Adjustment disorder (7.8%).
- The number of new MRCA mental health condition claims has increased by over 500% since 2009/10 and is continuing to grow year on year.

There would be further veterans with MHC claims under DRCA and VEA. The MRCA caseload alone is substantial and exceeds that observed in most or all Australian workers' compensation schemes. With this client profile, and given the unique nature of MHC claims, it may be feasible for the DVA to establish a specialist MHC claims team/s that focuses on these MH claims and adopts the Combined Benefits Processing model or an equivalent 'single point of contact' approach. Referral to this team could be triggered at claim lodgment, for any veteran making a MHC claim, thus obviating the need for referral through the existing escalation pathways that occur later in the claims process.

Under the Channel Transformation and Client Service (CT&CS) component of the VCR program DVA has already identified and described fifteen distinct client segments. Results from the reported data-driven segmentation model developed by DVA indicated that 5% of clients have needs or features that indicate a high level of complexity, a further 44% have indicators of a medium level of complexity, while the remaining 51% were considered to have a low level of complexity. While these data-based insights were derived from static data as at June 2017, the work provides a foundation of knowledge that may underpin a future segmentation model that can be integrated into day-to-day claims management.

## **Biopsychosocial screening**

The research evidence base has consistently demonstrated that psychological and social factors are the most powerful predictors of claim relevant outcomes in personal injury compensation schemes, including client health, cost and duration. Similarly co-morbid and pre-existing health conditions can complicate recovery from illness and injury. Such co-morbidities are common in people with MHCs.

Accurate prediction of claim outcomes, medium to long-term client health and targeted client-centric service delivery requires knowledge of a range of biopsychosocial information early in the claim process. The DVA model provides for psychosocial screening to be conducted by social workers following claim registration, and social workers may refer clients to external service providers. Most veterans are now referred for a social worker contact. Screening is conducted over the telephone, and the social workers have a high case load with an expectation of making at least 10 clients contacts per day. Data provided by DVA for this report demonstrates that in 54% of cases the client is unable to be contacted by the social worker, and that of those cases in which contact is made, 1.4% are referred by the social worker for case coordination. This data suggests a high volume, relatively low intensity service with relatively few veterans identified as requiring additional services provided by the DVA. The data provided did not enable determination of the percentage of contacted veterans referred to other, including external, service providers, however it seems clear that the social worker team spend significant time contacting many veterans who do not require additional support. Insights gained from the social worker checks also do not appear to be available in ISH, limiting the potential impact of this valuable information.

With respect to screening for co-morbid or pre-existing health conditions, there does not appear to be a process in place to capture this information. Of particular concern is the research evidence suggesting that there is a high prevalence of psychological stress in people making personal injury compensation claims for physical conditions [3, 4], and that many people with MHCs may be unwilling to divulge their condition. Thus it seems probable that there will be veterans making physical injury claims in whom MHCs are going unrecognized and potentially untreated.

Given the importance of these factors, one opportunity is to modify the current screening approach so that (a) the social worker resource is targeted towards veterans more likely to require additional support or more likely to have comorbid conditions; (b) the psychosocial

screening process is used more flexibly, for example at any point in a claim at which a risk flag is triggered, and to also capture additional information on pre-existing health conditions; and (c) information gained during the screening process is captured in a structured database and is able to be used to influence future actions by delegates and others in the claims process.

There is also potential to trial alternative approaches to screening, including for instance establishing processes and training to enable delegates to more routinely screen claims for psychosocial risks, as per the case example from WorkCover QLD described above. There are also now technology providers that enable clients to complete brief screening questionnaires online early following claim lodgment, with the gathered information and an analysis and summary returned to the delegate for use in determining follow-on claims management activity (see [www.claimlab.org](http://www.claimlab.org) for example).

### **Expand Combined Benefits Processing**

The recent trial of Combined Benefits Processing appears to have achieved positive results in terms of veteran experience, and enhanced the ability of delegates to more fully understand a veteran's needs. The approach essentially replicates the third stage of the good practice model described in Figure 2, and addresses multiple of the factors that have been found to impact veteran experience and mental health, including by reducing claims 'hand-over' between delegates, enabling development of better communication between the veteran and the DVA delegate, and potentially also reducing the time to process claims. There appears to be an opportunity to expand the CBP model, noting that this would have substantial implications for the current claims operational model (e.g., re-organisation of claims teams, further investment in delegate training). This approach could be combined with a more structured client segmentation / triage model in a way that enables the CBP model to be used in veterans with more complex cases or specifically in MHC claims, while less complex cases are diverted to the standard claims management model. A formal evaluation of the CBP trial would be valuable to determine the impacts on claims processes, delegate workload and veteran experience and outcomes.

### **Upgrade Claims Information System**

The recently implemented ISH claims information management system addresses multiple shortcomings of the previous systems, but does not currently fully meet the needs of DVA delegates. The system is hosted by a third party and is challenging to change / upgrade. Delegates are required to put in place work-arounds to support routine claims

management activities that are not supported by ISH. Claims lodged prior to the implementation of ISH have not been transferred across to the new system, and legacy systems are being maintained to enable delegates to perform the full range of functions required. Delegates need to proactively manage claims processes with few system generated prompts/actions. Access to the data produced by the systems appears difficult, limiting the ability of the DVA to use claims data for strategic and operational purposes. The recent ANAO audit describes some issues with the use of ISH including that the workflow claims is being managed through the use of spreadsheets that are maintained outside of ISH, increasing the risk of processing errors [59]. There are technical solutions to many of these issues that if implemented may reduce the potential for erroneous, poor quality or delayed decision making.

Many of the recent reforms in personal injury claims management schemes have been enabled by improvements or modifications to claims information management systems. For example, implementation of a data-based approach to client segmentation early in the claim lifecycle requires access to, and analysis of, data captured in the claims information system. This is also true in the DVA scheme, and while it is possible to make positive changes to claims management without significant reforms to ISH, an improved claims management and information system will be important to maximize the benefit of some of the other opportunities described.

### **Client Outcome Measurement**

At present the DVA appears to assess its performance using a mix of claims administration metrics and outputs (flow through, case load, processing times etc.), and an annual veteran experience survey. There is opportunity to expand this to include outcome measures, such as client health and wellbeing, including mental health. This would be consistent with the DVA's objectives of supporting the health and wellbeing of veterans and their families. Implementation of a veteran health and wellbeing measurement approach would provide information that could support claims strategy and operational delivery, and provide an evidence base for monitoring and evaluation of new initiatives. An approach such as that being implemented in the NSW workers' compensation system could feasibly be in place within a 12 to 24 month horizon, using a combination of existing claims data, third party data sources, and new survey-based health and wellbeing data collected from veterans.

## **Employer Engagement**

As noted in the evidence section of this report, there is a strong connection between employment and health, and return to work following injury/illness can support recovery. Employers can provide both ‘instrumental’ support for recovery and return to work as well as ‘emotional’ support. Both have been shown to be important. These links have been reinforced, for instance, through the Royal Australasian College of Physicians (RACP) national consensus statement on the Health Benefits of Good Work<sup>3</sup>. Evidence provided by veterans through submissions to Senate and Productivity Submission inquiries suggests that leaving the ADF can result in a loss of identity for some veterans, which may be one factor contributing to mental health conditions. Re-engagement in meaningful employment may address this.

Many veterans of working age will have a relationship with an employer at the time they make their DVA compensation claim. The employer may be ADF or another employer. There will also be a group of veterans who are unemployed when they make their DVA claim. The Government has established the Prime Minister’s Veterans Employment Program to raise awareness in the private sector of the skills of veterans and to promote their employment. This includes some joint DVA and Defence activity for veterans separating from Defence. The DVA also funds occupational rehabilitation services to support job finding among the veteran population. Given the powerful interaction between employment and health there is opportunity for DVA to expand its role to further support veteran’s making compensation claims. This may include, for instance, activities to engage employers of working veterans to better support their health and recovery, for example through ensuring that jobs are designed to minimise exacerbation of injury or illness and/or promoting the value of mentally healthy workplaces. For unemployed veterans with complex health conditions, there may be potential to offer further support in job finding, for instance through programs such as Individual Placement and Support (IPS), an approach to re-employment that has been shown to be effective at supporting people with complex health conditions including mental illness gain competitive employment [66].

## **Reform IMA processes**

Independent medical assessments (IMAs) are a central component of claims and benefit determination in personal injury compensation schemes. At the same time there is an

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<sup>3</sup> <https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-occupational-environmental-medicine/health-benefits-of-good-work>

evidence base suggesting that they can be experienced by clients as stressful [30], they may complicate the relationship between the treating practitioner and the client [19], and that through these mechanisms they can contribute to negative health impacts [27]. The DVA procures over 9300 medico-legal reports per year at a cost of nearly \$27 million per annum, to assist in a range of decisions including liability determination, permanent impairment, treatment and incapacity benefits. The DVA has recognized the opportunity to transform its IMA procurement processes, the way it engages with medico-legal service providers and its internal use of medico-legal evidence. This may also provide an opportunity to introduce processes that reduce the amount of time spent waiting for the production of medical reports, which was identified by the ANAO as a substantial contributor to extended claims processing times [59]. As this IMA reform appears to be underway, there is potential to incorporate evidence from the area of procedural justice which suggests methods of conducting IMAs that will minimize any potential adverse impact on the mental health of veterans (e.g., [19]). These include some straightforward procedural changes, for example ensuring that a copy of the medical assessment report, or a summary of the report, is made available to the client and/or their representative following the IMA, thus addressing the 'informational justice' principle.

### **Enhanced Data Analysis**

The DVA claims processes produce vast amounts of data, but this is currently not exploited to its full potential. There is a clear opportunity to better use data to support strategy and claims operations. For example, predictive analysis can be used to identify the range of personal, service, condition and claim factors that are associated with the onset of a mental health condition or a negative claims experience. Similarly, analysis can be used to identify specific 'pain points' in claims processes that trigger negative experiences or outcomes (e.g., [36]), and that may require action or greater attention. I note that some of this analysis has occurred through the CT&CS work under the VCR program. Claims data has been used to examine healthcare provider behavior [45, 67] and to support healthcare improvement initiatives, to evaluate the impact of policy settings or policy change on client and employer outcomes [29, 68], to characterize risk factors and outcomes in specific cohorts of clients including those with MHC claims [69, 70], to evaluate the impact of changes to claims operating models [71], and to characterize patterns of recovery and return to work following injury [72]. This sort of analysis is now conducted in, or supported by, other personal injury claims schemes, but much of this

existing evidence base will not be transferrable to the DVA due to differences in the claiming population, scheme design and operation. There is a need to develop a veteran specific evidence base. This appears to be an area of focus for the DVA with additional resources being allocated to address these issues.

### **Investing in claims teams**

Claims management in an environment like the DVA is a complex task. Delegates face many competing priorities and need to have technical expertise and administrative skills in addition to 'soft-skills' to support positive engagement with clients. Research evidence demonstrates that actions and behaviours of delegates can have a substantial (positive or negative) impact on the experiences and health of clients, and this is supported by the early feedback from the DVA's combined benefits processing trial. The DVA has a substantial proportion of clients with complex health conditions including mental health conditions, which require specialist expertise and knowledge for effective case management. These cases can be very challenging for front line claims staff. I also note the increasing case load for delegates managing MRCA and DRCA permanent impairment claims, which presents an additional challenge for these staff.

Experience with civilian compensation schemes who have implemented claims model reform suggests that failure to adequately prepare front-line staff for the reforms (i.e., for their new or modified roles) can be a major barrier to success, and that the extent of training required is often underestimated. Should the DVA implement any future claims model reform, investment in its claims teams will be a critical component. There also appears to be opportunity to provide further skills training within the current claims model. For example, in civilian personal injury schemes there has been a trend towards training front line staff in techniques such as motivational interviewing to enable staff to provide greater support to clients with more complex conditions. Resources that may support these sorts of activities include the Super Friend Best Practice Framework for Managing Psychological Claims, which includes a focus on optimizing claims management teams. The framework proposes some key competencies, provides information regarding competency based recruitment, structuring claims teams, and training and rewarding claims teams and managers. In addition there is a peak national personal injury claims management 'industry' body, the Personal Injury Education Foundation (PIEF). PIEF is a registered training provider and also provides a forum for engagement with other organisations that have claims management functions in similar settings.



The DVA has an existing information base that can be used to guide future investment in its claims staff. The CT&CS program identified a set of core capabilities and skills that were considered, by current service staff, to be important for effective claim management and veteran interaction. The program also describes a set of initiatives that DVA could undertake to enhance and embed these capabilities within the organisation, including for example identifying training needs, developing veteran-centric role profiles and recruitment criteria, and designing and embedding customer-focused KPIs in frontline service teams.

### **Legislative reform**

I note that neither the process via which legislative reform is achieved, nor the outcome of such reform, is within the DVA's control. However there is a clear rationale for legislative reform, as noted in the Productivity Commission draft report and the DVA submission to the issues paper for the PC inquiry. The requirement to administer three Acts with different sets of requirements adds multiple layers of complexity to the claims management systems and processes. In addition, the research evidence base demonstrates that system level policy settings exert a powerful influence over the health and recovery of personal injury compensation clients. Simplifying the legislative framework under which the DVA operates has the potential to support substantially improve mental health outcomes for veterans engaging with DVA compensation claim processes. Without such reform the DVA will be restricted in its ability to modify its claims management practices in ways that can benefit veterans, because the current complex legislative framework will need to be accommodated within any future claims model.

There are now multiple studies of the health and function of benefit recipients following the reform of benefit systems. One theme emerging from these studies is that there are often unintended consequences of reform. Careful design is paramount, and the existing evidence base will be a valuable input into any future reform.

### **Sequencing or packaging of actions**

Given the evidence that multiple components of claim assessment processes can have an impact on veteran mental health, I would also note that a comprehensive response will require action across multiple of these areas. While some of the opportunities listed stand-alone and may be approached as single actions, or are already underway, others are inter-related and would most logically be completed as part of a sequence or package of actions. Without being prescriptive about the sequence in which the opportunities should be pursued, it is possible to acknowledge that, for instance, the client segmentation and

enhanced data analysis actions would benefit from having upgraded the claims information management system. Similarly, expanding the Combined Benefits Processing approach would preferably be accompanied by increased investment in the claims staff who would be involved in that expanded model. It is also possible to take some action in most areas before implementing larger reforms. For instance, it would be possible to target the biopsychosocial screening using the existing social worker team, before proceeding to a model where capture of psychosocial information is captured and integrated into the claims information system and used for automated segmentation. Similarly, it is possible to develop and implement a veteran outcome measurement approach and to update or expand this approach as access to data improves. Co-ordination and planning of the sequencing or packaging of actions will be important, to ensure any actions are implemented efficiently and achieve the maximum possible impact.

## CONCLUSIONS

The past decade has seen a substantial shift in the approach to personal injury claims management in Australian, and some international, schemes. Best practice is moving from a liability and cost focused, claims processing model to a health and function focused, client-centred model. Claims processing is increasingly supported by sophisticated data analytics and claims information systems, for example to auto-segment clients into high and low risk claims management streams and identify client-specific services and supports. Claims operational models have been re-organised to ensure that clients with specific vulnerabilities or complex needs are managed by staff with relevant expertise and experience. Monitoring of health and wellbeing outcomes is becoming more common, in addition to claims processing, client experience and financial metrics that are routinely tracked.

There are multiple areas in which DVA could act to adopt these emerging best practices. These include opportunities to extend recent reforms and trials, modify existing claims processes or develop new processes and capabilities. Many of these require, or would benefit from, improvement in the claims information management system and data analysis capability, though action could be taken in some areas without major changes to the current supporting infrastructure.

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