SESSION D2

Best Practices in Workers' Compensation: Preventing Disability, Saving Lives

Gary M. Franklin, MPH, MD

Session Description:

Five percent of workers account for 80% of disability; most of this disability is preventable. Learning how to prevent the transition to chronic pain via best practices will contribute to the viability of workers in your communities.

Learning Objectives:
Following my presentation, participants will be able to:
1. Differentiate between primary, secondary, and tertiary prevention.
2. Recognize when and when not to use opioids for pain.
3. Deliver best practices sufficient to prevent disability.
1. **Disability Prevention in Washington State Workers’ Compensation**

   Gary M. Franklin, MD, MPH
   Advanced Practice Nursing
   Oct 9, 2014

2. **Changes in Disability Status among Injured Workers in WA State**

   Early Intervention Period

   % Workers Receiving Disability Payments

   Time Loss Duration (months)


3. **What is the relationship between health care delivery and prevention?**

   **Disability Prevention: Changing the Paradigm**

   - **Primary prevention**: Prevent workplace injuries and illnesses
   - **Secondary prevention**: Prevent disability among workers with work-related injuries and illnesses
   - **Tertiary prevention**: Prevent disability progression to reduce residual deficits and dysfunction in workers with established disability


4. **Strategic Focus in WA State**

   - Use best evidence to pay for services that improve outcomes and reduce harms for injured workers
   - Identify efficient method for identification of workers at risk for long term disability
   - Incentivize collaborative delivery of occupational health best practice care sufficient to prevent disability

5. **Disability Prevention in Workers’ Compensation**

   **Most important risk factor categories**

   - Medical
   - Work
   - Administrative
   - Psychosocial
   - Economic
   - Demographic
   - Legal

6. **What has contributed the most to decade long pattern of increased disability duration?**

   - Use of harmful treatments, which contribute to prolonged disability: opioids, spinal surgery (lumbar fusion)
   - Multiple diagnosis problem (eg, TOS)
   - Bad docs

Opiates and Disability

- 1/3 of all workers with compensable low back pain receive an opiate Rx in the first 6 weeks (Stover et al, J Pain 2006; 7: 718-25)
- Receipt of opiates for more than 7 days doubles the risk of one year disability (N=1843) in multivariate analysis (Franklin et al, Spine, 1/15/2008)

L&I's New Opioid Guidelines

- Clinical Meaningful Improvement in Function
- Case Definition & Algorithms for Discontinuing COT
- Proper and Necessary Care for Opioid Prescribing
- Stop and Take a Deep Breath at 6 weeks and before COT
- Managing Surgical Pain in Workers on COT
- Addiction Treatment
- www.opioids.lni.wa.gov

Reduce the Development of Preventable Disability

- Decrease the proportion of injured workers on Chronic opioids*
- Percent of claims received with opioids 6-12 wks from injury
  - Baseline: 4.9%
  - 1Q 2013: 4.6%
  - 2Q 2013: 3.3%
  - 3Q 2013: 1.4%
  - 4Q 2013: 1.1%
  - TARGET By 6/2015

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Strategic Focus in WA State

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Washington Workers’ Compensation Disability Risk Identification Study Cohort (D-RISC)*

- Prospective, population based
- Low back injury and carpal tunnel syndrome
- For LBP, N=1885 workers enrolled and completed baseline interview (median 18d)
- Predictors of disability at 1 year

CDC/NIOSH RO1 OH04069-and 8/31/2007

L&I’s New Opioid Guidelines

Clinically Meaningful Improvement in Function

Proper and Necessary Care for Opioid Prescribing

Stop and Take a Deep Breath at 6 weeks and before COT

Managing Surgical Pain in Workers on COT

Case Definition & Algorithms for Discontinuing COT

Addiction Treatment

www.opioids.lni.wa.gov
**Assessed >60 variables in 8 risk factor domains at baseline:**
- **Sociodemographic**
- **Employment-related (e.g., industry, job physical and psychosocial demands, offer of job accommodation, job duration)**
- **Pain and function** (multiple measures, including Roland)
- **Clinical status** (e.g., injury severity, radiating pain, previous injuries, comorbidities)
- **Health care** (e.g., provider specialty)
- **Administrative/legal** (e.g., attorney)
- **Health behavior** (tobacco use, alcohol use, BMI)
- **Psychological** (catastrophizing, blame for injury, recovery expectations, work fear-avoidance, Mental Health)

**D-RISC–Primary Outcome**

At 1 year: 261 of the 1,885 study participants (13.8%) were receiving work disability compensation (information obtained from workers' compensation administrative database).

**Baseline Predictors of 1 Yr Work Disability, Final Multi-domain Model (OR of worst category, adjusted for all other variables in model):**
- Injury severity rating (from medical records) (3.7)
- Previous injury with > 1 month off work (1.6)
- Roland Disability Questionnaire score (7.0)
- Multiple pain sites (1.7)
- Job is hectic (2.2)
- No employer offer of job accommodation (1.9)
- First provider seen for injury (ref=Primary care; Occupational Medicine 1.8, Chiropractor 0.4, Other 1.9)

AUC=0.88 (excellent ability to predict 1 year disability)

**Job Accommodation Offer**

<table>
<thead>
<tr>
<th>Offer</th>
<th>Disabled at 1 yr, %</th>
<th>Work disability days at 1 yr, median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>No offer</td>
<td>19</td>
<td>35</td>
</tr>
</tbody>
</table>

**Conclusions-D-RISC Study**

- Factors in multiple domains, internal and external to worker, are important in the development of chronic back-related work disability
- Injury severity is an important risk factor, but even after adjusting for this and other factors, more widespread pain, greater physical disability, job factors, health care provider type, and prior work disability were significant predictors of chronic work disability
- Results support clinical impressions that patients with similar clinical findings vary in disability outcomes, likely due to factors other than biological ones

**Conclusions-D-RISC Study**

- The biopsychosocial conceptualization of pain might benefit from greater emphasis on environmental factors (e.g., health care provider, employer, and family responses, and work and economic factors) that may interact with biological and psychological factors to affect disability
- Societal problem of chronic disabling back pain will likely require development of new, expanded approaches to prevention and treatment that consider environmental factors
Disability Predictors—Next Steps

- Link risk identification with practical interventions
- Targeted, graded exercise and incrementally graded activity
- Education Re: fear avoidance/expectations
- Workplace modifications
- Pilot brief questionnaire and interventions in community-based occupational-health pilots (COHEs)

Screening for Disability Risk Linked to Delivery of Occ Health Best Practices

Positive Functional Recovery Questionnaire (FRQ)
- Not worked for pay in past two weeks
- Pain interference ≥ 5
- Back and leg pain OR pain in multiple body sites
- Available at http://deoha.washington.edu/occepi/frq

Functional Recovery Interventions (FRI)
- Graded exercise/activity
- Address low recovery expectations
- Address any fear of usual activity reinjuring or worsening condition
- Flag additional HSC focus on RTW

Strategic Focus in WA State

- Use best evidence to pay for services that improve outcomes and reduce harms for injured workers
- Identify efficient method for identification of workers at risk for long term disability
- Incentivize collaborative delivery of occupational health best practice care sufficient to prevent disability

Important components of Centers of Occupational Health and Education (COHE) Model

- This is a health care system, not an insurance company, intervention
- Health care institutional support
- Occupational health leadership
- Business/labor advisory committee
- Community-based

COHE Organization and Governance


Wickizer et al. Med Care 201; 49: 1105-11
Key Results from COHE Pilots

- 20% reduction in likelihood of one year disability, 30% reduction for back injuries
- Among COHE participating doctors, high adopters of best practices had 57% fewer disability days than low adopters

Changes in Cost Savings Associated with Longer Follow Up Period

<table>
<thead>
<tr>
<th></th>
<th>1 Year Follow Up</th>
<th>Extended Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renton</td>
<td>$381</td>
<td>$819</td>
</tr>
<tr>
<td>Spokane</td>
<td>$591</td>
<td>$1,279</td>
</tr>
</tbody>
</table>

Receipt of SSDI for Compensable Claims: 8 Years Follow Up Post Injury, 2002 – 2010 (n=24,741)

Health Care Strategy

Goal: Improve worker outcomes

- Reduce disability by providing highest quality medical care
- Promote evidence based health care, including occupational health best practices

Every provider is a high quality provider via COHEs or Top Tier incentives

Expanding Access to COHE Services

The 6 current COHEs will serve 38 counties:

<table>
<thead>
<tr>
<th>COHE Name</th>
<th>Current # of Enrolled Providers</th>
<th>Proposed # of Enrolled Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Washington COHE at SW/INHS</td>
<td>1,149</td>
<td>1,491</td>
</tr>
<tr>
<td>The Everett Clinic COHE</td>
<td>230</td>
<td>230</td>
</tr>
<tr>
<td>Group Health Cooperative COHE</td>
<td>36</td>
<td>70</td>
</tr>
<tr>
<td>Harborview Medical Center COHE</td>
<td>181</td>
<td>333</td>
</tr>
<tr>
<td>Renton COHE at Valley Medical Center</td>
<td>265</td>
<td>300</td>
</tr>
<tr>
<td>Western Washington COHE at Franciscan Health System</td>
<td>109</td>
<td>1,308</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,960</td>
<td>3,492</td>
</tr>
</tbody>
</table>
Expanding Access to COHE Services

Emerging Best Practices: Current Pilots

Activity Coaching

Model: Progressive Goal Attainment Program (PGAP)

A provider in E. Washington said:

- "This patient had 22 red flags when I referred him to PGAP. At the next visit he was a completely different person."

Workers have said:

- "It gives you a reason to get out of bed and how to be in control of your life again."
- "It teaches you how to relearn to manage your pain and life."

http://www.lni.wa.gov/ClaimsIns/Providers/Reforms/EmergingBP/#2

Emerging Best Practices: Current Pilots

Functional Recovery

- Functional Recovery Questionnaire (FRQ)
  - Early identification of potentially "at risk" workers
  - Functional Recovery Interventions (FRI)
- Providers incorporate interventions to enhance recovery in addition to 4 the COHE Best Practices

http://www.lni.wa.gov/ClaimsIns/Providers/Reforms/EmergingBP/#3

Emerging Best Practices: Upcoming Pilot

Emerging Surgical Best Practices

Four best practices selected from the literature by a focus group of attending providers & surgeons related to:

- Transition of Care
- Return to Work

Creation of a Surgical Health Services Coordinator to:

- Coordinate care and transitions
- Help providers with complicated cases

http://www.lni.wa.gov/ClaimsIns/Providers/Reforms/EmergingBP/#4

Community Based Collaborative Care

 överrundade

Distribution of Quality of Care

RECOGNIZE

COHE Participation, Education, Mentoring, Best Practices, Evidence-based Medicine, Top Tier, Incentives, Care Coordination

REMOVE

Network Minimum Standards
Risk of Harm
Audit, Education and other interventions

Enhance Health and Disability Outcomes
Average Medical and Disability Costs

 качества

Zone 1: Zone 2: Zone 3: Zone 4: Clinical Efficiency
Good (Quality & Value) Poor
Distribution of Quality of Care

**IMPROVE**
- COHE Participation, Education, Mentoring, Best Practices, Evidence-based Medicine, Top Tier, Incentives, Care Coordination

**RECOGNIZE**
- COHE High Adopters Incentives, Recognition, Mentors

**REMOVE**
- Network Minimum Standards
- Risk of Harm
- Audit, Education and other interventions

**Clinical Efficiency**
- **Zone 1**: Excellent Health and Disability Outcomes, Low to Moderate Medical and Disability Costs
- **Zone 2**: Average Health and Disability Outcomes, Average Medical and Disability Costs
- **Zone 3**: Poor Health and Disability Outcomes, Average to High Medical and Disability Costs
- **Zone 4**: Very Poor Health and Disability Outcomes, High Medical and Disability Costs

**Community Physicians**
- Good (Quality & Value)
Status of denied applications – through January 1, 2014

<table>
<thead>
<tr>
<th>Providers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initially Denied</td>
<td>133</td>
</tr>
<tr>
<td>Approved on Reconsideration</td>
<td>28</td>
</tr>
<tr>
<td>TOTAL PROVIDERS WITH FINAL OR PENDING DENIAL</td>
<td>71</td>
</tr>
<tr>
<td>Denial Final &amp; Implemented</td>
<td>54</td>
</tr>
<tr>
<td>Pending or in Reconsideration</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL PROVIDERS WITH FINAL OR PENDING DENIALS</td>
<td>73</td>
</tr>
</tbody>
</table>

*Excludes 34 applications withdrawn after initial denial.

NOTE: Proportionate additional denials are expected as more applications are reviewed. The overall denial rate is currently 0.3%.

The State of US Health, 1990-2010

Burden of Diseases, Injuries, and Risk Factors*

- Years lived with disability 2010
  - Low back pain 3.18 million YLD
  - Major depressive disorder 3.08 million YLD
  - Other MSK disorders 2.6 million YLD
  - Neck pain 2.13 YLD
  - Anxiety disorders 1.86 million YLD
  - Diabetes (#8) 1.16 million YLD
  - Alzheimers (#17) 0.83 million YLD
  - Stroke (#23) 0.63 million YLD

*JAMA 2013; 310: 591-608

THANK YOU!

For electronic copies of this presentation, please e-mail
Laura Black
ljl2@uw.edu
For questions or feedback, please
e-mail Gary Franklin
meddir@u.washington.edu