Washington State Department of Labor & Industries

Therapy Stakeholders Group Meeting
November 30th, 2015 Tukwila Service Location, 12:30 p.m. – 3:30 p.m.

Present:

Therapy Members: Josh Cobbley – Northwest Return to Work, Cheryl French Nevin – Olympic Sports and Spine Rehabilitation, Barbara Harrington – Peoples Injury Network Northwest, Jim Strandy – Summit Rehabilitation, Lynda White – MVP Physical Therapy, Christina Casady – Capen and Associates, Jonathan Harrison – NW Work Options

Audience Members: Morgann Henry

LNI: Ryan Guppy – Executive Sponsor, Sarah Martin – Project Manager/Chair, Lauren Royer – Project Administrative Support, Rich Wilson - Project Director, Karen Ahrens – Project Lead

Updates:

- Webinar – Will be offering workshop via Webinar next year. Dates will be emailed to FCE email list.
- Foot and Ankle Resource- Shared the newest resource available on the L&I website developed by the Chiropractic Advisory Group. (ICAC)
- Complex Level – Noted that the proposal has been submitted to L&I management for consideration. Results will be shared once a decision is made.

FCE Forms Pilot:

Review of Version 3.1 of the FCE Summary form and feedback from pilot participants.

- Whole numbers- group agreed that clinicians need to use whole numbers and not decimal points. Rounding up or down is at the discretion of the evaluator.
- Sit/stand/walk – adding a minutes option per day in the alternate postures section: Group consensus is to keep it as it is with hours. Concerned that it would cause confusion if there were too many variables.
- Page 2: Responses Section –
    - Consensus to keep as is but allow the ability to unprotect form to add or remove columns.
    - Agreement to add a text box to include Job of Injury title.
- Auto populate heading information such as worker name and claim number – this will be given to our Forms section to see if this can be added.
- Discussion about adding NR (not restricted) vs Constant designation within each category. Consensus is to keep it as it is. An X means either NR and/or constant which is how the APF is designed.
- Define Perform work on ladders versus climb ladders – this will be pursued on the definitions document.

- Relook at the definition for crouch – is crouch also a partial squat. Consensus was that it is.
- For kneeling – Will add the R/L/B selection option.
- Crawl – Will add a distance text box option
- Changes to reaching, forceful grasp were not applied per group consensus
- Other category – will add lbs and more text box options
- Identified that working overhead is not part of form but is defined. This can be added in the Other category if noted on the JA.

UE Focused FCE discussion:

- Initially there had been a consideration to create an UE addendum to document capacities results. After further discussion, the group recommended creating an UE area of concern guideline that would be added to the comprehensive testing guidelines. This would be helpful guideline for tests that also needed an UE focus. Alternative option is to consider an extra comment section that specifies UE or specify guidelines for UE.
- Brainstorm: Types of testing to consider for UE: Sensibility testing, Coordination tests, repetitive motions (early vs. late day comparison tests), stereognosis, hand volume, eye hand coordination, fine motor control, hand transfer, hand manipulation, grip and pinch strength, variations of hand use with the different grip and pinch positions, Wrist flexion extension, deviations, forearm rotation.
- Same battery of tests for injured and non-injured side.
- Percentile or norms are not recommended as these are healthy population.
- Challenges occur when the JA is too general and doesn't provide detailed UE job demands information

Cognitive Focused FCE Discussion:

- Consider a similar approach for cognitive focused testing. Create an area of concern testing guideline.
- It was noted that an FCE may be able to identify areas of concerns that neuropsych testing cannot because of the work activity testing environment (ecological validity)
- Brainstorm: Type of testing: Memory, attention, simple and complex instructions, sequencing, multiple tasks, distraction, focus
- Would fit best with a JA that includes cognitive job demands.
- Clinicians would like to have a list of resources so if they find deficits, they have specific recommendations to suggest.
- It was noted that an OT may be more comfortable with cognitive testing than a PT.
- Consider identifying training in this area as this is a more specialized area.
- Not all clinicians will be comfortable doing a cognitive specific FCE although some of the basic cognitive abilities will be seen with a physical demand testing of a standard FCE.

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What is Quality?

- A trained clinician: Asked to consider requiring minimum training standards for evaluators – rule making would be necessary to implement this. First phase could be having training/certification strongly encouraged.
- Clinic who has their own quality assurance program – to include peer review of reports and internal training.
- Questions are answered in the report and no further clarification needed.
- Assessable clinician for when questions do arise.
- 6 minimum elements are included in testing
- Using publish peered reviewed research to guide testing and clinical judgement
- Results reflective of individualized testing (specific to job and worker)
- Consistency of results – internal consistency, task to task and standardized testing
- Prepared to legally defend their work in a deposition.
- Objective data to link conclusions to specific tests, heartrate monitoring.
- Does FCE help claim move forward,
- Timeliness of FCE to test and report in file
- Adherence to new L&I standards, use new forms
- FCE evaluator understands L&I/voc system

Consideration for more L&I resources for therapists: Recommendation by members to have webinars tailored to therapists- how to navigate the L&I system, how to complete forms, better understand how a therapist fits into the system, JAs, RTW priorities, tools for RTW (WSAW/PWP)

Testing Elements:
What is the shortest test duration to call it a comprehensive FCE?
Member response: Minimum 3 hours maximum 8 hours. Should be individualized. Some workers can get thru testing quickly (single diagnosis, limited concerns) and may only need 3 hours but that doesn't apply to all evaluations. Schedule 6 hours. 4-6 is typical duration time.

Heart Rate Reserve – Jim tested the Kodak calculation – He noted it was about the same as what he has been using in his formula for work demands. (based on Karvonen method) Members present noted that it is best to use multiple methods to determine work demands. Looking solely at HRR has limitations such as age dependent, may enable for low effort. Consensus to continue discussion at next meeting but using concrete scenarios.

Repetitive lifting:
Discussion to determine if there is an industry standard to define repetitive lifting/material handling. (i.e. how many lifts per min/hour to fit into a specific category) Members indicate there is no peer reviewed/published standard. At this time, we will just use the standard categories (S, O, F, C) and use the JA information to determine a job match. Encourage VRCs to document detail.

Reviewed current draft document for changes in content:

Cardiorespiratory Endurance Testing –

- Change isoinertial to MET testing.

Consistency/Level of Effort Testing –

- Correct typo
- Update to isometric grip test battery.
- Group consensus was to keep level of effort and consistency in the same category.
- Consider a and b subsets.

Musculoskeletal/Psychosocial Questionnaire:
Went thru the list to identify the ones that can be used for a single intervention versus over time. Single intervention: ODI, RMQ, NDI, SPADI?, PHQ-9, FABQ, TSK-11, EPIC, PACT, PDI, MPQ-SF. Added Dalles, Orebro, Ransford Pain Drawing, MTAP – combines the EPIC and PACT and requires a fee to use, IEQ (injustice experiences questionnaire)
Question raised if there are any cross cultural pain scales?

Round Robin:
No additional feedback.

Next Meeting: January 20th, 2016