Strategies for the prevention of disability after industrial injury/illness: The role of the insurance company – a Medical Director's perspective

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I. We are interested in *secondary* prevention, i.e. the optimization of rehabilitation after an injury/illness has occurred. This is because:

A. Most workers compensation claims are related to degenerative conditions of aging rather than acute trauma. *Primary* prevention of these conditions is very difficult.

B. The workforce is aging so these conditions are increasing in frequency among the employed population.

C. We are also concerned with tertiary prevention, i.e. prevention of recurrent injury. However, this often involves life-style changes such as weight loss, smoking cessation and exercise which are problematic in terms of coverage under the workers compensation system.

II. 90% of WC costs are generated by 10-15% of claims.

A. Most of these high cost claims are not severe injuries

B. They present as minor "strains and sprains"

C. Associated psycho-social factors cause delayed recovery.

III. We know that workers on temporary disability for > 6 weeks have a drastically reduced chance of ever returning. We also know that 80% of time away from work (temporary disability) is medically unnecessary. These facts suggest two key strategies for disability prevention:

A. The need for predictive modeling at the time of injury.

B. Early intervention to facilitate RTW for high risk cases.

IV. The treating physician's role: the importance of writing work restrictions.

A. Unless patient needs to be in bed, hospital or clinic everyday, there is some chance to continue being productive even if not usual job or even if not with usual employer. When patient is away from workplace, disability mindset and illness behavior quickly takes hold and delays recovery.

B. Without specific work-restrictions from the treating physician, there is no chance for RTW. Writing "off work" or "TTD" is never appropriate. Even if patient needs to be in bed with extremity elevated, just say that and let the job placement issues be handled administratively by employer and/or carrier.

C. Writing work-restrictions is not rocket science and formal FCE's are rarely necessary. Clinical impression, combined with routine physical findings is usually adequate to estimate work-capacity and provide guidelines for employers.

V. Simple predictive questionnaires have been validated in the peer-review literature that can predict who will is at high-risk for delayed recovery.

A. These can be administered during the first visit and patients can be triaged based on the results.

B. Results can also be used by insurer to identify claims needing extra attention (e.g. work-site visit).

C. State Fund uses Health professionals to review of all high-risk claims:

1. Is diagnosis and treatment plan appropriate (*doctor* issues)
2. Does the *employer* understand the need for transitional work assignments as part of the rehab process?
3. Does the *patient* have motivation and adequate coping skills for timely recovery?
4. Worksite visit is often needed to establish specific RTW goals that are integrated with treatment plan

VI. The goal is improving communication and collaboration among injured worker, employer and treating physician. State Fund will *reimburse* the treating physician to spend time on disability management!

VII. State Fund uses a "Safety-net" strategy and also reviews all claims at the time of first temporary disability payment.

VIII. We all need to review our failures - chronic pain from non-cancer musculoskeletal pain.

A. No established "centers of excellence" exist in California

B. Most pain management specialists do not really incorporate the "bio-psycho-social" model into their treatment planning and tend to be "interventionlists" with injections, medications and surgery.

C. Difficult to evaluate chronic pain treatment programs due to lack of data on long-term functional recovery outcomes.

IX. Overuse of narcotics is a major factor in poor outcomes – why narcotic prescriptions should not be refilled.

A. Recent evidence documents that long-term use of opioids in the treatment of non-cancer musculoskeletal pain delays functional recovery and RTW.

B. Diversion is a significant problem in the WC population but doctor's prescribing habits are a major factor.

C. Texas model to control abuse of narcotics has been successful in changing doctor behavior.