Start Up and Provision of Direct Access PT for Work Comp Injury

2016 Combined Sections Meeting

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Session Level: Basic

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Start Up and Provision of Direct Access PT for Work Comp Injuries

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Learning goals
1) How to discuss with key work comp stakeholders
2) Apply PT eval skills to the injured worker
3) Articulate how to coordinate care to optimize employee satisfaction/return to work
4) Integrate the concept of stratification for risk of delayed return to work with questionnaires

Background/Start up

Background
- The annual cost of msk care >cardiac disease + diabetes
- Work comp injury cost is increasing.
- Why is paying? Employer/carrier.

Overview
- Background/Start up
- Evaluation
- Management

Why are physician's gatekeepers?

Bone and Joint initiative (last accessed 12/17/15)
**Background**

- **B.S. or M.S.**
- **D.P.T.**

**Direct Access Work Comp**

**Physician Gate-Keeper Model**

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**Iatrogenic Harm?**

- 62yo female, materials manager ER
- Right inversion ankle sprain, no fracture
- Medical Management:
  - Air cast, cortisone injection, off work 4 weeks
  - Light duty 3 weeks
  - Full duty → off work again
- PT Eval 9 mos post injury with c/o discoloration, increased pain, sensitivity, and decreased function

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**Is a referral required to treat?**

- Yes
- No
-maybe
- Limited direct access
- Evaluation only

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**Market to businesses**

- Who is paying for inefficiencies?
  - Temple University
  - The patient
- Temple is self-insured

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**Referral required to see work comp pt?**

- Yes
- No
- Maybe
- Limited direct access
- Evaluation only

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**Roving Model but Direct Access**

**Rots to Recovery**

- Old approach:
  - 100% of costs covered by patient (including travel)
- New approach:
  - 90% of costs covered by patient (travel costs not included)

**Outcomes**

- >90% patient satisfaction
- <10% project completion

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[Image of a map with regions highlighted in different colors to indicate different access models.]
Roving Model

Start up process
- Director of Workers comp
  - Goal: to study outcomes for employee health DA
- Research
  - Timing: Ojha, Wyrosta, et al. 2015 *JOSPT (work comp)*
  - Direct Access: Ojha, Snyder et al. 2014, *Phys Ther*
- Did he care?
  - Patient satisfaction
  - Invitation for legal claims?

Preparation
- Spoke to department heads
- Screened work comp at front desk
- How many did we enroll?
  - Two over 4 months.
- Brainstorm
  - Work comp physician only wanted to give us the “less risky patients”
- Spoke to employees and department heads together

Capturing patients
- Front desk calls or walk-in
- Admin calls study coordinator’s cell
- Scheduled with PT

Examination

Musculoskeletal Triage
- Patient is appropriate for PT
- Categorize with use of questionnaires
- Tailor intervention based on risk category
Musculoskeletal Triage

- Patient is appropriate for PT
- Categorize with use of questionnaires
- Tailor intervention based on risk category

Appropriate for PT?

- Outpatient neuro-musculoskeletal injury?
- Red flags?

Red flags

- Utilize tests with good diagnostic accuracy

Imaging

- Can PT’s order imaging directly?
- Pennsylvania practice act doesn’t state PTs cannot...so PTs can.
- Employees at Temple University
  - Private Insurance: need MD signature for reimbursement
  - Work Comp: carrier agrees to reimburse w/o MD signature

Diagnostic Ultrasound

- Diagnostic ultrasound: more for reassurance
- Procedure code 076882
- Most practice acts allow
- More info on imaging
  - Imaging education manual
    http://www.orthopt.org/uploads/content_files/JSI/G/IMAGING_EDUCATION_MANUAL_FINAL_4.15.15.pdf

Intake exam

- Medical screening form
- Vitals
  - Temp (>99 F abnormal)
  - Blood pressure (>160/100 relative contraindication)
  - Resting heart rate (>100 abnormal)
If you are a practicing PT, how often do you take vitals in your clinic?

- 100% patients
- >75% patients, in cases when indicated
- >50% patients
- 0-25% patients

**Case Example**

Pt is a 50 y/o male presents with c/c lower leg pain and difficulty walking. Onset 5 days ago, no trauma. Examination reveals erythema at anterior lower leg superior to malleolli, +TTP, pain with AROM, and antalgic gait pattern. (-) Homan’s. Vitals: 122/78, 97.7°, 66bpm. Most likely dx?

A) anterior tibialis muscle strain  
B) tibial stress fracture  
C) cellulitis  
D) DVT

**Primary Care Tools for Stratification**

<table>
<thead>
<tr>
<th>Tool</th>
<th>Population for use</th>
<th>Link to tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>STarT back screening</td>
<td>LBP</td>
<td><a href="http://www.keele.ac.uk/media/keeleuniversity/group/startback/Keele_STarT_Backd_Item-1.pdf">http://www.keele.ac.uk/media/keeleuniversity/group/startback/Keele_STarT_Backd_Item-1.pdf</a></td>
</tr>
<tr>
<td>STarTmusc</td>
<td>Any msk pain (still under development)</td>
<td><a href="http://www.keele.ac.uk/media/keeleuniversity/group/startback/STarT%20Musc%20press%20release.pdf">http://www.keele.ac.uk/media/keeleuniversity/group/startback/STarT%20Musc%20press%20release.pdf</a></td>
</tr>
</tbody>
</table>

**Follow up visits**

- Red flags can emerge at any time
- Vitals
- Change in status
- No response to conservative treatment
- “gut feeling” something is not right

**Orebro Short Form**

<table>
<thead>
<tr>
<th>Cut Off Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
</tr>
<tr>
<td>High</td>
</tr>
</tbody>
</table>

**Musculoskeletal Triage**

- Patient is appropriate for PT
- Categorize with use of questionnaires
- Tailor intervention based on risk category
**Orebro 12-Item Short Form**

**Cut Off Scores**

<table>
<thead>
<tr>
<th>Level</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>&lt;57</td>
</tr>
<tr>
<td>Medium</td>
<td>57-72</td>
</tr>
<tr>
<td>High</td>
<td>&gt;72</td>
</tr>
</tbody>
</table>

**Question**

A 40 year old male presents with low back pain after a lifting injury at work. Based on this presentation, select the recommended questionnaire to stratify his risk of return to work?

A) STarT screening tool  
B) Orebro short form  
C) Orebro-12 short form  
D) Oswestry disability index

**Musculoskeletal Triage**

- Patient is appropriate for PT
- Categorize with use of questionnaires
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**Risk Stratification and Treatment**

**Psychological obstacles to recovery**
Enhanced package of care (complex)

**Physical obstacles to recovery**
Face to face ‘conservative’ treatment

Low risk of chronicity  
Advice, reassurance & medication

**Flags to consider in history**

- **Yellow Flags**  
  - psychosocial barriers to recovery

- **Blue/Occupational Flags**  
  - factors that are unique to the worker and their work environment

- **Black/Socio-occupational flags**  
  - work environment or organizational factors

**History: be nosy about their job**

- Stem and leaf questions…
- Can you tell me about what you do?
  - I’ve never been a retail manager, can you describe your duties?
  - Do you like your job?
  - How long do you think it will be before you are able to return to your job?

Podcast: [http://chewshealth.co.uk/?powerpres_pinw=2198-podcast](http://chewshealth.co.uk/?powerpres_pinw=2198-podcast)
Work Release Form

Includes:
- Patient treatment plan
- Ability of patient to return to work
- Work duty limitations
- Patient signature to demonstrate understanding

Patient Goals

- Should be work related
  - Example 1: Patient will be able to stand for 1 hour to allow him to mop patient care rooms in 1 week.
  - Example 2: Patient will lift 20lbs independently to allow him to return to work full duty in 2 weeks.

Collaboration/Notes

- Work Release Form
  - Supervisor
  - Payer
  - Work Comp Director
- PT eval and treatment notes
  - Payer

Management

From Day 1 onward

Musculoskeletal Triage (cont)

- Patient is appropriate for PT
- Categorize with use of questionnaires
  - Tailor intervention based on risk category
Treatment Goal

- Return to Work!
- But work=more pain=bad for me…
- What can PTs do with specific education?
  - Light duty vs. Full duty
  - Motivational interviewing

Low Risk Example

- 24 yo male, Researcher
- cc: ankle pain secondary to walking all day
- Aggs: standing, walking, AM pain
- Eases: ice
- Impairments: limited ankle ROM
- Orebro 12 score: 54 (low risk)

How many PT visits?

A) 1 visit
B) 2-4 visits
C) 5-8 visits
D) ≥9 visits

Low risk Education

- Diagnosis
  - Need imaging? Medication? If not, mention this.
- Prognosis
  - Passage of Time=most effective intervention
- Return to work assessment

Medium Risk Example

- 57 yo male, Univ Housekeeping
- BP: 125/90
- cc: R forearm swelling, pain after lifting heavy cabinets
- Patient beliefs: fearful of blood clot moving to lungs
- PSFS=9/10
- Blue flags: None, motivated, job satisfaction
- Orebro 12 score: 66 (Med risk)

What would you do?
A) Order further imaging.
B) Recommend return to work full duty
C) Recommend return to work with restriction

Medium risk treatment

- Physical obstacles to return to work
  - Manual Therapy
  - Exercise
  - Education
- Physical therapy=bridge to self management

Decision Making

- Manual Therapy Remote or local
  - Dependent on severity/irritability
- Utilization of work related asterisk sign to assess response
Can you add in a pic of lifting, then a thrust, then reassess lifting, maybe with arrows going to right between each?

Heidi Ojha, 12/18/2015
High Risk Example

- 26 yo male, University Dance Instructor
- CC: neck pain post demo of dance technique
- Yellow flags: history of neck pain, fearful of serious injury, restricted himself from all physical activity
- Blue flags: increased stress due to upcoming performances
- Orebro 12 score: 75 (high risk)

What would you do?
A) Order imaging
B) Treat
C) Refer to orthopedist

High Risk Treatment

- Physical exam:
  - ruled out red flags
- Neurological Exam:
  - DTR, myotomes, dermatomes intact/symmetrical
- Relevant Impairments:
  - severely limited ROM, headache, sharp cervical and thoracic spine symptoms

High Risk Intervention

- Workplace support
- Capability to return to work post session
- Barriers to return to work
  - Physical
  - Psychosocial

Home Exercise

- 1-3 exercises written or videos given
- Specific to impairment
- Feasible to perform
- Strategies to progress functional goals
Add in vitals.

Instead here can you create a table and on left column make a list of beliefs and in right column list how one sentence how your education addressed the belief? Try to make at least some of them work comp oriented if possible.
Follow Up

- Open Communication
  - Via email or phone
- Regular email/phone f/u
- Scheduled session

Conclusion

- Appropriate? Every visit= re-eval red flags.
- Stratify.

Manage

- Low, Med, or High risk care, goal RTW
- Address all work related relationships/beliefs

Co-ordinate

- Re-eval every visit, MD referral?
- How can stakeholders work together to RTW?

Discussion Questions

- Have any of you seen work comp direct access in your setting? Preventative programs?
- What can APTA do to support us in moving forward? What can we do ourselves?

References

1. Ojha HA, Wytrya NJ, Davenport TE, Egan WE, Gelbken AC. Timing of initiation of physical therapy for musculoskeletal disorders and effects on patient outcome: A systematic review. JOSPT. Accepted for publication.