Welcome to Work Disability Prevention Rounds

with host Dr. Jennifer Christian

Today's Topic

Patient Management III: Psychiatric Overlay

Call-in number: 218-862-7200 Conf code: 513651

August 10, 2011

Today's Guests

- **Benjamin Bushman, PhD**
  Psychology, Tucson, AZ
- **Robert Orford, MD, MS, MPH, FACOEM**
  Internal Medicine / Occupational Medicine,
  Mayo Clinic, Scottsdale, AZ
- **Jennie Ellen, MD**
  PM&R / Occupational Medicine,
  Concentra Health Systems, Tucson, AZ

Virtual Technology

- Email sent yesterday has:
  - phone number for audio portion
  - web address (url) for visual portion.
- Visual portion is optional.
- For help with audio or visual connection, call 508-397-1204 or 508-358-1681.
- Press 4* on your phone to mute / un-mute your line.

Design of Session

- Talk Show Format
- Introductions / Instructions / Orientation
- Review Foundational Concepts
- Discuss Vignettes and Related Topics
  - *Frank's headaches, fatigue, and insomnia*
  - *Patty's knee pain and job problems*
  - *Kate's neck and back pain*
- Conclude formal session
- 1:00 – 1:30 Open microphone / Q&A session
  - Your Examples, Comments, Cases, or Questions

Educational Objectives

As a result of participating in this series you will:

- Feel more prepared to respond appropriately to difficult issues that frequently arise in the SAW-RTW.
- Be able to identify and tease apart the medical and non-medical issues at play in a difficult SAW-RTW situation and handle them separately.
- Select an approach that will leave the patient feeling heard and satisfied while preventing needless work disability.

Financial Disclosures

The faculty for this session, the program planners, and the University of Arizona Health Sciences Center CME committee made no financial disclosures that could be a conflict of interest.

See project website for more details.

Session Recording, Slides, Evaluations & CME Certificates

1. Go to Webility's project website

   www.webility.md/az-cme

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3 Ways You Can Participate

1. Push 5* on phone to raise your “Hand”
2. Just speak up during Q&A session
3. Write in the “chat” box on WebEx screen

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Arizona Employment & Disability Partnership

Meet Today's Guests

- **Benjamin Bushman, PhD**
  Clinical / Forensic Psychology
  Evaluation & Development Centers, Tucson
- **Jennie Ellen, MD**
  PM&R / Occupational Medicine,
  Concentra Health Systems, Tucson
- **Robert Orford, MD, MS, MPH, FACOEM**
  Internal Medicine / Occupational Medicine,
  Mayo Clinic, Scottsdale

Meet Today's "Patients"

- *Frank, a salesperson who has headaches, fatigue, obesity -- and has missed a lot of time from work.*
- *Patty, a nurse who has knee pain, bipolar disorder -- and job problems.*
- *Kate, a home health aide who has neck and back pain -- and problems at home and at work.*

Frank, the Salesman

- Frank is 52. His wife is your regular patient, and this is his first visit to your office. He has missed a lot of time from work lately and has not met his sales quotas.
- CC: headaches, fatigue, and insomnia x 3 months.
- Meds for hypertension & hyperlipidemia.
- PE is unremarkable except for BP of 145/90, obesity, and avoidance of eye contact.
- He has tried his wife's Ambien and would like some better sleeping pills.

Patty, the Nurse

- Patty is a 37 year old nurse who works nights in a hospital. You've been her doctor for 10 years, mostly for annual gyn exams. She has never married and lives alone.
- She was diagnosed with bi-polar disorder at age 22 but refused further treatment. She recently fell and twisted her right knee at work. E.R. dx: knee sprain
- She was sent home due to inappropriate behavior while doing paperwork on "light duty" due to her knee sprain.
- She was told to see a doctor and get a medical clearance before she can return to work.
- She says her severe knee pain is the problem. She asks for stronger pain pills and more time off to heal.

Kate, the Home Health Aide

- Kate is a 32 y/o home health aide x 10 years. Does not get along with her supervisor. No health insurance benefits.
- 2 mos ago felt sudden sharp LBP while transferring a 400 lb. patient. WC claim initially denied then accepted. E.D. dx: lumbar strain. OOW x 60 d. Tx: Percocet for pain, Valium (and Jameson's Irish whiskey) at h.s.
- Husband accompanies patient. He is on disability. They were separated due to his abuse, but are living together again for financial reasons. Daughter has been doing all the housework
- RTW yesterday. Pain recurred while putting a shoe on client.
- Pain travels from neck to back with sudden spasms. No neurological sx; c/o insomnia and 50# weight gain.
- PE: Crying, pain behavior, benign exam.
- Your initial Tx: Light duty, NSAID, PT tiw x 2 weeks.
- 6 weeks later: No change except flatter affect. Husband says she needs time off to heal. Insurance company has refused your referral to psychology.

Patient Management III: Dealing with Psychiatric Overlay

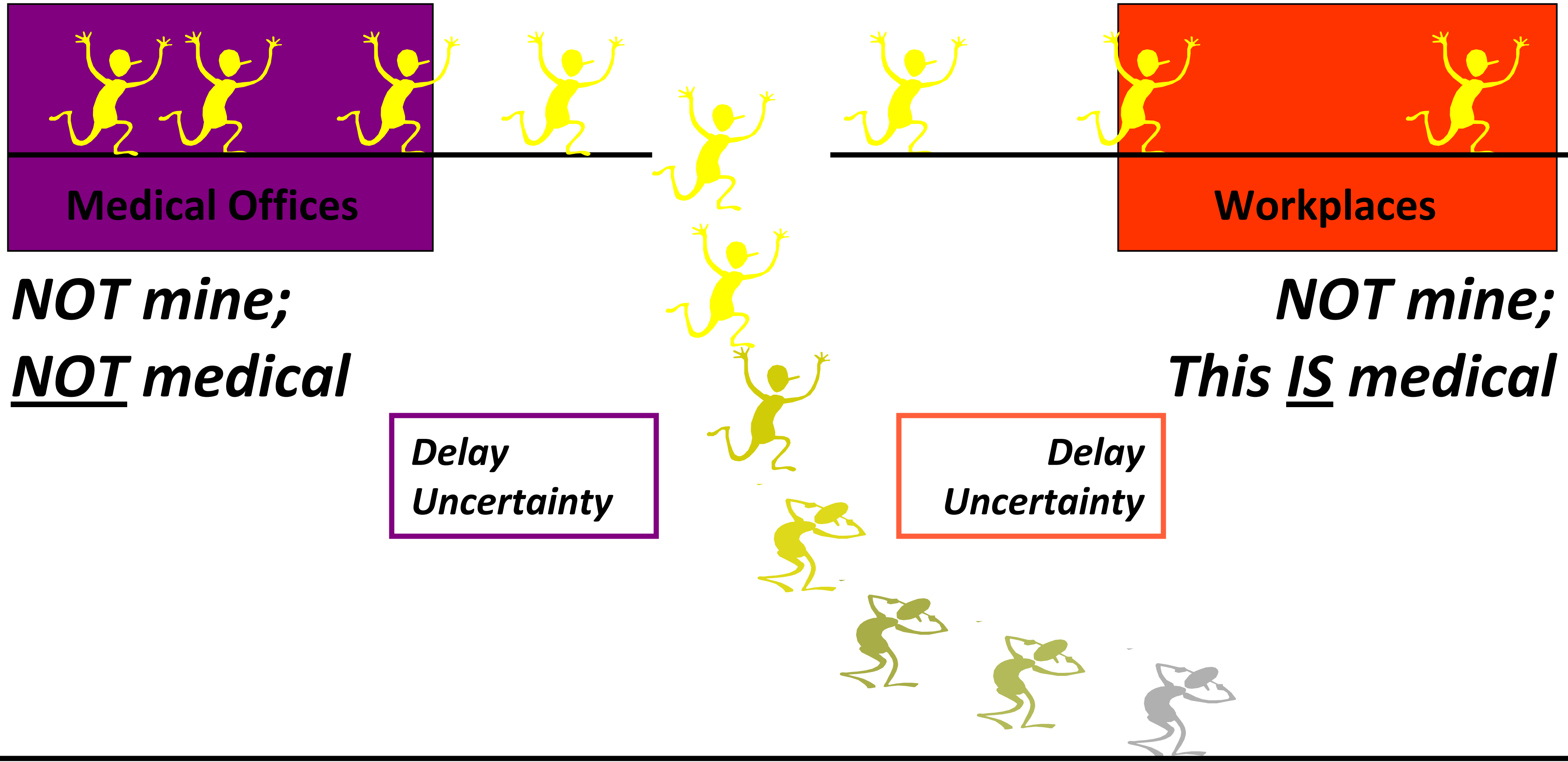
Setting the Context

Foundation for This Rounds Series

"Preventing Needless Work Disability by Helping People Stay Employed"

A report with 16 recommendations
to improve the SAW/RTW process from the
American College of Occupational &
Environmental Medicine (ACOEM) –
www.acoem.org

The Gap: Whose Responsibility IS it?



Result: Needless Work Absence, Job Loss, Withdrawal from Workforce

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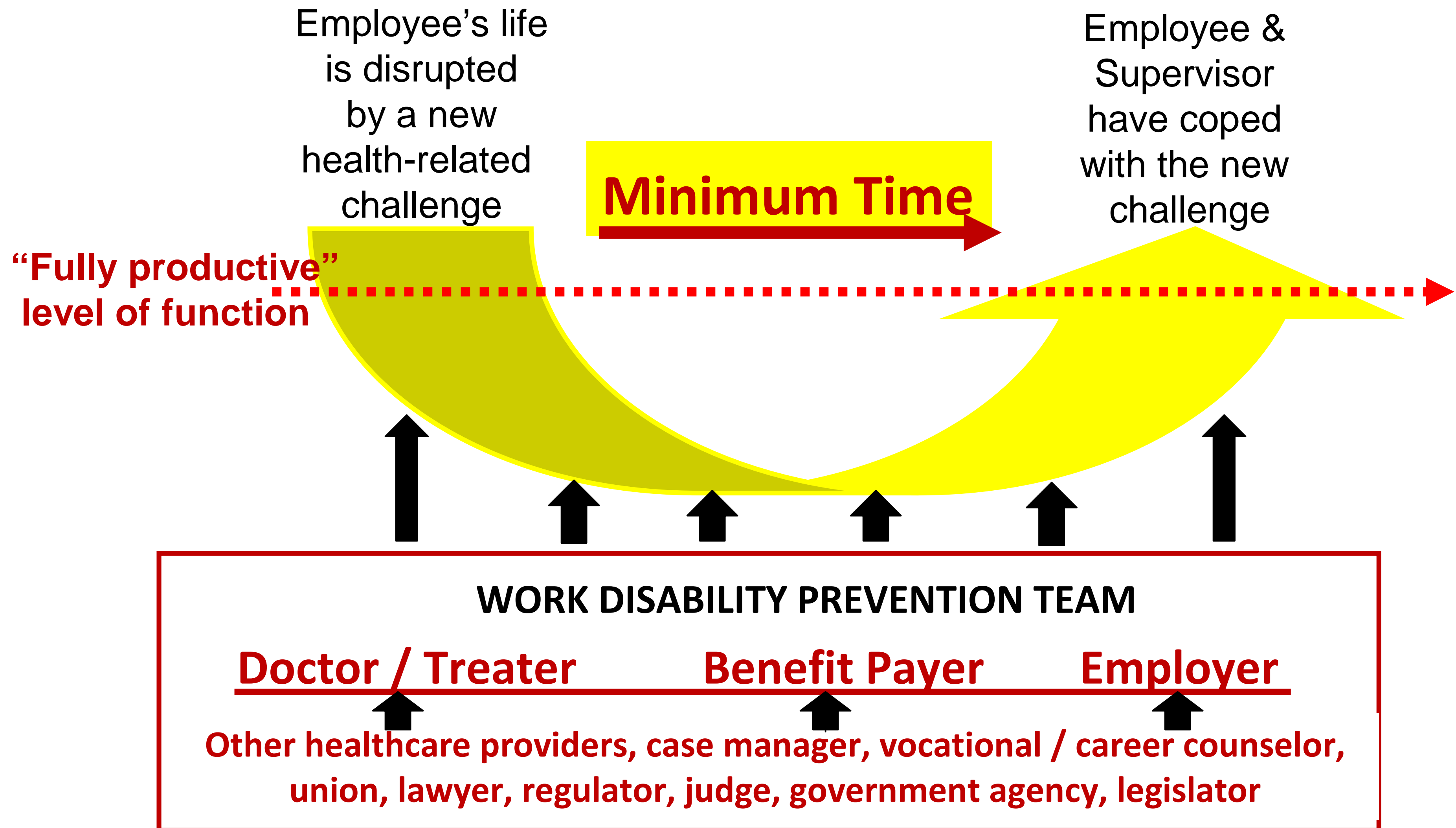
Needless Work Disability

Employee	• **IS HARMFUL**. Disrupts daily life, threatens career and self-esteem, leads to "iatrogenic invalidism".
Employer	• **IS DISRUPTIVE & COSTLY**. Reduces productivity, creates unnecessary hassle and expense.
Economy	• **IS WASTEFUL**. Diverts dollars from productive use, invites petty fraud and corruption, loss of taxpayers, gain of net dependents.

Work Disability Prevention Vision



Success = Both employee & supervisor **feel** supported – and outcomes improve

ACOEM's 4 General and 16 Specific Recommendations

1. Adopt a disability prevention model.
2. Address behavioral and circumstantial realities that create or prolong disability.
3. Acknowledge the powerful contribution that motivation makes to outcomes, and make changes to improve incentive alignment.
4. Invest in system and infrastructure improvements.

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2. Address Behavioral and Circumstantial Realities

- People’s normal human reactions need to be acknowledged and dealt with.
- Investigate and address social and workplace realities.
- Find a way to address psychiatric conditions effectively.

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3. Acknowledge Motivation and Align Incentives

- Pay *[or otherwise reward]* doctors for disability prevention work in order to increase their commitment to it.
- Support appropriate patient advocacy by getting treating doctors out of a loyalties bind.
- Reduce distortion of the medical treatment process by hidden financial agendas.

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Patient Management III: Dealing with Psychiatric Overlay

Detecting, Diagnosing, and Managing Comorbid Mental Illness & Psychosocial Issues that Interfere with Functional Recovery

Today’s Discussion Topics

- Normal human reactions to illness, injury and work disability – vs. mental illness.
- Bio-psycho-social factors that influence impact of health on work
- How to recognize and deal with normal human reactions and psychiatric co-morbidities
- Simple techniques to help patients with depression and anxiety
- Simple techniques to help patients with low resilience and poor coping skills.
- When to refer and to whom
- What to do when "doing the right thing" seems impossible
- Resources

Normal Human Reactions to New Illness, Injury, and Work Disability

Surprise, inconvenience, discomfort, vulnerability, dependency, social isolation, uncertain future

Unfamiliar territory, new role, unclear rules:

“Patient” “Claimant” “Beneficiary” “Disabled”

Patients wonder:

- What’s the matter with me?
- How long am I going to be laid up?
- How long will I have to take it easy?
- How long till I’m back to normal? …if ever.
- What can I do? What shouldn’t I do?
- Am I still me? What does this mean for my future?

Normal Human Reactions to Illness, Injury, and Work Disability

- How people think about their health problems determines how they deal with them and their impact.
- Beliefs influence perceptions & expectations, emotions & coping strategies, motivation, uncertainty.
- Obstacles to functional recovery and RTW are primarily personal, psychological, and social rather than health-related “medical” problems.

Research on Negative BPS Influences on Impact of Health on Work

- Personal / psychological: – Catastrophising (even minor), low self-efficacy, belief that “stress” is a cause.
- Social: – Single parents, unstable relationships, “victim” of society, rented or public housing.
- Occupational: --Job dissatisfaction, work seen as cause, weak attendance incentives
- Cognitive: – Health illiteracy; vigilant self-monitoring, false beliefs
- Economic: – Availability of other sources of income

Research on Positive BPS Influences re: Impact of Health on Work

- Respect for employer
- Job satisfaction
- Moral obligation
- Positive attendance incentives (esp. co-workers)
- Strong health literacy
- Well-managed chronic health condition
- Behaviors, beliefs, and confidence can be shifted using CBT (talking therapies)

Beware Over-Medicalization

1. Normal human reactions to life upset (e.g. grief, confusion, anger) are not mental illnesses. Avoid creating a medical condition where there is none.
2. Distinguish between medical and non-medical issues, and tell the patient / parents / school / employer that the non-medical issues need to be addressed.
3. Strengthen existing coping resources – sleep, nutrition, exercise. Avoid drugs and alcohol. Avoid isolation; rally social network.

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Detecting Issues and Concerns

- Look below the surface for subtle cues.
  - Choice of words
  - Body language
  - Interactions with others
- Express concern.
- Normalize the issues.
- Be alert and curious. Ask.

Screening Tools
Can Enrich Your Gut Feeling

- First line tools – small # of questions
  - PHQ-9 – 9 questions; best for depression
  - GAD-7 – 8 questions for anxiety
  - CAGE – 4 questions for alcohol
- Second line tools – 18-20 questions
  - Beck Depression Inventory - mild vs. mod vs. bad
  - Beck Anxiety Inventory
  - CES-D (depression)

Simple Techniques Can Help Patients with Depression and Anxiety

- Recognize the possibility that it's there; be alert to its common companions, including pain and obesity.
- Look for subtle cues, especially sleep disturbance.
- Distinguish "normal" difficulty coping and situational depression vs. diagnosable mental illness vs. severe symptoms vs. "red herrings"

You Are Part of the Therapy

- In order to create openness to your input, be respectful, listen carefully.
- Avoid coming across as judgmental; don’t pigeonhole by overemphasizing diagnosis vs. addressing their personal situation/distress.
- If you are comfortable with the mind-body connection and describe it as human / normal, they will find it more acceptable, too.

Treating Depression & Anxiety

- Two scenarios: Self-aware vs. non-self-aware patient.
- Acknowledge [name] the issue.
- Educate the patient, e.g., print out info from www.mayoclinic.com or www.medlineplus.gov)
- Normalize their experience / feelings. Vicious cycle: pain, sleep, emotions.
- Best therapy usually combines medication & talking / counseling.
- Daily practices – personal health, self care.
- Self-help resources

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- She was told to see a doctor and get a medical clearance before she can return to work.
- She says her severe knee pain is the problem. She asks for stronger pain pills and more time off to heal.

Time to refer? If so, to whom?

- When they aren't getting better with your regimen.
  - Consider possibility of inadequate dose or drug
  - Consider need to re-evaluate diagnosis
    - Physical vs. Mental
    - Criteria for Establishment of Diagnosis
    - Axis I vs. Axis 2
  - Consider need for more expertise
- When red flags are present

Medical Thought Process Is Separate from Communication & Billing

- Discipline: Differential diagnosis
- Working or presumptive diagnosis
- Rule outs & confirmatory testing
- Therapeutic trial
- Document your thought process
- Decide how to communicate what to whom
  - Awareness, acceptance & stigma
  - Eligibility, access, & payment

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- 2 mos ago felt sudden sharp LBP while transferring a 400 lb. patient. Employer did not file injury report; WC claim initially denied then accepted. E.D. dx: lumbar strain. OOW x 60 d. Tx: percocet for pain, valium (and Jameson's Irish whiskey) at h.s.
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- PE: Crying, pain behavior, benign exam.
- Your initial RX: Light duty, NSAID, PT tiw x 2 weeks.
- 6 weeks later: No change except flatter affect. Husband says she needs time off to heal. You recommend psychological referral. Insurance companies denies it.

Obtaining Mental Health Input

- Choice depends on expertise needed – and its availability/accessibility.
- If necessary and available.
  - EAP (Employee assistance program–company benefit)
  - Consult informally with a colleague
  - Refer to behavioral medicine (hospital rehab, private practice)
  - Refer for objective testing to psychology
  - Refer for therapy to psychology and/or psychiatry
  - Refer to a good multidisciplinary chronic pain program

Training Yourself

- Consider pursuing CME in mental health.
- AZ Psychiatric Society conferences
  - www.azpsych.org
- AZ Psychological Association conferences
- Semel Institute at UCLA weekly grand rounds via Internet

How to Get Yourself (or Others) Paid

- E&M code for patient “counseling”, up to 45 minutes, with adequate documentation.
- Health & Behavior Codes for behavioral medicine services related to physical conditions.
  - (Only psychologists can bill Medicare, but private payers may accept them)
- How to get approvals / pre-authorize referrals to mental health professionals.
  - Health & Behavior codes do not require a mental health diagnosis.
  - If applicable, use a benign-sounding dx like Adjustment Disorder

Self-help resources for patients with low resilience & poor coping skills

- Self-Help Resources:
  - Mayo Clinic (website) www.mayoclinic.com
  - David Burns (book) *Feeling Good*
  - Aaron Beck (book) *Love is Never Enough*
  - Frederick Luskin (book) *Forgive for Good*
  - Lucinda Bassett, Midwest Center for Stress & Anxiety (website) www.stresscenter.com
  - Martin Seligman (website) Authentic Happiness www.authentichappiness.com
  - American Chronic Pain Association (website) www.theacpa.org; (book) *From Patient to Person*
  - Ellen Bass & Laura Davis (book & facilitator manual) *The Courage to Heal*

Thank You, Guests & Sponsors

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Arizona Health & Disability Partnership (AHCCCS)

Arizona Work Disability Prevention Assn. (AWDPA)

University of Arizona Health Sciences Center

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September 13 Guests

- **Marc Leib, MD, JD**
  Medical Director, AHCCCS
- **Peter Swann, MD**
  Occupational Medicine, San Francisco, CA
- **Jennifer Hallden**
  Pre-injury consultant, Chartis Insurance

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Open Mike Discussion Time: Your Comments & Cases

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