How to Prevent or Change Disability Conviction for Injured Workers

International Association of Rehabilitation Professionals

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Tacoma, WA

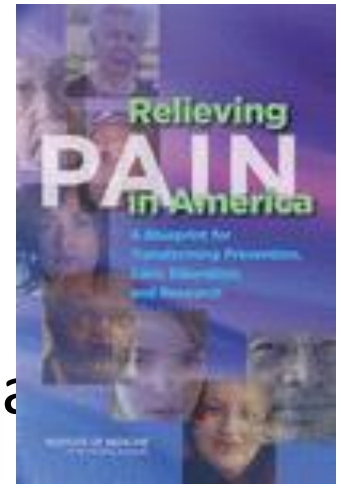
pra Progressive Rehabilitation Associates

Disability from workers compensation system is a public health problem

- Workers compensation likely contributing a large proportion of the permanently unemployed/disabled

David Leonhardt, NYT, 4/8/2011 from Dr. Gary Franklin's talk NAOEM Sept 2013

Institute of Medicine Report 2011



- Chronic pain costs the nation up to $635 billion in medical treatment and lost productivity and is a major cost of disability

- *The 2010 Patient Protection and Affordable Care Act* required the Department of Health and Human Services to enlist the IOM in examining pain as a public health problem.

- Encourages federal and state agencies and private organizations to accelerate the collection of data on pain

- Relieving pain should be a national priority.

Disability Prevention

Primary prevention → prevent workplace injuries and illness

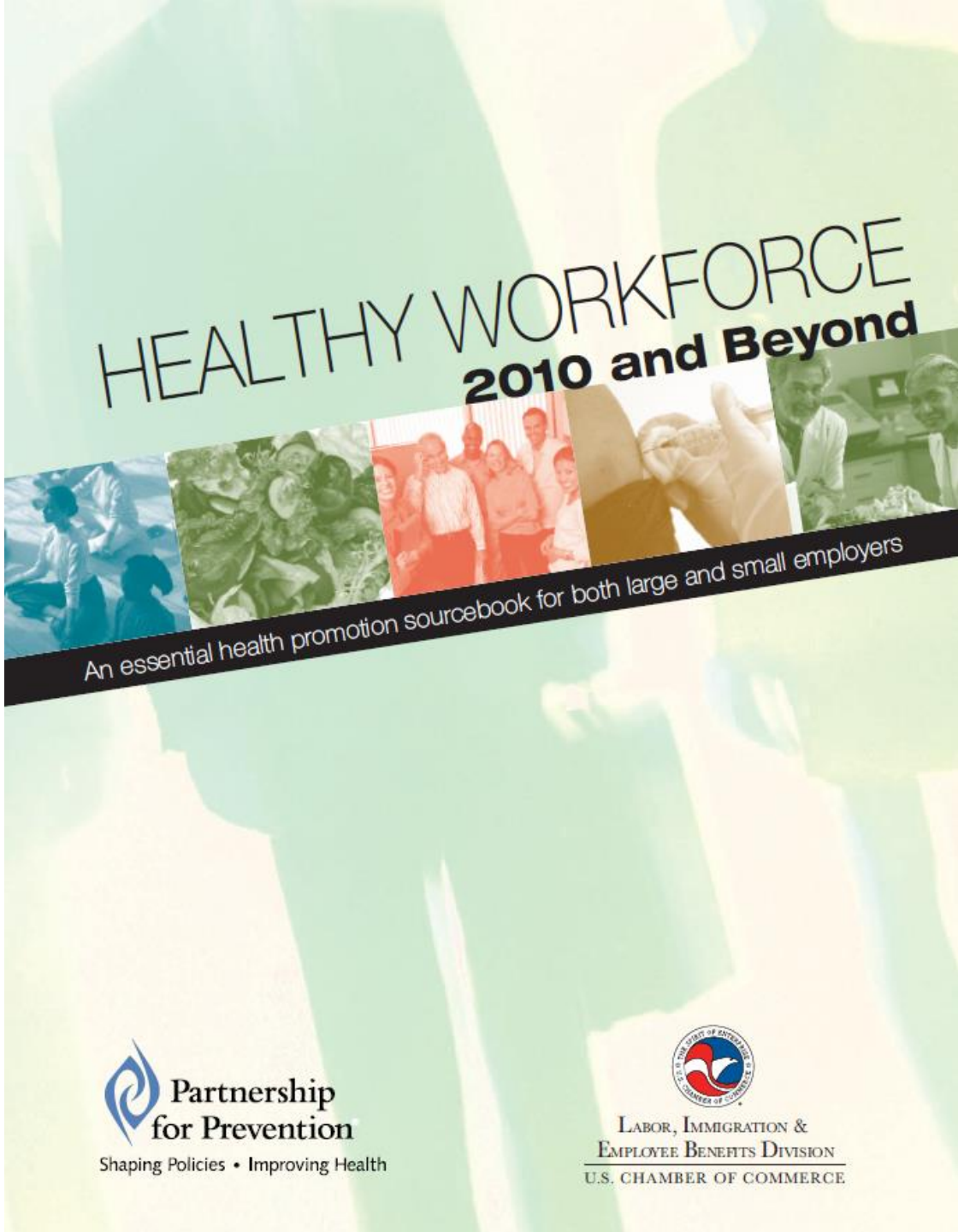
Secondary prevention → prevent disability among workers with work-related injuries and illnesses

Tertiary prevention → prevent disability progression to reduce residual deficits and dysfunction in workers with established disability

Franklin et al. 2003. Disability Prevention. In: Encyclopedia of Pain. RF Schmidt and GF Gebhart, eds. Springer-Verlag: Berlin. DOI 10.1007/978-3-642-28753-4. From Nicholas Reul talk June 2014. L&I

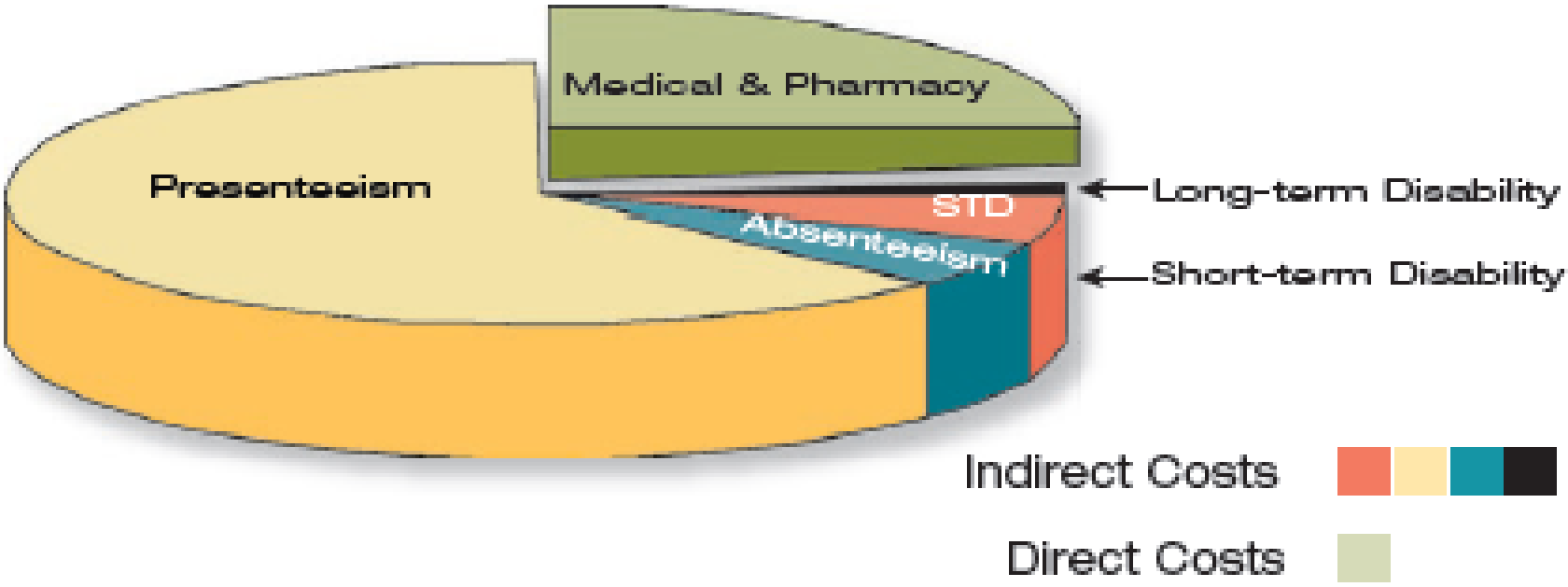
Chronic diseases, , like chronic low back pain, significantly drive health care costs

Workplace health promotion/wellness programs help increase quality of life, decrease health care costs, decrease business bottom line, and increase productivity



IS YOUR ORGANIZATION AWARE OF THE TOTAL COST BURDEN OF POOR EMPLOYEE HEALTH?

Relative Contribution of Direct and Indirect Costs Within a Large Financial Services Corporation



Source: Edington DW, Burton WN. Health and productivity. In: McCunney, RJ: *A Practical Approach to Occupational and Environmental Medicine*. Philadelphia: Lippincott Williams & Wilkins. Third edition. 2003:140-152[16]

Presenteeism is the measure of lost productivity cost due to employees showing up for work but not being fully engaged and productive because of personal health & life issues distractions. Healthy Workforce 2010 and Beyond

Legislatively mandated (EHB 2123) program

Stay at Work is a financial incentive that encourages employers to bring their injured workers quickly and safely back to light-duty or transitional work by reimbursing them for some of their costs.

Eligible employers can be reimbursed for:

- 50% of the base wages they pay to the injured worker.

- Some of the cost of training, tools or clothing the worker needs to do the light-duty or transitional work.

www.workingSolutions.Lni.wa.gov and
www.stayatwork.lni.wa.gov

Early Return to Work Program L&I

- The longer injured worker remains off work, the harder it is for them to return to their original job and income
- After 14 days of time loss, claim is assigned to the Early Return To Work Program
- Risk management specialist can show employer how WC claim impacts the company
- On site safety consultation to prevent future worker injuries

- <u>Options</u>
  - Work shorter hours
  - Perform transitional work (lighter demand)
  - Perform a different job temporarily
  - Job modification (tools, equipment)

StayAtWork@Lni.wa.gov 1-866-406-2482

Stages in the Development of Disability

Premorbid Stage	Crisis build-up	Demanding work, job dissatisfaction, situational stress, poor general coping skills, social model for disability
Stage 1	The accident	Relationships among the nature of the accident, the severity of the injury, & the claimed inability to work are often weak.
Stage 2	Medical intervention	Following recovery from the injury, pt fails to return to normal social roles & productivity. Repeated medical interventions may be performed, leading to possible iatrogenic complications, chronicity, & learned pain behavior
Stage 3	Stabilization of chronicity	Confusion, anger & hostility; increasing dependency & idleness; economic preoccupation & difficulty; decline in competence for gainful employment.
Stage 4	Legal intervention	Lack of systematized documentation to support proof of disability & the adversary system further foster attitudes of passivity, exaggerated illness behavior, & possibly malingering.
Stage 5	Learned helplessness	Sick role solidifies; loss of hope for health recovery; generalized incompetent coping, frequently irreversible.

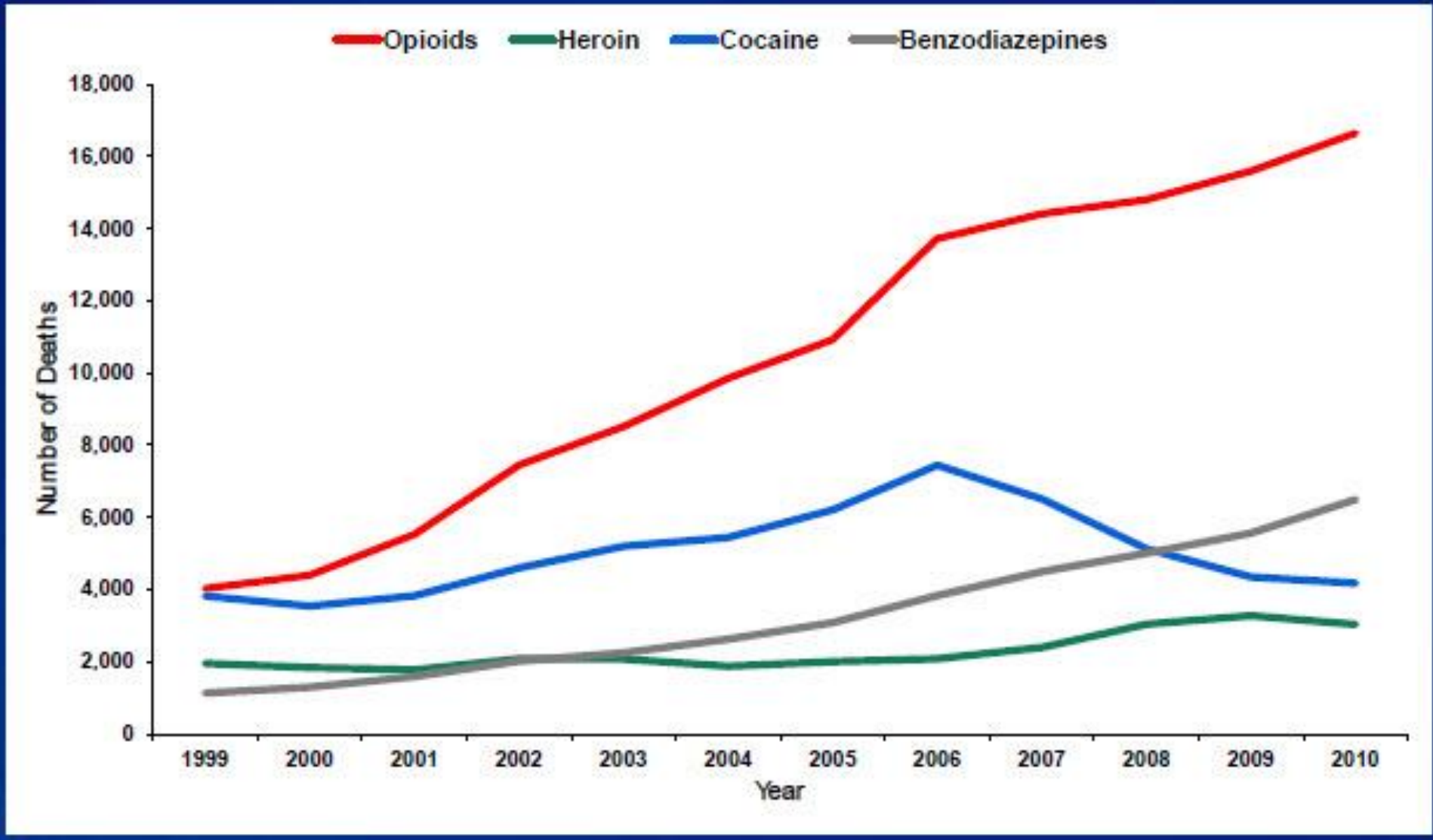
Brena SF, Chapman, SL. Pain and litigation. In Wall PD, Melzack R, eds. Textbook of Pain. Edinburgh: Churchill Livingstone; 1989

Predictors of Persistent Disabling LBP

- Maladapative pain coping behaviors
  - Fear avoidance (avoiding movement, activities)
  - Catastrophizing (excessive negative thoughts)
- Nonorganic signs (somatic focus)
- Functional impairment
- Low general health status
- Presence of psychiatric co-morbidities

Chou, R., & Shekelle, P. Will This Patient Develop Persistent Disabling Low Back Pain? JAMA. April 7, 2010; Vol 303, No. 13, 1295-1302

Drug Overdose Deaths by Major Drug Type, United States, 1999–2010



CDC, National Center for Health Statistics, National Vital Statistics System, CDC Wonder. Updated with 2010 mortality data.

Opioids and Injured Workers

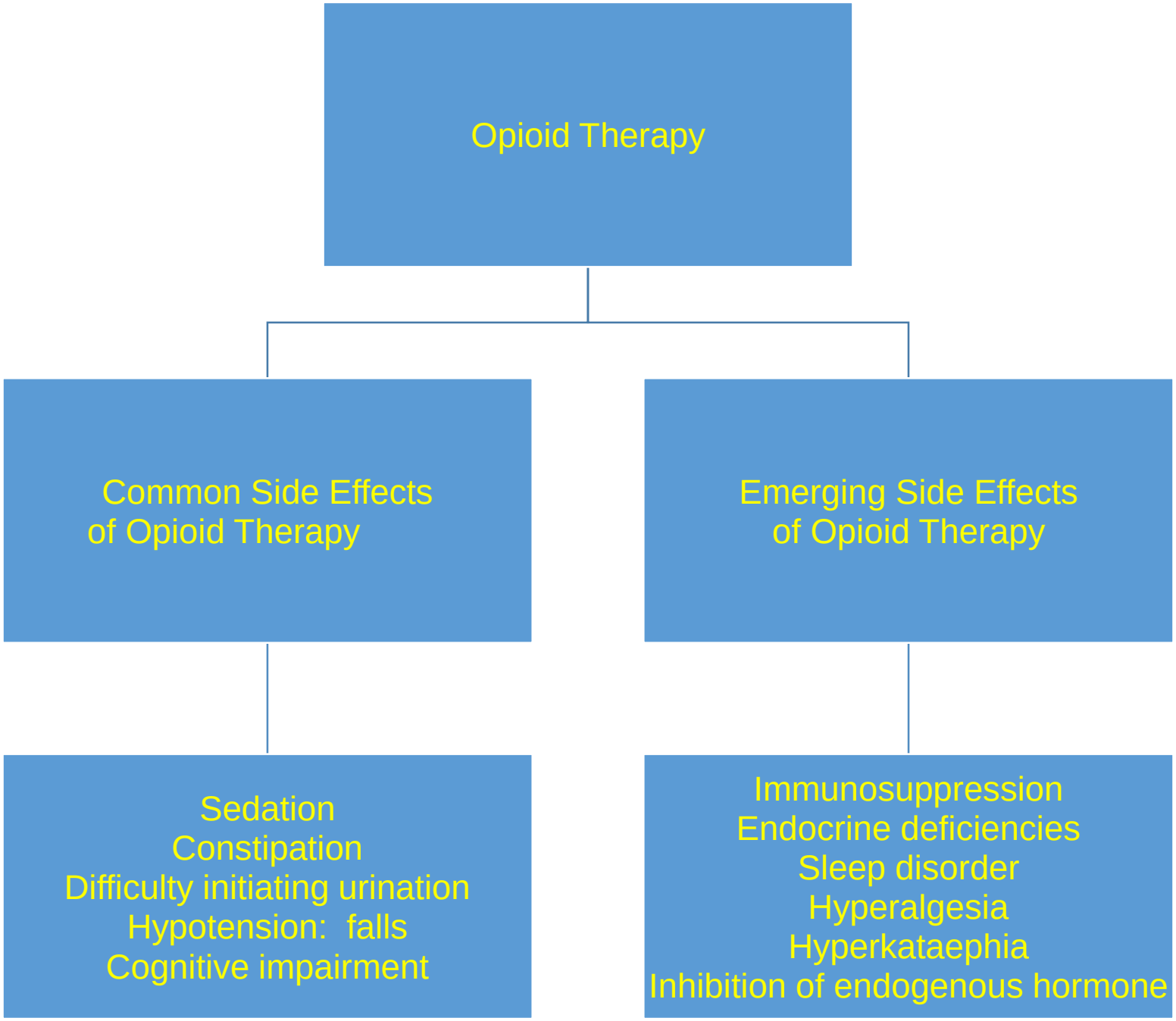
- 100% of patients on opioids chronically develop dependence

- The amount of prescribed opioid received early after injury strongly predicts long-term use (Franklin et al, *Clin J Pain* 2009)

- More than 50% of patients on opioids for 3 months will still be on opioids 5 years later (Ballantyne. J. Pain Physician 2007;10:479-91; Martin BC et al. J Gen Intern Med 2011; 26: 1450-57)

- Receiving > 1 week supply of opioids or > 2 opioid prescriptions soon after a back injury doubles a workers chance of disability at 1 year post-injury (Spine 2008; 33: 199-204)

- Risk of morbidity and mortality increased 8.9 fold at 100 mg MED (Dunn et al, Ann Int Med 2010; 152: 85-92)


Opioid Therapy
Common Side Effects of Opioid Therapy
Emerging Side Effects of Opioid Therapy
Sedation
Constipation
Difficulty initiating urination
Hypotension: falls
Cognitive impairment
Immunosuppression
Endocrine deficiencies
Sleep disorder
Hyperalgesia
Hyperkataephia
Inhibition of endogenous hormone

Guidance for Primary Care Providers on Safe and Effective Use of Opioids for Chronic Non-cancer Pain

- Establish an opioid treatment agreement
- Use PDMP (prescription drug monitoring pgm)
- Screen for:
  Depression (PHQ-9)
  Prior or current substance abuse (ORT, SOAPP-R, DIRE or CAGE-AID)
- Use random urine drug screening judiciously:
  Shows patient is taking prescribed drugs
  identifies non-prescribed drugs
- Do not use concomitant sedative-hypnotics
- Track pain and function to recognize tolerance (2 Question tool)
- Seek help if dose reaches 120 mg MED, and pain and function have not substantially improved

Guidance for Primary Care Providers on Safe and Effective Use of Opioids for Chronic Non-cancer Pain22http://www.agencymeddirectors.wa.gov/opioiddosing.asp
MED, Morphineequivalentdose .(http://www.agencymeddirectors.wa.gov/opioiddosing.asp)
From Gary Franklin's talk Sept 2013

Washington State Department of Health January 2014

In Washington State, the overdose death rate from prescription pain medication dropped by 27%. The number of deaths decreased from

512 in 2008 to 388 in 2012

The Oregon Pain Guidance group (OPG) is a diverse group of healthcare professionals from Jackson and Josephine Counties. The group was formed to engage healthcare professionals and community partners on the current opioid problem, to learn best practices for managing complex, chronic non-cancer pain (CCNP) and to bring them into standardized, general use in Southern Oregon

These guidelines are resources for local prescribers to help them understand and adopt best practices for the treatment of complex chronic non-cancer pain
http://www.southernoregonopioidmanagement.org/

"And with 10 being the highest, you're sure you're only at a 6?"

2 item pain and functional assessment by Dr. Michael Von Korff

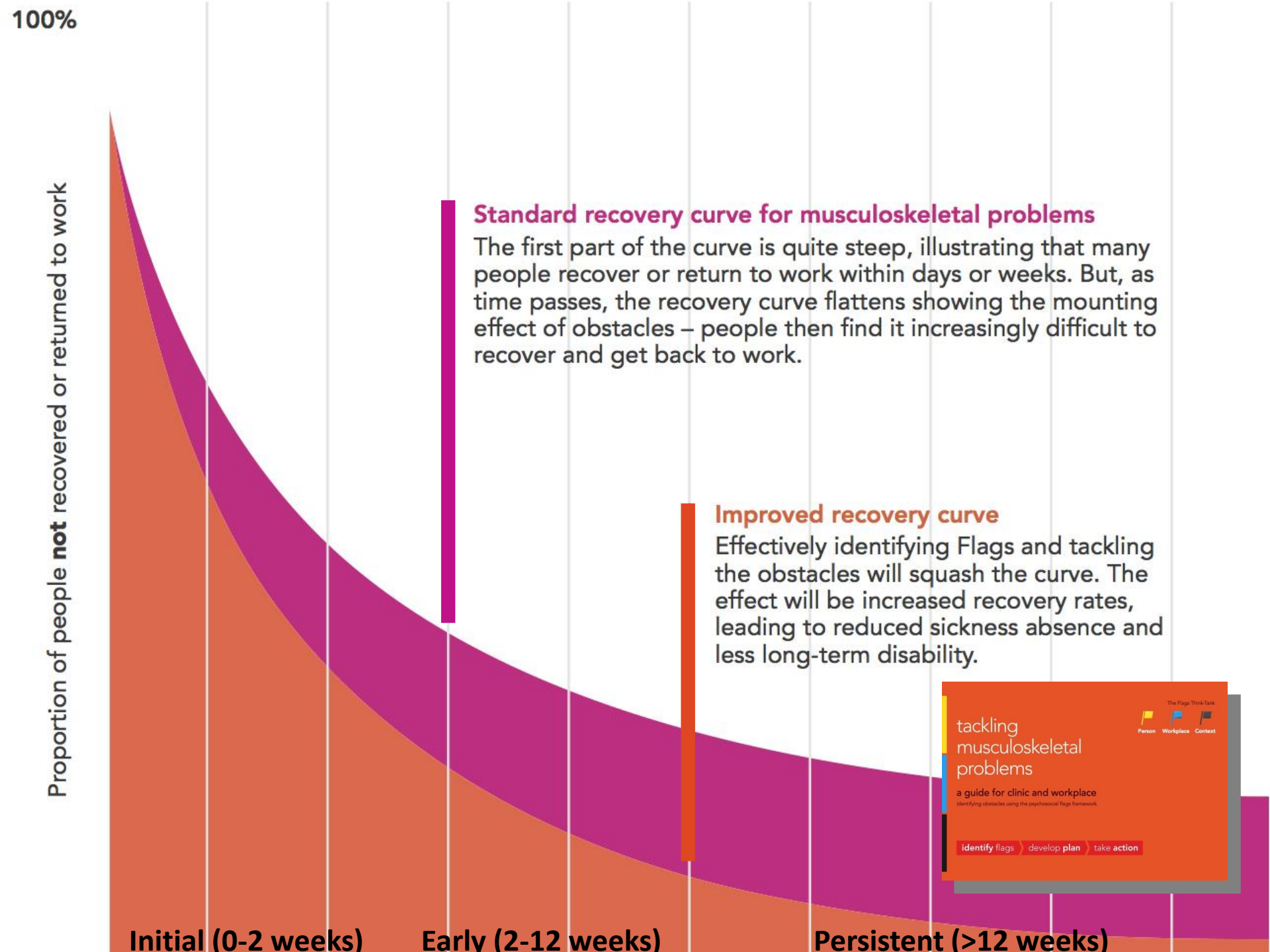
http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf

Standard Questions: Pain interference and intensity										
1. In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities."										
No interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10
1. In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as it could be." [That is, your usual pain at times you were in pain]										
No pain										Pain as bad as It could be
0	1	2	3	4	5	6	7	8	9	10

- **Acute Phase (< 2 weeks)**
  - symptom relief, maintain activity, provide support
  - high proportion return to activity and work

- **Sub-acute (2-12 weeks)**
  - develop plan for RTW/activity, healthcare and workplace accommodation, identify psychosocial obstacles, cease ineffective healthcare
  - optimal time to prevent the development of long term consequences including work loss

- **Chronic (> 12 weeks)**
  - multidisciplinary approach, cognitive behavioral techniques, consider shifting goals, max RTW/activities
  - requires more resources and more difficult to achieve.


100%
Proportion of people **not** recovered or returned to work
Standard recovery curve for musculoskeletal problems
The first part of the curve is quite steep, illustrating that many people recover or return to work within days or weeks. But, as time passes, the recovery curve flattens showing the mounting effect of obstacles – people then find it increasingly difficult to recover and get back to work.
Improved recovery curve
Effectively identifying Flags and tackling the obstacles will squash the curve. The effect will be increased recovery rates, leading to reduced sickness absence and less long-term disability.
tackling musculoskeletal problems
a guide for clinic and workplace
identifying obstacles using the psychosocial flags framework
Person
Workplace
Context
identify flags
develop plan
take action
Initial (0-2 weeks)
Early (2-12 weeks)
Persistent (>12 weeks)

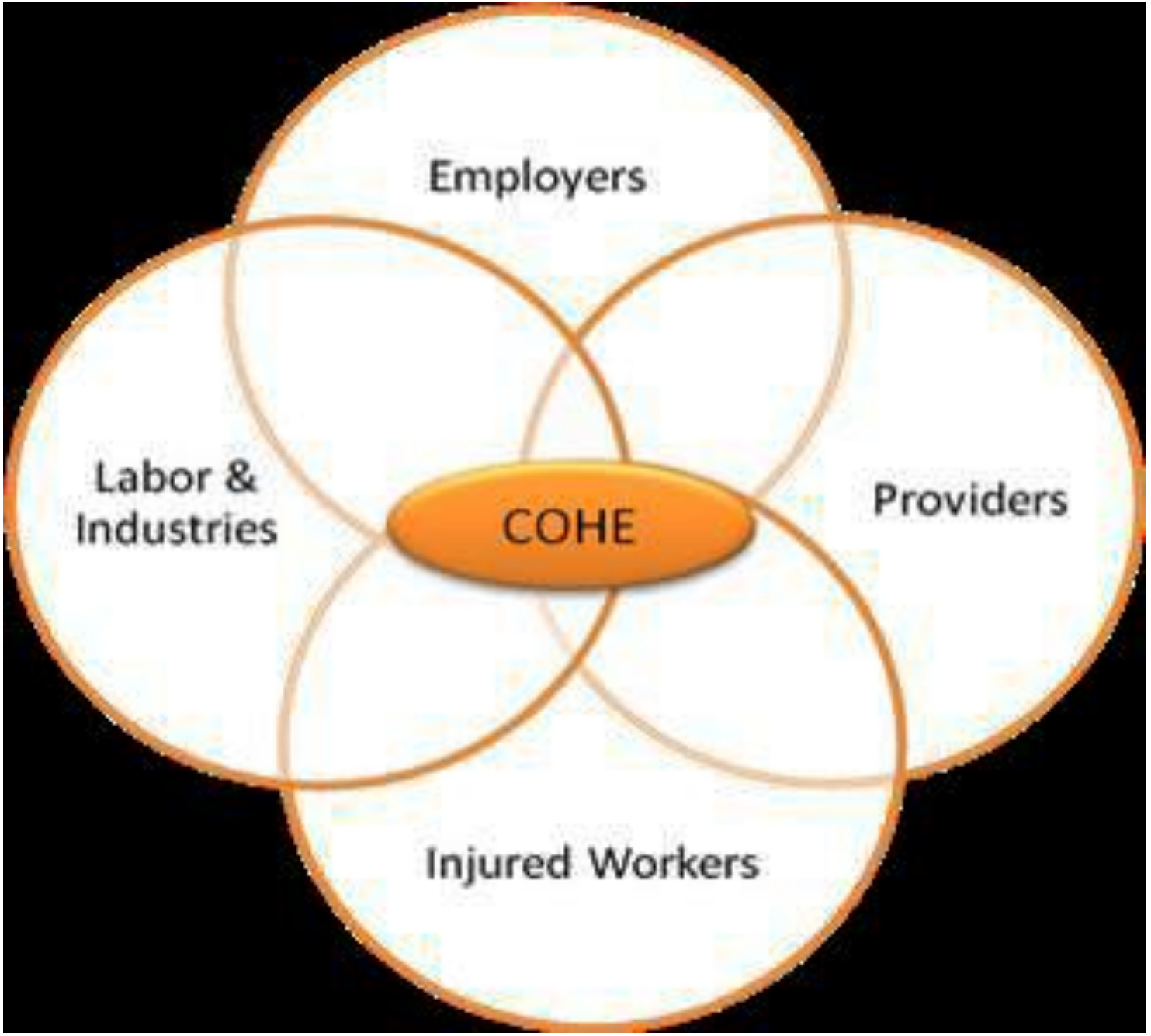
Centers of Occupational Health and Education (COHEs)

- Focuses on Early Intervention (first 12 weeks of claim – 6 mo)
- Work with medical providers, employers, and injured workers in a community-based program.
- Involves occupational health experts and Health Services Coordinators
- Improve injured worker outcomes and reduce disability by training providers and coord cases.
- Occupational health best practices
- COHE Pilot: 20% reduction in likelihood of one year disability, 30% reduction for back injuries
- Average $480 savings per claim first year, $1200 per claim
- 9 fewer disability days
- Goal is to have 100% IW access by Dec 2015

From Gary Franklin's talk 2013

6 COHE Locations in WA

1. UW Medicine Valley Medical Center of the Puget Sound (in Renton + p
and Pierce ctys)
2. Community of Eastern Washington (St Luke's Rehab Institute)
3. The Everett Clinic
4. UW Medicine Harborview Medical Center
5. Alliance of Western Washington (Franciscan Health Systems with providers in 19 counties)
6. Group Health (Greater Puget Sound, plus Spokane)


Employers
Labor &
Industries
COHE
Providers
Injured Workers

The Progressive Goal Attainment Program (PGAP™)

- Evidence-Based Treatment Program for Reducing Disability Associated with Pain, Depression, Cancer and other Chronic Health Conditions

- The Progressive Goal Attainment Program (PGAP™) is the first disability prevention program

- Specifically designed to target psychosocial risk factors for disability.

- Psychosocial factors were chosen as targets of the intervention on the basis of emerging research supporting their relevance to return to-work outcomes and their amenability to change through intervention.

The Progressive Goal Attainment Program (PGAP™)

- Primary goals of PGAP™:
  - reduce psychosocial barriers to rehabilitation progress
  - promote re-integration into life-role activities
  - increase quality of life
  - facilitate return-to-work

- Goals achieved through:
  - targeted treatment of psychosocial risk factors
  - structured activity scheduling
  - graded-activity involvement
  - goal-setting
  - problem-solving
  - motivational enhancement.

Work Hardening
&
Work Conditioning

Structured Intensive Multidisciplinary Program (SIMP)

Structured individualized treatment plan

Intensive 6-8 hours a day

Multidisciplinary - multiple areas of expertise in at least medicine, psychology, and physical or occupational therapy, nursing, and vocational services when needed

Program – interdisciplinary pain rehabilitation program that provides outcome-focused, coordinated, goal-oriented team services

http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2012/MARFS/Chapter34/default.asp#VocSIMP

Structured Intensive Multidisciplinary Program (SIMP) For Individuals Who…

- Previously failed less intense intervention
- Have higher rates of opioid use (dose escalation)
- Activities limited due to fear of pain
- Have problems with vocational functioning
- Experience high levels of emotional distress
- Are disability convicted
- Are passive about tx & put life on hold waiting for fix
- Feel hopeless and helpless
- Multiple therapies with no improvement in function

Goals of Interdisciplinary Pain Program

- INCREASE FUNCTION and activity level
- Reduce pain
- Simplify medication / reduce opioids
- Graded physical exercise
- Reduce emotional distress, such as depression and anxiety (CBT)
- Increase self-management / coping skills
- Increase quality of life
- Teach self-regulation of psychophysical arousal
- Decrease inappropriate health care utilization
- RTW

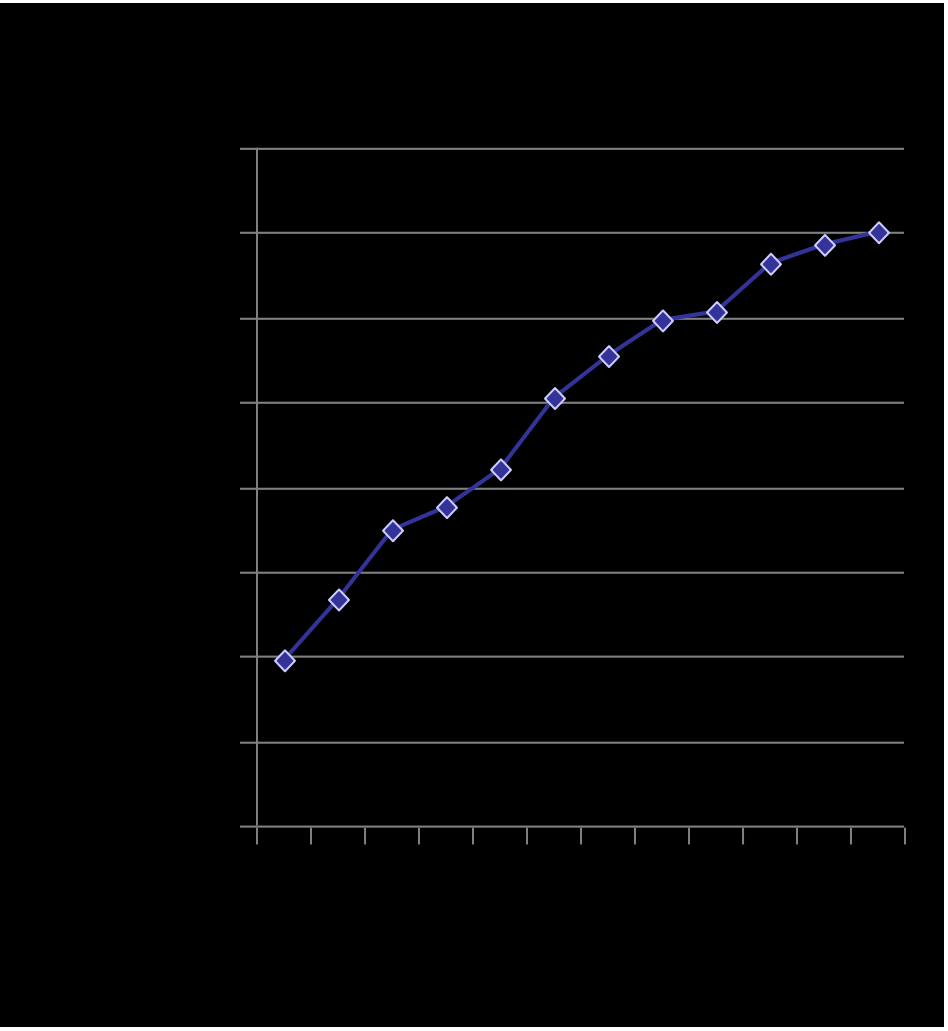
Pain Management Programs by the American Chronic Pain Association

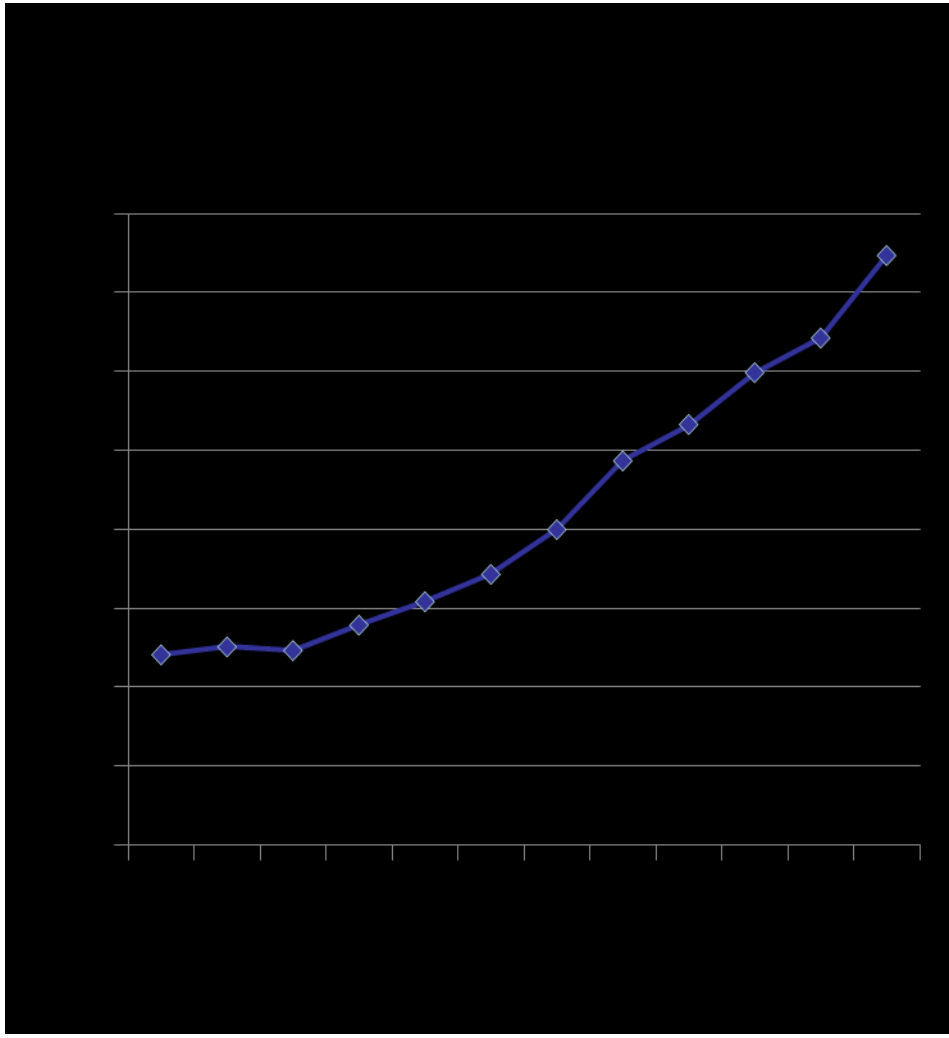
Outcomes PRA Pain Program

- 48% Decreased pain
- 98% increased lifting tolerance
- 89% increased endurance
- 80% decreased depression (BDI-II)
- 70% increased self-confidence in ability to cope with pain (PSEQ)
- Of those who entered program on opioids 70% reduced their dose
- Average dose reduction 70%
- 96% recommended medically stationary (MMI) and recommended RTW full time with restrictions

Nationwide spine fusion numbers & charges

(source: HCUPnet, AHRQ)





Deyo

(All spinal levels, all indications, all techniques)

“Spinal fusion surgeries under critical microscope” Oregonian 11/6/13

- 465,000 spinal fusions performed in US in 2011
- Rate of spinal fusion surgeries risen 6x in past 20 years
- $200 million spent on unnecessary surgeries
- Approximately 50% spine fusions in US are unnecessary (Rick Deyo, OHSU)

In Washington State successful completion of a CARF* accredited Structured Intensive Multidisciplinary Program (SIMP) is required prior to lumbar fusion or disc replacement, unless there is back instability

Provider should refer to SIMP if 3 months of conservative therapy fail to relieve pain or restore function to an acceptable level)

(CARF = Commission on Accreditation of Rehabilitation Facilities)

http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/LumbarFusion.pdf

Tackling Musculoskeletal Problems

a guide for clinic and workplace

identifying obstacles using the psychosocial flags framework

Kendall, Burton, Main, & Watson: TSO Books, 2009 www.tsoshop.co.uk/flags

PERSON

WORKPLACE

CONTEXT

➔ Flags are about identifying obstacles to being active and working

➔ The important thing is to figure out how these can be overcome or bypassed

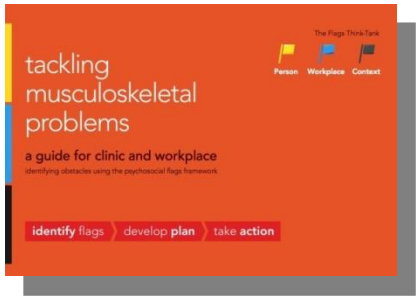
➔ Combining work-focused healthcare with an accommodating workplace is best:
that means all players onside - consistency, coordination and collaboration

applying the

biopsychosocial model

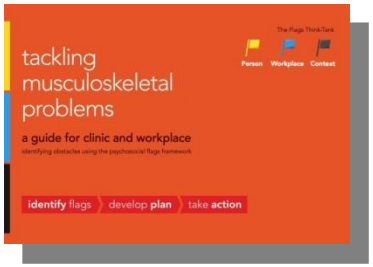
identify flags > develop plan > take action

How it all goes wrong… Manu's story

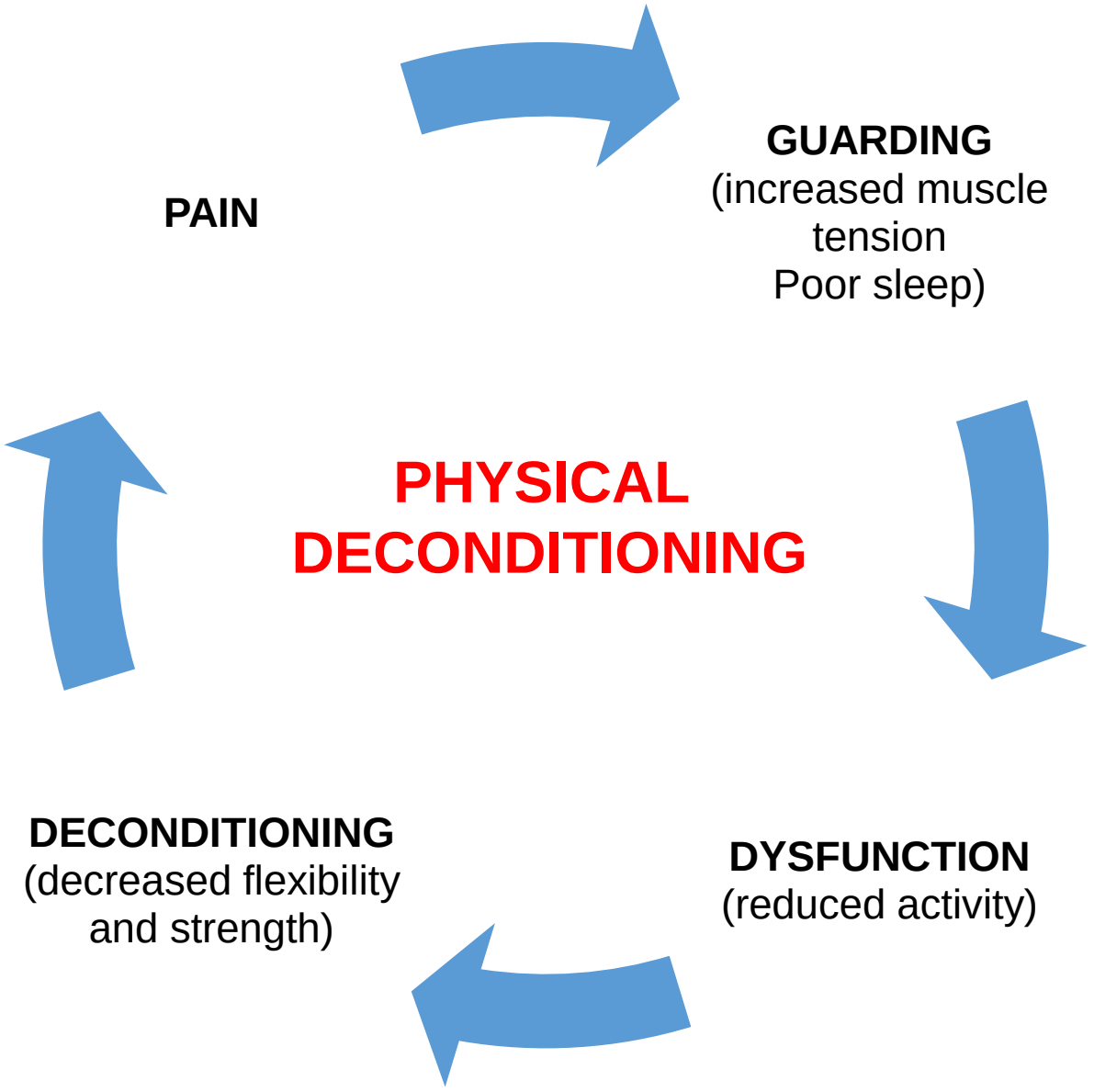


"I got a back problem that made my work a bit difficult. The doc signed me off work, saying work probably caused the injury. The people at work didn't call, so I couldn't discuss getting back to work. The company has this rule that you have to be fully fit to go back. The pain kept coming and going so I was stuck. I got really worried and depressed. I don't get out much now and I've lost the job. To start with it wasn't too bad – all I needed was some help with the job for a while and I could have stayed at work."

Myths that Create Obstacles for RTW



- Pain means serious damage and injury
- Work/activity is the cause and will make it worse
- Medical treatment is necessary
- Musculoskeletal problems must be rested
- Sick leave is needed as part of the treatment
- Contacting an absent worker is intrusive
- No RTW /activity until 100% fit and pain free



Cycle of pain, Guarding, Dysfunction, and Deconditioning
(Fibromyalgia, Arthritis Foundation, 1997)

PAIN

(hurt = harm)

MENTAL DECONDITIONING

STAGE 1

(initial psychological distress
fear, anxiety, worry, etc)

STAGE 2

(development or exacerbation
of psychological problems)

STAGE 3

(acceptance of “sick role”
abnormal illness behavior)

A Conceptual Model of the Transition from Acute to Chronic Pain Where Physical Deconditioning Leads to Mental Deconditioning
(Gatchel, 1991; Copywright 1991 by Lea & Febiger)

Obstacles to Recovery & RTW
Red Flags Predicting Disability

1. Catastrophizing
2. Fear of movement or re-injury
3. Expectations
4. Preoccupation with health
5. Worry and distress
6. Depression
7. Uncertainty
8. Extreme symptom report
9. Passive coping strategies
10. Serial ineffective therapy

Tackling Musculoskeletal Problems: A Guide for Clinic and Workplace, 2009

Red Flag #1: Catastrophizing

- Magnifying the negative and anticipating the worst case scenario for events and experiences

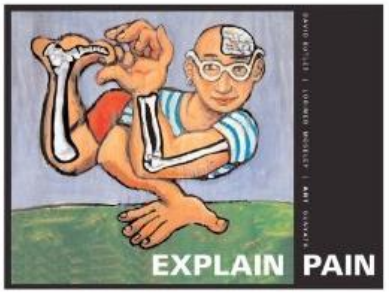
- Can occur when feel pain or expect to feel pain

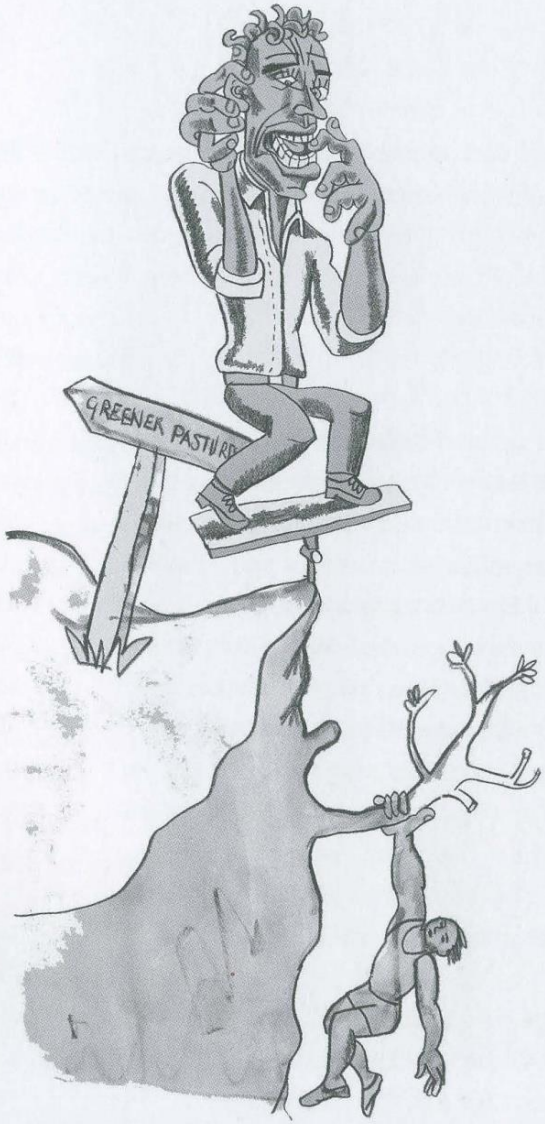
- Effect is increase in pain and suffering and avoidance behavior, rumination about pain, feelings of helplessness

- *"I can't stand this pain another minute!"* *"If my pain continues like this, I'll end up in a wheelchair."*

- Influences pain perception through altering attention and anticipation and heightening emotional response to pain

All of these thought viruses are common in people with persistent pain who don't understand the physiology of pain. They are often enough to take you right 'to the edge'.





I'm in pain so there must be something harmful happening to my body.

I'm staying home, not going out, I'm keeping quiet and out of things.

Even their whiz-bang scanning machine can't find it - it must be bad.

We can put a man on the moon, why can't someone just fix this pain for me?

I'm so frightened of my pain and of injuring my back again that I'm not doing anything!

I'm not doing anything until all the pain goes.

The fear of pain is more disabling than the pain itself.

(Waddell, 1993)

Red Flag #2: Role of Fear of Movement (kinesiophobia) and Harm Avoidance

- Fear avoidance is one of the most powerful predictors of chronic disability in back pain patients (Klenerman et al, 1995)
- Belief that moving specific body parts or engaging in activities will exacerbate pain and cause injury
- Affects participation in activities leading to decrease in quality of life
- Strong association between pain-related fear and increased physiological arousal (Vlaeyen, Haazen, et al, 1995; Vlaeyen, Kole-Snijders, Boeren, & van Eck, 1995).
- Physiological arousal might contribute to maintenance and increase in pain severity (Flor & Turk, 1989)
- Chronic pain pts with elevated pain-related anxiety tend to anticipate higher levels of pain than those with low anxiety and anticipation of pain often results in poorer behavioral performance (McCracken, Gross, Sorg, & Edmands, 1993).

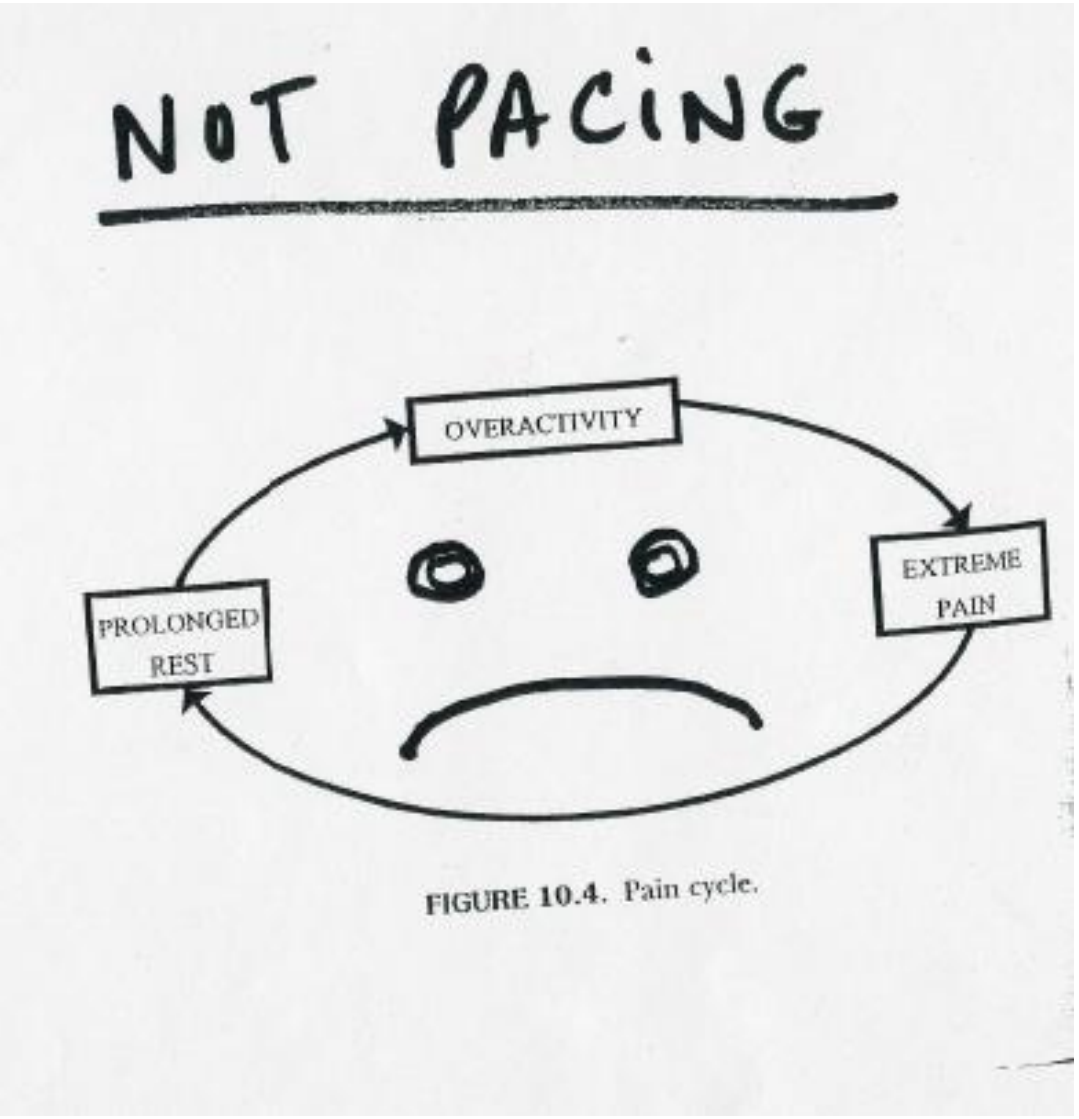
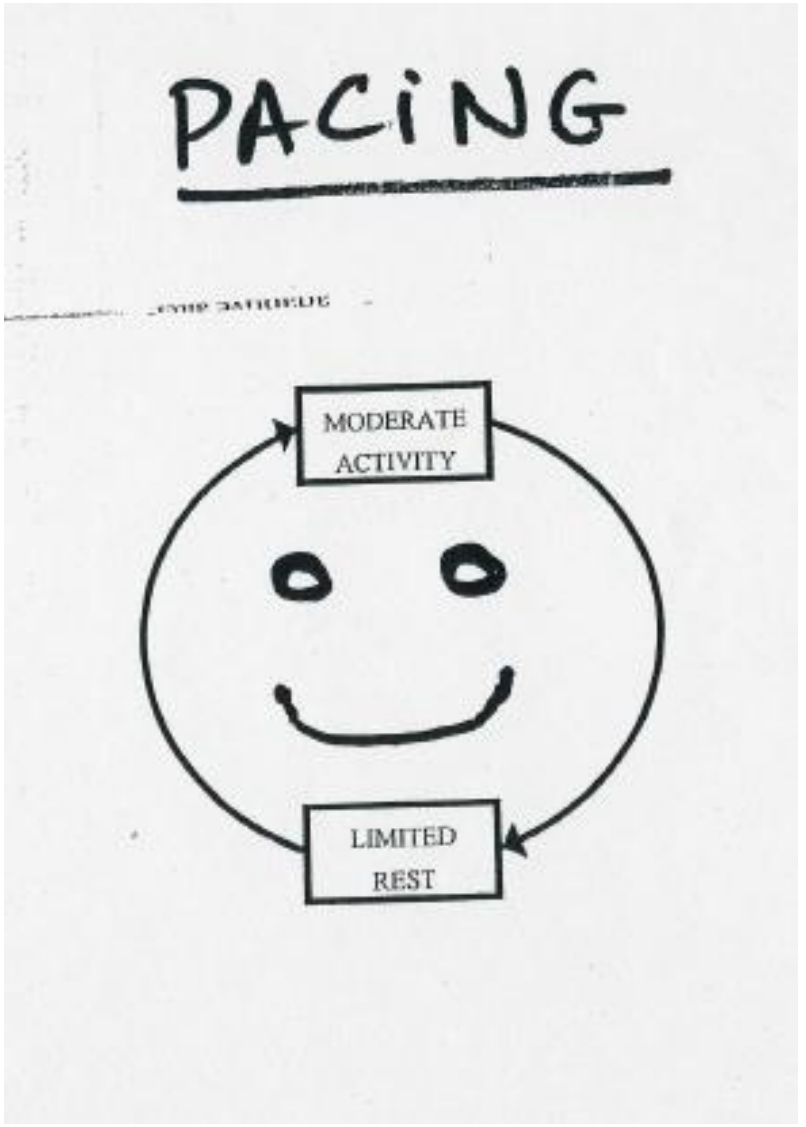
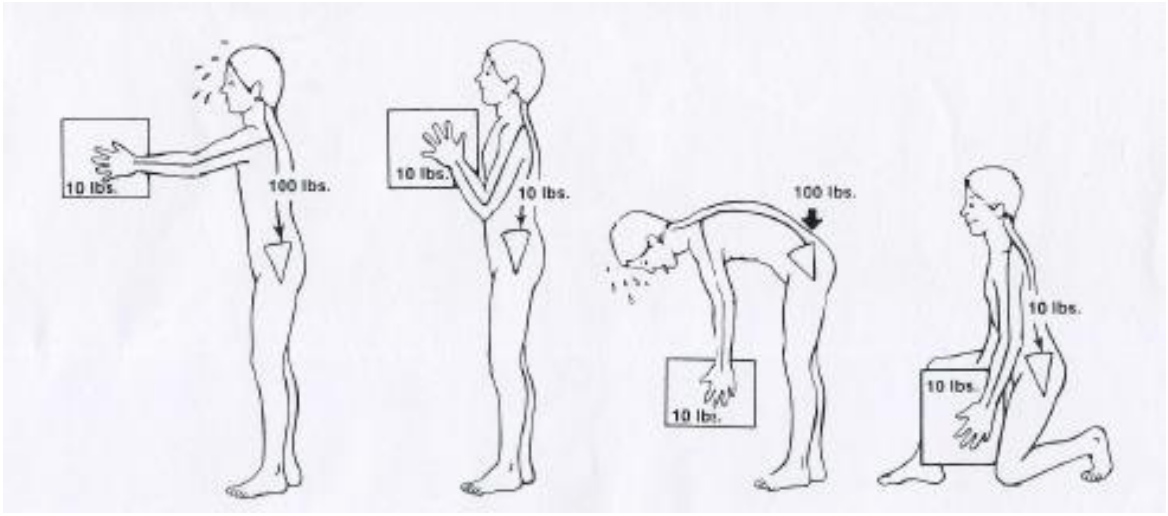


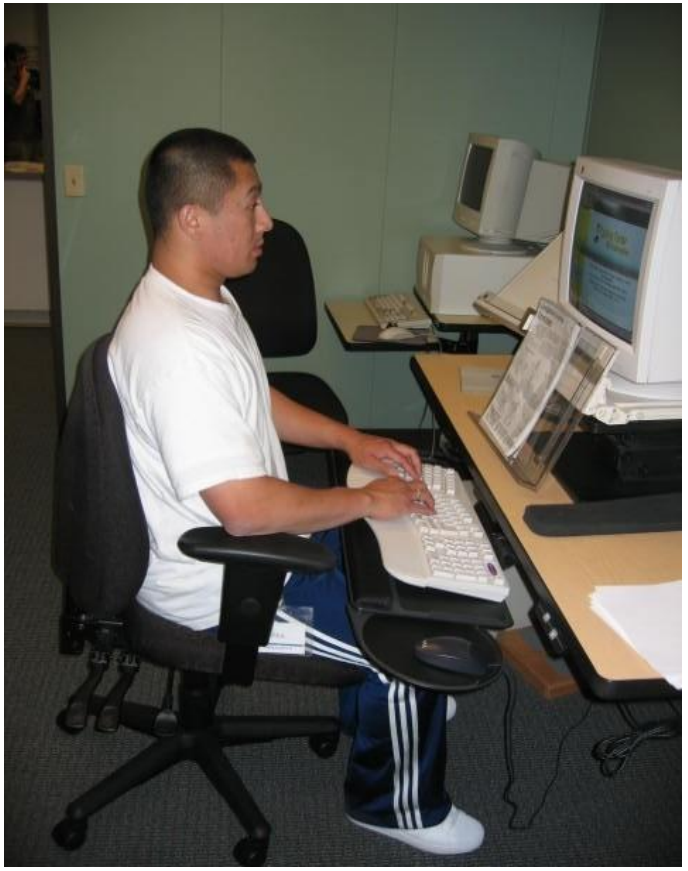
FIGURE 10.4. Pain cycle.



The Activity-Rest Cycle in Chronic Pain (Gil, Ross, & Keefe, 1988) in Psychological Approaches to Pain Management: A Practitioner's Handbook. Edited by Robert J. Gatchel and Dennis C. Turk (1996)

Body Mechanics



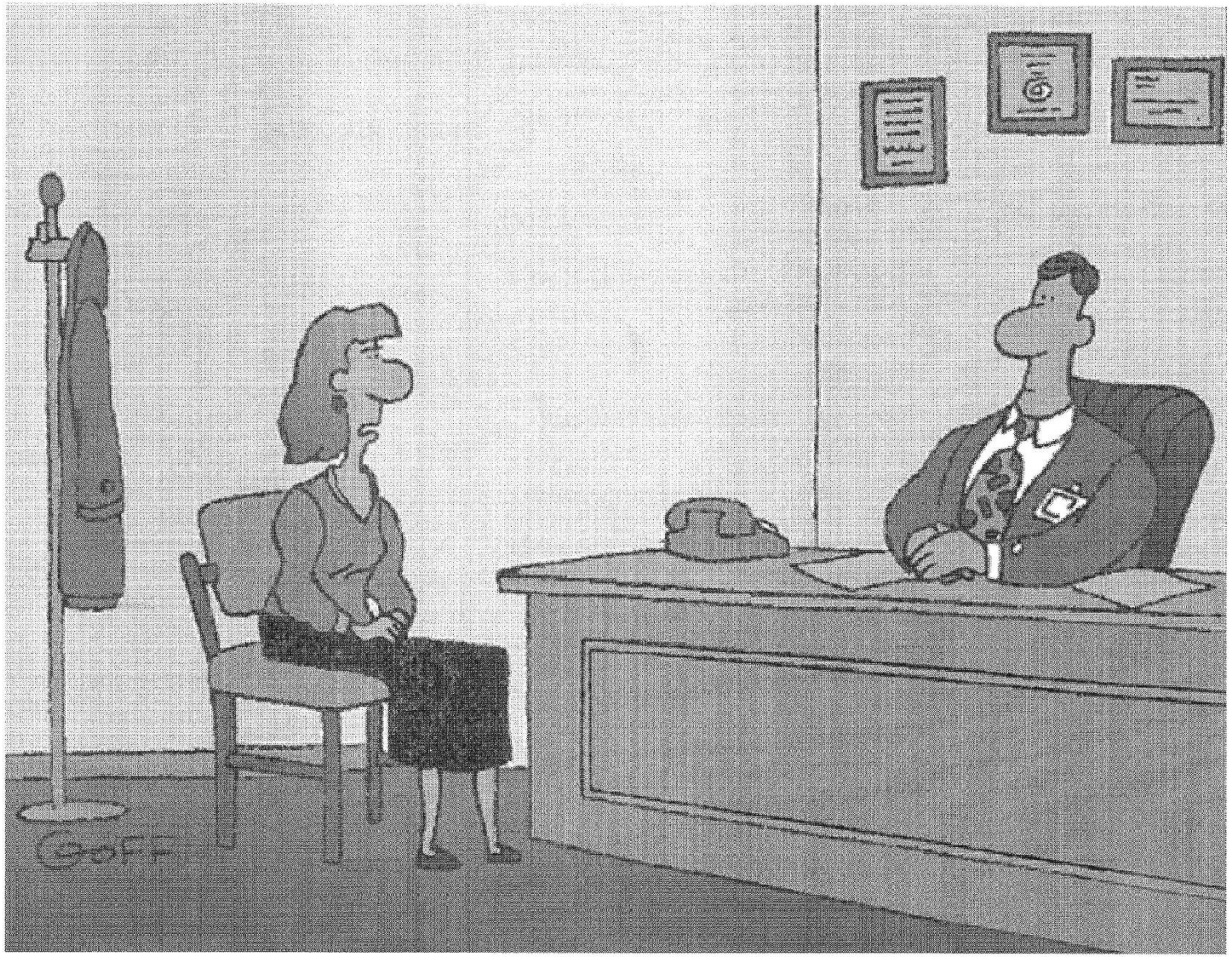


Ergonomics
&
Body Mechanics
for
Activities of Daily Living

Red Flag #3:
Expectations

- Expectations for a “fix”
- Negative expectations of recovery and return to work
- Belief that work is harmful and will do damage or be dangerous
- Unsupportive work environment
- Beliefs lead to our emotions and drive behavior

Tackling Musculoskeletal Problems: A Guide for Clinic and Workplace, 2009



"I hope you're not going to be like the twenty incompetent doctors who couldn't find anything wrong with me."

Red Flag #4:
Preoccupation with Health

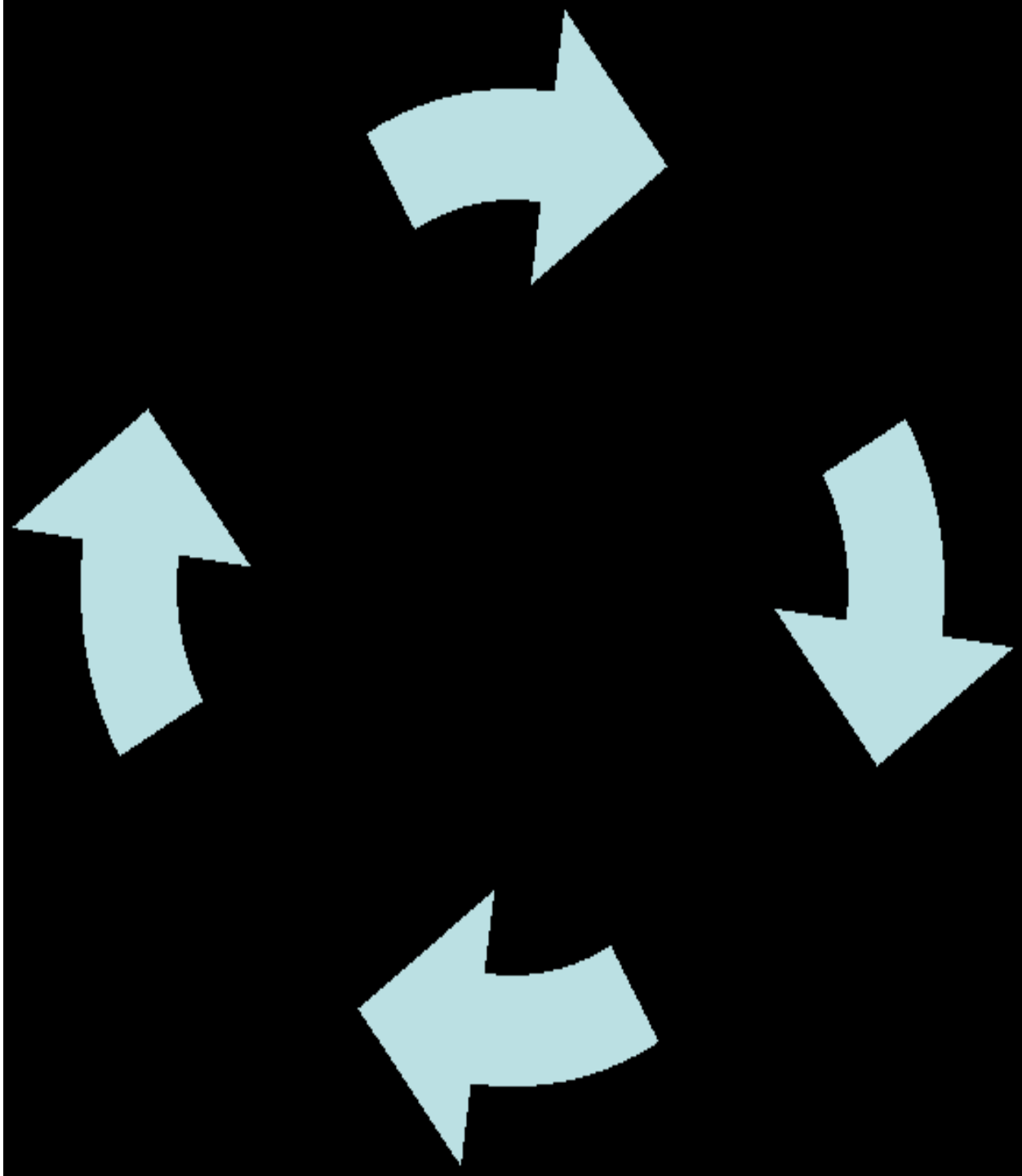
- Excessive preoccupation or worry about having a serious injury or disease
- Usually based on person's misinterpret symptoms
- Effect can be treatment– seeking
- Belief that all pain has to be gone before attempting to RTW or normal activity
- Decrease in activity level and withdrawal from ADLs
- More downtime than uptime

Tackling Musculoskeletal Problems: A Guide for Clinic and Workplace, 2009

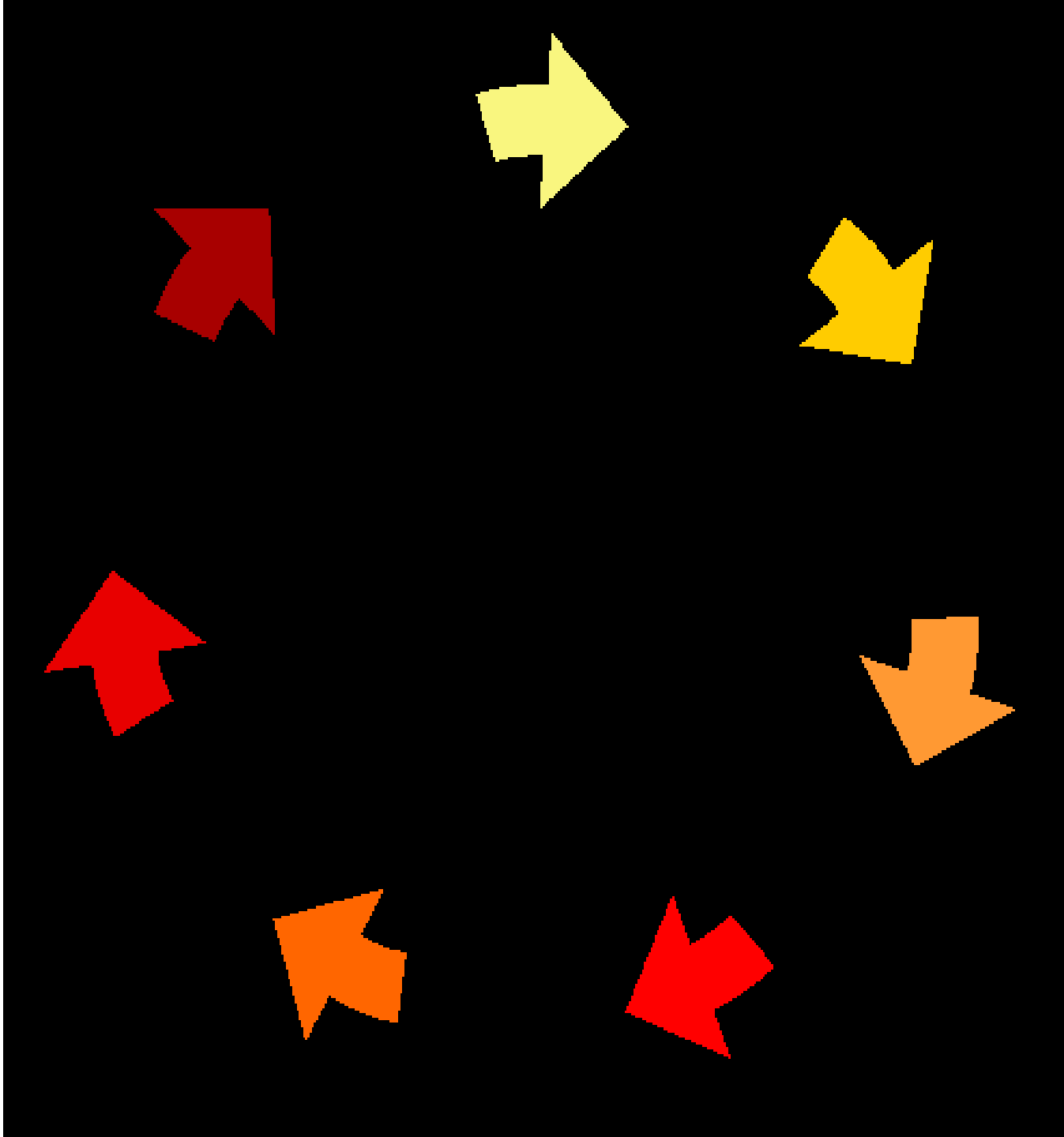
PAIN DOES NOT EQUAL HARM

How Does Chronic Pain Develop?

The Fear-Avoidance Cycle



Central Sensitization



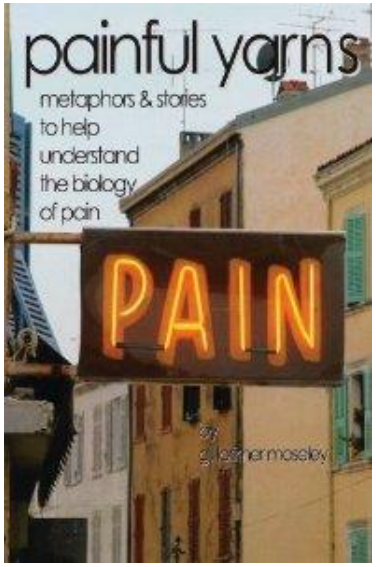
Painful Yarns, written by Dr. Lorimer Moseley, is a compilation of hilarious stories and images intended to help explain the complexity of pain. These stories

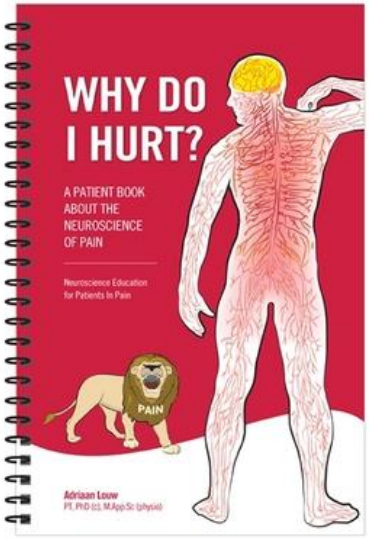
Explain Pain II (2003)

David Butler & Lorimer Mosley, Ph.D.

Explain Pain by David Butler and Dr. Lorimer Moseley is an evidence based book designed for therapists, patients and students. It answers the most common questions asked by pain sufferers: 'why do I hurt?' and 'what can I do for my pain?' Written in simple language that anyone can understand, it encourages patients to move better and research shows that they will have less pain once they have understood its underlying causes.

Painful Yarns
Lorimer Mosley



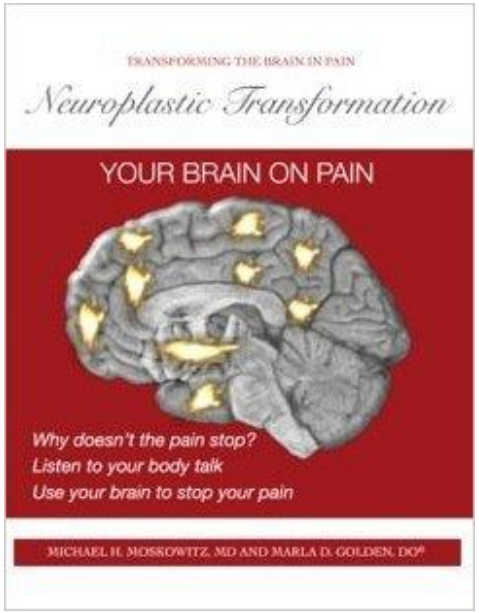


Why Do I Hurt (2013)

Adriaan Louw, PT, Ph.D., M.App.Sc

Written by physical therapist Adriaan Louw. Pain is a normal, human experience. Living in pain, however, is not. A big reason why pain rates are increasing is the fact that too much focus has been placed on tissues, such as muscles, ligaments and joints, which generally heal between three and six months. Persistent pain, however, is more due to the sensitive nervous system and how the brain processes information from the body and the environment.

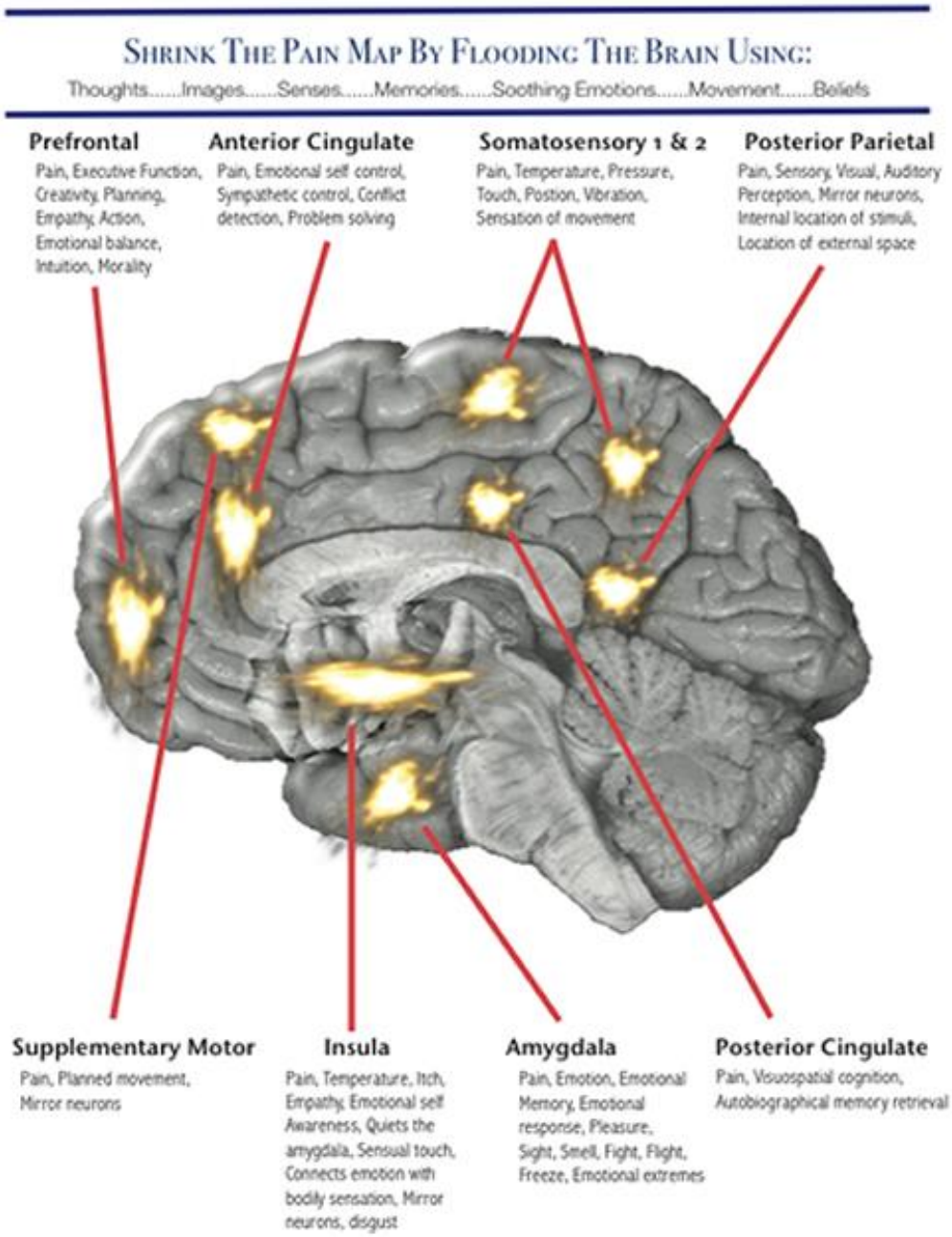
“Pain is normal – living in pain is not. Chronic pain is commonly due to an extra-sensitive nervous system and how the brain processes information from the nerves. Understanding more about the neuroscience of pain has been shown to allow patients to hurt less, exercise more and regain control of their lives. “Why Do I Hurt?” teaches patients the science of pain in approachable language with metaphors, examples and images”



Neuroplastic Transformation(2013)

Michael Moskowitz, MD & Marla DePolo Golden, DO

The Neuroplastic Transformation workbook presents a revolutionary treatment for the millions of people suffering with the disease of persistent pain. The authors have developed an innovative approach to reverse runaway pain by harnessing the brain's amazing neuroplastic ability to heal the body. The program presented in this workbook applies the discoveries of cutting edge research in the fields of Pain Medicine, Neurology, Immunology, Psychiatry and Neuroscience to help people transition from a life of chronic pain to a life of health and wellness. The book can be used independently or as a tool for an interactive partnership between practitioner and patient.



- 9 areas of the brain process pain
- These areas have several functions
- All become distorted w cp
- Amount of brain tissue that processes pain expands
- Nerves will begin to fire on own
- Non painful stimuli are perceived as painful over time

Moskowitz and Golden, 2013

Shrink the Pain Map by Flooding the Brain Using:

- Beliefs and Thoughts
- Images
- Smell (peppermint blocks release of Substance P)
- Touch
- Sound (Brain Music – low frequency sounds)
- Memories
- Soothing Emotions (serenity, relaxation, empathy, attunement, gratitude, happiness, and love)
- Movement (connects brain and body)
- Pleasure (citris oils evoke pleasure circuits)

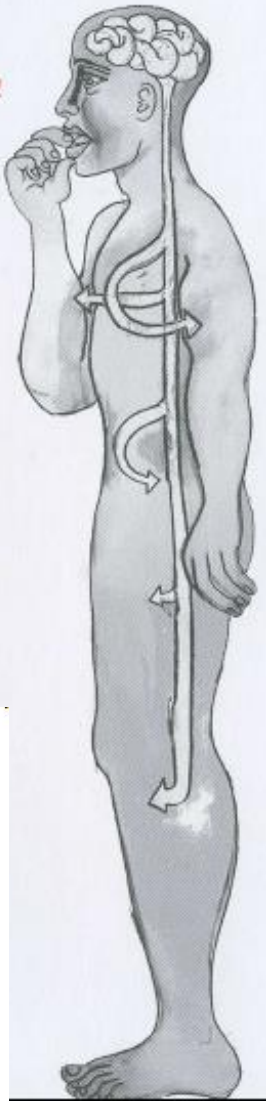
From Neuroplastic Transformation, Moskowitz and Golden, 2013

Red Flag 5:
Worry and Distress

- May have difficulty stopping unhelpful thoughts or expectations
- Can increase pain, disrupt relationships, ADLs
- Ex – excessive guarding, taking too much medication
- Sense of feeling overwhelmed and loss of control

Tackling Musculoskeletal Problems: A Guide for Clinic and Workplace, 2009

The Response Systems



SYMPATHETIC NERVOUS SYSTEM

increase heart rate, mobilise energy stores, increase vigilance, sweat

MOTOR SYSTEM

run away, fight, protect damaged area

ENDOCRINE SYSTEM

mobilise energy stores, reduce gut and reproductive activity

PAIN PRODUCTION SYSTEM

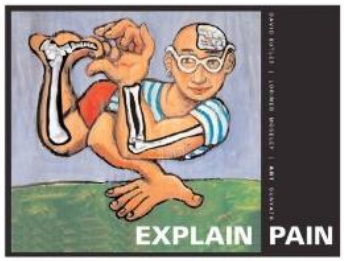
motivate to escape and seek help, attract attention

IMMUNE SYSTEM

later: fight invaders, sensitise neurones, produce fever, make sleepy to promote healing

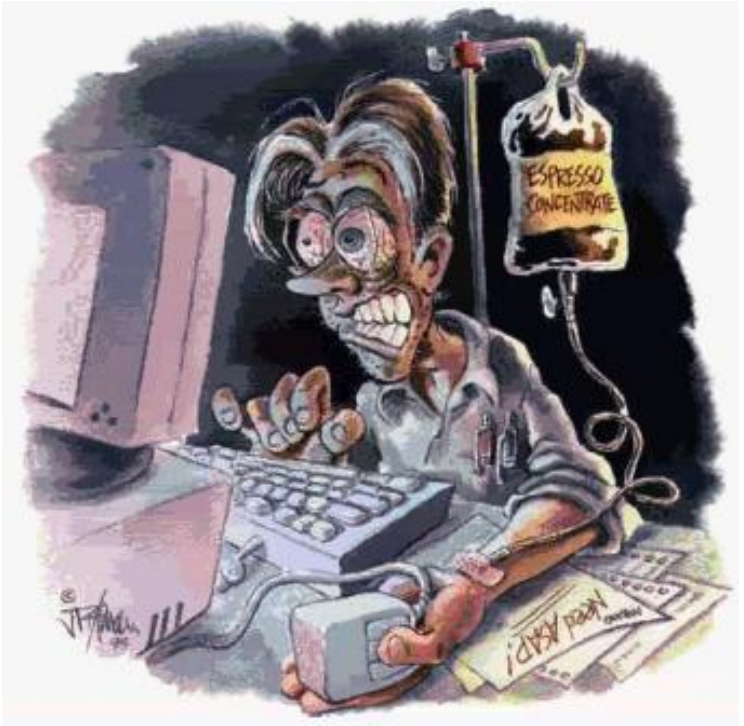
PARASYMPATHETIC SYSTEM

later: nourish cells, heal tissue



What Happens When Stress Continues

- Depression, mood swings
- Cell death in the hippocampus
- Memory changes
- Poor tissue healing
- Weight gain
- Altered immunity



Factors that Improve our Immune System

- An ability to develop coping skills
- The perception of the stressor
- Health perceptions
- Social interactions
- Medical support system
- Belief systems
- Exercise
- Humor
- Intimacy
- Diet

From Explain Pain, 2003

PTSD and Chronic Pain

- Prevalence of PTSD is substantially elevated in pts with chronic pain (15-35%) compared to those who do not have chronic pain (2%) (Asmundson, Bonin, Frombach, & Norton, 2000)

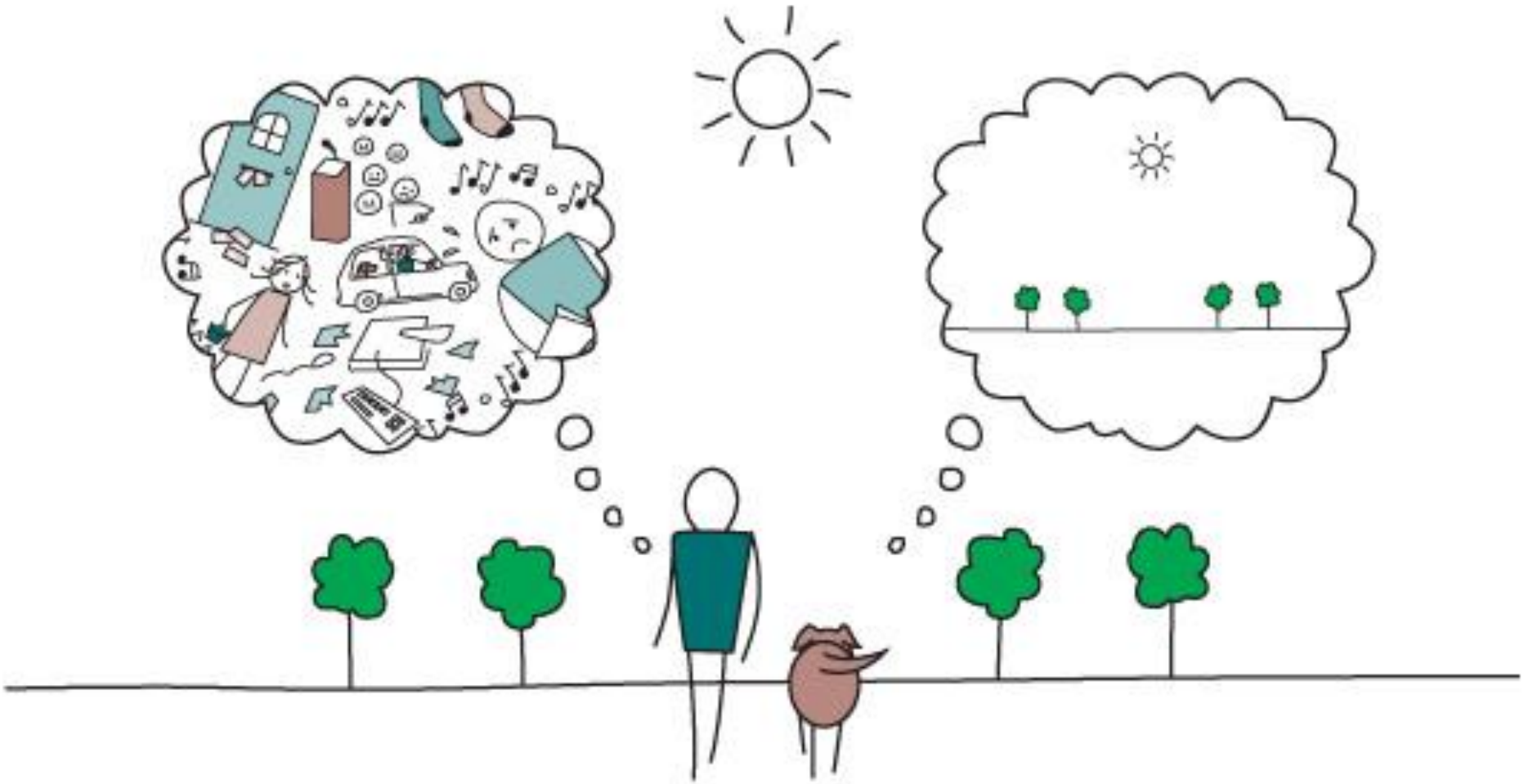
- For those with history of abuse, having chronic pain can feel like being abused again. Anxiety, vulnerability, lack of control, and not being believed can magnify pain emotionally and physically (Caudill, MA., 2002)

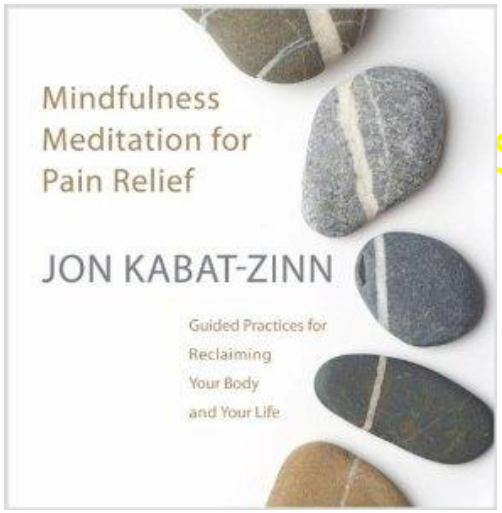
- The pain may serve as a reminder of the traumatic event, which will tend to exacerbate the PTSD (DeCarvalho, L. T.)

- Important to treat the PTSD and the pain

Case example of PTSD and Chronic Pain

- 45 yr old nurse injured OTJ at MH hospital
- Attacked by patient in the “bubble”
- Accepted condition: L5-S1 disc bulge
- PCLC (67) → PTSD
- Other dx: OCD, MDD
- Childhood emotionally abusive
- Bed to escape pain
- Tx: CBT, PT, OT, BFT, MD/RN, VRC


Mind Full, or Mindful?



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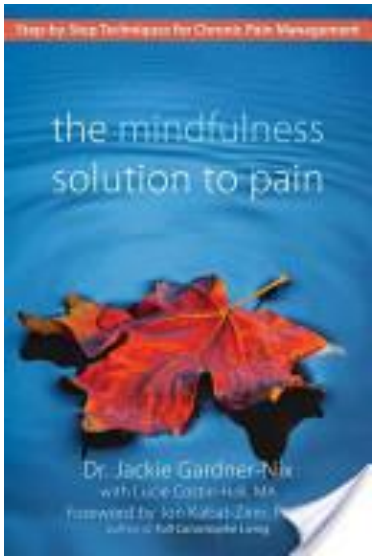
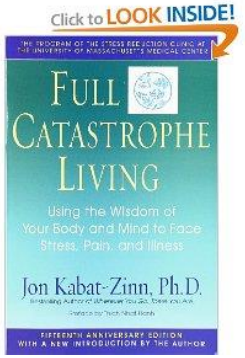


Mindfulness means paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally.

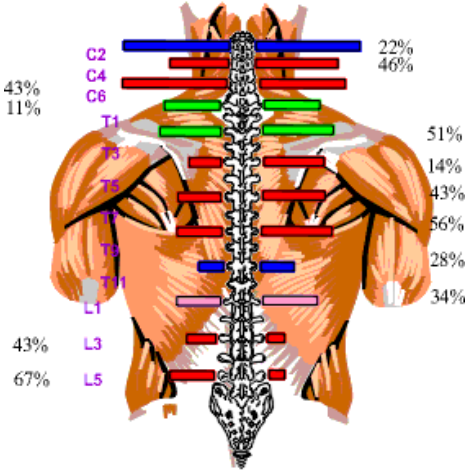
Jon Kabat-Zinn

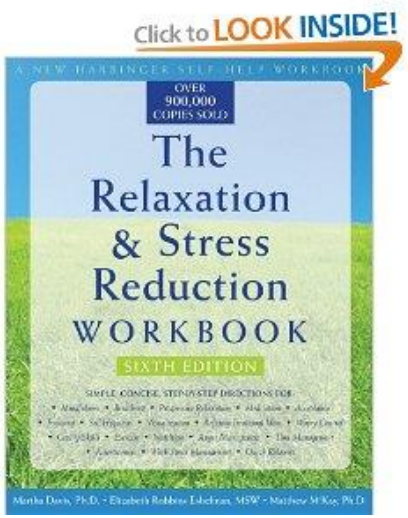
From Segal, Williams, and Teasdale (2002)

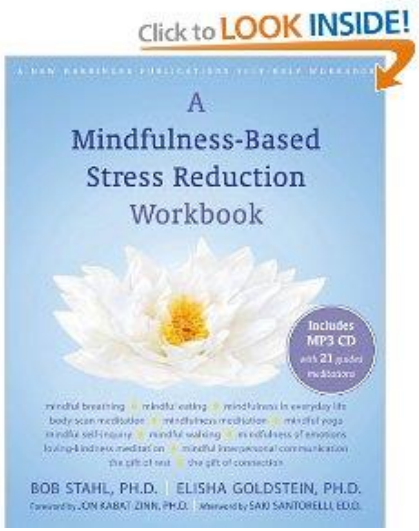


Biofeedback

- Diaphragmatic breathing
- Stress management through relaxation
- Muscle tension reduction
- Heart rate variability
- I phone app:
  - Breathe2Relax
  - Breath Pacer







The Downward Spiral or Black Hole of Chronic Pain…

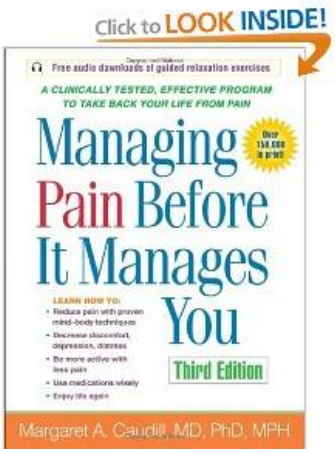
"Chronic pain is a thief, it breaks into your body and robs you blind. With lightning fingers, it can take away your livelihood, your marriage, your friends, your favorite pastimes and big chunks of your personality. Left unapprehended, it will steal your days and your nights until the world has collapsed into a cramped cell of suffering."

"The Right and Wrong Way to Treat Pain",

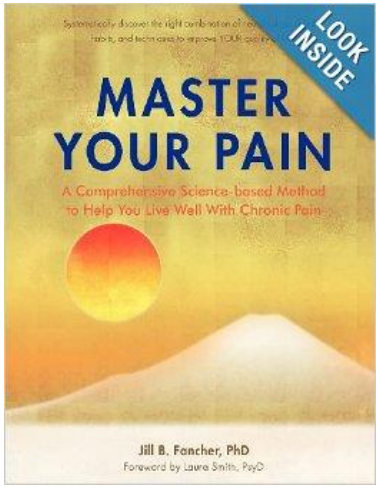
Time Magazine by Claudia Wallis, February 2005.

Red Flag #6:
Depression

- Depression makes pain more difficult to treat
- Described as sadness, feeling down, irritable, angry, helpless, loss of interest, frustration, agitation
- Pain & depression feed on themselves by changing both brain function and behavior
- Depression can amplify the perception of pain and disrupt sleep, eating, and ADLs
- Pain and depression share common pathways in the emotional (limbic) region of the brain



Cognitive Behavioral Therapy

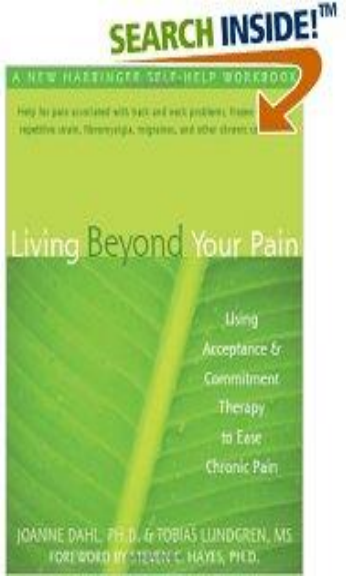


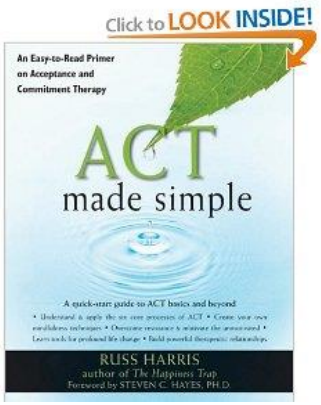
"CBT is based on the premise that perceptions and observable displays of pain are influenced by complex interactions between environmental events and individuals' emotional, physiological, behavioral, and cognitive responses. Effective interventions for chronic pain must address the emotional, cognitive, and behavioral dimension of pain, and must also help patients become active participants in learning new methods of responding to their problems."

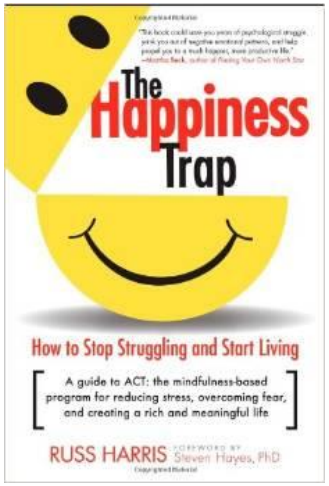
Bradley, L.A. Cognitive-Behavioral Therapy for Chronic Pain in Psychological Approaches to Pain Management: A Practitioner's Handbook Gatchel, R.J. & Turk, D. C. Eds.

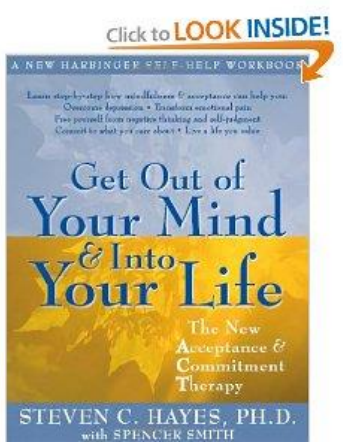
Acceptance & Commitment Therapy

Goal of ACT is to help you live a rich, full, and meaningful life while effectively handling the pain that inevitably comes your way.

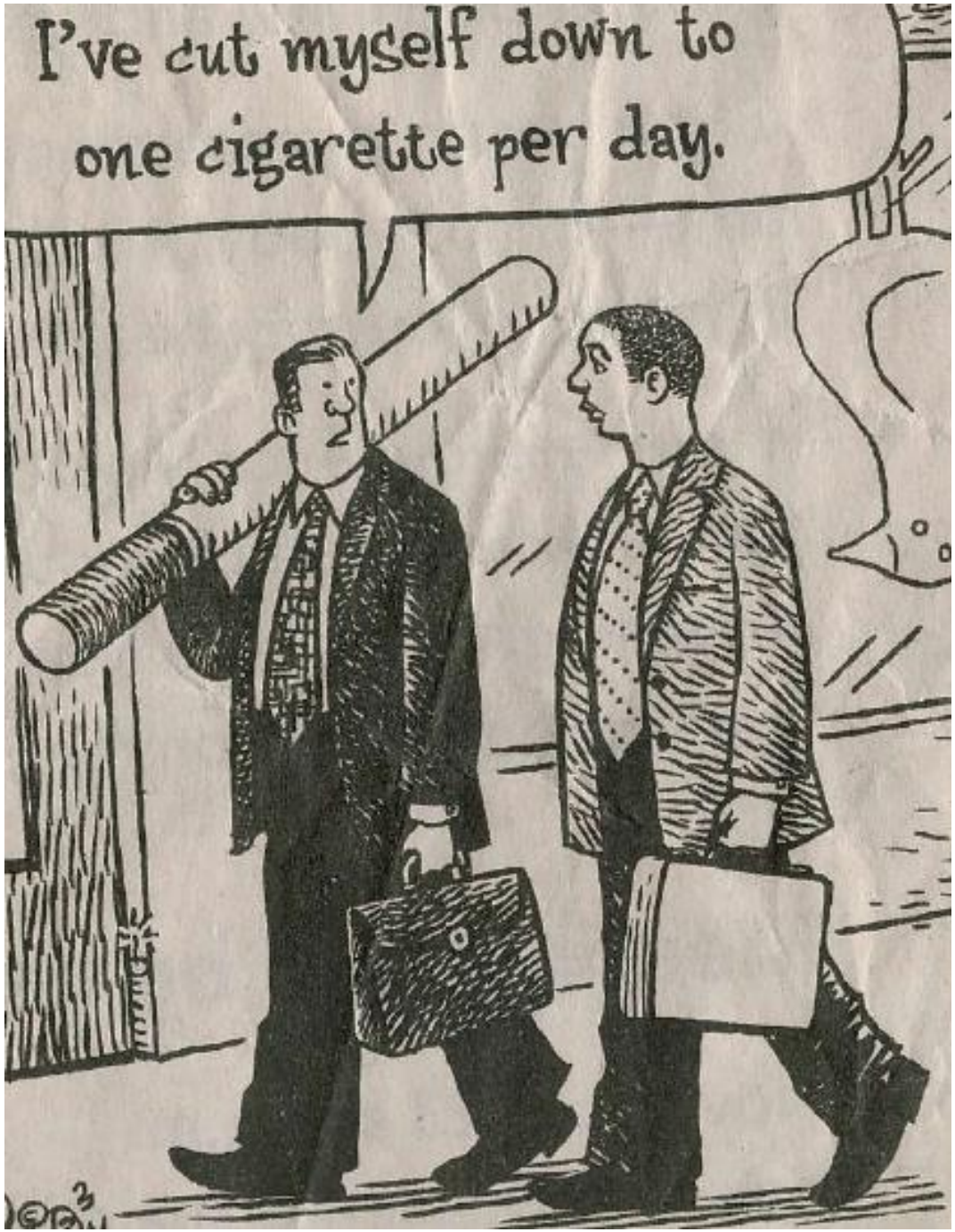








Helping Change Unhealthy Habits



Sleep Hygiene

1. Maintain a regular bed and wake time schedule including weekends
2. Establish a regular, relaxing bedtime routine
3. Create sleep conducive environment
4. Use bedroom only for sleep and partner time
5. Finish eating at least 2-3 hours before bed
6. Workout regularly
7. Complete workout few hours before bed
8. Avoid nicotine, caffeine, alcohol

Sleep Tips from the National Sleep Foundation

Red Flag #7:
Uncertainty

- Doubt of what has happened and of future
- Conflicting diagnoses
- Health professional sanctioning disability
- Health professional producing dependency on passive treatment
- Exposure to language may lead to fear or catastrophizing
- Ex – doctor said my disc is “bulging” or my back is “broken”

Tackling Musculoskeletal Problems: A Guide for Clinic and Workplace, 2009

Three Key Shifts in Perspective to Effectively Self-Manage Chronic Pain

1. Accept the diagnosis of chronic pain

2. Understand the mind/body connection with regard to pain symptoms

3. Change to an active orientation regarding self-management

Red Flag #8:

Extreme Symptom Report

- Person rates pain 12/10
- Expression of distress
- Person may not feel their problem taken seriously by medical system or family
- May develop maladaptive behaviors

Tackling Musculoskeletal Problems: A Guide for Clinic and Workplace, 2009

Red Flag #9:

Passive Coping Strategies

- Reliance on external sources of control over the pain (resting, hoping the pain will go away catastrophizing)
- Overprotective family
- Active coping strategies (exercise, productive activity, diverting attention, ignoring sensations, reinterpreting pain sensations, coping self-statements, and increased behavioral activities)

Tackling Musculoskeletal Problems: A Guide for Clinic and Workplace, 2009

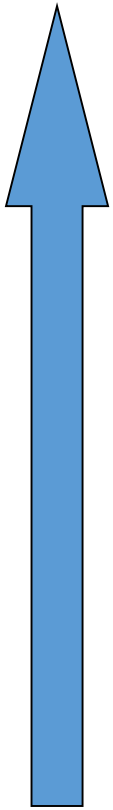
The most potent medications reduce pain in fewer than 50% of patients and only by approximately 35%!

Turk, DC. Pain Management in:
The Need for CPR in American Pain Society Bulletin, Fall 2005.

Self-Management Tools

Hierarchy of Pain Treatment Developed by WHO (2006)

finish



- Nerve ablation
- Implanted pumps
- Spinal stimulation
- Surgery
- **Behavioral treatments**
- Nerve blocks and other injections
- Narcotics and other oral analgesics
- Muscle relaxants
- Physical and occupational therapy, Chiropractic, Acupuncture
- Non-steroidal anti-inflammatories
- Over-the-counter medications

start

ABC's of Pain Relief and Treatment: Advances, Breakthroughs, and Choices. Dr. Tim Sams (2006)

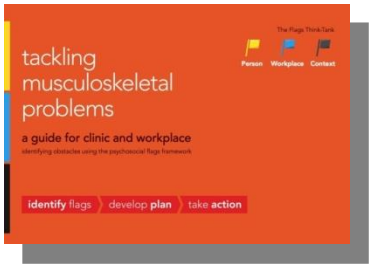
Red Flag #10:
Serial Ineffective Therapy

- Sequence of tx that yield little or no actual benefit to the person
- May occur because the person seeks them, or because the healthcare providers is over-enthusiastic in providing interventions, expectation pain resolve
- Result in failure to return to activity and work

What Would You do to Help Manu?

"I got a back problem that made my work a bit difficult. The doc signed me off work, saying work probably caused the injury. The people at work didn't call, so I couldn't discuss getting back to work. The company has this rule that you have to be fully fit to go back. The pain kept coming and going so I was stuck. I got really worried and depressed. I don't get out much now and I've lost the job. To start with it wasn't too bad – all I needed was some help with the job for a while and I could have stayed at work."

Action for Employers



- Contact the absent person within a day or 2
- Tell them the workplace will be supportive
- Point out the RTW buddy
- Ask the person to come in to work to sort out the return plan
- Ask doctor what worker can do (with release)
- Assess the job and offer modified work if necessary for a fixed period
- Allow graduated RTW
- Monitor progress: review the plan if setbacks

Early RTW can be helped by simple modifications

- **Temporary** steps to gradually ease them into usual work

- Alter work to reduce physical demands: provide seating, reduce weights, reduce pace of work/frequency, get help from co-workers, vary tasks

- Alter work organization: reduce hours/days, flexible start/finish times, more rest breaks graded RTW, work at home

- Flexibility: daily planning sessions with buddy, allow time to attend healthcare appts, help with transport

Useful questions to ask the injured worker to assess for red flags

- What do you think has caused the problem?
- What do you expect is going to happen?
- How are you coping with things?
- Is it getting you down?
- When do you think you'll get back to work?
- What can be done at work to help?

People don’t hurt if they have something better to do.

W. Fordyce, Ph.D.

Summary

Time Since Injury	Programs for Washington Injured Workers
0-14 Days	Stay at Work Program & Early Return to Work Program
2 weeks	P-GAP Program/Activity Coaching
1-3 Months	Work Hardening Work Conditioning
3-6 Months	Structured Intensive Multidisciplinary Program (SIMP)

State of Washington's official site for online employment services.
Find a job, get job search help, locate workforce services in your area,
access career information and more.

https://fortress.wa.gov/esd/worksource/

www.go2worksource.com

Questions

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