Preventing Needless Disability:

What is the problem and how can we intervene?

COA Annual Meeting April, 2010

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Take Home Message

Communication and *Teamwork* are essential for successful rehabilitation and prevention of delayed recovery after disabling occupational injury or illness.

Prevention is the Goal

- **Primary** - prevent *occurrence* of injury/illness
- **Secondary -** optimize efficiency of *rehabilitation*
- **Tertiary -** prevent *recurrence* of injury/illness

Two Components of Secondary Prevention:

- Quality Medical Treatment
- Management of Disability

Quality of Medical Care

- Method of measurement is problematic: mortality, morbidity, physiologic parameters, patient satisfaction, disability
- In WC system, *functional recovery* is easily measured and is a goal shared by all parties

Effective Treatment for Work Injuries:

- Immediate triage to reinforce attitude that the worker's well being is of primary importance
- Establish patient trust (sit, listen, examine, explain); need to overcome "company doctor" image

Effective Treatment for Work Injuries :

- Patient included as *partner* is his/her care
- Return to Work goals discussed at first visit & incorporated into the treatment plan

ICIS Claims Distribution

Claim Type	Claim Count	% Claims	%Total Cost
Med Only	1,193,020	66.5	5.9
TD	361,664	20.2	11.7
PD	238,055	**13.3**	**81.4**
Death	1,439	0.1	1.1

Delayed Recovery:

Disability duration out of proportion to severity of injury or illness

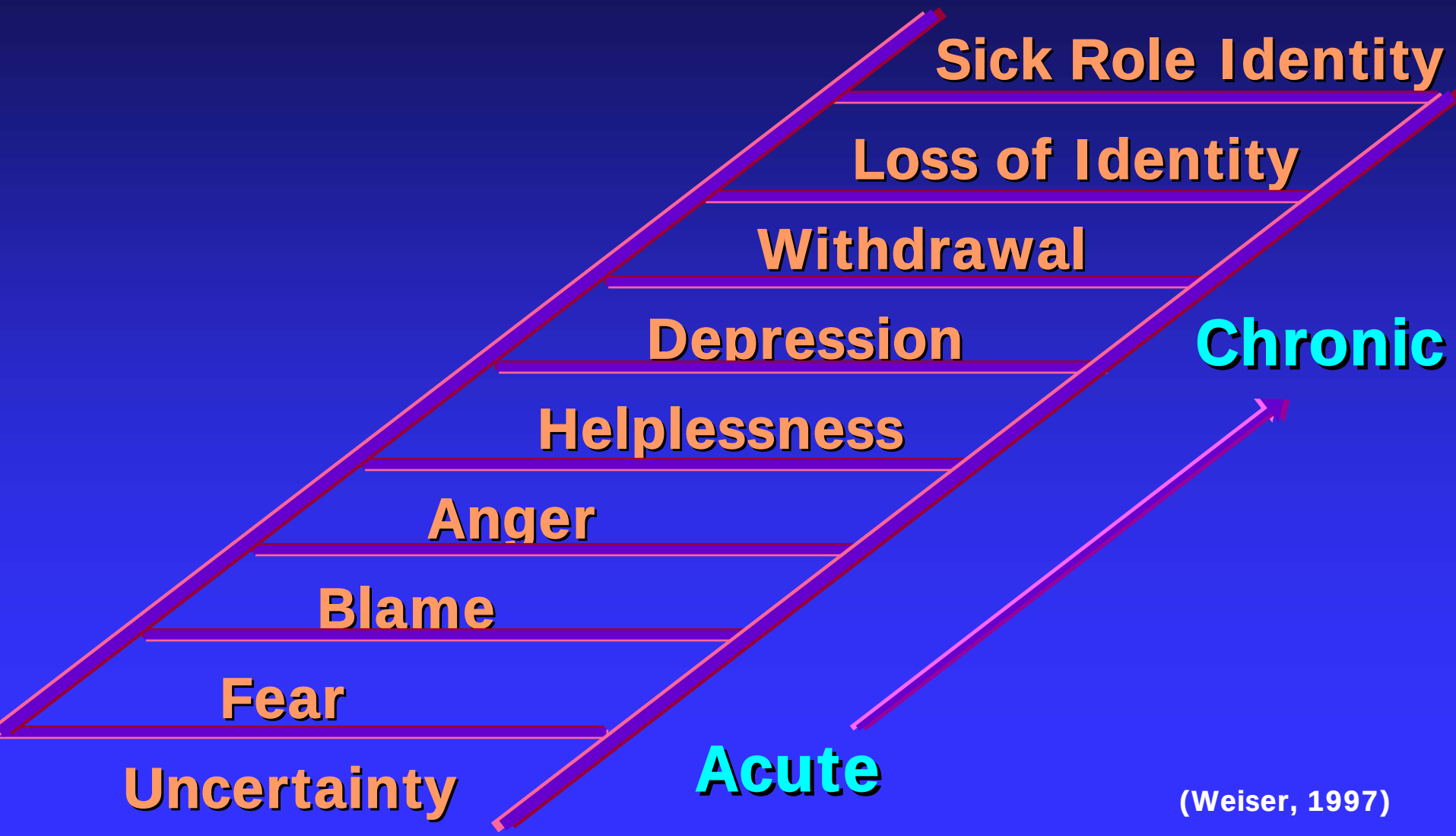
Delayed Recovery:

- Nature of Injury/Anatomy
  - sprain/strain
  - “cumulative trauma”
  - soft tissue
  - spine & upper extremity
- Severity
  - associated with minor injury
  - pathology obscure or absent

Risk factors for delayed recovery: *psychosocial* issues

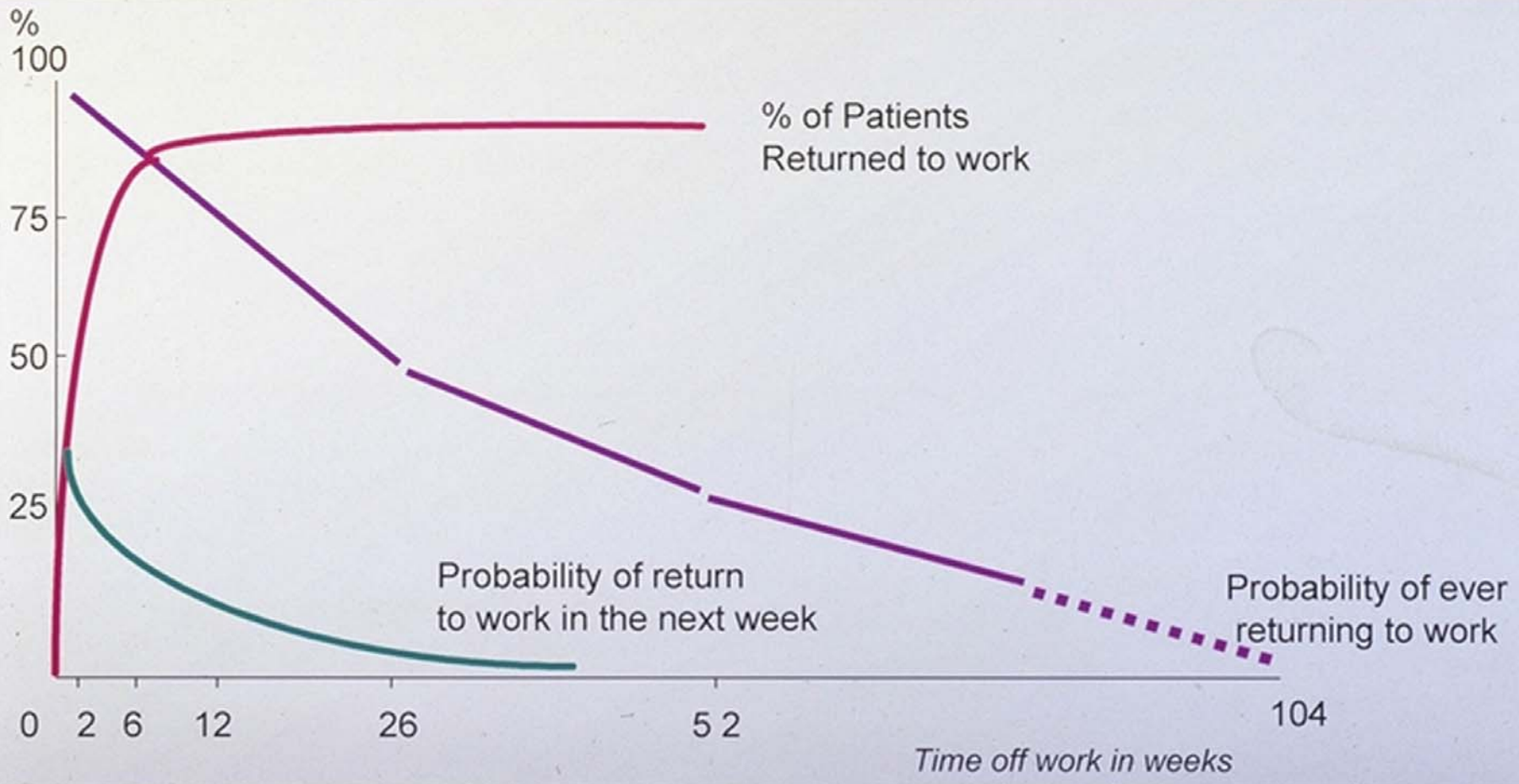
- Low job satisfaction
- Attorney involvement
- Sense of entitlement
- “Secondary gain”
- Age, co-morbidity
- Past history

The Pain Ladder



(Weiser, 1997)

Return to Work as a Function of Time



According to a recent survey of Industrial Medicine Physicians

Up to 80% of paid indemnity expense is unnecessary ...

Stated Reasons

Employer has a policy against light duty

The treating doctor is not equipped to determine the right work restrictions

Too little information about the physical demands of the job is provided to the physician

Managed Comp Survey of
Industrial Med Physicians April 1998

Chronic pain and opiate use/abuse

- Prolonged opiate use is a marker for delayed recovery and iatrogenic disability
- Narcotic abuse inhibits functional recovery and is a major cost-driver in the California WC system
- Diversion of narcotics is a public health issue

What is the problem?

- We shouldn't consider narcotic abuse in isolation
- Inappropriate drug use is a marker for *delayed recovery*
- Delayed recovery has many causes but all cases of narcotic overuse have delayed recovery.

Who is the problem?

- Can vary from case to case
- One or more of key stakeholders may be enabling *delayed recovery*
  - Patient
  - Employer
  - Doctor
  - Claims administrator
  - Attorney

What can the Insurer do?

- Range of interventions defined by jurisdiction and regulatory context
- Recent reforms in California provide opportunities
  - Increased emphasis on *evidenced based medicine* (utilization review standards)
  - Improved channeling/retention in *networks*

What can the clinician do?

- Early identification/intervention on high-risk cases is best strategy
- After “horse is out the barn door,” interventions are more difficult

What can the clinician do?

- Focus should be on what is known to be effective:
  - Active care including daily *aerobic exercise*
  - Psychological support such as *cognitive behavioral therapy*
  - Lifestyle changes such as smoking cessation, weight loss
  - Avoid the “magic bullet” approach with focus on pills, injections, surgery
- Detox is essential part of treatment plan

The importance of work-restrictions

- Needed for every patient at every visit
- Help facilitate RTW by enhancing communication
- Not “rocket science” and formal FCE’s rarely needed.

Key Message

- Rest and activity can be compared to therapeutic drugs with specific indications and contraindications.
- Activity prescriptions (work restrictions) should be part of every treatment plan.

When the doctor is the problem…

- Common treatment patterns are counter-productive, i.e. “standard of care” conflicts with the evidence
- Clinician habits die hard, especially when change threatens income.
- When someone is watching, behavior changes

Texas model to Control Opiate Abuse

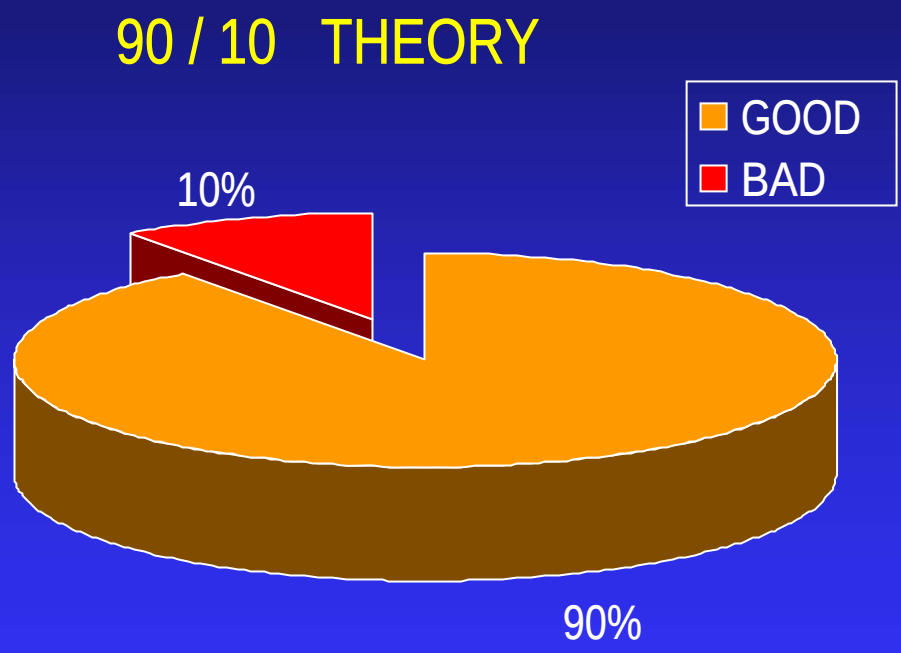
- Use PBM data to indentify problem doctors
- Doctor notified re: questionable prescriptions
- If no response, case sent for file review with peer and report sent to treating MD
- If still no response, telephone call to treating physician by Medical Director
- If no change results, case referred to DEA, Medical Board and/or State Division of WC

State Fund Interventions

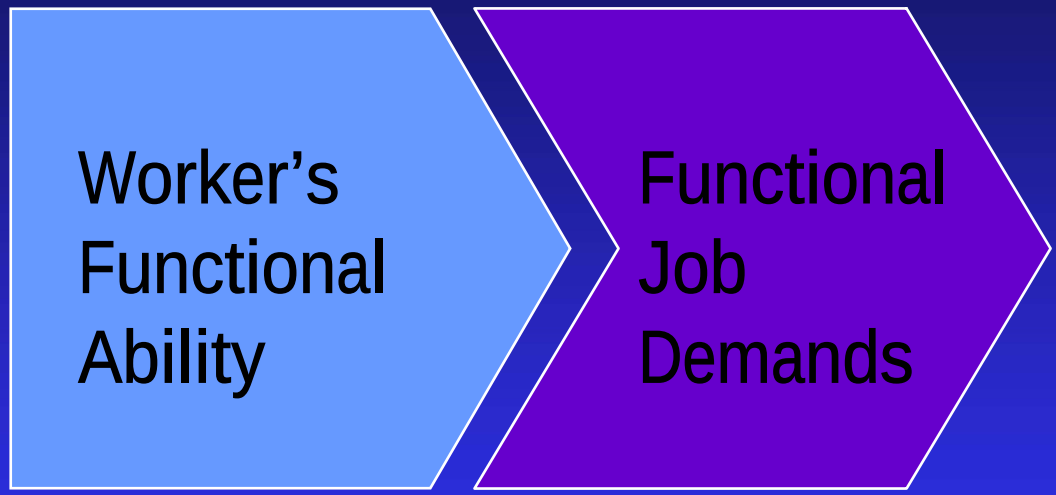
- Early identification of high risk cases
  - Risk assessment software at case make-up
  - First TD payment as “safety-net”
- High risk flags trigger worksite intervention

Purpose of Risk Assessment

- Identify claims at high risk for “delayed recovery”
- Refer for early intervention



HOW DO WE GET PEOPLE BACK TO WORK?



A SIMPLE SOLUTION
TO A COMPLEX PROBLEM

Worksite Assessment

- Identify areas of stress related to diagnosis
- Can be minimized through changes by *Employer* ?
- Can be minimized through changes by *Employee* ?
- Identify appropriate modified duty

Case Example #1: 47 year old high-tech manufacture plant worker

- She had been off work 4 months with shoulder injury (rotator-cuff tendonitis)
- Being treated by an orthopedic surgeon;
- Employer apparently had no “modified duty.”

State Fund Interventions

- Flagging of “claims gone wild” is also needed
  - Narcotic prescriptions are a good marker for problem claims
  - Contact with the prescribing physician is first step
  - Peer-peer discussion of evidence as applies to specific patient
  - Referral to functional restoration programs with proven outcomes when appropriate
- Intervention effectiveness depends on cooperative treating physician

State Fund Interventions

- Use of PBM to help flag cases
- Criteria based on timing of first use, duration of use, type of opioid, multiple prescribing physicians
- Flagged cases are referred to physician advisors for review and recommendation

Identification and referral of high risk cases

- By doctor at time of office visit – patient is referred for behavioral interventions
  - Use of validated questionnaires
  - Focus is on coping skills, motivation
  - Short-term program with specific goals
- During telephonic interview by adjuster – case is referred for special handling
  - Meeting at worksite with employer, claimant, physical therapist to discuss transitional work options
  - Discussion with treating physician if medical care services appear inappropriate (UR staff)

Triage of LBP/CT claims

- Adjuster (or doctor's office) administers questionnaire
- Claimants with high scores (risk of delayed recovery) are scheduled for worksite visit
  - Focus of visit is placement in appropriate transitional duty position to minimize TTD
  - If unsuccessful due to patient factors, then referred for behavioral program

Key References

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