

Delayed Recovery Prevention, Communication and Causation

A Clinical WC Perspective

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DELAYED RECOVERY

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Part I

What is delayed recovery?

- What is “slow” RTW?
 - *ODG Definition*
 - *Where does ODG data come from?*
- TTD
 - Pernicious impact on return to work
 - Why setting restrictions helpful
 - *Allow you to follow progress even if it's TDD*
- How does an adjuster identify a patient with delayed recovery?

What causes treatment delays?

Logistical Issues

- Failure to recognize co-morbidity.
 - *DM, DJD/OA, psychological factors, obesity, etc.*
- Contact /scheduling difficulties.
- Missed appointments.
 - *Try to reschedule immediately.*
- Records not sent.
- Unclear/poorly defined responsibilities.

What causes treatment delays?

Interpersonal Issues

- Doctors uninformed about UR/IMR process.
- Doctors think it is adjuster responsibility to provide records.
- Contact difficulties d/t avoidance.
- Inconsiderate behavior making both sides avoidant.

How can adjuster help treater?

- What does adjuster need to do to facilitate?
 - Provide awareness & Information.
 - *E.g., of alternative duty, past history, etc.*
 - Supply medical records from other providers.
 - Educate on WC process.
 - *E.g., "Does P&S mean patient can't treat any more?"*

What does adjuster need to do to facilitate?

- Provide awareness of alternative duty.
 - *Doctors often unaware (or misled)*
 - *Get the Job Description to the doctor!*
- Need for restrictions even if no alternative duty available.
 - *“TTD” pernicious*
 - *Can follow progress as restrictions improve*
- Provide medical records from other providers if needed.
 - *With proper releases*

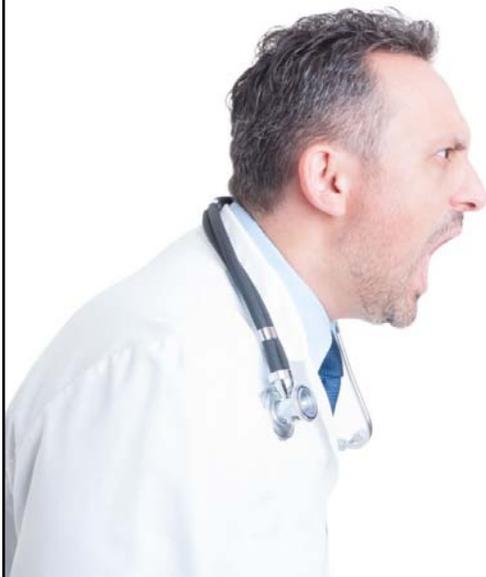
Take-home messages on Delayed Recovery

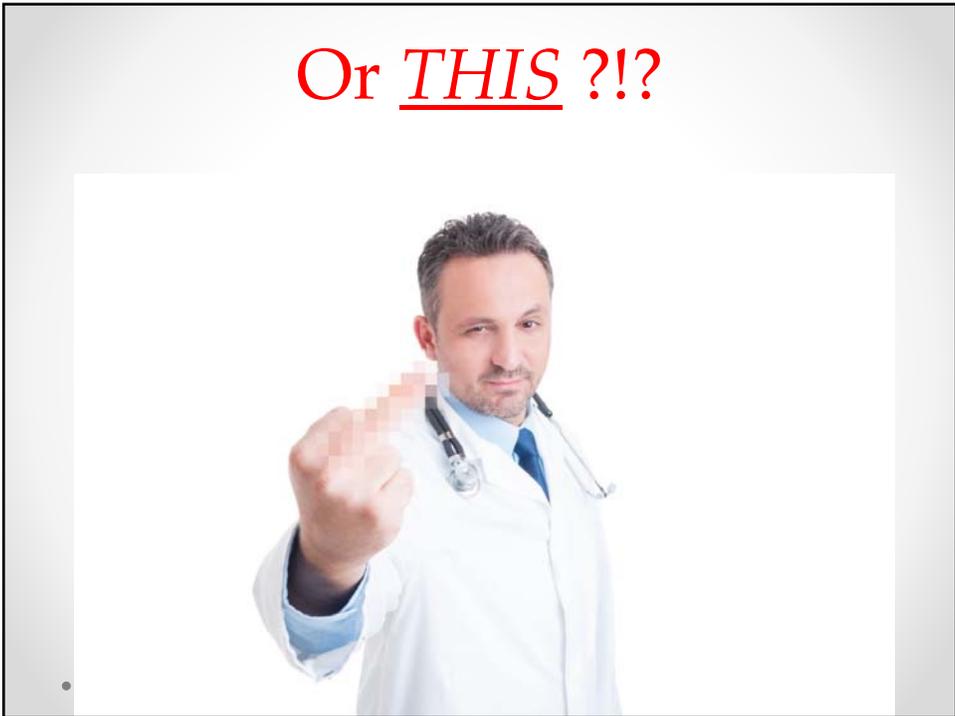
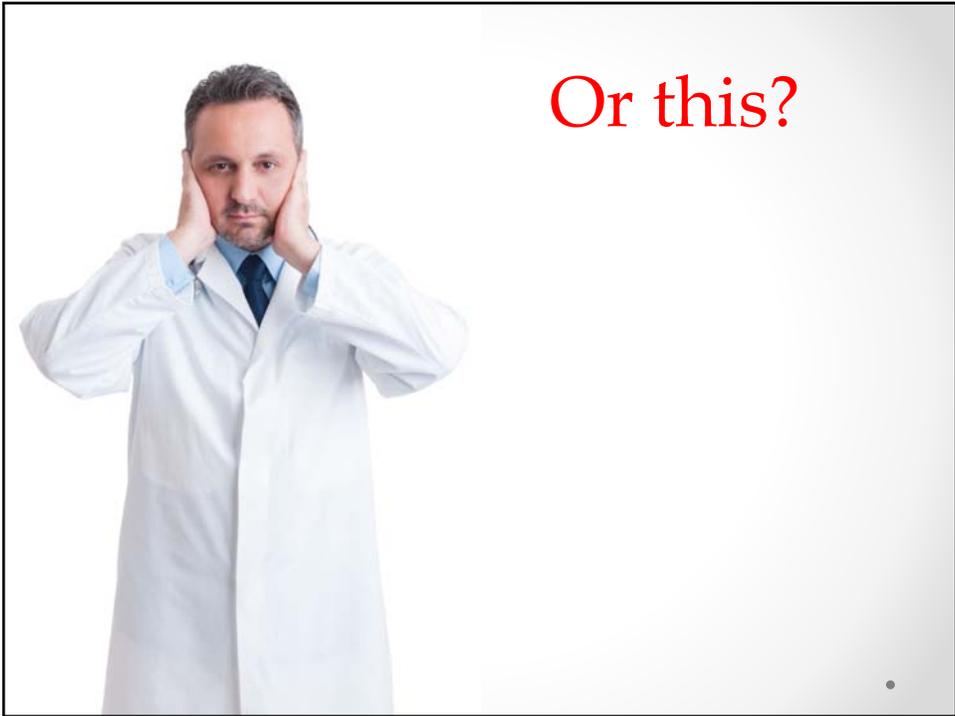
- *Practical value of always getting doctor to define restrictions.*
 - *Even if no Alternative Duty available*
- *Recall that “TTD” has a pernicious impact.*
- *Understand and correct for some causes of treatment delays.*
 - *Records not sent*
 - *Inconsiderate behavior*
 - *Missed appointments*
 - *Failure to recognize co-morbidity*
- *Unclear/poorly defined responsibilities*

*PRINCIPLES
OF
EFFECTIVE
COMMUNICATION*
...

Part II

Has this happened to You?





Your Overall Direction/Goal

*You want to
facilitate
coordination
and
cooperation.*

Kaplan's Communication Tenants

- Common identification
- Mutual high regard
- Effective Communication
- Will to Work

Common identification

- You share something in common.
 - *Welfare of the patient*
 - *Other goals (e.g., no complaints)*
 - *Organization or institutional affiliation*
- Overlapping interests.
 - *Rapid cure*
 - *Expeditious RTW*

Mutual high regard

Consciously hold the person you are communicating with in high regard.

Effective Communication

- Set of complex skills.
- Typically develops over time.
- Often idiosyncratic to a particular relationship.

Will to work

- Not passive.
- You have to want to get along.
- You have to want to communicate.
- Need positive intention to actually make something happen.

Kaplan's Communication Tenants

- Common identification
- Mutual high regard
- Effective Communication
- Will to work

Use Basic Communication Skills

- Always give your provider due respect.
 - *Don't patronize or assume motives*
- Put yourself in the providers' shoes.
 - *Injured workers are "Patients" [NOT 'claimants']*
- Use common courtesy.
 - *'Please'*
 - *'Thank you' (and mean it)*
 - *'I very much appreciate your assistance'*

Some Thoughts on Approaches

- Start with
 - “*How is your patient doing?*”
 - Then LISTEN to the answer.
- Be brisk
 - Know what you want to achieve before you call.
 - *Next step(s), restrictions?, MMI date prediction?*
 - Quickly Bring doctor up to speed on relevant info.
 - ONLY if relevant.
 - “*There have been 3 new developments...*”
 - *Provider past deficiencies mentioned ONLY when absolutely necessary.*

Communication Recommendations

Try first to understand

- “*Can you help me understand what issues are preventing the patient from improving?*”
- Use reflective listening, “*So you are hopeful the patient will be able to return to modified duty next week?*”

Use 3rd person

- “*It appears that...*”
 - [NOT “*Your office never...!*”]
- “*It would be helpful if this could be arranged.*”
 - [NOT “*I want you to do this.*”]
- “*The chart notes indicate...*”
 - [NOT “*You said...*”]

Ask, do not demand

- “*Are you able to say...*”
- “Any sense *this might allow him to do light duty, now or in a week or two?*”
- “*Could you help me understand...*”

End on a positive note

- How things end up is remembered the longest
 - *Research on colonoscopy memory failures show if procedure ends well, later memory of it is much more favorable.*



Memories of colonoscopy: a randomized trial. International Association for the Study of Pain. 2003; Kahneman, et. al

Take-home messages on Communication

- *Mutual high regard, common identification and effective communication will prevent delays.*
- *Use non-confrontational communication on the phone and in letters.*
- *Understand some treatment delays are personal, some logistical – and act accordingly.*

*Causation
&
When is
Carpal Tunnel Syndrome
Work-related?*

Part III

Let's Review Causation

"Logic is a poor model for cause and effect" Gregory Bateson

- The DWC administrative director adopts and incorporates into the MTUS ACOEM Practice Guidelines chapters on:
 - *Prevention.*
 - *General approach to initial assessment and documentation.*
 - *Initial approaches to treatment.*
 - *Cornerstones of disability prevention and management.*
- Useful resource:
 - *ACOEM Practice Guidelines, Chapter 4, "Work-Relatedness"*
 - *AMA Guides to the Evaluation of Disease and Injury Causation, 2nd edition. Melhorn, JM, Talmage JB, et.al.*

6-Step Causation Analysis: NIOSH

- What is the diagnosis?
- What are the known causes?
- Is this patient exposed to known causal factors at work? Elsewhere?
- Is the work exposure sufficient to have caused the current diagnosis?
- Are there other risk factors present?
- What is your conclusion?

Causation Concepts

- Two primary clinical situations that need to be considered when providing your work relationship opinion:
 1. Do you have **substantial evidence** to
 2. State with reasonable **medical probability** (not medical certainty and not medical possibility) that the patient's presentation is consistent with a work etiology?
- If you don't have substantial evidence, ask for what you need.
 - E.g. a job description, review of prior records, additional diagnostic information, etc.
- Medical probability
 - This means that you have clinical/**evidence-based justification** for your opinion and can defend your opinion if questioned.

Does computer use cause injury?

“One of the first things taught in introductory statistics is that correlation is not causation. It is also one of the first things forgotten.”

-Thomas Sowell

Where are these injuries?

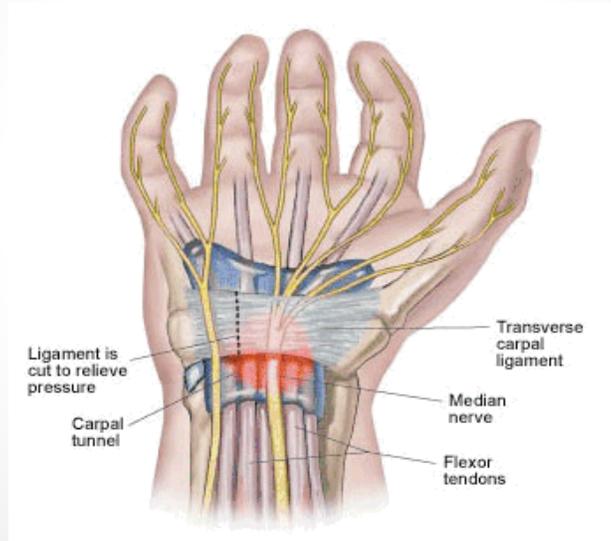
The neck?



The forearm?



What about here at the carpal tunnel?



Early Reviews

- NIOSH: Bernard 1997
 - Evidence for CTS associated w/ repetitive work.
 - Evidence for CTS associated w/ forceful work.
 - Evidence for CTS associated w/ hand/wrist vibration.
 - Strong evidence for CTS associated w/ force plus repetition.
 - Insufficient evidence for CTS w/ extreme postures.
- CONCLUSION:
 - Therefore, given that computer use is repetitive, computer use may be associated with CTS.

Musculoskeletal disorders and workplace factors: a critical review. Bernard BP, et al. 1997.
<http://stacks.cdc.gov/view/cdc/21745>

CTS Risk Factors

- Physiologic Observation:
 - Increased carpal tunnel pressure is associated with median nerve function.
- Rempel et al.
 - Wrist postures associated with increased CT pressure.
- Keir et al.
 - Mouse use associated with moderate CT pressure increase.
 - Other studies suggest typical computer keyboard postures would have modest increased CT pressure.

Rempel D, et al. Effects of forearm pronation/supination on carpal tunnel pressure. J Hand Surg Am. 1998 Jan; 23(1):38-42.
Keir PJ, et al. Effects of computer mouse design and task on carpal tunnel pressure. Ergonomics. 1999 Oct; 42(10):1350-60.

Which one meets these criteria?

Light rapid finger motion?



Forceful grasping with vibration?



CTS Risk Factors

Prospective Studies

- Gerr et al. 2002.
 - Positive association between computer use and various musculoskeletal disorders.
 - This study suggested that computer use was a risk factor for development of CTS.
- Andersen et al. 2003.
 - No association between keyboard use and CTS.
 - But association found w/ mouse use of > 20 hrs/week

Gerr F, et al. A prospective study of computer users: 1. Study design and incidence of musculoskeletal symptoms and disorders. *Am J Ind Med.* 2002; 41(4):221-35.
Andersen JH, et al. Computer use and carpal tunnel syndrome; a 1-year follow up study. *JAMA.* 2003; 289:2963-9.

Modern Reviews

- Thomsen et al., 2008.
 - 3 studies that had possible misclassification showed an association between computer use and CTS.
 - 3 studies found **Risk levels < 1**.
 - Protective against CTS or no association!
- van Rijn, et al., 2009.
 - “Jobs with the highest risk of CTS included work in the meat- and fish-processing industry, forestry work with chain saws, and electronic assembly work (OR = 76.5, 21.3, and 11.4, respectively).”
 - “The occurrence of CTS was associated with high levels of hand-arm **vibration**, prolonged work with a **flexed or extended wrist**, high requirements for **hand force**, high **repetitiveness**, and their combination.”
 - “**Contradictory findings** were reported for associations between computer work and CTS”.

Thomsen JF, et al. Carpal tunnel syndrome and the use of computer mouse and keyboard: a systematic review. *BMC Musculoskelet Disor.* 2008; 9:134. van Rijn RM, et al. Association between work-related factors and the carpal tunnel syndrome- a systematic review. *Scand J Work Environ Health.* 2009; 35:19-36.

Modern Reviews

- Andersen et al. 2011
 - CTS:
 - 3 reviews focusing specifically on carpal tunnel syndrome
 - Consistently concluded that epidemiological evidence for computer use and the occurrence of CTS is **insufficient**.
 - Upper extremity musculoskeletal disorders:
 - When considering prospective studies and accepting the inclusion of clinical criteria incorporated in some of the reviews, the **evidence seems moderate or even limited for an association between computer use and UEMSDs**.

Andersen JH, et al. Risk Factors for Neck and Upper Extremity Disorders among Computers Users and the Effect of Interventions: An Overview of Systematic Reviews. PLoS. 2011. <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0019691>

The final word?

- Mediouni et al. 2015 (double study, both prospective)
 - The Cosali cohort (France):
 - CTS diagnosis based on symptoms and exam c/w CTS.
 - PrediCTS cohort (U.S.):
 - New hires with baseline history, physical and nerve conduction test. Then follow up history, physical and NCT.
 - In both studies:
 - Jobs with the highest computer use had a **protective odds ratio** in comparison to other jobs.
 - Cosali cohort OR=0.39
 - Predi CTS cohort OR=0.16

Mediouni Z, et al. Carpal tunnel syndrome and computer exposure at work in two large complementary cohorts. BMJ Open. 2015. <http://bmjopen.bmj.com/>

Take-home messages on Causation

- *Initial assessment and documentation is crucial to accurate attribution*
- *Causation only stated with reasonable medical probability*
 - *Not medical certainty nor medical possibility.*
- *AND (despite the conventional wisdom to the contrary), research to date shows:
“Jobs with the highest computer use had a protective (!) odds ratio in comparison to other jobs.”*

Communication Sample Conversation

*(Dr. Kurt Blunt
and
Adjuster Harmony Jones)*

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Appendix

Sample Adjuster Conversation (1 of 3)

- **Adjuster**
 - Hello Dr. Blunt, my name is Harmony Jones and I am an adjuster at Premium Insurance. I am calling concerning John Fallbottom.
- **Dr. Blunt**
 - I'm pretty busy ...
- **Adjuster**
 - Thank you very much for taking this call - I will be brief. Whenever someone is out more than a couple of weeks **part of our approach** is to ask for specific information about of the patient's **function and response to therapy**.
 - **How is your patient doing?**
- **Dr. Blunt**
 - Not as well as I hoped. Well he can't stand or drive for more than ½ hour; he can't walk more than 2 blocks without sitting down. He can't lift more than 10 pounds.
- **Adjuster**
 - That is **very helpful, thank you**. **Could you also let me know what functions he can perform?** For example, can he cook or shower by himself? Type at a computer?

Sample Adjuster Conversation (2 of 3)

- **Dr. Blunt**
 - Yes, he can do all those things, though he can only type for about 30 minutes before he has to briefly lie down.
- **Adjuster**
 - That **helps a lot, many thanks**. **Are you able to say** if his pain level has improved recently compared to prior visits? Also, **any feel for** when he might be able to return to alternative duty?
- **Dr. Blunt**
 - Well he's not improved much lately – and return to work is hard because he has to lift bags of cement all day. Is there any alternative duty?
- **Adjuster**
 - No, not until he is able to lift at least 50 pounds and work at least 4 hours per day. **If you would like** I can fax your office a current job description.
 - One more thing, **can you please put in your notes** what restrictions he would have if light duty were available? Specific work restrictions **are very helpful** for following Mr. Fallbottom's improvement over time.

Sample Adjuster Conversation (3 of 3)

- **Dr. Blunt**
 - Yes! Thanks. A job description will help.
- **Adjuster**
 - Is there **anything else that would assist** with your care of the patient?
- **Dr. Blunt**
 - He said he had had some injections in the past but could not remember when or where he was injected. Can you get these records?
- **Adjuster**
 - I do not know, but I will speak with the patient and see what we can come up with. **I will let your office know** what we find out.
- **Dr. Blunt**
 - Thank you.
- **Nurse B:**
 - **I really appreciate your assistance**, and your willingness to put specific restrictions **in your office notes** going forward.
 - **I really appreciate your time.**
 - **Thank you** so much for helping and **good luck with your patient.**