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Session 32
Managing the Psychosocial Risk Factors for Disability
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Objectives
• Discuss non-medical risk factors for needless disability*
• Describe psychosocial factors related to the patient, the work place and the treating provider
• Identify case management strategies to address identified risk factors

*(Other than intention to abuse the system, i.e. fraud)

What Is Needless Disability?
• According to the American College of Occupational and Environmental Medicine:
  • “Only a small fraction of medically excused days off work is medically required—meaning work of any kind is medically contraindicated.
  • The remaining days off work result from a variety of non-medical factors such as administrative delays of treatment and specialty referral, lack of transitional work, ineffective communications, tax management, and logistical problems.
  • These days off are based on non-medical decisions and are either discretionary or clearly unnecessary.
  • Participants in the disability benefits system seem largely unaware that so much disability is not medically required.
  • Absence from work is “excused” and benefits are generally awarded based on a physician’s decision confirming that a medical condition exists.
  • This implies that a diagnosis creates disability.”

From the ACOEM position document
Preventing Needless Work Disability by Helping People Stay Employed

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Medical factors (severity of illness, physical recovery) are just the tip of the iceberg.

Barriers to Return to Full Duty

- Severity
- Complications
- Access to care
- Access to meaningful LD jobs
- Tendency to let employee determine work disposition
- Unfamiliarity with occupational medicine practices
- Unfamiliarity with the patient’s job
- Catastrophizing
- Fear
- Disability role
- Feeling mistreated

Other Agendas

Physician Practice Risk Factors

- Poor communications
- Lack of understanding of stay-at-work/return-to-work principles
- Misunderstanding of job requirements and limited duty programs
- Lack of continuity in practice (multiple providers)
- Tendency to give patients whatever they ask for related to work and time off
- (What can we do to help make sure patients are asking for the right thing?)
Job Risk Factors

- Lack of positions for IWs with restrictions
- Little flexibility in limited duty job options
- Mixed feelings about bringing problem employees back – WC claim can look like solution to a manager’s disciplinary problems with an employee

Employee Factors

- Case example:
  - Employee has a back strain, with persistent pain, prolonged course of physical therapy, failed attempt to RTW, now off 3 months
  - Bulging discs, can’t sleep due to pain, going to pain management
- Show of hands – fraud?
- Other possibilities?
- What other factors help you decide how to manage?
  - Good employment history, good relations at work
  - Frequent friction, disciplinary problems, multiple past claims

Employee Attitudes and Beliefs

- Fear of re-injury
- Thinking catastrophically
- Tendency to feel depressed or anxious
- Feeling mistreated
- Belief that condition is disabling
- Low self-efficacy
Fear and Catastrophizing

- Fear of pain has been defined as a “highly specific negative emotional reaction to pain eliciting stimuli involving a high degree of mobilization for escape/avoidance behavior.”
- Catastrophizing has been defined as “an exaggerated negative mental set brought to bear during actual or anticipated painful experience.”
- Translated............

Catastrophizing

- Catastrophizing:
  - Dwelling on the worst possible outcome of any situation in which there is a possibility for an unpleasant outcome.
  - Examples of catastrophizing:
    - Dwelling on possibility that plane you are in will crash
    - While taking an examination, being preoccupied with the possibility of failing
  - Related to perception of being vulnerable and unable to control dangerous situation
- Fear of pain:
  - Misinterpretation of pain as a signal of harm
  - Avoiding activities that hurt

Example – Knee Pain

- 51 year-old fairly intelligent office worker
- Sudden excruciating pain while walking, followed by inability to fully flex knee without recurrence of sharp severe pain
- ER visit – X-ray, narcotics and a knee brace
- No instructions on knee brace use
- Severe pain on bending → decision to even sleep with brace to avoid possible sharp pain if bending in sleep
- Compensatory gait due to knee immobilization → pain in other leg and back after just 2 days
One Possible Response

Oh! My knee is shot! I bet I tore my meniscus. I will certainly need surgery – perhaps a total knee replacement. It is a good thing I have a sedentary job. No wonder I can’t do squats or lunges. What a wreck. No wonder it hurts. I better be careful what I do.

Another Possible Response

OK, it’s abnormal. I knew that. So, what does this mean? Anything that can be fixed? What is the cause of that terrible sharp pain and feeling of getting stuck when I bend it? What can I do to make it better?

Catastrophizing and Pain Beliefs

- Avoiding activities that hurt due to belief they are causing harm
- Leading to deconditioning and failure to return to work
- Which leads to further pain, depression, and additional problems
- And can be reinforced by significant others (and even doctors) ("Doc, it hurts when I do this...")
- Leading to decreased patient participation in usual activities
- And eventual reinforcement of disability belief ("chronic pain disorder")
Physician Messages

- Recommendations to avoid activities that cause pain feed into catastrophic thinking
- Focusing on elimination of pain as treatment goal is usually unrealistic and almost always detrimental
- Messages that offer reassurance and emphasize maximizing activities (within safe limits) promote recovery and maintenance of function

Back to our Example

- Orthopedist at first visit:
  - Your X-rays show a fair amount of arthritis and you have a mild effusion (swelling) on exam
  - An MRI is a good idea to see if maybe you tore a meniscus
  - Get rid of the brace – it will make you weak
  - Use ibuprofen at high dose for the pain and to reduce the swelling
  - Walk as much as you can tolerate. Cycling would be a good exercise until we find out what is wrong.
- What do you think of this message?

Example – Knee Pain

- MRI report conclusion:
  - There is severe degenerative osteoarthritis in the patellofemoral compartment with grade 4 chondromalacia loss in the lateral aspect.
  - There is heterogeneous signal abnormality within the posterior intercondylar notch, which could be in part due to synovitis and possible small intraarticular bodies. Within the posterior and medial aspects of the knee, there is a 4 mm intraarticular body.
  - There is patellar tilt and there is marked retroquadriceps fat stranding. These findings can be seen in patellar tracking disorders.
  - There are cystic intraosseous lesions within the central tibial plateau which have an extraosseous extent and lie adjacent to the PCL. These likely represent ganglion cysts.
Reaction to the MRI Report

How would an anxious or catastrophizing patient interpret that report?

How might an inexperienced or nonspecialist physician interpret this report?

Importance of physician message

Ideas on getting the right physicians involved in the care of your injured employees?

MRI Report Interpretation

Example – Physician Message

Your MRI shows a lot of wear and tear.

It is probably this area (using knee model) of arthritis that is causing that stuck feeling and pain.

Most of your arthritis is in this area behind the patella.

If your pain gets bad enough, we can try some injections (steroids or synthetic cartilage) -- they won’t cure you but will give you relief.

Your quadriceps muscles are very weak – stop babying them and get yourself on a strengthening program.

Set a 3 month goal – here are some suggested exercises (demonstrated) – we can refer to PT if you need extra help with this.
Clinical Course
- Brace was put away
- By day 3, swelling had subsided
- Rare pain on bending by day 3, by day 5 pain was gone
- Patient was able to walk without problems and resumed use of elliptical trainer in week 2 after episode

Any guesses on who the patient was?
Any guesses on which of the two responses was a closer match?
Would you like this doctor to be available to see your employees?

Recognizing statements and behaviors
Screening tools and how to deploy them
Involving your OH team
Management actions that can make a difference
When and how to involve other resources
Statements Related to Fear of Pain

• “It’s terrible.”
• “I think it’s never going to get any better.”
• “I can’t stand it anymore.”
• “I’m afraid the pain is getting worse.”
• “I keep thinking about how much I want the pain to stop.”

Feeling Mistreated

• Several studies have shown that patients who feel wronged report more pain and have worse outcomes
• “I can’t believe this has happened to me.”
• “My life will never be the same.”
• “Nothing will ever make up for what I have gone through.”

Emotional Responses

• Anxiety statements:
  • “I can’t stop worrying about my job.”
  • “I can’t sleep because I keep on thinking about whether I’ll ever get back to normal.”
• Depression statements:
  • “I just can’t get myself going.”
  • “I don’t have much hope that I’ll ever recover.”
  • “I feel sad all the time; I’m just not myself.”

What is your emotional response to these statements?
Anxiety and Depression

- Anxiety / depression may follow an injury
- Anxiety / depression can impede recovery and may need to be addressed
- Ignoring this problem does not usually work
- Can be treated without consequential condition claim (more later)

Beliefs about Recovery

- Several studies have shown that the most important predictor of when a patient will RTW is the patient’s belief
- Patient’s beliefs and wishes influence physician decisions
- Several studies have also shown that health care provider messages early in an injury can influence a patient’s beliefs about recovery

So What?

- OK, so you probably knew a lot of that already
- What can you do about it?
- What should you do about it?
### Proactive Management to Prevent Needless Disability

#### Pre-injury:
- Establish expectations and a culture that supports them
- Collaborate with OH, labor and management for messages and approaches
- Research what has worked elsewhere and be prepared with handouts, policies, forms and approaches
- Return to Work Knowledge Base has great summaries and references about research on what works:

#### At time of injury:
- Avoid expressing suspicion/cynicism
- Establish RTW full duty as the goal with IW and doctor
- Letter to doctor should establish this goal as expectation
- A friendly call by the supervisor the day after an injury was the most important factor in recovery in one study of multiple interventions
- Solicit help from OH in reinforcing the right messages, tracking progress, and corresponding with the treating provider
The Right Messages to Prevent Needless Disability

- The importance of exercise and staying active
- Maintaining function as the most important goal (not necessarily pain relief)
  - Correspond with community treating provider
  - Address function and activities at follow-up visits
- Use and share tools that reinforce messages for recovery
  - Patient education materials
  - Activity logs
  - Share tools with treating doctor
- Example of an activity prescription and log:
  - http://www.managedcareadvisors.com/#vstc7=activity‐prescription‐and‐log/vstc0=resources

Using Disability Benchmarks

- Use EDD to benchmark expected recovery –
  - Show of hands – who is using this?
- Evaluate cases that are not progressing as clinically indicated
- Use diagnosis and physical requirements of job to estimate how long it should take to be back to full duty, based on national disability data
Screening for Psychosocial Risk Factors

- Early identification of psychosocial risk factors provides an opportunity to address them
- Many different screening tools
- Need to plan, with OH staff:
  - Which tools are appropriate
  - Whether, when and how to use them
  - What to do with the information
- What resources do you have for employees at risk for unnecessary disability due to fear, anxiety, or catastrophic thinking?

Disability Risk Screening Tools Available on Internet

- Linton activity screening questionnaire:
- Orebro activity screen questionnaire:
- Pain Catastrophizing Scale
- IEQ (Perceived Injustice) Questionnaire:

Interventions with Treating Doctor

- If progress stalls:
  - Letter to doctor about goal of preserving function and RTW full duty
  - Share ACOEM* guidelines information
  - Provide updates to doctor on IW progress at work
  - Propose incremental decreases in restrictions to doctor – develop forms
- If IW needs mental health help:
  - Facilitate referral for cognitive behavioral therapy when indicated
  - Accepted mental health diagnosis codes not needed

* American College of Occupational and Environmental Medicine
Hot Tip: Cognitive Behavioral Therapy

- Health and Behavioral Intervention CPT codes (not psychiatric care codes) can be used.
- CBT can help manage the cognitive, behavioral and psychosocial factors that interfere with recovery from the physical impairment.
- No psychiatric diagnosis is required under this code for a psychologist or psychiatrist to receive authorization and fee schedule reimbursement to evaluate and treat a patient with a medical condition.
- The goal of the CBT program is to facilitate acceptance of pain and not equate chronic pain with disability.

CBT Approach for Pain and Work Disability Prevention

- Brief and time limited
- Collaborative effort between the therapist and the client
- Structured and directive
- Based on an educational model
- Work activity focus
- Homework is a central feature of CBT
- Handout to help CBT providers understand FECA rules

Research on Work-Focused CBT


February 27, 2012

*Work Focused Psychotherapy Can Help Employees Return to Work Sooner*

Speakers return to work after medical onset, according to new study

WASHINGTON—Employees on sick leave with common mental health disorders such as depression and anxiety take longer to return to work than other workers, according to new research published by the American Psychological Association.

Employees who received brief, return-to-work-focused CBT did not suffer adverse effects and showed significant improvement in mental health over the course of one year, according to the article, published online in APA’s *Journal of Occupational Health Psychology*.

“People with depression or anxiety may have a lot of obstacles to address when they return to work,” said the study’s lead author, Suzanne Lösche, PhD, of the National Institute of Occupational Safety and Health. “The plan worked for employees with mental health issues who wanted help getting time off work with the goal of completing their tasks at home and returning to work.”
Interventions at Work as Recovery Progresses

- Follow the doctor’s restrictions, but don’t coddle the injured worker
- Try to find tasks that let the employee work maximally within the doctor’s orders
- Activity and exercise are important to recovery – can walking be included in LD tasks if prescribed?
- Modify assignment as work restrictions decrease
- Involve the injured worker and supervisor in identifying additional tasks as recovery progresses

Case Management Meetings

- Show of hands – who has case management meetings?
- Who do you involve in these meetings?
- Anyone have meetings that include the injured worker?
- What would be the benefit of including the injured worker in a case management meeting?

Learn More

- Great blog and resources from an Orthopedic Surgeon who now helps patients with chronic pain:
- Return-to-Work Knowledge Base – nicely organized summaries of research from different perspectives:
- Research from McGill University on pain and disability risk:
- A model program for proactively addressing disability risk:
  - [http://www.bmj.com/content/suppl/2010/03/16/bmj.c1035.DC1/fm665600.ww1_default.pdf](http://www.bmj.com/content/suppl/2010/03/16/bmj.c1035.DC1/fm665600.ww1_default.pdf)
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<td>• Plan – policies, messages, coordination, training, tools</td>
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<td>• Communicate expectations, share tools with treating providers</td>
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| • Identify injured workers at risk for needless disability  
  o Consider screening tools  
  o Plan appropriate interventions |
| • Intervene early to facilitate recovery  
  o Communicate with treating provider  
  o Help get CBT if needed  
  o Involve IW in problem-solving |

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