Preventing disability and improving pain care among injured workers in Washington State

Pain at Work Symposium
May 31, 2018

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Co-Chair, WA Agency Medical Directors Group (AMDG)

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Prevent Chronic Disability Through Improving Workers’ Compensation Health Care

Increase use of occupational health best practices to reduce disability

### 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: 3.05 million YLD
  - Other MSK disorders: 2.6 million YLD
  - Neck pain: 2.13 million YLD
  - Anxiety disorders: 1.86 million YLD
  - Diabetes (#8): 1.16 million YLD
  - Alzheimer's (#17): .83 million YLD
  - Stroke (#23): .63 million YLD

*JAMA 2013; 310: 591-608
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

Why is disability prevention so important?

• 5-10% of cases account for 75-80% of costs
• Most of the cases developing long term disability were routine, non-catastrophic injuries
• Transition from acute/subacute to chronic pain is equivalent to development of long term disability
• Disabled workers frequently experience family disruption and lifelong inability to return to productive work
• A relatively small number of providers account for a large proportion of these cases

— Bernacki et al, J Occup Environ Med 2010; 52: 22-28
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
History of Medical Care in Workers’ Compensation

- Some of the worst care in America-repeated surgery, inaccurate diagnoses, workers with rather simple injuries (backs, CTS) can become increasingly disabled while they are in workers comp

- Outcomes of surgical procedures in workers comp far worse than in non workers comp-reasons unclear-4 fold increased risk for unsatisfactory outcome:
  
  Harris et al, JAMA 2005; 293:1644-52
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
WA State Laws Require Evidence-Based Health Care Purchasing Decisions

2003-Prescription Drug Program for all agencies-uses evidence within drug classes to determine coverage (SSB 6088)

2003-all agencies to conduct formal assessment of scientific evidence to inform coverage, track outcomes (SHB 1299)

2005-Agencies to collaborate on coverage and criteria (guidelines)- (Budget Proviso) -Opioid dosing guideline-June, 2010

2006- WA State Health Technology Assessment Program- uses evidence of safety, efficacy, and cost to determine coverage for devices/interventions/test (HB 2575)

2011-Bree Collaborative: establishes public/private collaborative on guidelines and research, including anti-trust protection (HB 1311)

2011-Workers Comp Health Reform-includes authority to require compliance with evidence based guidelines and define harmful care using evidence (SSB 5801)
“A health technology not included as a covered benefit...shall not be subject to a determination in the case of an individual patient as to whether it is medically necessary.”
Agency Medical Directors Group Website

AMDG Mission Statement

The Agency Medical Directors’ Group (AMDG) mission is to maximize the value, quality, safety, and delivery of state purchased health care.

AMDG Goals

AMDG members collaborate across state agencies to accomplish the following goals:

1. Identify and assess ways to improve the quality of healthcare delivered to Washington citizens,
2. Promote the cost-effective purchase of health care services, and
3. Simplify the administrative burden for providers in Washington’s health care financing and delivery systems.

"These goals support RCW 41.05.013 on coordinating state purchased health care programs and policies."

AMDG Priorities

The AMDG’s medical directors and senior policy makers focus available resources on the following priority areas that provide immediate and long-term benefits for Washington’s health care delivery system:

1. **Protect public health**: by advancing initiatives and programs that keep people safe and improve their health.
2. **Purchase high value care**: so public funds are used wisely for high quality care.
3. **Implement evidence-based best practices**: by using research to produce policies and guidelines on clinical topics that affect everyone.
4. **Coordinate state health care coverage and purchasing**: to make efficient use of resources.
5. **Support and integrate healthcare reforms**: that affect all Washington citizens.
AMDG outputs

- RWJ funded task group on technology assessment-Ramsey et al, Am J Manag Care 1998; 4: SP188-199
- AHRQ funded EBM conference for state health policy makers-2004-directly led to HB 2575 (2006)
  - >44,000 hits on AMDG website since Jan, 2016
- Health technology assessment dossiers
- Bree Collaborative-opioid metrics; dental opioid guideline; draft peri-operative opioid guideline
Evidence-Based Decisions in Workers Compensation
- A Conceptual Framework

Coverage → No
↓
Yes
↓
Treatment Guideline
↓
Medical Necessity
↓
Yes
↓
No
A. Developed by Agency Medical Directors Group for all WA public payers
   - Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain-developed April 2007, updated June 2010 and June 2015
     • Established first “yellow flag” dose of opioids (120 mg/day MED) at which consultation recommended if pain and function not improving
     • New CDC guidelines-90 mg red flag, 50 mg yellow flag
     • ESHB 2876 repealed older, permissive rules and establish new rules by June, 2011, also based on “yellow flag” dose
   - 2015 AMDG opioid guideline endorsed by Statutory Bree Collaborative for statewide implementation
WA Laws-ESSB 5290-2007
- Medical and Chiropractic Advisory Committees -

“...advise... on matters related to the provision of safe, effective, and cost-effective treatments for injured workers, including...development of practice guidelines and coverage criteria,...technology assessments, review of medical programs...”
Translate outcomes research into treatment guidelines

Advice and consent from Medical Advisory Committee

Medical Advisory Committee → Labor and Industries
- Guidelines development ← -Utilization review-

Policy relevant outcomes research (UW)
Lumbar Fusion Outcome

Probability of Ending Total Disability: Lumbar Fusion Group Versus Historical Control

<table>
<thead>
<tr>
<th></th>
<th>Lumbar fusion group n=388</th>
<th>Historical control group</th>
<th>RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One year after</td>
<td>.16</td>
<td>.24</td>
<td>.66 (.50-.84)</td>
</tr>
<tr>
<td>lumbar fusion</td>
<td>Two years after</td>
<td>.32</td>
<td>.36</td>
</tr>
<tr>
<td>lumbar fusion</td>
<td>Three years after</td>
<td>.49</td>
<td>.52</td>
</tr>
<tr>
<td>lumbar fusion</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RR=unadjusted relative risks; CI=confidence interval

Adapted from Franklin et al. Spine 1994;17:1897-1904
Question of medical necessity

Data can't explain whether an individual surgery was necessary or not. But a Washington Post analysis shows that about half of the Florida surgeries have a diagnosis that professional guidelines and other experts say should not routinely be treated with spinal fusion.
## L&I Lumbar Fusion, SIMPs & Pensions

<table>
<thead>
<tr>
<th>Year</th>
<th>Procedure count</th>
<th>Avg. number of years*</th>
<th>Number of SIMPS</th>
<th>Number of claims §</th>
<th>% On pension</th>
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<tbody>
<tr>
<td>2000</td>
<td>407</td>
<td>3.9</td>
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<td>157</td>
<td>41%</td>
</tr>
<tr>
<td>2001</td>
<td>419</td>
<td>3.9</td>
<td></td>
<td>166</td>
<td>41%</td>
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<tr>
<td>2002</td>
<td>447</td>
<td>3.3</td>
<td></td>
<td>190</td>
<td>44%</td>
</tr>
<tr>
<td>2003</td>
<td>418</td>
<td>3.7</td>
<td></td>
<td>164</td>
<td>40%</td>
</tr>
<tr>
<td>2004</td>
<td>412</td>
<td>3.5</td>
<td></td>
<td>156</td>
<td>39%</td>
</tr>
<tr>
<td>2005</td>
<td>366</td>
<td>3</td>
<td>190</td>
<td>113</td>
<td>33%</td>
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<tr>
<td>2006</td>
<td>382</td>
<td>3.5</td>
<td>230</td>
<td>112</td>
<td>31%</td>
</tr>
<tr>
<td>2007</td>
<td>341</td>
<td>3.1</td>
<td>269</td>
<td>86</td>
<td>26%</td>
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<tr>
<td>2008</td>
<td>345</td>
<td>3.3</td>
<td>277</td>
<td>87</td>
<td>26%</td>
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<tr>
<td>2009</td>
<td>415</td>
<td>3.3</td>
<td>365</td>
<td>66</td>
<td>17%</td>
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<tr>
<td>2010</td>
<td>412</td>
<td>3.7</td>
<td>549</td>
<td>42</td>
<td>11%</td>
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<tr>
<td>2011</td>
<td>403</td>
<td>3.5</td>
<td>632</td>
<td>10</td>
<td>3%</td>
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<tr>
<td>2012</td>
<td></td>
<td></td>
<td>528</td>
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</table>

*Avg. number of years from claim established to lumbar fusion date

§Number of claims that received a fusion that are currently on pension
Spine SCOAP outcomes after spine surgery

- N=1965 spine surgery candidates with baseline and at least one follow up interview; 80.6% with elective fusion
- Overall 306/528 (58%) improved in Oswestry by at least 15/100 points at 12 months among those with moderate/severe symptoms
- Odds of functional improvement if:
  - Workers comp 0.20 p<.001
  - Current smoker 0.43 p<.01
- Odds of NRS back pain improvement if:
  - Rx opiate use 0.65 p<.65
WA HTA 1/15/2016 Lumbar fusion

- HTCC Coverage Determination:
  - Lumbar fusion for degenerative disc disease uncomplicated by comorbidities is **not a covered benefit**.
  
- Implemented by DLI March, 2016
Early Opioids and Disability in WA WC

- Population-based, prospective cohort
- N=1843 workers with acute low back injury and at least 4 days lost time
- Baseline interview within 18 days (median)
- 14% on disability at one year
- Receipt of opioids for > 7 days, at least 2 Rxs, or > 150 mg MED doubled risk of 1 year disability, after adjustment for pain, function, injury severity

Source: Spine 2008; 33: 199-204
Claims With Opioid Prescriptions within 6 to 12 Weeks of Injury

Data as of 7/3/16
The Franklin-Mai Opioid Boomerang
1991-2015 WA Workers Compensation

Projected Percent of Loss and Percent of Claims
Claims with Opioids Compared to All Claims

Projected Percent of Claims With Opioids by Accident Quarter
Distribution of Quality of Care

Clinical Efficiency

Good (Costs & Quality) Poor

Zone 1
- Low or Average Medical Costs
- Reduced Disability Costs
- Excellent Health/Disability Outcomes

Zone 2
- Average Medical Costs
- Average Disability Costs
- Questionable Health/Disability Outcomes

Zone 3
- Moderate to High Medical Costs
- Moderate to High Disability Costs
- Poor Health/Disability Outcomes

Zone 4
- High Medical Costs
- High Disability Costs
- Very Poor Health/Disability Outcomes
Does physician education work for all docs?

- Docs in Zones 1-3 most amenable to education by Guidelines, mentors, and peer pressure.
- Docs in Zone 4 are the least amenable to education, have the highest variation in practice, conduct the most controversial procedures, and cause the most harm.

State Medical Boards do not have the legal authority to systematically identify and stop very bad care.
# L&I Medical Provider Network - Update

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percent of Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications Processed</td>
<td>26,132</td>
<td></td>
</tr>
<tr>
<td>Providers Approved</td>
<td>23,522</td>
<td></td>
</tr>
<tr>
<td>Administratively withdrawn*</td>
<td>2,610</td>
<td></td>
</tr>
<tr>
<td>Providers reviewed by credentialing committee^</td>
<td>446</td>
<td>1.9%</td>
</tr>
<tr>
<td>Total non-approved providers</td>
<td>159</td>
<td>0.7%</td>
</tr>
<tr>
<td>Percent Approved</td>
<td>99.3%</td>
<td></td>
</tr>
</tbody>
</table>
A legislative mandate makes it the attending provider’s job to follow the guidelines

RCW 51.36.010
“Network providers must be required to follow The department's evidence-based coverage decisions and treatment guidelines, policies, and must be expected to follow other national treatment guidelines appropriate for their patient”

• In other words, our policies for network providers are THE medical standard of care in the WA workers comp system
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
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-end 8/31/2007

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)
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.
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://deohs.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
## Functional Recovery Questionnaire

**Screen** → **Assess** → **Intervene**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>STOP here, You are done – thank you</th>
<th>Please continue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. During the past week have you worked for pay?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. In the past week how much has pain interfered with your ability to work, including housework?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you have persistent, bothersome pain?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ No Please go to question 4 below</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes In the next column to the right, please indicate where you have pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Since your injury, has your employer offered you light duty, part time work, a flexible schedule, special equipment, or other job modifications if needed to allow you to work?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. How certain are you that you will be working in six months?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Are you concerned that your work will make your injury or pain worse?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Please indicate your answers in this column</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>STOP here, You are done – thank you</td>
</tr>
<tr>
<td>□ No</td>
<td>Please continue</td>
</tr>
</tbody>
</table>

Please circle one number

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Interference</td>
</tr>
<tr>
<td>1-10</td>
<td>Unable to carry on any activities</td>
</tr>
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</table>

Please circle one number

<table>
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<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all certain</td>
</tr>
<tr>
<td>1-10</td>
<td>Extremely certain</td>
</tr>
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</table>

Please circle one number

<table>
<thead>
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<th>Number</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>Low Back without any leg pain</td>
</tr>
<tr>
<td>1-10</td>
<td>Low Back with pain, numbness, or tingling that travels down your leg</td>
</tr>
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<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Head</td>
</tr>
<tr>
<td>1</td>
<td>Neck</td>
</tr>
<tr>
<td>2</td>
<td>Shoulder(s)</td>
</tr>
<tr>
<td>3</td>
<td>Arms/Hands</td>
</tr>
<tr>
<td>4</td>
<td>Abdomen/Pelvic Area</td>
</tr>
<tr>
<td>5</td>
<td>Hips/Buttocks</td>
</tr>
<tr>
<td>6</td>
<td>Legs/Feet</td>
</tr>
<tr>
<td>7</td>
<td>Chest/Rib Cage</td>
</tr>
<tr>
<td>8</td>
<td>Upper/Mid Back</td>
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</table>

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
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<td>Yes</td>
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<td>1</td>
<td>No</td>
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<th>Number</th>
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<td>1</td>
<td>No</td>
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</table>
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 system institutional support
• Occupational health leadership
• Business/labor advisory committee
• Community-based
• Health services coordination function is critical
COHE Organization and Governance

UW Research Team

Dept. of Labor & Industries

WCAC/HC

Pilot Community

COHE

Community Physicians

Business Labor Advisory Board
Key Results from COHE Pilots

Wickizer et al, Medical Care; 2011: 49: 1105-11

One year follow up

- 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

Eight year follow-up-Submitted: 26% reduction in permanent disability (SSDI offset, TPD, 5 yrs TL) among back sprains and other sprains
US Dept of Labor Demonstration projects


- >$100 million for up to three projects

- In current Federal budget
Healthy Worker 2020
Innovation in Collaborative, Accountable Care
An Occupational Health Home for the Prevention and Adequate Treatment of Chronic Pain
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
Prevent Chronic Disability Through Improving Workers’ Compensation Health Care

Increase use of occupational health best practices to reduce disability

Sample Training Slide: Orientation to Collaborative Care: What a Collaborative Care Manager Does

Coordinates and delivers care
- Care plan coordination
- Helps patient adhere to treatment and medication
- Facilitates referrals & helps patient connect to services
- Outreach to patients who miss appointments
- Flexible delivery of care by phone or in person

Provides evidence-based care
- Tailored behavioral treatments to meet patient’s goals
- Care management is brief; re-evaluate & reset goals if progress is not being made; & step up care if needed
- Care team treatment includes chronic pain and/or behavioral health treatment and appropriate pharmacological care if needed
The future health workforce:

New* roles/functions

- Care coordination
- Care/case management
- Care transition management
- Patient navigation
- Health coaching
- Patient education
- Community health worker
- Community health team
- Community paramedicine
- Health IT
- Recovery coaches

Who will perform?

- Physicians/NPs/PAs
- RNs
- Pharmacists
- Licensed practical nurses
- Social workers
- Nurse assistants
- Medical assistants
- Home care aides
- EMTs/Paramedics
- Receptionists
- Family members
- Patients
- Others?

Occupations? Skills? Or Both?

*or being defined differently

Center for Health Workforce Studies
University of Washington
Healthy Worker 2020
Best Practices for:

Primary Occupational Health Care
Ensure ongoing care provided to injured workers is delivered using available best practices.

Surgical Care
Ensure surgical care provided to injured workers is delivered using available best practices; explore the opportunity to use innovative payment methods.

Chronic Pain and Behavioral Health Care
Implement methods to prevent chronic pain and/or behavioral health issues from creating or extending disability. Create a stepped care pathway that includes collaborative care and appropriate clinical care steps.

Physical Medicine
Develop best practices for physical therapists that will encourage early use of active care with a focus on function.

Catastrophic Care Services
Implement internal and external support systems for IW with catastrophic injuries.

Model of Care

Care Coordination

Opioid Prescribing Best Practices

Incentive Methods

Operations
## Healthy Worker 2020
### Innovation in Collaborative, Accountable Care

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Occ. Health Model/System  <em>(Community and Organizational leadership, Mentors, Information systems, aligned payment)</em></td>
<td><strong>Existing</strong> Program needs updates for add on components and capacity.</td>
</tr>
<tr>
<td>Core Occ. Health Best Practice Cluster  <em>(Assigned coordination, timely and complete ROA, APF, Barriers to RTW, Conference and Plan, Functional measures, PGAP, standard work/defined handoffs and plan, follow EBM guidelines)</em></td>
<td><strong>Existing</strong> best practices need integration; standardization and full deployment strategies</td>
</tr>
<tr>
<td>Surgical Best Practice Cluster  <em>(Core Occ BP, Min DAW; Access timelines standards, documented RTW plan, Warranty and Bundle Purchasing)</em></td>
<td>Mix of <strong>existing</strong> best practices, pilot, and <strong>new</strong> model</td>
</tr>
<tr>
<td>Chronic Pain and Behavioral Health Collaborative Care Services  <em>(Stepped care; regular consult with behavioral and/or pain expert; brief interventions; functional measures, EBM pain interventions)</em></td>
<td><strong>New</strong> best practices; research underway</td>
</tr>
<tr>
<td>Structured Multidisciplinary Pain Evaluation and Program</td>
<td><strong>Existing</strong> program Needs Evaluation and Update to Integrate with Vision</td>
</tr>
<tr>
<td>Opioid Prescribing Best Practice Cluster  <em>(Guideline compliant; functional measures; coordinate dose info.; taper and dependence)</em></td>
<td><strong>Existing</strong> best practices need integration and full deployment</td>
</tr>
<tr>
<td>Structured Physical Medicine Best Practice Cluster  <em>(Core Occ BP; standard referral criteria; active treatment; stepped care w/goals; fx measures)</em></td>
<td><strong>New</strong> best practices; data analysis started</td>
</tr>
<tr>
<td>Catastrophic Services and Centers of Excellence  <em>(E.g. Chemical Illness; Catastrophic Burn, TBI, Spinal Cord Injury, Amputee, Multiple Trauma; enhanced case management, discharge and life plan)</em></td>
<td><strong>Existing</strong> and <strong>new</strong> services. Deployment underway.</td>
</tr>
</tbody>
</table>
Behavioral Interventions

Psychosocial Risk / Symptoms

- Physical inactivity
- Catastrophizing
- Pain flare-ups
- Self-efficacy
- Distress (stress or depression)
- Anxiety (fear of movement/re-injury)
- Perceived injustice
- Disability conviction
- Sleep issues
- Poor treatment adherence
- Substance issues
ped Approach

Assessment
- Hx of injury and pain
- Work status
- Mood assessment
- Screeners (pain, pain interference, mood, med adherence)
- Initial goal setting if appropriate

Psychoeducation
- Biopsychosocial model of pain
- Set expectancy of recovery (that they will get better & can manage pain/mood)

Case management
- General care coordination
- Employment issues etc.

Medication and treatment adherence
- Monitor use
- Monitor side effects
- Facilitate psychiatry tx rec's
- Track chronic opioid therapy; facilitate tapering as needed

Brief behavioral interventions
- Physical activity
- Relaxation
- Pacing
- Pain flare planning
- Pain coping thoughts
- Managing emotions
- Mindfulness
- Sleep hygiene
- Depression tx (PST, BA)
- CBT for anxiety (brief exposure / anxiety management)

Referrals
- Psychologist
- Pain consultation
- Other specialists
- More intensive mental health care
- Rehabilitation care

Symptom Measurement (mood and pain)
Emerging Examples Of Stepped Care Management/Collaborative Care For Pain

• VA Health System Stepped Care Model of Pain Management

• Vermont Spoke and Hub regional support for medication assisted treatment for opioid use disorder/severe dependence

• WA state Centers of Occupational Health and Education/Healthy Worker 2020
Improve Systems/Community Capacity To Treat Pain/Addiction

• Deliver coordinated, stepped care services aimed at improving pain and addiction treatment
  – Cognitive behavioral therapy or graded exercise to improve patient self-efficacy
  – Opioid overdose case management by ED to identify behavioral health needs, evaluate for MAT, notify providers involved and discuss recommendations (e.g. Vermont spoke and hub)

• Develop systematic method to evaluate all patients on opioids for chronic pain to determine best treatment pathway-stay on opioids if proven effective, taper plan with multimodal care, MAT if addicted

• Collaborative care conference June 2017: http://www.agencymeddirectors.wa.gov/collaborativecare symposium.asp
THANK YOU!

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