Occupational Health Best Practices

A Role for Chiropractic Consultants

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Overview

- Washington Workers’ Compensation
- What we know about DCs impact
- Best Practices Across Episodes of Care
- Patient Intake
- Functional Improvement
- Curative & Rehabilitative
- Consultant “Best Practices”
Washington Workers’ Compensation

- **Unique**: State fund or self-insured employers
- **State Fund**:
  - 165,000 Employers
  - 2.4 Million Workers
  - 125,000 Claims annually
  - $1.5 Billion premiums collected
  - $1.5 Billion benefits paid to workers
- **Culture of evidence-based policy**
  - Collaboration and funding with UW
  - Iterative policy-research history
- **Culture of stakeholder involvement**
  - Employers, workers, providers, state agencies
Washington Workers’ Compensation

- 20,000 + Provider network
- Workers can choose their provider
- Employer premiums 75%
  - all of Accident Fund and half of Medical Aid Fund
- Worker premiums 25% (half of Medical Aid Fund)
- Provider Advisory Committees
  - Medical (IIMAC) and Chiropractic (IICAC)
  - MD, DC, Employer & Labor (ACHIvE)
- DCs full attending physicians
Development of Chronic Disability

Disability: How big a problem is it?

- **From Low Back Pain Alone:**
  - Most common/expensive musculoskeletal problem
  - Half of all occupational injuries are LBP
  - Annual costs exceed $50 billion (>$15 billion direct)

- **Only a few:**
  - Less than 10% of LBP claims use 80% of resources

Mayer 1991; Webster 1994; Frymoyer 1997
Percentage of time-loss claims with duration beyond given month

Average of fiscal accident years 2009 to 2011

70% Return to work in first 3 months
Disability and Chronic pain coincide at 3 months

8% account for 85% of cost
Less than 1% catastrophic injury

Queried: May 28, 2014
Actuarial Services includes time-loss and LEP claims

Disability

- The percentage of workers becoming chronic has increased over the past decade
- Chance of getting back to work diminishes dramatically after 60-90 days
- Patients of COHE providers have about 20-25% less disability than those not seen in the COHEs
- COHEs support use of best practices
  - Care coordination, training, financial incentives, performance feedback
Disability: What is it?

- Loss of ability to ever earn a productive living
- Inability to function without pain
- Devastation to family, personal life, career

*But from a non-catastrophic low back sprain & strain???
Being Off Work…
It Costs More Than Money

- Potential loss of
  - Seniority
  - Health insurance
  - Retirement

- The longer a worker remains off work, the more difficult it becomes to ever return
Disability: What causes it?

- **Powerful LTD risk factors:**
  - older age, female, diagnosis of back or neck sprain
- **Lower magnitude:**
  - divorced, < 50 employees, high unemployment
- **No correlation:** severity (other than catastrophic)
- **Psychosocial** may predispose injury

Cheadle 1994, Tsai 1991
DCs

- DC as first Physician is strongest predictor of someone not being off work a year after injury (Turner 2008)
- DC as first physician strongest predictor of never getting into trouble with opioids
- 12% of COHE providers are DCs
- ~30% of L&I’s low back patients see DCs
- DCs in L&I are dealt with in regulation and policy as primary care providers (same as MD, DO)
Best Practices Topics

- Disability Prevention
- Patient Intake
- Curative and Rehabilitative Care
- Rapid and Safe Return To Work
- Consultation
Disability Prevention

- **Primary Disability Prevention**
  - Prevent injury – Safety, ergonomics
  - AP role: sentinel (may see pattern at an employer)

- **Secondary Disability Prevention**
  - Recovery to prevent disability
  - AP role: evidence-based curative & rehabilitative care, return to function

- **Tertiary Disability ‘Prevention’**
  - Management of disability to minimize impact
  - AP role: usually less involved
Secondary Disability Prevention Best Practices

- **AP**
  - Address recovery expectations
  - Fear avoidance or catastrophizing behavior
  - Incrementally increase activity
  - Patient empowerment role: don’t be an ‘enabler’ or medicalizer
  - Identify and overcome RTW barriers

- **Consultant**
  - Identify and overcome stalled care progress
    - Concurrent care, PT/OT, specialty referral, care plan modification, 2nd opinion
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### ROA
- Accurate
- Timely
- Complete
- Consistent

### APF
- Complete
- Capabilities
- Work Status

### Records
- Know what’s accepted
- Document differences
- Know what’s been done

### Care
- Substantially different
- Curative
- RTW focus!

### Clarify
- Each provider’s role
- Written request from AP with CM approval

### Care
- Clear plan, goals, outcome, timeframe
Curative and Rehabilitative Care

- What the law requires
- Defined as documented functional improvement

**Baseline**
- Subjective
- Objective
- Functional Ability

**APF**
- Complete!!!!!
- Capabilities!!!!!!
- Work Status
- RTW info

**Follow-up**
- Subjective progress *since care began*
- Objective progress *since care began*
- Functional Ability at time of follow up and reconciliation to ability at baseline
- Function Instruments (eg Oswestry)

**APF – when work status changes**
- Complete
- Capabilities
- Work Status
- RTW info
Functional Improvement

- “Pain Interference” instead of “Pain”
  - On a scale of 0 to 10 how much does your [pain or condition] interfere with your ability to [activity patient identifies as something that the condition interferes with]

- Validated function instruments
  - Condition or region specific (eg, Roland, StartBack, NDI, SPADI)
  - IICAC Resource: Documenting and Tracking Functional Improvement
Rapid and Safe Return To Work

- Set RTW as an explicit clinical goal
- Make contact with employer at first visit to learn of availability of modified duty
  - Assure patient knows employer connection is important in their recovery

- Resources
  - IICAC employer resources
  - RTW Desk Reference
  - L&I Support (Stay at Work, ERTW, COHE)
Consultant Best Practices

- **Understand clinical best practices**
  - IICAC Best Practice Resources
  - Constructive input to AP including care goals

- **Understand claims issues**
  - Get temporary CAC access
  - Identify claim concerns (e.g., how much care to date, what functional progress has been made, care for accepted condition vs. concurrent/pre-existing)
  - Address any work issues

- **Clearly address both in reports**
“Orange Flags” and resources to help

- Curative/rehabilitative vs. palliative
- Additional diagnoses inconsistent with work exposure
- Timeloss exceeding ~ 2 weeks
- Multiple early referrals without severity
- “Circular” 60 day reports
  - Objective vs. subjective findings
Most common problems

- Over treatment after maximal improvement
- Poor documentation of functional improvement (ability to work)
- Enabling disability behavior
- Low adopters of best practices
- Small number of DCs are outliers

Resources: ONCs, Drs. White & Austin
Remember
The Injured Worker…

- Is a patient with a physical condition
- May also have
  - Bio-psychosocial issues
  - Workplace issues
  - Confounding problems
- Is a patient with a concurrent disorder:
  “Systemosis”
"Systemosis"

A condition where all those pesky pragmatics of a no-fault liability system established in law over 100 years of political compromises between labor and employer interests attenuated by case-law, precedent, and bureaucratic inertia get in the way of doctors’ business-as-usual clinical practice.
COHE Best Practices

- Day 1 Employer Contact *(ideally with patient)*
- Activity Prescription – clear work and physical ability
- Health Services Coordination
- Impediments to Return-To-Work with action plan
- Under development
  - High disability risk identification **FRQ**
  - Active PT, rehabilitation, etc **FRI**
  - Psychosocial Determinants Influencing Recovery **PDIR**
  - Activity coaching **PGAP**
  - Intensive multidisciplinary chronic pain interventions
Challenges For DCs

- Not enough of us speak “employer”
- Not enough of us speak “health-care resource”
- Too many of us speak “victim” or “whiny special interest”
Fixes?

- Become an occ health **GO-TO** resource
  - Speak “employer,” “health care resource,”
  - Live “customer service” i.e., frame your services to meet their needs, not the other way around
  - Understand patient advocacy includes RTW

- Develop your networks
  - Prioritize some shadowing & sponge activity
  - Ask “How can I do a better job to meet your needs”
  - Increase your familiarity and comfort in and around other peoples wheel-houses.
  - Think of others as resources not competition
“WE COLLABORATE. I'M AN EXPERT, BUT NOT AN AUTHORITY, AND DR. GEPPAS IS AN AUTHORITY, BUT NOT AN EXPERT.”
IICAC’s Becoming a GO-TO Resource Effort

- Clinical Resources
- Practice Workflow Resources
- Working With Employer Resources
- Working With Other Provider Resources
Clinical Resources

- Psychosocial Determinants Influencing Recovery
- Documentation Best Practices
- Work-related Foot & Ankle Conditions
- Work-related Shoulder Conditions
- Work-related Epicondylosis
- Work-related Carpal Tunnel Syndrome
- Active Rehabilitation for Low Back Conditions
Practice Resources for Attending Providers

**IICAC occupational health practice resources**

- 📄 2016 Reducing Disability: Psychosocial Determinants Influencing Recovery (PDIR) (1.48 MB PDF).
- 📄 2015 Work-Related Foot and Ankle Conditions (1.82 MB PDF).
- 📄 2014 Work-Related Mechanical Shoulder Conditions (700 KB PDF).
- 📄 2014 Occupational Carpal Tunnel Syndrome (347 KB PDF).
- 📄 2014 Documenting Functional Improvement (439 KB PDF) plus Functional Scales (558 KB PDF).
- 📄 2014 Work-Related Epicondylitis (297 KB PDF).
- 📄 2011 Active Rehabilitation for Work-Related Low Back Conditions (256 KB PDF).
Resources For Working With Employers

- AP’s RTW Desk Reference
- Employer Contact Resource
- Notice to Employer of Injured Worker Care
- Occupational Health Readiness Assessment
- Return-to-Work Assistance
  - Stay At Work
  - Early Return To Work
  - COHEs
- Self-insured Employers
Resources for Working with Other Providers

- Referral Practices Quick Reference Card
- AP’s Referral Form
- PT/OT Active Care Referral Form
IICAC Initiative  - work in progress

1. IICAC Members
2. Chiropractic Consultant Program
3. COHE Providers