PART II

POTENTIAL INTERVENTIONS
PART I – CONCEPTS AND INFLUENCES

• Why DFRUD important, and why we need BPSE approach
• Three specific aspects:
  • Cognitive Behavioral (CB) causation model
  • Complex causation/integration
  • Work Related Illness/Injury (WRII) and Work Relevant Conditions (WRCs)
• Psychological Factors (PFs)
  • Psychophysiology
  • Health cognitions (AABEs, CAT and FA, HLOC and self-efficacy)
  • Motivation, Reward, and Gain, and Learning and Memory
  • ACEs and PI
  • Psychopathology
  • Workplace Elements
PART I – CONCEPTS AND INFLUENCES

• Medically Unexplained Physical Symptoms (MUPS)
  • Somatization
  • Central Sensitization

• Iatrogenicility (IAG)
  • Advocagenicity
  • Medicalization
  • Fear of Missing Organic Disease
  • Focus on Symptom Relief vs. Functional Restoration
  • Critical Nature of Time

• The Dilemma of WRCs, and why we aren’t addressing these concerns more completely
PFS, MUPS, IAG, AND DFRUD

**PREDISPposing** (Diathesis)

**PREcipitating** (usually with WRII)

**PERPETUATING**

**DOMAINS**

- Administrative and Medical
  - Psychological
    - Psychophysiology
    - Health Cognitions
    - Motivation/Learning
    - ACEs
    - Perceived Injustice
    - Psychopathology
    - Workplace Aspects
- Personal
- Sociocultural
- Systemic
- Workplace

**Iatrogenicity**

**MUPS/Chronic Pain**

**DFRUD**
SOMATIC SYMPTOM DISORDER – SSD

- Somatization (DSM III) replaced by Somatic Symptom Disorder (SSD) in DSM-5 (Dimsdale 2013; Kurlansik 2016)
  - One or more somatic symptoms that are distressing and/or significantly disrupt daily life
  - Excessive thoughts, feelings, and/or behaviors related to symptoms or associated health concerns
  - Chronicity (at least one symptom for at least 6 months)
- SSD and Body Distress Syndrome (BDS) based on neutral and non-judgmental assessment of bodily symptoms only
  - Gradual shift away from psychopathological emphasis to more neutral, nonetiological, and functional approach
  - Intended as unifying concept across multiple symptoms and syndromes (Budtz-Lilly 2015; Fink 2007)
SYMPTOM ESCALATION (SE)

- Generally refers to worsening instead of improvement, as expected with time and treatment
- **Amplification**: increase in intensity of existing complaints
- **Expansion**: development of new complaints, e.g., experience of paresthesia, numbness and tingling, and weakness in addition to pain
- **Extension**: spread to new body region(s), especially extremities, on same or contralateral side
SYMPTOM ESCALATION

• Potential mechanisms:
  • Psychoendocrine or immunologic mechanism
  • Psychological mechanisms, including expectancies, learning, loss aversion, and somatization (Silver 2012)
  • Central sensitization
• Usually a BPSE phenomenon, and not organic pathology in a new body part
• Does not require de novo biomedical workup and treatment (may be iatrogenic and artificially perpetuate claim)
PART II – POTENTIAL INTERVENTIONS

• **Understand:** Develop better grasp of underlying influences and coherent vision of how they work

• **Change Approach:** Make basic conceptual and practical shifts

• **Prevent:** Avoid modifiable PPP factors

• **Recognize:** Develop methods of identifying at-risk AWs as early as possible

• **Manage:** Refine methods of ethically, legally, and practically managing DFRUD, and addressing barriers to change
CAVEAT

• This is a complex topic with a lot of material

• I have constructed a very detailed presentation with much supporting documentation to serve as resource (will only hit high points in the webinar presentations)

• Copies of PowerPoint and bibliography will be on the webinar website (significantly upgraded since Part I in October)

• Most of my comments will be focused on WC system, but will also be applicable to personal injury and STD and LTD
UNDERSTAND

We need a consolidated, cohesive, evidence-based body of knowledge about DFRUD based on science and administrative and clinical best practices

• Major contributing factors (e.g., PFs, MUPS, and IAG) and balanced approach to occupational causation

• Evidence-based and cost-effective management interventions

• Operationalization: Management principles and practices need to be acceptable and accessible to and adopted by wide variety of clinicians, administrators, and other stakeholders
CONCEPTUAL/PRACTICAL SHIFTS

- Eliminate Dualism/Reductionism
- Change from Disability to Capability Emphasis
- Reduce Inappropriate Claims
- Improve Management of Valid, Accepted Claims
- Enhance Collegiality and Communication
- Adopt Cost Utility vs. Absolute Cost Basis
ELIMINATE DUALISM/REDUCTIONISM

• Cannot continue to consider mind and body as separate entities, or WRII separate from individual AW, especially in potential DFRUD (Salmon 2006)
  • Examples: psychophysiology; MUPS (especially central sensitization); psychosocial influences on eventual disability

• Need more holistic view of AW including psychosocial considerations earlier in claim (WRCs)
  • Need to develop more reasonable approach to these psychosocial considerations
DISABILITY TO CAPABILITY EMPHASIS

• Shift medical practice to focus on functional outcomes (Mueller 2017)

• Micro (e.g., unnecessary and/or inappropriate work activity proscriptions) to macro (assumption of static disability for insurance and legal purposes, e.g., SSA)

• Functional restoration approach (Gatchel 2014), including vocational rehabilitation in WC, STD, LTD, and SSA

• Change to “Workers’ Recovery” (Wilson 2018)

• ACOEM Proposed Alternative Documentation Criteria (ACOEM 2017)
REDUCE INAPPROPRIATE CLAIMS

• Medical care (especially in WC) is not an inherently benign process (Steenstra 2016), with many potential hazards in DFRUD (e.g., IAG and Type II medical malpractice)

• Many reasons for improper claim acceptance:
  • Claimant health cognitions
  • Clinician and insurer failure to effectively consider causation; advocogenicity; and acquiescence to path of least resistance (especially in symptom escalation and revision)
  • Early legal representation and engagement in adversarial process (and resignation)
  • Systemic factors, especially low threshold for PFME and reliance upon suboptimal IMEs
REDUCE INAPPROPRIATE CLAIMS

• Need to keep inappropriate claimants from ever entering system
  • Need more attention to forensics and physics (mechanism of injury)
  • Need more application of stepwise causation protocol (Hegmann 2014, Ch. 3)
  • Insurer needs improved methods and processes to recognize and act on basic claim flaws (e.g., adjuster training, Medical Director/Physician Advisor review)
  • Need clinician motivation, fortitude, and willingness to explain rationale to claimant, employer, and insurer

• Melhorn 2014
IMPROVE VALID CLAIM MANAGEMENT

• Need more critical thinking in compensation cases and less unquestioning acceptance of assertions by claimants and clinicians

• Examinee credibility (Barth 2009)
  • Less reliance on subjective complaints and more corroboration of claims such as sleep and sexual dysfunction, ADL compromise

• Clinician credibility
  • Less reliance upon unsupported medical opinion by “experts” using BM model (systemic problem with both treating and IME)
  • Addition of new body parts and diagnoses based solely on AW complaints, with no relation to original injury mechanism
  • More diagnostic precision (“chronic sprain”)
IMPROVE VALID CLAIM MANAGEMENT

• Administrators and clinicians must spend more time on case details
  • Volume is major problem; these cases cannot be adequately managed in 15 min visits
  • Both manpower and remuneration issue

• Need administrative and clinical improvement in medical records
  • Template-based notes degrade quality of clinical documentation
  • Information overload – only need findings relevant to claim – (“summary” versions for clinical and reimbursement use?)
  • Should not be accepted unless support impressions and treatment
COLLEGIALITY/COMMUNICATION

• **This is a team sport:** need multidomain, multifactorial interventions synergistically involving all stakeholders and perspectives (Cullen 2017) with **all players “onside”** (Waddell 2006a)

• Interprofessional communication failings negatively impact AWs, reduce RTW, and increase costs (Russell 2017)

• **Meaningful communication improves outcomes,** including among all stakeholders (Epstein 2008; Mauksch 2008; Pransky 2004); AW and clinician (Shaw 2011) and supervisor (Linton 2016); proactive clinician with AW and employer (Dasinger 2001; Kosny 2006)
COST UTILITY VS. ABSOLUTE COST

• Enterprise and societal resources are limited, so must select interventions with highest gains in health at reasonable cost (Burdorf 2007, 2011)

• Cost utility evidence:
  • Early interventions in WC claims (Bevan 2015)
  • Interdisciplinary approaches (Rogerson 2010)
  • System-level disability management interventions (Tompa 2009), e.g., WA State COHE Program (Wickizer 2011)
  • Worksite mental health (Hamberg 2012; APA 2017) and other interventions (van Vilsteren 2015)
  • CBT (Norton 2015)

• Cost offset determinations very complex (Langlieb 2003) ⇒ need more research and better definition of business case for psychological interventions
PREVENTION

DFRUD Management Currently Suboptimal ⇒ Prevention Limited but Necessary Approach

• First Do No Harm
• Address Modifiable Psychological Factors
• Quaternary Prevention – Avoid IAG
• CLRRT Paradigm
• Recognition of Free Will
FIRST DO NO HARM

• Need holistic view of AW with more consideration of how WRII (or WRC) affects their entire life, not just isolated medical interventions (e.g., surgery and pain management)

• Need to temper natural advocacy for patients with reasonable and informed administrative and clinical practice
  • Provide what AWs need, not what they or we want (e.g., health beliefs)
  • Clinicians need to become comfortable with saying “I don’t know” when they don’t

Fava 2010; Laisne 2012
MODIFIABILITY OF PFS

• Some influences, especially diathesis factors, may be largely unmodifiable:
  • Psychophysiology, ACEs, some psychopathology
  • Little or no information on prevention of MUPS (van der Feltz-Cornelis 2012)

• Some factors may be modifiable:
  • Maladaptive health beliefs and other cognitions, e.g., with AW health literacy education and training (Woby 2004)
  • Motivation, reward, and gain, learning and memory, and some psychopathology
  • Workplace psychological influences (PI and stress effects) within limits of business needs (Linton 2016)
QUATERNARY PREVENTION – IAG

• “Action taken to protect individuals from medical interventions that are likely to cause more harm than good” (Martins 2018)
  • Appropriate advocacy, e.g., therapeutic alliance (Conboy 2010) and shared decision making (King 2013)
  • Use best administrative and medical practices (ACOEM 2010; Glass 2017; Jurisic 2017; Mueller 2017)
  • Avoid medicalization and nocebo effects (Colloca 2011)
  • Keep focus on function
  • Avoid unnecessary claim delays
QUATERNARY PREVENTION – IAG

• **Treatment planning**, beginning with likely outcome in mind (RTW, voc rehab, pain management?)

• “Watchful waiting” versus aggressive workup (van Bokhoven 2009, 2012), e.g., in MUPS, mTBI
CLRRT AND FREE WILL

• **CLRRT Paradigm** (Talmage 2011)
  - Capacity and Limitation: what AW can and can’t do
  - Risk and Restriction: what AW should and should not do
  - Tolerance: what AW wants to do

• **Recognition of Free Will**
  - Personal responsibility and conscious choice of action (Waddell 2010)
  - “Neural biology does not have to be one’s destiny” (PC, Karandikar 2017)
  - Moral hazard of compensation systems
RECOGNITION AND MANAGEMENT

Need to recognize potential for DFRUD and intervene as early and effectively as possible

- Early intervention “the next best thing to prevention” (Lewis 2016); delay allows psychosocial drivers of chronicity more time to operate (Linton 2018b)

- We should expect these cases (PC, Christian 2018) and anticipation and awareness should be included in our overall management
RECOGNITION AND MANAGEMENT

• Management using both risk stratification and stepped/matched care (Linton 2018b)
  • Identify health risk status based on known risk factors (RFs) (Bernstein 2007; Hingorani 2013; Meenan 2003) and use RFs as basis for selective treatment (Bergbom 2014; Linton 2018a)
  • Basis for WA L&I Centers of Occupational Health and Education (COHE) and Psychological Determinants Influencing Recovery (PDIR) programs (Wickizer 2017)
  • Can improve outcomes and reduce costs in primary care (Foster 2014; Hill 2011; Whitehurst 2015); evidence in pain-related disability is conflicting (Asenlof 2005, 2009; Bergbom 2014)
  • I propose one approach incorporating many elements (in three levels), but best practice is not clear
EARLY RECOGNITION

• Many potential markers but no clear best way to do this (yet); possible methods include
  • Primary: Use of Associated RFs
  • Primary/Secondary: Psychometric Screening and/or Predictive Modeling
  • Tertiary: Ongoing Monitoring by Natural History (NH), Disability Duration (DD), and Symptom Escalation (SE) (evaluation for MUPS/CS/SSD)

• Looking for condition with incidence of less than 10%; need both high sensitivity and specificity
TRIAGE BY ASSOCIATED RFS

- First Report of Injury (FROI) or early insurer and clinician contacts with AW, including structured ("recorded") interview
  - Historical elements, including ACEs, prior WC claim in AW or SO with or without litigation and/or settlement, prior sick leave (Alipour 2013), multiple surgeries, chronic pain and/or opioids
  - **AW’s self-expected time to RTW** (Young 2017)
  - Workplace influences (disgruntlement and PI, low job satisfaction)
- Many of these factors contribute to data analytics
PSYCHOMETRIC SCREENING

• No single tool assesses all phases and complexity of work disability or stakeholder perspectives

• Potential target factors include pain perception (psychophysio logic/cognitive perspectives); health cognitions, including CAT/FA and HLOC (self-efficacy); ACEs and PI; psychopathology in various forms; and workplace elements (3 imbalance approaches)

• May be psychologically distinct subgroups (Bergstrom 2001)
PSYCHOMETRIC SCREENING

• Poor predictive ability for chronic pain, better for long work absence and disability outcome (Karran 2017a)

• Poor sensitivity but high specificity in method to identify MUPS using EMR data (den Boeft 2014)

• Many uncertainties
  • Optimal time of administration (Karran 2017b)
  • Office practicality, interpretation, clinical relevance, and remuneration (Woolf 2012)
PSYCHOMETRIC SCREENING

• Best approach may be to use several measures based on individual situation

• “The assessment of psychosocial risk factors is only worthwhile if there are plans to institute an intervention specifically designed to target these risk factors.” (Sullivan 2013, p. 414)

• Good overview resources
  - APG-3 Chronic Pain chapter (Feinberg 2011)
  - Colorado DWC Medical Treatment Guidelines (CDWC 2012)
  - Behavioral Health Disability Chapter 6 (Bruns 2018)
SCREENING – INSTRUMENTS

- BHI2/BBHI2: Battery for Health Improvement (Bruns 2014)
- FABQ: FA Beliefs Questionnaire (Cleland 2008; Wertli 2014)
- OMPSQ: Orebro MSK Pain Screening Questionnaire (Gabel 2012, 2013)
- ODI: Oswestry Disability Index (Fairbank 2014)
- PHQ: Patient Health Questionnaire (2- to 15-item scales and screens (Kroenke 2010)
- SBST: StarTBack (Hill 2011; Hayden 2010)
- WHODAS 2.0: WHO Disability Assessment Schedule (Federici 2016)
SCREENING – INSTRUMENTS

• Specific personality disorders associated with chronic pain (Kinney 1993; Rief 2007), and might be identified by MMPI-2 or Millon

• Symptom validity testing, e.g., Test of Memory Malingering (TOMM) (Greve 2013)

• Modified Rankin Scale (Kohli 2016)

• Abilita Rehabilitation Index (ARI) (Garton 2016)

• Recovery time: short form FCE (Branton 2010)

• RTW: Readiness to RTW Scale (Franche 2007); RTW Self-Efficacy Scale (1-2 wks post injury) (Brouwer 2011)
PREDICTIVE MODELING

• Nearly all information about data analytics in WC and disability insurance is proprietary, with little or no peer reviewed literature

• Can be used to trigger higher level of review or intervention, or for treatment vs. settlement decision (Advisen 2015)

• Current examples (most using models to screen claims and identify risk with client-specific criteria) include Cigna (Melton 2012); Genex (Genex 2014); Milliman (Milliman 2018); and Sedgwick (Sedgwick 2014)
PREDICTIVE MODELING

• Many claims of cost savings in gray literature (Despres 2016; Lewis 2017; Sedgwick 2014)

• Now considered WC best practice (Esola 2018)

• Not clear how or whether translates to decreased DFRUD (most models explain less than 50% of outcome variability and few independently tested) (Hayden 2010)

• Main characteristics (Yotis 2015): Data accuracy; emphasis on prediction rather than description; rapid analysis (hours or days); business relevance; ease of use; and does it work?
ONGOING MONITORING

• Need to identify as early as possible when AW deviates from expected recovery trajectory

• NH and DD
  • Need accurate and reliable data for WRIIs (and WRCs)
  • Current DDs may be based on actuarial data and not evidence-based healing periods, and may not be representative (Franklin 2013)
  • Need to be used both by clinicians and insurers
  • DDs not effectively used to date (Fassier 2013)

• SE should be major red flag after elimination of obvious causes (e.g., increased activity)
SECONDARY/TERTIARY EVALUATION

• Need more detailed (structured?) interview for potentially modifiable factors
  • Clues to pathophysiology, HCs, MRG, LM, ACEs, PI, psychopathology, WFs

• Role for motivational interviewing? (Lundahl 2013)

• Need detailed physical and psychiatric evaluation in suspected MUPS/CS/SSD (Creed 2011c; House 1995)

• Practical concerns: Who is to do this? When? How? Who pays for it?
EVALUATION – CS AND SSD

- PSCEBSM Evaluation Model (Wijma 2016)
- PHQ-15 (moderately reliable for somatization) (van Ravesteijn 2009)
- Somatic Symptom Scale 8 (SSS-8) (Gierk 2014) and SSD-B Criteria Scale (SSD-12) (Toussaint 2016, 2018)
- Central Sensitization Inventory (CSI) (Mayer 2012; Neblett 2015)
- Quantitative Sensory Testing (QST), Nociceptive Withdrawal Reflex (NWR), Temporal Summation by EMG (Curatolo 2015)
- Diagnosis is challenging (Murray 2016)
MANAGEMENT

• Three Overarching Goals
  • Optimize administrative and clinical treatment of AW
  • Protect all stakeholders from excess
  • Overcome barriers to intervention
• Three general considerations (early intervention, avoidance of IAG, stepped care) and multiple specific considerations
• Precise mix of methods individualized to AW and situation
EARLY INTERVENTION

- **Multiple positive effects** (Bevan 2015; Stapleton 2015), including decreased chronicity and increased cost of treating such chronicity (Rogerson 2010; Whitfill 2010), although Cochrane found little effect (2017).

- **Claimants may benefit from earlier behavioral health (BH) interventions, e.g., CBT** (Marco 2018).

- **Chronic LBP Intervention Program** (Albertsons) (Algire 2017).

- **Integrated Disability Prevention Program** (Torres 2018).
AVOIDANCE OF IATROGENICITY

• Maintain holistic view of AW
• Refrain from inappropriate advocagenicity and medicalization, and avoid excessive workup
• Use evidence-based evaluation and treatment
• Always maintain functional focus
• Pay attention to case duration (all stakeholders need to be both assertive and proactive)
• Role for preferred adjusters (Kilgour 2015a and b) and clinicians? (Eaton 2015; Wickizer 2011)
STEPPED CARE

• Applies hierarchy of interventions, from least to most intensive, matched to individual’s needs
  • Anxiety and/or depressive disorders (Ho 2016)
  • Chronic musculoskeletal pain (Bair 2015) and opioid pain management (Dorflinger 2014)
  • Functional somatic syndromes (Creed 2011b)

• At least 3 levels in WC DFRUD:
  • Primary (basic) level includes education, activation, workplace interventions, nurse case management
  • Secondary (intermediate) level includes short course CBT
  • Tertiary (advanced) level includes more intensive measures to address WRCs/MUPS/CS/SSDs
MANAGEMENT

PRIMARY
• AW and SO Education
• AW Activation
• NCM/Recovery (RTW) Coordinator
• Employer/Workplace Interventions

SECONDARY
• Psychotherapy (CBT)

TERTIARY
• Pharmaco- and/or Psychotherapy
• Disability Prevention Specialist (DPS) and/or Functional Disorders Clinic (FDC)
• Comprehensive Programs (e.g., IFRP)
• Shift in Overall Goal
MANAGEMENT SUMMARY

PRIMARY EVALUATION
- Prior WC claim in AW or SO, prior sick leave, multiple surgeries, chronic pain and/or opioid use
- Self-expected time to RTW

SECONDARY EVALUATION
- HCs (AABEs, HLOC/self-efficacy, CAT/FA)
- ACEs, PI, Psychopathology
- Other Workplace Factors

TERTIARY EVALUATION
- NH/DD/SE ⇒ MUPS/CS/SSD
  - BPS Appraisal (e.g., PSCEBSM Model)
  - PHQ-15
  - SSS-8 OR SSD-12
  - CSI
  - QST, NWR, TS by EMG

PRIMARY INTERVENTION
- AW and SO Education
- AW Activation
- NCM/Coordinator
- Workplace Changes
- Preferred Adjuster and/or Clinician

SECONDARY INTERVENTION
- Cognitive Behavioral Therapy (CBT)
- Other Psychotherapy
- Therapeutic Adjuncts

TERTIARY INTERVENTION
- Pharma- and Psychotherapy
- DPS and FDC
- Comprehensive Programs (IFRP)
- Cure → Coping
MANAGEMENT ALGORITHM

WC CLAIM

PRIMARY EVALUATION
- Prior WC claim in AW or SO, prior sick leave, multiple surgeries, chronic pain and/or opioid use
- Self-expected time to RTW

NO INCREASED RISK

USUAL CARE

INCREASED RISK

PRIMARY INTERVENTION
- AW and SO Education
- AW Activation
- NCM/RTW Coordinator
- Workplace Changes
- Preferred Adjuster and/or Clinician

SECONDARY EVALUATION
- HCs (AABEs, HLOC/self-efficacy, CAT/FA)
- ACEs, PI, Psychopathology
- Other Workplace Factors

NO INCREASED RISK

CONTINUED ON NEXT DIAGRAM
MANAGEMENT ALGORITHM

CONTINUED FROM PREVIOUS DIAGRAM

NH/DD/SE ⇒ MUPS/CS/SSD
- BPS Appraisal (e.g., PSCEBSM Model)
- PHQ-15
- SSS-8 OR SSD-12
- CSI
- QST, NWR, TS by EMG

SECONDARY INTERVENTION
- Cognitive Behavioral Therapy (CBT)
- Other Psychotherapy
- Therapeutic Adjuncts

TERTIARY EVALUATION

NO INCREASED RISK
- A → GO TO

INCREASED RISK
- B → GO TO
- C → GO TO

TERTIARY INTERVENTION
- D → GO TO
- Pharma- and Psychotherapy
- DPS and FDC
- Comprehensive Programs (IFRP)
- Cure → Coping
AW (AND SO) EDUCATION

• Establish and support realistic understanding of condition(s), interventions, and expected outcome (Dasinger 2001)

• Address Maladaptive Beliefs
  • “De-educate to re-educate” (Louw 2017)
  • Pain physiology education, e.g., Pain Neuroscience Education (PNE; Nijs 2011 and 2014b; Wijma 2016) may reduce catastrophization and pain experience and improve function (Lee 2016)
  • Green Light Imaging Interpretation to Enhance Recovery (GLITtER) (Karran 2018)
AW (AND SO) EDUCATION

- **Enhance Self-Efficacy**
  - Established in arthritis (Du 2011), other chronic diseases (Franek 2013), and SAW/RTW (Johnston 2013)
  - Resilience training (Smith 2018)
  - May be role for motivational interviewing (Alperstein 2016)

- **Reinforce basic benefits of activation and RTW**

- **Who is going to do this?**
  - Roles for insurer, clinician, CM, employer
  - New role for “clinical educator”? 
  - May benefit from standard curriculum or armamentarium from which to draw
ACTIVATION

• Continuum from simple activity (walking) to HEP and supervised OT/PT or graded exercise therapy (GET) to volunteerism and SAW/RTW in restricted or unrestricted duty

• Should support AW in self-generated activity

• PT useful in CS (Nijs 2010); GET effective in CFS and FMS as supervised or guided self-help (Clark 2017; Nijs 2013)

• Many benefits to SAW/RTW (Modini 2016; Waddell 2006b)

• Must avoid bogus activity restrictions (CLRRT paradigm)
NCM/RECOVERY (RTW) COORDINATOR

• Workplace assessment, planning for transitional duty, and facilitating communication among stakeholders

• Success more related to competencies in job accommodation, communication, and conflict resolution than medical training

• Low-stress contact with RTW coordinator improved RTW compared to no or high-stress contact (Black 2017)

• At least 2x improvement (Shaw 2008) and “major factor” (Rinaldo 2016) in RTW; net savings of $10.2K/case (Loisel 2002)
WORKPLACE INTERVENTIONS

- Multidomain interventions including **health-focused, service coordination** and work modification efforts (Cullen 2017) and enhanced communication and problem-solving (Linton 2016)

- **Facilitate SAW/RTW** by changes to work environment, design and organization, working conditions, and relationships (Franche 2005)

- Address PI where applicable

- **Enhance access to treatment, facilitate navigation of disability management system, and provide workplace-based psychological care** (Pomaki 2012)

- Decreased lost time (to RTW) and reduced disability rates (Midtsundstad 2016; van Vlisteren 2015)
PSYCHOLOGICAL TREATMENT

• At secondary level, address negative health cognitions including CAT/FA and HLOC (self-efficacy); motivation and gain issues; PI and other workplace issues; and external influences on claimant (SOs, attorneys)

• “It’s not all in your head, but it’s partly in your head, and we need to address that part if you’re going to get better” (PC, Kertay 2018)

• Must be limited in time (and thus cost) and scope (to WRCs; a difficult problem, and currently a major challenge with behavioral health practitioners)
COGNITIVE BEHAVIORAL THERAPY

• Can be done in person, in group, or by telephone or Internet (Donker 2015)

• Must be focused on work issues or combined with RTW intervention (Cullen 2017)

• Long term improvement in pain, QOL, and disability (Richmond 2015)

• Cost-effective in LBP (Norton 2015); in short courses (Lamb 2010; Norton 2015); combined with PT (Rogerson 2010); and by Internet in anxiety disorders (Naidu 2016), e.g., $5275 benefit for employer (Lagerveld 2012)

• Broadspire, Liberty Mutual using more liberally in WC (Ceniceros 2012)
COGNITIVE BEHAVIORAL THERAPY

• Many problems: AW acceptance, geographic access, practitioner quality, lack of functional and occupational focus

• Effectiveness may be enhanced by stratification by illness severity (Schroder 2012)

• Consider prophylactic use in LBP (Besen et al. 2015) and surgical patients who have been identified as being at risk (Nicholls 2018)

• May need to develop evidence- or consensus-based guidelines on nature and duration of CBT for various WRCs to protect both AW and insurer against unnecessary or unreasonable treatment
OTHER PSYCHOTHERAPY

• Short term psychotherapy for PD and depressed mood (Abbass 2011) and SSD (Abbass 2009)

• Extended Reattribution and Management (TERM) for MUPS (Fink 2015)

• Adjunctive techniques:
  • Biofeedback reduced pain, depressed mood, and disability (Sielski et al. 2017)
  • Hypnosis, in acute (Kendrick 2016) and chronic (Jensen 2014) pain and palliative care (Brugnoli 2018)
  • Mindfulness (Cash et al. 2015; Lakhan 2013)
  • Motivational Interviewing may improve RTW (Flodgren 2017; Gross 2017)
PHARMACOTHERAPY

- Guideline-based use of nonopioid and opioid analgesics, muscle relaxants, neuroleptics, and topical agents

- Antidepressants (TCAs, and SSRIs and SNRIs) can be effective for health anxiety (Woolf 2012) and may be useful for mood disturbance components (anxiety and depression) of SSD (Somashekar 2013)
SPECIFIC MANAGEMENT OF SSD

• Generally low-quality evidence

• Some evidence for TCAs, newer generation anti-depressants, and combined antidepressants and antipsychotics, with caveat of side effects (Kleinstauber 2014)

• Psychological therapies effective but with small effect sizes (van Dessel 2014)

• “The behavioral and psychological treatment of somatic symptoms disorders is still in its infancy” (Sharma 2013, p. 122)
SPECIAL INTERVENTIONS

• Disability Prevention Specialist
  • Occupational + orthopedic + physiatric (rehab) + psychology/psychiatry/psychosomatic medicine

• Functional Disorders/BDS Clinic
  • Extensively used in Belgium and Denmark
  • Feeds from primary care, specialties, and psychiatry
  • Not much literature on outcomes (Creed 2011)
  • Currently little economic incentive in US; need more ROI studies

• Creed 2011
COMPREHENSIVE PROGRAMS

• Progressive Goal Attainment (PGAP) (Sullivan 2013)
• Washington State L&I COHE (Wickizer 2011) and PDIR (Wash L&I 2016) Programs
• Chronic Disease Self-Management (Lorig 2015)
• Interdisciplinary Functional Rehabilitation (IFRP)
  • Clinical effectiveness and cost-utility studies showing superiority to usual care (Becker 2012; Busch 2011)
  • Effects modest, should be balanced against time/cost requirements, only recommended for those with significant psychosocial overlay (Kamper 2014)
  • Current problems like CBT: availability and access, quality, cost, acceptance (Gatchel 2014)
SHIFT IN OVERALL GOAL

• Change from “Cure” to “Coping” Approach
  • Focus on capability, not symptoms (Buchbinder 2012)
  • Chronic disease management approach (Cheatle 2016)
  • Disability management (Loisel 2014)

• Goals are avoidance of iatrogenicity (“harm reduction”) and maximization of residual comfort and function ⇒ overall best outcome for all stakeholders

• May incorporate acceptance and commitment therapy (ACT) (Hayes 2012; Wetherell 2011)
BARRIERS TO INTERVENTION

• Jurisdiction (primary specialty responsibility)
• Nonspecific symptom diagnosis (Murray 2016)
• Changing maladaptive health cognitions, including apprehension about psychology
• Implementing evidence (Fassier 2013) and changing clinician behavior (Mostafian 2015)
• Cost to employer/insurer (absolute vs. -utility)
• Remuneration to clinicians
• Balance of insurer control and AW protection
TAKE HOME POINTS

• DFRUD are complex, multifactorial problems with many likely contributing influences

• We are not doing well at managing these patients with a BM approach, in part due to failure to recognize BPSE contributors

• There is a large body of knowledge about these BPSE influences which is not well appreciated or is being ignored in current practice

• Improvement in management and outcomes requires change at individual, organizational, and systemic levels
TAKE HOME POINTS

• We need greater recognition, understanding, and acceptance of real drivers of DFRUD, including psychological influences (many pre-existing), IAG, and MUPS and their contributions to WRCs
  • Seven major psychological influences
  • MUPS
  • Five facets of IAG
• Industrial causality and apportionment are extremely problematic for clinicians, employers, and payors in these cases, but must be addressed
TAKE HOME POINTS

• General Interventions
  • Coherent, evidence-based, accessible body of basic knowledge and best practices
  • Conceptual and practical changes, including elimination of dualism, shift from disability to capability, expansion of cost utility, reduction in inappropriate claims, and improvement in stakeholder competence, performance, and communication and cooperation
  • Prevention of modifiable elements
  • Early identification of at-risk individuals
TAKE HOME POINTS

• Focused interventions:
  • *AW* education and self-efficacy enhancement
  • Evidence-based pharmacotherapy, activation, and psychological intervention
  • Workplace changes and RTW coordinators
  • May involve specialists or specialized clinics, or IFRPs
  • Some cases may need major shift from cure to coping focus
TAKE HOME POINTS

• We must expand our awareness and management of DFRUD, but be very cautious in exploring and implementing new practice approaches and patterns to protect all stakeholders and achieve an appropriate balance of responsibility in these very difficult cases
THE BASIC LIBRARY

- The Power of Belief
  - Psychosocial influences on illness, disability, and medicine
  - Edited by Peter Holligan and Mansel Aylward

- Chronic Pain
  - An Integrated Biobehavioral Approach
  - Herta Flor and Dennis C. Turk

- ABC of Medically Unexplained Symptoms
  - Edited by Christopher Burton

- From Paralysis to Fatigue
  - A History of Psychosomatic Illness in the Modern Era
  - Edward Shorter

- The Medicalization of Society
  - Peter Conrad

- Functional Disorders and Medically Unexplained Symptoms
  - Assessment and treatment
  - Edited by Per Fink and Marianne Rosendal

- Medically Unexplained Symptoms, Somatisation and Bodily Distress
  - Developing Better Clinical Services
  - Edited by Francis Creed, Peter Henningsen, and Per Fink
QUESTIONS/CONTACT

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