Washington State Department of Labor & Industries

Therapy Stakeholders Group Meeting
January 20th, 2016 Tukwila Service Location, 12:30 p.m. – 3:30 p.m.

Present:

Therapy Members: Theodore Becker – EPI , Christina Casady – Capen and Associates, Josh Cobbley – Northwest Return to Work, Barbara Harrington – Peoples Injury Network Northwest, Terry Moon – Pacific Rehabilitation, Jim Strandy – Summit Rehabilitation, Lynda White – MVP Physical Therapy,

Audience Members: None

LNI: Sarah Martin – Project Manager/Chair, Lauren Royer – Project Administrative Support, Karen Ahrens – Project Lead

Testing Elements

Handout: FCE Testing Elements

- Reliability of Worker report
  - Member requested consideration to have reliability of worker report added to our minimum testing elements.
  - Member brought copies of the Matheson chapter on "Reliability of Pain an Disability Reports and functional pain scale with permission of Matheson.
  - All members currently test for reliability in relation to demonstrated abilities.
  - Need to be aware that individuals may over or under report their pain and abilities. High pain is tied to the illness model of behavior.
  - One can have high effort but low reliability of report and still considered to have a valid test.
  - Many benefits to include:
    - Allows for a safer evaluation
    - Allows the evaluator to have a discussion with the individual if a participation level needs to change.
    - Allows others to know if the individual is able to accurately report their abilities.
  - Consensus was yes to add this under #6: Musculoskeletal/Psychosocial Questionnaires. Reliability is one of the results when using these questionnaires.
  - Will need to use a term that is generalized and not specific to a type of system.
  - Consider providing further education on this and other elements for future workshops.
  - Member recommended adding the WHODAS back to #6 as it can be used as a single progress marker.

- Consistency/Level of Effort – Element #5
    - Let members know that this element was updated to provide subcategories of consistency and level of effort respectively.
- Cardiorespiratory endurance – Element #4
    - Isoinertial, MET testing terminology discussed.
    - Need a more generic term.
    - Members agreed with changing term to work physiology.

Heart Rate Reserve
Handout: Pages 182-183/Volume 18 Lesson 16: Directions in Rehabilitation Counseling Classification of Work by Heart Rate and Severity Table, Calculations for Determining the Heart Rate in Relation to the percentage of aerobic capacity table.

- Member discussed in more detail one method used for predicting full time work.
    - Used for material handling, standing/walking types of jobs. This method is not directed to address seated work. Based on work physiology research from the 70's and 80's which have similar conclusions. Seated work is measured using biomechanical methods.
    - Method requirements:
        - Seated resting heart rate,
        - worker age,
        - monitored heart rate during work circuit that best matches job demands,
        - A minimum of 16 minute exposure for light demand job and 28 minutes for medium/moderate work,
        - Heart rate seated recovery response time
        - Results calculated using heart rate reserve formula. 6 different tables included but for purposes of our discussion, we used the Jiang table.
    - Goal of circuit is to reach a steady state heart rate which typically occurs within 60-90 seconds. An individual achieves their steady work pace at 30-90 seconds. This means that motor skill and heart rate has a parallel response.
    - If the heart rate keeps elevating during the activity or needs more than 3 minutes of recovery time, the activity was too high of a demand for the individual on a full time basis. The time prediction for the activity is less than full time. The job would need to be modified or combined with less demanding tasks.
    - Member advocates this research is more accurate than age adjusted maximum resting heart rate method and proprietary algorithm.
    - What about jobs that have a mix in physical demands? For example, 2 hours of material handling but the rest of the time is a sedentary job.

        - You may need to use a different method/test to determine full time capacity when there are only brief lifting job demands. (biomechanical model)
        - Could start the circuit at a low level and then increase it.
        - You could do the circuit based on the material handling demands portion of the job and then use the formula to determine if there is a match with the results and the material handling duration. For example, if the heart rate result is 128 bpm, the worker would tolerate up to 3 hours of a heavy demand activity per day. The rest of the day would need to be light/sedentary tasks.
            - If this type of situation comes up, it could be noted in the grid comments section: able to do 3 hours of the heavy demand material handling duties and 5 hours at the light level.
- If individual is on beta blockers, you have to use other methods besides heart rate reserve as this medicine impacts the heart rate response.
- Contraindications:
    - Cardiac
        - Heart Rate: 120 bpm = tachycardia.
        - BP: Some members stop test at159/99, others use 180/110. Per ACSM Guidelines for Exercise Testing and Prescription 8th ed, relative indication includes >200/ and/or 110 at rest.
        - Using clinical judgement, stop test and refer to medical provider. Reschedule when medically cleared.
    - Other
        - Treadmill: ACSM contraindicates for neurological, musculoskeletal and rheumatologic conditions.

L&I Low Effort Procedures

Handout: FCE/Unable to Make RTW Conclusions CM Workflow

- Shared a new resource for claim a manager that was developed when the FCE provider wasn't able to make RTW conclusions. The resource provides a specific process for vocational providers and claim managers to follow in this situation. The non-cooperation process is not being pursued unless it is one of many examples of obstructive behavior.

Other FCE Topics

1) Issues with FCE changes expressed by APs/VRC's?

- Concern by VRC about no review of future JAs by FCE providers.

- There is some confusion about roles that will likely respond to planned outreach activities.
    - Need to increase awareness for VRC's to send JA's to the FCE provider prior to the test.
        - When no voc provider – about 10% of the time, it would come from the CM. May need a stand-alone job analysis (SAJA) completed if one does not exist and the VRC has approx. 14 days to complete this activity.
    - Some VRCs are still asking the FCE provider to fill out the signature page.

2) Pilot FCE Summary form: Future suggestions and considerations related to form.
    a. Page 1 Unrelated factors: is self-limiting behavior intended to be an unrelated factor? Yes. What about deconditioning? No.
    b. Question about AP Restriction section: L&I does not need to differentiate between the None and Test to Tolerance box so this is a combined box.
    c. Evaluator conclusion section: ideally, need enough detail to give the reader confidence that testing was done related to validity and consistency.
    d. Formatting: The George icon is dropping into the name row.
    e. We may need to consider adding a definition key or reformat sit/stand/walk categories (S/O/F/C). This section doesn't match the APF format. Also members use different durations to come up with the category. For example 20-40 mins = seldom but another system indicates that 30 minutes = frequent, 60 min to 2 hours = constant. This will be monitored.
    f. Look at developing clearer instructions when the FCE provider can make RTW conclusions on part of the test and not for another part of the test. How much validity is necessary to still complete all the sections? How does this get documented?
3) Mini FCE's – prior agreement not to support this level of evaluation. An FCE will need to meet our minimum testing elements. Agreement by members that those clinics performing mini FCEs would either need to bill as a standard therapy session or do a full FCE meeting our minimum standards.
4) Complex level decision is still pending with management
5) Scenarios when a worker has to come back for a 2nd day (not a pre-planned consecutive day test). Illness, cardiac issues, inconsistent result that need to be redone, child care issues. Clinics currently do not bill extra when this happens. Some send their report after the initial testing day with what they have as sometimes the worker never comes back, some redo all of the testing if the worker returns.

6) Is the 21 day scheduling expectation a rigid timeline? No, but we do want a sense of priority/urgency. Documentation is not specifically needed if not able to meet the 21 day turnaround. However, if barriers arise, the claim manager needs to be alerted.
7) Member noted that their clinic started to use a modified pain scale with pictures. Found different response compared to prior method.
8) Tips for electronic record keeping – because forms for FCE are unique, members do not use the ERM to create the form. Instead the form is attached to the EMR system.

Work Hardening Data Form – deferred as not enough time to address this topic.

Next Meeting: March 14th, 2016