Fall Vocational Conference

10/05/2016
Welcome

Joel Sacks, Director
DASHBOARD – HELP INJURED WORKERS HEAL AND RETURN TO WORK
Ability to Work Assessment referrals are now targeted to address the onset of long-term disability

The goal is to decrease this number

New low July 2016 at 89 days!
New focus on return to work in AWA process has increased positive employable outcomes for early AWAs

The goal is to increase the share of RTW and ATW JOI outcomes

Outcome distribution when first AWA referral made with less than 90 days of time-loss

- Able to Work Job of Injury
- Able to Work Transferable Skills
- Return to Work

New Process
Initiatives such as early ability to work assessment, Centers for Occupational Health and Education (COHE’s), and the return to work score are improving return to work outcomes.

The goal is to increase this number.
Our ultimate goal is to reduce the number of injured workers who experience long-term disability.

Long-term disability is the share of claims that receive a time-loss payment 12 months from injury.
Focusing on Better Outcomes Impacts Costs and Premium Rates

- Result Examples from Dashboard
  - Long-term disability has decreased 14% since 2012
  - Time to start vocational services has decreased 60%
  - Resulting return-to-work outcomes have increased 50%

- Projected long-term claim cost by over $700M since 2012
Safety Message

Kristine Ostler, Vocational Services Specialist Supervisor
High Disability Risk
Identification and Early Intervention

Functional Recovery Questionnaire (FRQ) and Interventions (FRI)
The Disability Conundrum

At least 5% of work injuries end up badly

- Permanently disabled
- Loss of career, benefits, retirement
- Frequently with dissolution of families, marriages

The Biggest Tragedy…

- Almost all of these cases begin as simple, non-catastrophic musculoskeletal injuries
  - e.g., low back pain, carpal tunnel syndrome
- But early on, they look the same as the 95% that do just fine…

What if we could figure out who they were before they get there?
You start to have

– Chest pain, shortness of breath, nausea, left arm pain

– And your dad and aunt had heart attacks before they turned 55 and your grandmother died of a stroke at 62…
▪ Wait a month to see if it goes away?
▪ Two weeks of arm and shoulder work by a PT?
▪ Prescribe some morphine for the pain?
▪ Certify a few weeks off work?
Pain >> Chronicity >> Disability…

- Pain usually provides protection for healing
- Almost everyone has acute back pain in their lifetime
- Over 90% recover within days or weeks
- When good pain turns bad:
  - ~5% go on to chronic pain, notoriously refractory to treatment-why?
Why does acute pain become chronic?

- Pain persists, annoys, inhibits, prevents...
Why does acute pain become chronic?

- Central nervous system (brain and spinal cord pathways) becomes “sensitized” to pain pathway stimulation
Why does acute pain become chronic?

- Pain experience may persist after injury itself heals
Sensitized pathways affected by…

- Brain’s active role in processing pain
  - fMRI studies show effects of attention to pain, catastrophizing on brain areas involved in pain

- Social and environmental contingencies shape pain and disability behaviors
  - family and employer responses
  - workplace factors
  - financial consequences
Translating research into practice

- **Usual care based on conventional models:**
  - Pain control
  - Patho-anatomical treatment (disc, joints, muscles)

- **Occupational Health Best Practices:**
  - Preclude adversity (worker employer connection, timely adjudication-ROA, etc)
  - Incremental activity with functional goals/outcomes
  - Care coordination, timely decisions
Occupational Health Best Practices: 1st 90 days

- **Prevent adversity**
  - Early ROA for quick benefits adjudication
  - Recruit employer for RTW

- **Foster return to normal activity**
  - Identify & set recovery expectations
  - Active patient role in recovery

- **Secure effective care**
  - Dx, referral, graded increases in activity, coordination of concurrent care

- **Timely barrier identification & action**
  - Recovery, RTW, patient factors
Centers for Occupational Health & Education – COHE

Occupational Health Best Practices:
- Day 1 Employer Contact
- 48 hour ROA
- Activity Prescription
- Health Services Coordination
- RTW Impediments Assessment if not working within 1 month

Accounted for 20% reduction in disability
How might we get at that next 80%?
Patho-anatomy is not enough…

- Treatment aimed solely at peripheral factors may not relieve pain maintained by CNS mechanisms
  - Pain behaviors maintained by social/environmental/work factors need to be addressed

- Cognitive (e.g., attention, appraisals) and emotional (e.g., depression, anxiety) factors affect cortical and other CNS processes
  - Influence pain
  - Affect behaviors that lead to disability (e.g., activity avoidance)

- Altering cognitive and emotional factors may improve pain via neurobiological mechanisms
  - Endogenous pain inhibition processes, reversing central pain sensitization processes) and effects on activity/role function
Is There Any Evidence?
Psychological Factors Predict Outcomes

- Sciatica patients who are depressed and anxious have worse pain and function after surgical or non-surgical care
  - Edwards et al., Pain, 2007, 130, 47-55

- Non-work comp patients with better mental health prior to lumbar fusion showed greater 2 year improvement (Oswestry, SF-36)
  - Carreon et al., Spine 2009, 34: 725-730

- Low recovery expectation, low SF-36 MH, fear avoidance, catastrophizing predicted ≥180 work disability days over next year in workers with recent CTS claims
Systematic review of chronic disabling back pain risk factors and risk prediction instruments

- 20 prospective studies of patients with <8 wks back pain from which likelihood ratios could be calculated
  - Chou and Shekelle: Will this patient develop persistent disabling low back pain? (JAMA 2010; 303:1295-1302)
Findings

- **Maladaptive pain coping at baseline predicted chronic back pain**
  - high fear-avoidance, catastrophizing, somatization/generalized pain, high functional disability, psychiatric comorbidities, and low general health status.

- **Similar for:**
  - workers’ comp & non-workers’ comp
  - work versus other functional outcomes
  - patients with acute & subacute pain

  Chou and Shekelle, JAMA 2010; 303:1295-1302
Pragmatics of Disability Prevention

MORE MODIFIABLE

– Clinical
– Work
– Administrative
– Psychological
– Legal
– Demographic

LESS MODIFIABLE
Psychological Characteristics in Work Disability Due to Back Pain

- Baseline (18 days after claim filing) telephone interviews of 1068 workers with back injuries.
- Adjusting for baseline demographics, pain intensity, and physical disability, baseline
  - *high work fear-avoidance* (OR = 4.6)
  - *very low recovery expectations* (OR = 3.1)
  predicted work disability at 6 months.

Turner et al., Spine, 31, 2006
Early Psychosocial Disability Predictors

- Physical disability may be intertwined with psychological variables soon after injury
  - *Assess psychological variables in acute pain patients when disability is high.*

- Recovery expectations, fear-avoidance, and SF-36 Mental Health each predicted 1-yr disability
Early Psychosocial Disability Predictors

- Roland substantially correlated with each of these
  - strongest predictor of all variables assessed
  - more important than pain intensity

- “Chronic disabling pain” may be present early after injury
  - mistake to distinguish between chronic and acute pain based on duration alone?

- May be useful to define “chronic pain” in terms of prognosis/likelihood of recovery
  
  Von Korff, Pain, 2005, 117: 304-313
Environmental factors shape chronicity

- **Job accommodation** consistently protective against chronic work disability
  - workers not offered accommodation by 3 wks had twice the odds (adjusted) of 1-yr disability

- **Job demands** consistently found to predict chronic work disability
Biopsychosocial models

- emphasize patient psychological factors;
- need to also focus on health care provider, employer, family responses, & work/economic factors that affect disability
Already addressed by COHEs

- Connection with employer
- Reduction of delays
- Early health services coordination
- Earlier Identification of who’s at risk
- Effective interventions to address individual risk factors
- Better empowerment/coping skills for patient
- Better coordination of system variables
  - Care, RTW, Incentives, etc
Turner’s Disability Research at UW

Identified three questions for injured workers unable to work the previous week that strongly correlate with disability status one year later

- Earliest way to identify who is at risk of long term disability and why, alerting docs to needed additional interventions at a time when they may be most helpful
- Questions also correlate with psychosocial concerns linked to chronicity (fear of re-injury, low recovery expectations)
Functional Recovery Questionnaire

“Positive” FRQ Questions
- Not worked for pay in past week
- Pain interference greater than 5 on VAS
- Back and leg pain **OR** pain in multiple body sites

“Figure Out Why” Questions
- No modified duty (accommodation) by employer
- Fear of worsening, catastrophizing
- Low recovery expectation
Positive FRQ = High Disability Risk
aka *Work Comp Heart Attack*

- More Attending Provider Attention Required
- Business As Usual: Not Good Enough
- It Needs To Be Taken Seriously
- More Time Should Be Spent With Them
- Assure These Workers **DO NOT** Fall Through The Cracks
An Urgent Situation

- Nearly 40% of Washington workers with a Positive FRQ are still off work one year later.
- Even those back to work at 1 year had more time lost from work during that year.
- It’s a rare event - less than 10% of injured workers on time loss are at risk.
- It may be even rarer in COHE practices: 3.5% of COHE patients become disabled (instead of 5% average for workers compensation)
Yeah, So What?
Functional Recovery Interventions

1. **Active Participation**
   - Self-participation in recovery, keeping appointments

2. **Normal Recovery & Recovery Expectations**
   - Explain normal, good recovery process and timeline

3. **Work Accommodation & Job Concerns**
   - Ensure employer contact and RTW goal is done and communicated with worker
   - Obtain HSC assistance if RTW barriers identified

4. **Incremental Increasing Activity**
   - Activity diary, regular movement of any kind
   - Active PT referral and follow-up if appropriate

5. **PT/OT Referral Oversight**
   - Assure active care

6. **Track Functional Progress**
   - Assure active care
Extra Attention To Patient Care

- Potentially More Frequent Office Visits
- More Time for Patient Counseling
- More Attention to Physical Activity
- More Oversight if PT is Included
- More Attention to Workplace Issues
- More Attention to Documenting Functional Improvement
- More Communication with HSC/other providers

(Most everything that is extra is billable for this 3-7% of COHE patients)
Plan B Strategies

- Physician Advisors/Specialists
  - Coach/mentor
  - Take over

- Activity Coaching
  - Progressive Goal Attainment Program

- “It’s Not Psych” Resources
  - Surgical Best Practices
  - Structured Integrated Multidisciplinary Programs
  - Psychosocial Determinants Influencing Recovery
Resources To Assist

COHE Community of Eastern Washington

- Functional Recovery Interventions (FRI) Tracking Sheet
- HSC assistance/tracking
- Involvement of COHE Advisors as a resource
- OHMS centralized tracking system for you and your HSCs to have real time information
- FRI Toolkit
  - Blank Forms (FRI Tracking Sheet, Activity Diary, PT Referral)
  - Talking Points for activity, psychosocial, RTW
  - Situation specific work-flows
  - Best Practice Resources (background papers, slides, CEs)
- Fallback: Activity Coaching when additional FRIs are inadequate
FRI Toolkit

Blank Forms

- FRI Tracking Sheet
- Activity Diary
- AP Referral Form
- PT/OT Referral Forms (COHE & IICAC)
- PT Progress Goal Sheet

FRI Resources

- AP QRC
- FRI Step by Steps
- Usual/Most Common
- Complex Cases – Multiple problems
- Awaiting Surgery
- No accommodation
- Talking Scripts
- Getting COHE Assistance
  - COHE Health Services Coordination
  - COHE Advisers

Best Practice Resources

- Functional Tracking Resource
- Papers &/or Bibliography – Disability – Best Practices – Guidelines
  - FRQ & disability papers
  - IICAC Conservative Care Resources
  - Best practices research summaries
- FRQ/FRI training modules
- CME Opportunities
  - On-line modules
  - L&I programs
  - COHE programs
  - Occupational health programs
Psychosocial Determinants Influencing Recovery

Robert Mootz, DC
Nicholas Reul, MD, MPH
Disability prevention happens within first 3 months

Improvement Goal: Right interventions at right time to help reduce disability

D-RISC Study – Washington Workers

• Injury severity is an important risk factor
• Other factors significantly predict chronic work disability
• Patients with similar clinical findings vary in disability outcomes
  • Likely due to factors other than biological ones

D-RISC Study – Washington Workers

- **Higher disability risks**
  - *Vocational connection: No accommodation*
  - *Activity avoidance: Fear of work activity worsening injury*
  - *Low recovery expectations*

- **Lower disability risks**
  - *No opioid prescriptions*
  - *DC as first physician*


Characteristics associated with disability

Perceived Injustice


Catastrophic Thinking


Low Recovery Expectations


Activity Avoidance

Strategic Focus in WA State: **Reduce Preventable Disability**

- Use best evidence to pay for services shown to improve outcomes and reduce harms
- Identify workers at risk for long term disability as soon as possible
- Target best interventions at appropriate times to achieve early functional improvement
- Incentivize collaborative delivery of occupational health best practice care sufficient to prevent disability
What are PDIRs?

Workers’ Compensation Perspective of Injury

Adapted with permission from Michael D. Harris, PhD
Worker’s Perspective of Injury

- Parent-teacher conf on Wed
- Can’t wait to retire
- Jill’s 12th birthday is next week
- Mortgage due
- Just can’t get a good night’s sleep
- Why can’t I get a cushy job?
- L&I: What a hassle!
- Who’s getting Mom to the dentist?
- What if this doesn’t get better?
- The boss is really upset now
- Sure is cold today
- What if I lose my insurance?
- Gutters need cleaning
- Out of milk...
- Sheesh! Neighbor’s burning again!
- BBQ’s leg busted
- Really should be happy but I’m bummed instead
- Car needs tires
- I really need to lose a few pounds
- Spaced on credit card bill

Psychosocial Determinants Influencing Recovery (PDIR)
PDIRs

Psychosocial Determinants Influencing Recovery:

Those non-biological factors most associated with impacting recovery from work injuries...
“Its Not Psych…”

Mental Health (MH) Conditions

- Psychological or psychiatric diagnosis (DSM-5)
- WAC 296-20-330(a): "Mental illness means malfunction of the psychic apparatus that significantly interferes with ordinary living."

Psychosocial Determinants Influencing Recovery (PDIR)

- Psychosocial factors identified to be associated with chronicity and disability
- Need not be a psychiatric diagnosis
PDIR Resource

Algorithms, Tips, Useful Resources, & Evidence Summaries

Screen ➔ Assess ➔ Intervene
Psychosocial History
Special Attention for injured workers

- How much is going on in your life?
- How is the new injury impacting it?
- How is your job going?
  - coworkers, employer, work activities
- What support do you need working through the injury?
Algorithm 1
Attending Provider Routine Screening for PDIRs\textsuperscript{(b)} with All New Injured Workers

New injured worker off work due to non-catastrophic musculoskeletal injury

Conduct standard workup; During psychosocial history, ask:

- Is everything OK?\textsuperscript{(a)}
  - Yes → Check with them again in a visit or two
  - No → Back to work?
    - Yes → Assess and manage PDIR (c) factors as needed
    - No → FRQ + Positive?
      - Yes → Implement FRI\textsuperscript{(c)} best practices for any identified PDIRs (See Algorithm 3)
      - No → If RTW\textsuperscript{(c)} does not happen within a few weeks, assess for barriers including PDIRs

- Uncertain/No
  - Explore / identify their concerns (e.g., injury, work, home, family concerns), then ask:
    - Think all will be OK in 6 months?\textsuperscript{(b)}
      - Probably/Yes → Back to work
      - Uncertain/No → Administer WHODAS\textsuperscript{(c)} 2 or more focused PDIR/MH scale to identify underlying contributors. Answers inform additional care options or further screening to consider.

Annotations
(A) During verbal psychosocial history exploring work, family, activities, etc. pay attention to how the patient responds, including body language, the volume of tasks, attitudes, stress levels and the like. The aim is to assess if they seem able to cope with everything they have to deal with on top of their new work injury.
(B) Essential: Watch for suicide warning signs such as mentioning self-harm, talking about death or suicide (including suicide methods). More information is the Additional Materials section.
(C) FRQ = Functional Recovery Questionnaire
  FRI = Functional Recovery Interventions
  RTW = Return To Work
  PDIR = Psychosocial Determinants Influencing Recovery
  WHODAS = World Health Organization Disability Assessment Schedule

To Algorithm 2
Can you handle everything that’s going on?

**YES**

- Care as usual
- Functional Recovery Questionnaire (FRQ) if no RTW in 2 weeks
- Double down on any psychosocial factors

**NO / UNCERTAIN**

- Additional Psychosocial Screening
  - WHODAS 2
  - PHQ 4
  - PHQ 9
- Address any concurrent behavioral health concerns
Key Flags
For Emphasizing Psychosocial Interventions

No RTW within 2 weeks (all reasons, including awaiting surgery)
- Screen for recovery barriers (e.g., activity avoidance, low recovery expectation, no employer accommodation)
- Aggressively address incremental activity, self efficacy strategies within patient’s physical capabilities
- Attend to deconditioning

Challenges if coping with multiple factors during injury
- Further screen for psychosocial issues, anxiety, depression
- Address and/or triage for appropriate interventions concurrent with injury recovery
# Functional Recovery Questionnaire

The Functional Recovery Questionnaire (FRQ) is a self-administered tool used to assess the psychosocial determinants influencing recovery. It helps in screening, assessing, and intervening to improve recovery outcomes. The FRQ includes questions that evaluate various aspects of a person's recovery, such as pain management, job modifications, and future employment certainty. The questionnaire is designed to be straightforward and easy to understand, with clear instructions and response options.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. During the past week have you worked for pay?</td>
<td>□ Yes □ No □ STOP here. You are done - thank you</td>
<td>Please indicate your answers in this column.</td>
</tr>
<tr>
<td>2. In the past week how much has pain interfered with your ability to work, including housework?</td>
<td>Please continue</td>
<td>Please circle one number: 0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>3. Do you have persistent, bothersome pain?</td>
<td>□ No □ Yes □ Please go to question 4 below</td>
<td>No interference: 0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>4. Since your injury, has your employer offered you light duty, part time work, a flexible schedule, special equipment, or other job modifications if needed to allow you to work?</td>
<td>□ Yes □ No</td>
<td>Unable to carry on any activities: 0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>5. How certain are you that you will be working in six months?</td>
<td>Please circle one number: 0 1 2 3 4 5 6 7 8 9 10</td>
<td>Not at all certain: 0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>6. Are you concerned that your work will make your injury or pain worse?</td>
<td>□ Yes □ No</td>
<td>Extremely certain: 0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
</tbody>
</table>

The FRQ is a valuable tool for occupational health professionals to identify potential barriers to recovery and to implement targeted interventions to improve the overall recovery process.
### WHODAS 2.0 Screen

**In the past 30 days, how much difficulty did you have in:**

(circle number that best describes your difficulty)

<table>
<thead>
<tr>
<th>Q1</th>
<th>Standing for long periods such as 30 minutes?</th>
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<tbody>
<tr>
<td></td>
<td>None</td>
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<tr>
<th>Q2</th>
<th>Taking care of your household responsibilities?</th>
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<tbody>
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<td>None</td>
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<tr>
<th>Q3</th>
<th>Learning a new task, for example, learning how to get to a new place</th>
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<td>None</td>
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<tr>
<th>Q4</th>
<th>How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?</th>
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<td>None</td>
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<tr>
<th>Q5</th>
<th>How much have you been emotionally affected by your health problems?</th>
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<tr>
<td></td>
<td>None</td>
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<tr>
<th>Q6</th>
<th>Concentrating on doing something for ten minutes?</th>
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<td>None</td>
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<tr>
<th>Q7</th>
<th>Walking a long distance such as a kilometer or half mile?</th>
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<tr>
<th>Q8</th>
<th>Washing your whole body?</th>
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<td>None</td>
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<tr>
<th>Q9</th>
<th>Getting dressed?</th>
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<td>None</td>
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<tr>
<th>Q10</th>
<th>Dealing with people you do not know?</th>
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<td>None</td>
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<tr>
<th>Q11</th>
<th>Maintaining a friendship?</th>
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<td>None</td>
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<tr>
<th>Q12</th>
<th>Your day-to-day work?</th>
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<td></td>
<td>None</td>
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Screening (PDIR & MH)  
Motivational Interviewing  
Incremental Activity  
Patient Education  
Self-Efficacy  
Coping Skills  
Relaxation  
Referral (social, PDIR, MH)

Vocational Recovery  
Activity Coaching  
Targeted Brief Interventions

Cognitive Behavioral Therapy (CBT)  
Structured Pain Programs

Majority of workers with PDIRs only need AP’s PDIR CARE

Some workers may need Specialist’s PDIR CARE

A few workers may need Specialist’s MH Care

Psychosocial Determinants Influencing Recovery

Screen  ➔ Assess  ➔ Intervene
KEY RECOVERY MESSAGES FOR CLINICIANS TO CONVEY

About Pain
- Pain does not mean your body is being injured. Examples:
  - Putting a jalapeño on your tongue or exercising a body part enough for a muscle to start to hurt.

Dealing with Stress
- Everybody has stress – it’s normal. You can learn to handle stress and bounce back from difficult situations.
- There are many effective ways to relax your body and to cope with emotions.

Also...

Staying Active
Getting Better
Taking Baby Steps
Dealing with Stress
Enhancing Sleep
<table>
<thead>
<tr>
<th>AP-Provided PDIR Options</th>
<th>Specialist-Provided PDIR Options (Brief Interventions)</th>
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<tbody>
<tr>
<td>Motivational Interviewing</td>
<td>Vocational Recovery and Rehabilitation</td>
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<tr>
<td>Physical Activation</td>
<td>Activity Coaching</td>
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<tr>
<td>o Activity Diary</td>
<td>Emotion Management / Behavioral Training</td>
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<td>o Rehabilitation / Exercise</td>
<td>Acceptance Interventions</td>
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<tr>
<td>Patient Education</td>
<td>Resilience Training</td>
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<tr>
<td>o Positive workplace connection</td>
<td>Targeted Brief Interventions (e.g., CBT by psychologist, collaborative care support)</td>
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<tr>
<td>o Understanding pain</td>
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<td>o Overcoming unrealistic fear</td>
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<td>o Pacing oneself</td>
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<td>o Problem solving</td>
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<td>o Goal setting</td>
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<td>o Coping with emotions / mindfulness*</td>
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<td>Self-Efficacy</td>
<td>Specialist-Provided Mental Health Interventions</td>
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<tr>
<td>Pain Coping (tailored to patient)*</td>
<td>Cognitive Behavioral Therapy</td>
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<tr>
<td>Support Systems</td>
<td>Structured Chronic Pain Programs</td>
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<tr>
<td>o Patient obligations (time, finances, child care, etc.)</td>
<td>Other Psychotherapies</td>
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<td>o Support resources (personal, community)</td>
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<td>Relaxation Training and Techniques*</td>
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<td>Sleep Hygiene &amp; Management*</td>
<td>Medication Management</td>
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<td>Referral to PDIR and MH specialists**</td>
<td>Opioids</td>
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<tr>
<td>o Vocational Recovery Services</td>
<td>Psychotropics</td>
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<tr>
<td>o Activity Coaching</td>
<td>Sleep Medications</td>
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<td>o Targeted Brief Interventions</td>
<td>Substance Abuse Treatment</td>
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<tr>
<td>o Cognitive Behavioral Therapy (CBT)</td>
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<td>o Structured Chronic Pain Programs</td>
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* Straightforward consultation / counseling in these areas may be within AP’s capabilities and skill sets, but alternatively may be addressed by referral for more intense specialist-provided PDIR approaches / brief interventions.

** In collaborative care settings, referral, or consult with trained PDIR specialists may be available.
PDIRs By Attending Providers

Motivational Interviewing

- It's just good doctoring - ask the right questions:
  - What's important about getting back to work?
  - What things have you found to help deal with your pain?

Physical Activation

- Incremental increases in activities they want/need to do; “Baby steps”
- Use an Activity Diary
- Utilize rehabilitation that emphasizes active intervention

Patient Education

- Normal recovery
- Understanding pain
- Pacing, relaxation, coping strategies

Triage For Additional Support

- Vocational recovery, Activity coaching, CBT
Psychosocial Determinants Influencing Recovery (PDIR)

PDIRs concurrently provided by specialists

**Activity Coaching Programs**
- Systematic programs to train self-reliance, goal setting
- Overcoming unrealistic fears, catastrophic thinking
- e.g., Progressive Goal Attainment Program ®

**Vocational Recovery Services**
- Early Return To Work programs, employer assistance

**Targeted Brief Interventions**
- CBT for specific maladaptive behaviors
- Resilience programs
- Emotion and behavior training programs

*Typically addressed with behavioral health services for non-psych conditions*
Mental Health interventions

• CBT for more intense anxiety or depression issues
• Structured chronic pain programs

Mental Health services for psych conditions

• Challenges common regarding work-relatedness
• Specific requirements for barriers to recovery
• Requirements for documentation and reporting by mental health specialists
Authorization and Reporting Requirements for Mental Health Specialists

Purpose
This document will help mental health specialists (i.e., psychiatrists, psychiatric Advanced Registered Nurse Practitioners and doctoral level psychologists) understand the authorization and reporting requirements when treating injured workers with mental health conditions.
# Table of Contents

## Summary Information
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- PDIR and MH Screening and Tracking Scales
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Links

Psychosocial Determinants Influencing Recovery (PDIR) Resource:

Progressive Goal Attainment Program (PGAP):
http://www.lni.wa.gov/ClaimsIns/Files/Providers/ohs/FY14-61ActivityCoachingFlyerProviders_Print.pdf

Early Return to Work:

Authorization and Reporting Requirements for Mental Health Specialists:
http://lni.wa.gov/mentalhealth
Who are we?
WorkSource Re-Employment Specialists

Victor Chacon, Beth Rokstad, State-wide, Tumwater WA

Walter Hughes Snohomish County, Everett WA

Call us at 360-902-6040 (Call preferred)

Email (Email preferred over call or fax): whughes@esd.wa.gov
Re-Employment Specialists offer assistance to you and your clients:

- Bridge between LNI & WorkSource services
- Help you & clients connect with WorkSource
- The sooner you connect clients with us the more services we can provide

Who to refer? Anyone who...

- Expresses a desire to return to work, but can no longer return to employer of injury *and*
- Is motivated to participate in job search, needs one-on-one re-employment assistance
What we offer your clients

State Wide, Beth and Victor:

- Remote services over the phone & screen
- Connections to WorkSource offices
- Resume assistance
- Skills assessment
- Job search coaching
- Bilingual assistance
- Referral to a VSS across the state

Snohomish County, Walter:

- In-person case-managed services to help overcome barriers
- Connections between clients & employers
- Job Clubs Mondays & Thursdays
- In-person employment assistance
- Help with Unemployment Insurance
What we offer your clients

State wide, Beth and Victor:

- Remote services over the phone & screen
- Connection to WorkSource offices
- Resume assistance
- Skills assessment
- Job search coaching
- Bilingual assistance
- Referral to a VSS across the state

Snohomish County, Walter:

- Connects clients with services & programs at WorkSource Housing, low cost medical insurance providers, AARP, Veterans benefits
- Free computer skills training, & more!
- Resume building
- Targeted Job leads
Refer your clients - it’s easy!

Check out the WorkSource VSS and RES table in the lobby during the break if you have any questions!
Preferred Worker Program

New website:

www.Lni.wa.gov/PreferredWorker

“Employees who come with benefits like these are good for business.”

Mike O’Dea, DVM
Pet Emergency Clinic
Spokane
Ethics of a Vocational Recommendation

October 5, 2016

Barbara Berndt, M.Ed, CRC, CDMS, CCM, D-ABVE
Introduction

- Ethics in the provision of vocational services
- CRC
- ABVE
- CDMS
Code of Professional Ethics

- Certified Rehabilitation Counselor

The primary obligation of rehabilitation counselors is to clients, defined as individuals with or directly affected by a disability, functional limitation(s), or medical condition and who receive services from rehabilitation counselors.
American Board of Vocational Experts

Vocational Experts are primarily committed to determining the vocational capacities of individuals.

The client: In a forensic setting, the professional who is engaged as an expert witness has no client.

The vocational expert witness’ role is to provide assistance to the trier of fact in identifying the effect of injury or other event on an individual’s capacity to work, earn money and/or to maintain a quality of life.
Code of Professional Conduct

- Certified Disability Management Specialist

As a CDMS the goal is to facilitate an employee’s physical recovery, rehabilitation, and return-to-work process while seeking to control the escalating costs of injury, disability, and absence for employers, insurance carriers, and government.

As a CDMS certificant one must also function in an objective and ethical fashion within a context of competing interests.
Work Product

- Who is your client
- What happens to your work product when you complete:
  - Assessment
  - Plan
  - Closing
  - Option 2
- Why the dispute process
- When may the VRC or a Vocational Expert be called by plaintiff, defense and/or AAG counsel to uphold or dispute the vocational work product.
VE Scope of Work

- Conflict check
- CV / Testimony Log
- What is the appeal
  - Know the question
  - Know the case: records request
  - Know the financial arrangements before
  - Know the time frame of deposition / Board testimony
  - Know your own scope of expertise
  - Are you able to meet with the worker?
    • Disclosure Statement
Records Review

- Records request
  - Claim-Medical, Pre-existing, Psychological
  - Work records, Employment Security, Employer/Wage
  - Other: FCE, neuropsych, declarations of professional(s)

- Know the question / WAC ~ RCW that applies

- Review of records
  - Know your case!
  - Be able to offer strengths & weakness to referring attorney

- Staffing with the attorney
  - Facts and data you rely upon
  - Worker interview: possible or not
  - Critique of assigned counselor work product
What is Your Opinion?

- Testimony by Expert Witnesses
- You are qualified as an expert by your knowledge, skills, experience, training, or education…and your credentials if:
  - Your scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;
  - The testimony is based on sufficient facts or data;
  - The testimony is the product of reliable principles and methods; and
  - You have reliably applied the principles and methods to the facts of the case.
Assessment

- Was the worker fully assessed:
  - Age
  - Education
  - Experience
  - Pre-existing physical & mental limitations
  - Physical & mental limitations caused, at least in part, by the industrial injury or occupational disease
  - Employability: LMS / JA

» CRC / ABVE / CDMS: codes of conduct
Rehabilitation Plan

- Documentation to support the feasibility of the goal
  - Testing for appropriateness of job goal
  - LMS
  - JA
  - Curriculum
  - Reasonable request of worker to participate
    - CRC: Autonomy (A.1.d) – client engage in decision-making
    - CDMS: Autonomy – honoring the right to make individual decision

- Option 2 – development of Plan
Closing Report

- **Plan successful**
  - Courses completed: specifics
  - Work-related skills: more specifics
  - Job search assistance
  - Barriers resolved
  - Employability: LMS

- **Plan not successful**
  - Ability to modify, accommodate barriers
  - Description of barriers
Why your work product matters

- Nonmaleficence: to do no harm to others
- Beneficence: to do good to others (CRC/CDMS)
- Acting to alleviate personal distress and suffering (CRC)
- The prevention and minimization of the human and economic impact of illness and disability for the employee/employer to optimize the quality of care, productivity, organizational health, and regulatory compliance (CDMS).
Forensic Case Example

- **DOI**: 12-3-2004
- **DOB**: 12-23-1953  (Age at injury 51)
- **JOI**: Surveillance System Monitor/Security Guard from 9-2002 to 12-3-2004 (LDW)
- **ROI**: Neck sprain; aggravation in PT - Low Back
- **Educ**: HS / CC for AA / on-line BA in Psych 1994
- **Military**: 1972-1975 Viet Nam era vet  E-4 Honorable
- **Work Hx**: Bartender / MH Outreach / Child Care Provider / Office Assistant/ Security Guard
- **FCE**: 11-2006 Sedentary (CPMP)/ 7-29-14 Sedentary
Forensic – VRC Work Product #1

- 11-8-2005 AWA - ATW transferable skills in Social Services Aide, Security Guard, Bartender, Hotel Clerk, Director of Childcare, Day Care Provider and Gen Office Clerk

- Review: AP provided less than full-time approval on JA for JOI. Required sit-stand work station, or ability to alternate position. AP specifically requested a transitional return to work effort to augment capacities.
Forensic – VRC Work Product #2

- 4-6-2006 VRC opined pre-post injuries precluded vocational services.

4-9-2007 VRC – ATW opined transferable skills as Mental Health Outreach Counselor, Case Aide, Job Developer and Front Desk Receptionist.

Review: FCE done at chronic pain management program and at Sedentary full-time
Forensic – VRC Work Product #4

- 3-29-2008 VRC – ATW as Security Guard

- Review: Issues at BIIA regarding consolidation of 1999 claim of low back and this claim.
Forensic – VRC Work Product #5

- 10-4-2011 VRC - NATW due to combination of pre-existing conditions of arthritis and psychological conditions (PTSD, anxiety, insomnia and depression) and this industrial injury. The unrelated and on-going psychiatric issues were unresolved. Medication issues were both sedating and impairing decision-making per ARNP record.

- Review: This is first mention of pre-existing barriers in any work product by any VRC.
Forensic – Review of Records

- Stop and look at facts and data

- Summary of Work History and Transferable Skills:
  - Work History
  - Obtain Employment
  - Work Pattern
  - Sustain / Maintain Employment
  - Meet SVP
1991  Student-Pierce College: Communication & Sociology (GPA 3.9)
1992  Student-Grays Harbor CC: Psych, Computer, Nutrition
1993-1994 (6 mos.) Bartender (physically assaulted)
1994 (2 mos.) Bartender (part/time seasonal - stadium)
1994-1997 Student – Southern Illinois University Psychology/ Biology/Psi Chi (GPA 3.1)
1996-1998 (18 mos.) Mental Health Outreach Counselor (SVP 7)
Analyzing a Work History - Middle

- 1997-1998 (18 mos)  Self-employed Child Care Provider
- 1998-1999 (10 mos)  Bartender (found another job due to drug dealing occurring in bar)
- 2001 (1 mo)         Bartender (supervisor disagreement)
- 2001 (2 mos)         Bartender (let go/business rehired prior bartender)
- 2001 (2 mos)         Unemployment benefits
- 2001 (1 mo)         Bartender Instructor (SVP 7)
- 2001 (5 mos)         Bartender (let go)
- 2002                Bartender (part-time fill in)
- 2-93 to about 2002  Bartender (on and off, full time and part-time)
Analyzing a Work History - End

- 6-04 (2 weeks) Office Assistant (SVP 2)
- 9-02 to 12-3-04 Custom Protection Officer/ Surveillance System Monitor (SVP 2,3)
Forensic – My analysis

- 1975-1992 Ms. Worker offered the summary of her work experience as working as a bartender at The Flame in Reno, Nevada. She relocated to Yakima where she worked for 4-5 employers in asbestos abatement. She also worked at the Bavarian Garden as a bartender. She had a daughter and did not work for two years. In 1986 she went to work at The Bon in Seattle for short time then she was out of work for about six months. In 1988 she volunteered for the Welfare Rights Organized Coalition at Catholic Community Services (poverty and social awareness advocacy; and if so then this is SVP 7). On her resume she stated she was involved for six years. Ms. Worker stated she was at the Arlington Naval Base, something happened and she reported it, and she lost this job when it turned into an EEOC issue. She resumed bartending and went to work for the golf course as a bartender where she was fired after one month. She moved to Aberdeen where she went to school.

- Ms. Worker reported she had two (2) Article 15’s while in the US Army.
I requested and obtained VA records, then I interviewed Ms. Worker. She corroborated VA records in that she experienced sexual harassment two times in the military and she reported she thought she “dealt” with it by ignoring it and drinking it away. She was sexually assaulted one month after discharge in Seattle. When reviewing her career path her bartending jobs allowed Ms. Worker to leave or change jobs when “issues” arose. She stated she left for “various” reasons. I found Ms. Worker had 26 jobs in 32 years. She had three (3) jobs which lasted 2 years each. These were the longest jobs she ever sustained and that she maintained in employment for over three decades. This is a highly unusual work pattern.
8-28-2012 VRC/Forensic – Opined additional information is needed before a vocational determination can be made, and cited the following:

- Noted significant medication issues and Department pharmacy consultation in records
- Documented emotional and psych9-social barriers are a problem to recovery as early as 12-30-2004 (DOI 12-3-04)
- Documented 3-22-2006 L&I Occ Med Nurse note re: pre-existing or concurrent conditions delay recovery.

Review
Forensic – VRC Work Product #7

- 10-15-2014 VRC – ATW as Security Guard (JOI) due to AP concurrence and concurrence of PCE of 7-29-2014
Forensic – Additional Info

- **Pre-injury**
  - Military Sexual Trauma / PTSD – some treatment
  - 1999 work injury: sprain/strain low back/sciatic nerve
  - 2000 work injury: sciatic nerve
  - Decrement in work / quality of life began in 1999
  - 2004 tried office work - fired

- **Post-injury**
  - Lost income
  - Death of daughter by suicide
  - Moved to Tonasket

10 IME’s
My Vocational Testimony

- At the Board of Industrial Insurance Appeals, my opinion was
- Ms. Worker held the job of injury for the longest time in her entire employment, even beyond her military service time. Her ability to adapt, to respond and to diminish barriers from the work injury of 12-3-2004 is of concern. Ms. Worker has been out of the work force since age 51. She is now 62. She has not worked in twelve (12) years nor has she been attached to the workforce at all. Her education/clerical skills are 22 years old.
- I found no vocational rehabilitation services that were provided to her to assist her in services that may have been likely and necessary to have helped her in overcoming and diminishing barriers to work. Specifically, Dr. Doctor opined in 10-5-2005 conditional approvals on several job analysis that Ms. Worker required transitional work assistance for her to regain her capacity to work on a full-time basis. (Provisional work approval)
“Despite having a college degree in psychology, Ms. Berndt believes that Ms. Worker has no transferable skills and is not capable of obtaining or maintaining full-time employment on a reasonably continuous basis during the period 10-17-14 to 6-15-15.

This conclusion is based on a combination of factors, including the opinion of Ms. Worker’s attending providers who concluded that there was not a preponderance that she could go back to work…”
as well as Ms. Worker's physical abilities,
mental health conditions,
a 12-year absence from the workforce,
lack of retraining and services to re-integrate back into the workforce,
her age (being over 60), and
an obsolete psychology degree that was never used.
On cross examination, Ms. Berndt stated that the general skills to function in an office would have been possible when closer to when she obtained her B.A. (1994) but not 22 years later.
Ethical Recommendations In Vocational Recommendations

- Nonmalefiecence: to do no harm to others
- Beneficence: to do good to others (CRC/CDMS)

- Acting to alleviate personal distress and suffering (CRC)
- Control the escalating costs of injury & disability (CDMS)
- Rendering an opinion with your methodology and rules/regulations (ABVE) to the trier of fact

- Who is your client

- Thank you
Lunch

- Combined Fund Drive Taco Bar Next Door!
  - $6.00 for:
    - Taco Salad or Nachos or Tacos
    - Ground Turkey or Beef
    - Refried and Black Beans
    - Chips or Taco Shells
    - Shredded Cheese
    - Lettuce, Tomatoes, Onions
    - Olives, Guacamole, Jalapenos
    - Salsa, Hot Sauce, Sour Cream
    - Dessert and a Beverage

Benefits Thurston County Food Bank!
Career Bridge

- Lindsay Elwanger
- Dave Wallace
Building a Supportable Labor Market

Cloie Johnson

Jan Donley
Where the Rubber Meets the Road

- John Cary, MA, CRC, CDMS
- Nick Choppa, MA, CRC, CDMS
- Jamie Gamez, MA, CRC, CDMS
- Amber Parmley, MRC, CRC, CDMS
JAMIE GAMEZ, MA, CRC, CDMS
LMS/R and the Transferable Skills Analysis (AWA)

- **STEP 1: Transferable Skills Analysis (TSA)**

- **STEP 2: Data Collection:** Look at important data points which may include:
  - SVP Requirement
  - Training requirement
  - Education requirement
  - Projected growth
  - In Demand / Not in Demand
  - Case specific clues (ex: language level)

**Analysis (important):** Is this a viable position for further exploration based on available data?

- **STEP 3: Job Analyses** - development and sent to provider for review

- **STEP 4: Employer Sampling:**
  - After data analysis, is information missing? Employer sampling needed?
  - If so, establish specific, consistent questions to ask each contact based on the client (N of 1).

**WHAT YOU END WITH:** A solid recommendation includes a mix of quantitative / qualitative data to support an opinion. This is also a helpful tool to explain your research to the worker.
**Data Evaluation** - Assess preliminary labor market data (WOIS, O-NET, WorkSource, etc), physical demands, duties and qualifications noted in this quantitative data. Educate yourself on the job and the labor market to begin to formulate further research questions.

**Compare to the “n of 1”** – Utilize clinical judgement of the quantitative data to compare to approved Job Analysis, worker and background, and specific retraining goal and program. We don't just “slap data on people”.

**Clinical Vocational Assessment** - Review and provide a full clinical assessment of each piece of data gathered. Are there any incongruent aspects? How will you address them? Have all the case specific and injury specific aspects been addressed by the quantitative data present? If not, in clinical assessment do they warrant further research through employer samplings? Apply qualitative data to address any remaining case specific questions.

**Inclusion and Transparency** – Include the worker in the analysis and data gathering process. This way, they see and understand the labor market with you. If a goal is negative, they fully understand the logic behind such a recommendation.

**Vocational Recommendation** - Use your clinical judgement of the data to make a conclusion and provide a recommendation for retraining. This method incorporates many sources and provides “more legs on the stool” for your vocational recommendation. We are not relying on one piece of data solely, but rather the collective whole of data gathered, combined with our own clinical judgement of what the labor market is.
This Labor Market Survey Research process improves vocational services from the start!

Know your resources, for example, Dictionary of Occupational Titles, local WorkSource professionals and resources, Employment Security Data - WILMA, WorkForce Explorer, WOIS, O*Net, etc.

Any research conducted as to transferable skills as to potential return-to-work options whether it be for ability to work or for skills required in plan development can potentially be used later for research to support your LMSR.

Comprehensive, on-site job analyses, again at the beginning of process, are vital for the LMSR process. It is important to gather as much information directly from the employer, worker, and direct observation and measurement.

Job analysis should also include VRC’s recommendations for any accommodations for restrictions that may apply later to other clients with restrictions. The better the job analyses the more supportive the labor market survey research!
The reliability of data collection in the LMS/R is based on multiple resources grounded in valid measures of industry-based and occupational information derived from a combination of occupational staffing by industry, payroll or establishment survey, systematic research design methodology, and analytics conducted by qualified experts in occupational analysis and assessment research and development.

- These are data resources that the vocational rehabilitation community regularly use to inform their opinions, but may not necessarily fully analyze in their labor market reports.

- Triangulation of quantitative and qualitative data collection assists in reliably communicating particular regional labor market conditions for any specific occupational title.

- The combination of data analysis and employer contacts fortifies the legitimacy of a vocational recommendation. It limits survey sampling bias that results from employer contacts being saturated with questions that they may or may not be qualified to answer, or are answering haphazardly.

- From a Vocational Forensics perspective, the LMS/R methodology increases reliability in vocational recommendations concerning employability.
LMS/R Training

LMS/R Webinar was held in September of 2015. Available for rebroadcast at www.wsiassn.org
Option 2 Updates

Kate Cashman
New Benefit

- RCW 51.32.096 (4)(b) “…Up to ten percent of the total funds available to the worker can be used for vocational counseling and job placement services.”
Vocational Counseling Services

May include, but are not limited to:

- Help in accessing community re-integration services.
- Assistance in developing a training plan.
- Coaching and guidance as requested by the worker.
- Interests and skills assessment, if worker requests or agrees such is needed to reach the worker’s training or employment goals.
- Other services directly related to vocational counseling, such as job readiness and interview practice.
Job Placement Services

May include, but are not limited to:

- Help in developing an action plan for return to work
- Assistance with applying for preferred worker status, if this has not already happened.
- Job development, including contacting potential employers on the worker’s behalf
- Job search assistance
- Job application assistance
- Help in obtaining employment as a preferred worker
- Other services directly related to job placement, such as targeted resume development and referral to community resources (WorkSource).
Option 2 Information Coming Soon

- How is the 10% for Option 2 vocational services and job placement services calculated?
- How does the Voc Provider submit bills for Option 2 services?
- What if the Option 2 vocational services were provided over 1 year ago?
- And more

Stay Tuned to:
“What’s New for Vocational Counselors”
PGAP
(Progressive Goal Attainment Program)
aka: Activity Coaching
What is PGAP?

- A structured program of goal setting and achievement tracking.
- Coaches are physical or occupational therapists or vocational counselors who have been trained in providing PGAP services.
- Worker meets weekly with the coach for a maximum of 10 weeks.
- Worker sets their own weekly goals to incrementally increase their chosen activities and eventually begin the return to work process.
Who is it For?

- Workers who are either not working or have been unable to return to full time work.
- Recovery is progressing slower than expected
- The worker may have psychosocial issues:
  - Fear of re-injury at work
  - Avoidance of increased activities of daily living
  - Catastrophizing
  - Perceived injustice
How do I help my client access PGAP services?

- Talk to the worker about PGAP
- Explain that PGAP is voluntary
- Give the worker a “Referral form” and the “PGAP flyer for Providers” to take to their medical provider.

Lni.wa.gov/Coaching

- Or talk to the Claim Manager or the Medical Provider about PGAP
Structured Settlements

Natividad Valdez