



OSC 10
Ohio Safety Congress & Expo

PSYCHOLOGICAL IMPACT OF INDUSTRIAL INJURIES: CURRENT PROBLEMS AND INNOVATIVE SOLUTIONS

Session 544

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Chairperson
The Ohio Psychological Association Task Force on BWC Reform

Wednesday, March 31, 2010 1:30 to 2:30 p.m.

Continuing Nursing Education Disclosures

- **Goal:** To educate conference attendees on specific aspects of accident prevention and Ohio's workers' compensation system
- **Learning objectives:**
 - Describe a joint initiative by the Ohio Psychological Association and the BWC to identify and intervene with IWs in the early stages after an injury (1-6 months) where psychological factors are negatively impacting RTW.
 - Define the role of psychological factors that can negatively impact return to work,
 - Recall problems in the current system that handicap intervention efforts,
 - List behavioral indicators of psychological issues; and
 - Explain the new joint OPA/BWC initiative and how to identify and refer IWs who will benefit.
- **Criteria for Successful Completion:** Attend the entire event and complete a session evaluation.
- **Conflict of Interest:** The planners and faculty have no conflict of interest.
- **Commercial Support:** There is no commercial support for this event.
- **Continuing Education:** Awarded 0.1 IACET general CEUs and 1.0 RN* contact hour.

*The Ohio BWC (OH 18801-01-2013) is an approved provider of continuing nursing education by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

OVERVIEW

- History of Ohio Psychological Association's (OPA) interest in BWC issues
 - 2007- OPA gathering of psychologists who were BWC providers, led to Task Force
 - Perception of high incidence psychological/behavioral issues seen in IWs
 - Complicate treatment and prolonged length of disability
 - Tremendous obstacles to obtaining treatment

Why Psychological Issues matter in Industrial Injuries

- 90-10 rule- a small percentage of cases account for a disproportionate percentage of treatment costs and disability
- "Obvious" concerns- pre-existing psychological vulnerability to disability (abuse history), substance abuse, unrelated psychosocial stressors, failure to progress with associated increase in emotional distress
- Malingering is RARE- 1-2% or less in chronic pain literature
- Reactive psychological distress is extremely common (50-100% incidence in the literature)

Regardless of the origin...

- Psychological issues have a huge impact on suffering, time off work, and medical and disability costs
- Research shows that behavioral/psychological issues (job satisfaction, depression/anxiety, fear of re-injury) are significantly better predictors of prolonged disability than medical and diagnostic variables

Cause or Effect?

- In a small percentage of IWs, pre-existing psychosocial issues are primary (these IWs will show a lifetime history of poor adjustment and coping in work and in relationships)
- In a larger percentage, pre-injury issues create increased vulnerability to/risk of disability given a perfectly legitimate injury
- Normal reaction to injury can include significant distress, especially if the IW sees his/herself at risk to not return to work

Why Psychological Problems Develop in reaction to Industrial Injuries

- Pain
- Fear (of reinjury, movement, meaning of symptoms): lack of understanding of injury, inappropriate expectations for treatment progress; patients with higher fear of pain/reinjury more at risk)
- Stress- worries about ability to RTW, finances
- LOSS OF CONTROL- IW is denied medical care and/or pay for reasons they do not understand → anger/adversarial, feelings of helplessness → Depression

Impact of Psych/Emotional Issues

- Anxiety/Stress increase perceived level of pain
 - IWs who are high in fear of movement/reinjury are at high risk to not progress in physical rehabilitation, depend more heavily on pain medications, and become increasingly passive and inactive
 - Depression negatively impacts virtually ALL medical treatments!
 - Surgery (especially major joint replacement/fusion), rehabilitation, compliance with meds/appointments. -depression leads to significantly poorer outcome
- Pain, anxiety, depression → sleep disruption, cognitive impairment, increased pain → lack of RTW progress → increasing fear, hopelessness, withdrawal → “The Death Spiral”
- Growing body of evidence evidence that brief psych interventions can have a powerful impact on both treatment costs and disability outcomes

Obstacles to Effective Psych Intervention in the BWC system

- Detection/Recognition- clinicians and caseworkers not trained to recognize behavioral issues
- Denial of services when requested-Adjustment Counseling, Even in catastrophic cases it often isn't authorized (Post-concussion syndrome/TBI, amputation;OSU burn unit)
- Catch-22
 - MCO-no psych evaluation without a psych condition
 - BWC- no C-86 for psych without an evaluation!
 - “learned helplessness” on the part of providers

Brief (and Sad) Case Example

- 29 year old construction supervisor with excellent work history, no pre-injury psych issues
- Fell on ice, SEVERE cervical/UE muscle spasm and guarding w/o significant pathology on MRI; unresponsive to chiro, PT, meds
- Continues to work despite severe pain, but with increasing difficulty
- Treating DC felt that fear/guarding were blocking progress and creating a “self-fulfilling prophecy” (pain → tension/guarding/loss of ROM → more pain.
- PERFECT candidate for brief intervention (relaxation, biofeedback, psychoeducation)

The plot sickens...

- MCO would (can) not authorize any psych services, as there is no psych condition
- IW, awaiting evaluation with psychologist who will see him in advance of allowance, becomes increasingly frantic and feeling pressured to RTW, goes to another MD and is put on additional medications
- IWs “doctor-shopping” is discovered, discharged by both physicians. Cannot maintain work
- IW hires attorney...

Where we are now

- Problems that are a normal and common consequence of industrial injuries, that have a huge impact on treatment costs and disability, and respond well to brief, cost-effective treatment, CANNOT BE ADDRESSED DURING THE MOST CRUCIAL WINDOW OF TIME!
- When addressed, psychological issues end up as additional allowances, often years after the injury, and are seen as adding cost with little impact on RTW (but legitimate and probably do help contain treatment costs somewhat)

What's wrong with this picture???

- IW showing clear signs of complicating behavioral factors 3 months post-injury; high risk for prolonged disability→evaluation not allowed
- 1 year later→ IW being considered for fusion surgery-“watershed” event→ evaluation not allowed
- 2 years after fusion-and extensive pain management- Spinal Cord Stimulation- expensive procedure that rarely changes vocational status→ REQUIRES psychological evaluation!
- “barns and horses...”

How can we change this?

Two crucial elements (Not either-or...)

- Health and Behavior Codes
- Joint OPA/BWC/MCO Initiative on Risk Factor Identification and Reduction

Health and Behavior Codes

- Specifically designed to address behavioral aspects of medical disorders such as stressful medical procedures, compliance, and normal reactive distress (i.e. preparation for painful medical procedures, smoking cessation)
- Accepted by Medicare and all major private carriers
WERE on BWC approved codes in 2008... but not reimbursed! Dropped for 2009.

Initial Assessment (CPT 96150)

- Determines the biological, psychological, and social factors affecting the injured worker's physical health and any medical treatment.
- Identifies factors in need of and amenable to intervention, and suggests approaches to do so (i.e. education, relaxation, and behavioral goal-setting in a PT program for patient with high fear)
- Does NOT assign (or require the assignment of) a psychological diagnosis, but can recommend further assessment where clearly indicated

Initial Assessment continued

- Can identify IWs who have significant pre-injury or co-incident psychosocial issues/stressors, who are in need of more intensive psychological treatment and should NOT be expected to RTW along the normal pathways (Psych, or failed fusion?)

Intervention Services (CPT 96152-96155)

- Short term approaches that modify these health-related behaviors.
- Emphasis is on education, relaxation/stress management skills, coping, and communication
- Does NOT aim at long-standing psych issues
- Time and session-limited

- Allowing reimbursement of the H&B Codes would allow rapid and timely intervention in cases where psychosocial issues are complicating response to treatment EARLY in the course of an industrial injury
- By treating these factors as normal consequences of an injury, the need for additional psychological allowances would be greatly decreased

Joint OPA/BWC/MCO Initiative on Risk Factor Identification and Reduction

- Goals:
 - Early Identification of IWs at elevated risk for prolonged disability
 - Rapid, focused intervention to reduce disability
 - If possible, avoiding addition of psychological allowance
- Based upon review of literature, expert consensus, and/or other implemented systems

Improving Return-to-Work in Low Back Pain: Early Prevention and Intervention

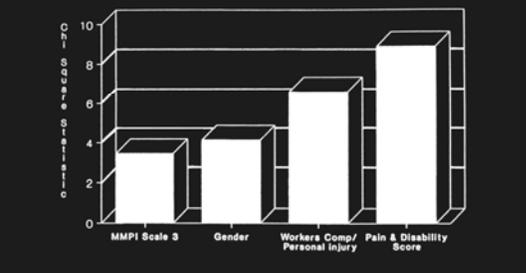
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Relative strength of each variable in logistic regression model



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Early Intervention Study with High-Risk Acute Low Back Pain (ALBP) Patients

- High Risk (HR) ALBP Early Intervention
- HR ALBP Treatment as Usual
- Low Risk (LR) ALBP Treatment as Usual

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Early Intervention

- Resolve any outstanding medical problems
- Interdisciplinary Functional Restoration – exercise, psychology, attitude, general problem-solving

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Long-term Outcome Results at 12-mos Follow-up (from Gatchel et al., 2003)

Outcome Measure	HR-I (n=22)	HR-NI (n=48)	LR (n=54)	p Value
% RTW at FU	91%	69%	87%	.027
Average # Health Care Visits Regardless of Reason	25.6	28.8	12.4	.004
Average # Health Care Visits Related to LBP	17.0	27.3	9.3	.004
Average # of Disability Days Due to Back Pain	38.2	102.4	20.8	.001

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Outcome Measure	HR-I (n=22)	HR-NI (n=48)	LR (n=54)	p Value
Average of Self-rated Most "intense Pain" at 12-mth Follow-up (0-100 scale)**	46.4	67.3	44.8	.001
Average of Self-rated Pain over Last 3 mos (0-100 scale)**	26.8	43.1	25.7	.001
% Currently Taking Narcotic Analgesics*	27.3%	43.8%	18.5%	.020
% Currently Taking Psychotropic Medication*	4.5%	16.7%	1.9%	.019

*Chi-square analysis

**ANOVA

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Cost-comparison Results (Average Cost per Patient/YEAR; from Gatchel et al., 2003)

Cost Variable	HR-I (n=22)	HR-NI (n=48)
Health Care Visits Related to LBP	\$1,670	\$2,677
Narcotic Analgesic Medication	\$70	\$160
Psychotropic Medication	\$24	\$55
Work Disability Days/Lost Wages	\$7,072	\$18,951
Early Intervention Program	\$3,885	NA
Totals	\$12,721	\$21,843

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Tasks for Ohio BWC/MCO/OPA Program

- Development of risk identifiers (preliminary version)
- Training of MCO caseworkers in identification (brochure, in-service)
- Development of brief, focused intervention program (treatment manual)
- Training of psychologists (with appropriate background) in intervention program
- Mechanics of referral process, treatment authorization, and tracking of progress/impact

Behavioral Indicators (Red Flags) for MCOs and providers:

- Injured Workers 1-2 months post-injury
 - Obvious and extreme emotional reaction
 - Passivity and non-compliance
 - Excessive pain complaints
 - Excessive fear/guarding
 - Escalating pain medication
 - Concerns with alcohol and or/substance use/abuse
 - Severe/traumatic injury

Injured Workers 2-6 months post-injury

- Any of the factors noted above plus:
 - Presumptive diagnoses-fibromyalgia, RSD, CRPS
 - Memory/concentration difficulties
 - Expressions of lack of confidence /Fears of inability to return to work
 - Medication escalated to long term opiates
 - candidates for spinal fusion or other major surgery

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Questions/Discussion