IMPROVING QUALITY IN WORKERS' COMPENSATION

A PSYCHIATRIST'S PERSPECTIVE

Robert K. Schreter, MD
Associate Professor of Psychiatry
University of Maryland

Learning Objectives:

1. Recognize the importance of identifying disabled workers with psychiatric contributions to their distress, dysfunction, and work impairment

2. Better understand the process of Quality Improvement (QI) in medical care and disability management

3. Organize treatment planning around evidence-based medicine and outcomes driven interventions

Visualize The Industry of Workers Comp As A Three Legged Stool

Quality Improvement in Managing Disability:

The Three Legs

- Access - Improve diagnosis and case finding of patients with psychiatric disorder

- Quality - Rely on evidence-based medicine and outcomes

- Cost - Recognize value as an important quality measure

Access to Care:

- Portal to available services and dollars.
- Get the patient to the right provider
- Avoid the wrong provider - if you have a hammer everything looks like a nail
- Utilize interventions most likely to return worker to health and function, not one that furthers disability.

Access to Care is Driven by Patient Recognition and Psychiatric Diagnosis:

- Diagnostic and Statistical Manual (DSM-V) is psychiatry's Bible.
- Codifies all diagnoses recognized by psychiatrists and reimbursed by payers
- Purely descriptive - if you have two from column A and three from column B, you have it.

An overweight, out of shape 48-year-old heavy laborer sustains a soft tissue musculoligamentous injury to the lumbar spine. He complains of pain in the back and lower limbs. His physical examination demonstrates no specific localizing neurological findings. His x-rays, MRI, and possibly a CAT scan demonstrate degenerative changes with osteophytic changes, disc space narrowing, degenerative spondylolisthesis, and possibly scoliosis. He also complains of headaches, muscle spasms in the mid-back that when "bad" leads to trouble breathing and chest pain. Additional complaints include numbness and tingling in both lower legs, equally.

He is treated with ongoing narcotic medication, multiple injections and continues to complain. After a period of four to six months, his complaints persist. He is then treated with a lumbar fusion which may or may not heal. He reports frustration and anger with his caretakers and feelings that "they don't do anything to help." A course of physical therapy failed to produce benefit. Providers report less than optimal effort in sessions and at home. He may require a second or third procedure to achieve a solid fusion. At the end of this period of about 18 to 24 months, he has not worked and has become an addict.

Somatic Symptom and Related Disorders:

- Diagnosis made on basis of positive signs and symptoms - distressing somatic symptoms plus abnormal thoughts, feelings, and behavior, but not the absence of a medical explanation.
- Distinctive characteristic is not symptoms, but way it presents and how patient interprets them.
- Typically appear in medical, not psychiatric settings.
- Approximately 75% were previously diagnosed as hypochondriacs

Somatic Symptom and Related Disorders: DSMV

- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Psychological Factors Affecting Physical Condition
- Conversion Reaction
- Factitious Disorder

Somatic Symptom Disorder:

a) One or more (often multiple) somatic symptoms that are distressing and result in significant disruption of daily life.

b) Excessive thoughts, feelings, or behaviors as manifested by:

- disproportionate and persistent thoughts and feelings about the seriousness of one's symptoms.
- persistently high level of anxiety about health or symptoms.
- excessive time and energy devoted to symptoms or health.

c) Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent.

Somatic Symptom Disorder (cont.)

d) Diagnostic features:

- pain is most common symptom.
- suffering is authentic even if not associated with a medical condition.
- health concerns may assume a central role in their life.
- High level of medical utilization and multiple providers possible.
- often unresponsive to medical interventions and new interventions may only worsen problem.
- often feel clinicians and treatment have been inadequate.

Illness Anxiety Disorder:

a) Preoccupation with having a serious illness.

b) Somatic symptoms are not present or are mild though preoccupation is clearly excessive.

c) High level of anxiety about health.

d) Excessive health-related behaviors, checking, avoiding.

e) Common features:
   - thorough evaluation fails to identify serious medical condition.
   - distress emanates not primarily from physical complaint, but anxiety about the significance or cause of the complaint.
   - symptoms may be a normal physical sensation - dizziness, ringing in ears.

Psychological Factors Affecting Physical Condition:

a) A medical symptom or condition is present.
b) Psychological or behavioral factors adversely affect condition:
   - factors interfering with treatment (poor adherence).
   - factors adding health risks (substances, doctor-shopping).
   - factors influencing underlying pathology (not taking insulin).
   - personality factors impacting treatment and treatment relationships.

Steps To Take When Recognizing Psychiatrically Disabled Claimants:

a) Identify psychological factors that contribute to disability or complicate recovery.

b) Early recognition and referral to appropriate behavioral health clinicians can shorten course of disability and promote RTW (Cope Program, behaviorally oriented Rehab and RTW

c) Later referral, when standard/accepted treatment options are being exhausted, can avoid the search for zebras and utilization of possibly further endangering interventions.

PATIENTS SUITABLE FOR THIS PROGRAM

- Failed usual and customary care
- Chronic pain syndrome
- Complex regional pain syndrome
- Failed back surgery syndrome
- Delayed recovery from concussion

Quality in Workers' Compensation:

- Every clinician believes his/her judgment is sound and treatment exemplary.
- Miles Shore, M.D. and his 50 Percent Rule.
- Deming and Toyota.

Quality of Care Through Evidence-Based Medicine

- Evidence from the level of Clinical Trials
- Evidence organized in Best Practices, Clinical Guidelines and Algorithms – including ODG and ACOEM criteria
- Evidence and the Hayes Rating

POTS Study:

- Clinical trial on treatment of OCD.
- Twelve-week, placebo-controlled, double-blind.
- Four arms:
  - Placebo
  - Sertraline
  - CBT
  - Combined

- CBT already established as the preferred treatment versus usual community treatment for anxiety disorders.

Yale-Brown Obsessive Compulsive Scale(Y-BOCS):

Percent reduction in symptoms - 12 weeks

PBO 3.6%

SER 39%

CBT 21%

COMB (combined) 53%

Take Home Message: Evidence supports medication and behavioral intervention in treatment of anxiety.

POTS   Site x Treatment Interaction: (Site x Treatment Affect)

	COMB	SER	CBT
PENN	0.7	2.0	1.5
DUKE	0.9	0.5	1.4

Take Home Message: Better Find an Expert

Cognitive Behavioral Therapy (CBT)

- Psychosocial intervention focused on challenging and changing unhelpful cognitive distortion (thoughts, beliefs, attitudes) and behaviors, improving emotional regulation and developing coping strategies
- Problem-focused and action-oriented solution rather than past history, unconscious, or relationship-based treatment
- Based on belief that thoughts and distortions and maladaptive behaviors play a role in development and maintenance of presenting problem

Cognitive Behavioral Therapy (continued)

- Goal is to learn new information processing and coping skills to address symptoms and distress
- Often utilized in combination with psychoactive medications
- Brief intervention (8-12 up to 20 sessions occurring in 1-3 week intervals)

Evidence at the Level of Best Practices, Clinical Guidelines and Treatment Algorithms

Meta-analysis is the statistical approach that combines (pools) the results of multiple studies on the same subject to increase the power (over individual studies) to identify trends.

- Medical Specialty Society Guidelines and Best Practices- including ODG and ACOEM Criteria
- Texas Algorithm.
- Hayes Rating.

Hayes Rating:

- Industry benchmark evaluating medical interventions and technologies in order to improve quality and cost-effectiveness
- Review clinical studies to determine strength and direction of evidence including safety, efficacy, outcomes, and indications of interventions as compared to alternatives
- Ratings are scaled from A through D1 and D2

Hayes Rating

A. Established Benefit - published evidence shows conclusively that safety and outcomes are comparable or even better than standard (FDA-approved).
B. Some Proven Benefit - published evidence indicates safety and at least comparable to standards of treatment.
C. Potential But Unproven Benefit - some studies suggest comparable but questions remain because of poor quality of studies, conflicting results, or sparse data.
D. No Proven Benefit - published evidence shows no improvement or is unsafe.
E. Insufficient Evidence.

Cost of Workers' Compensation

- Total: $61.9 billion in 2015
- Medical benefits: $31.1 billion
- Wage loss compensation: $30.7 billion
- Mental health and substance abuse: $80 billion to $100 billion in direct and indirect costs including lost productivity, absenteeism and presenteeism

SSA, 2015

COST OF WORKER’S COMPENSATION TO THE US ECONOMY

National Institute of Health estimates cost to American economy of stress-related health at $150 billion per year-decreased productivity, absenteeism, massive increase in medical costs

McNees, 2018

Cost of Workers' Compensation (continued)

- Hartford Financial Services Group analysis of claims data, 2002 to 2015, found 10% of claims featured at least one psychosocial issue, either preexisting or reactive to incident
- Claims with psychosocial issues such as anxiety and depression accounted for 60% of overall claims costs

Hartford Financial Services Group, 2017

Cost of Care:

Recognize Value as an Important Quality Measure:

$$\text{VALUE} = \frac{\text{OUTCOME}}{\text{COST}}$$

Summary:

1. Recognize the importance of identifying disabled workers with psychiatric contributions to their distress, dysfunction, and work-disabling impairment

2. Refer psychiatrically impaired workers to appropriate providers and programs

3. Organize treatment planning around evidence-based medicine and outcomes-driven interventions