Principles of Management – a biopsychosocial approach

AKA: Matched care

Presented by

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Key Messages

- Psychosocial factors are major predictors of poor outcomes for injured workers,

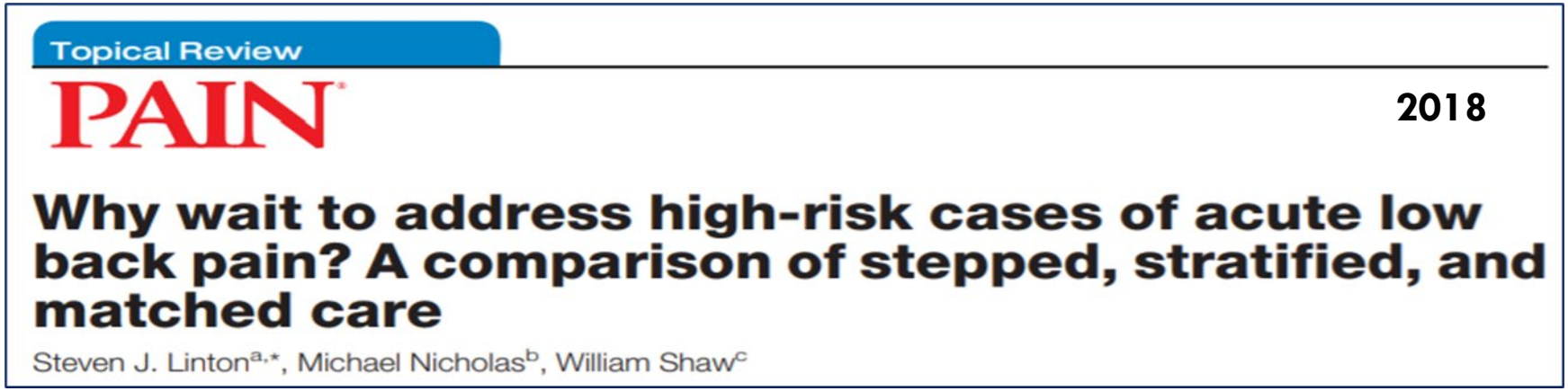
  but mainly if ignored

- They are identifiable within days of an injury
- Many are modifiable if targeted in treatment
- Targeting these (modifiable) risk factors ASAP yields better outcomes than usual care and ‘wait and see’
- But there are obstacles to overcome in implementation

Bottom line:

- If we want outcomes to change, we must do things differently

Why wait and see?



What should we do when high risk case is identified?

Standard approach to injured people

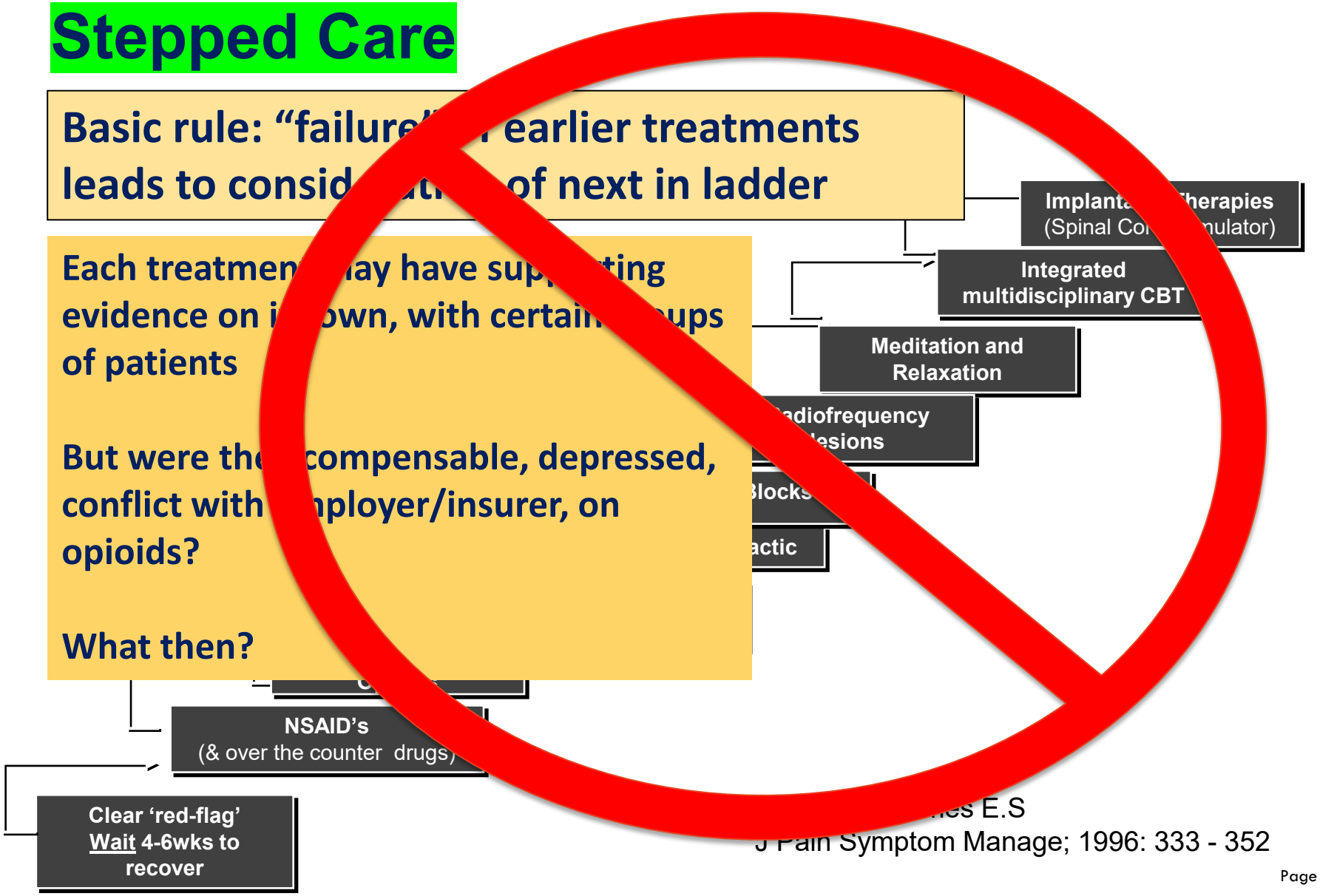
Stepped Care

Basic rule: "failure" of earlier treatments leads to consideration of next in ladder

Each treatment may have supporting evidence on its own, with certain groups of patients

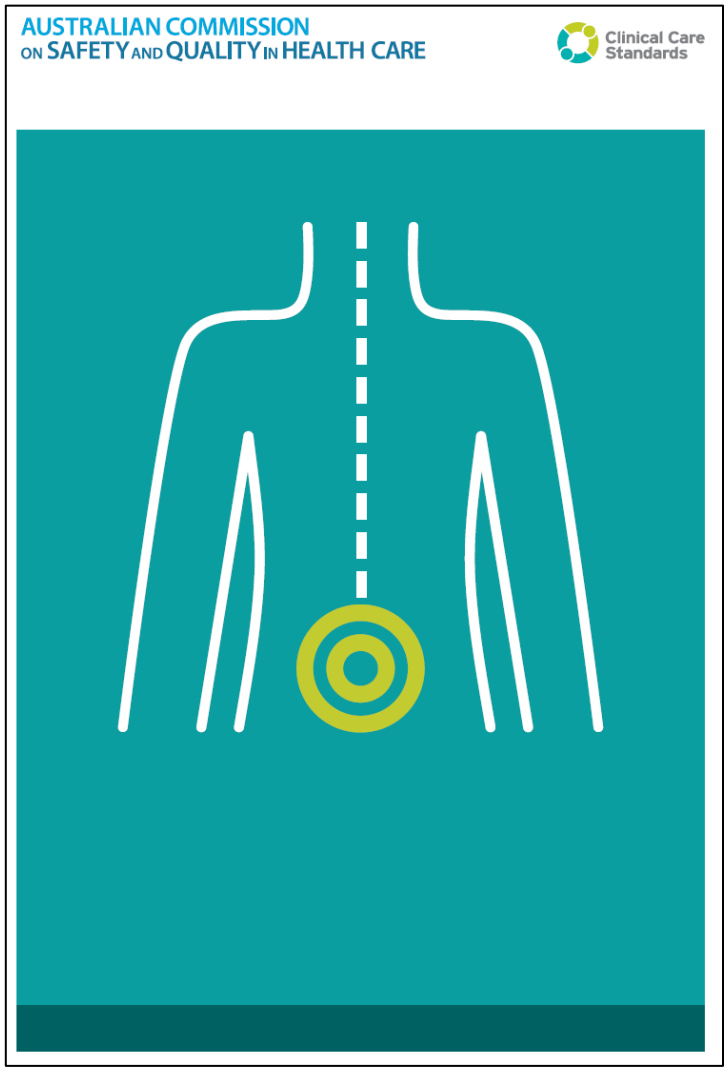
But were the compensable, depressed, conflict with employer/insurer, on opioids?

What then?



…les E.S
J Pain Symptom Manage; 1996: 333 - 352

Happily, a new model of care has arrived in town



aci.health.nsw.gov.au

Model of care for the management of low back pain

Summary

DECEMBER 2022

The *Model of care for the management of low back pain – Summary* is a guide for primary care practitioners caring for people with low back pain.

This summary model of care is a primary care-based model. While multiple practitioners could be involved in the care of patients with low back pain, the primary care team members are considered to include:

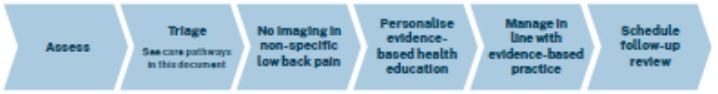
- the patient and their family[1]
- the treating general practitioner and practice nurse
- treating allied health practitioners.

The summary model provides different care pathways for people with low back pain based on a triage approach. A physical examination and medical history is to be conducted when a person presents to primary care with low back pain.

The result of this assessment determines which care pathway is suitable for each patient.

- Pathway A – non-specific low back pain
- Pathway B – acute low back pain with progressive neurological loss
- Pathway C – acute low back pain with leg pain, or
- Referral to multidisciplinary pain management program

The model of care is underpinned by basic standards of care in six areas: assessment, triage, no imaging in non-specific low back pain, personalised evidence-based health education, management in line with evidence-based practice, scheduled follow-up review.



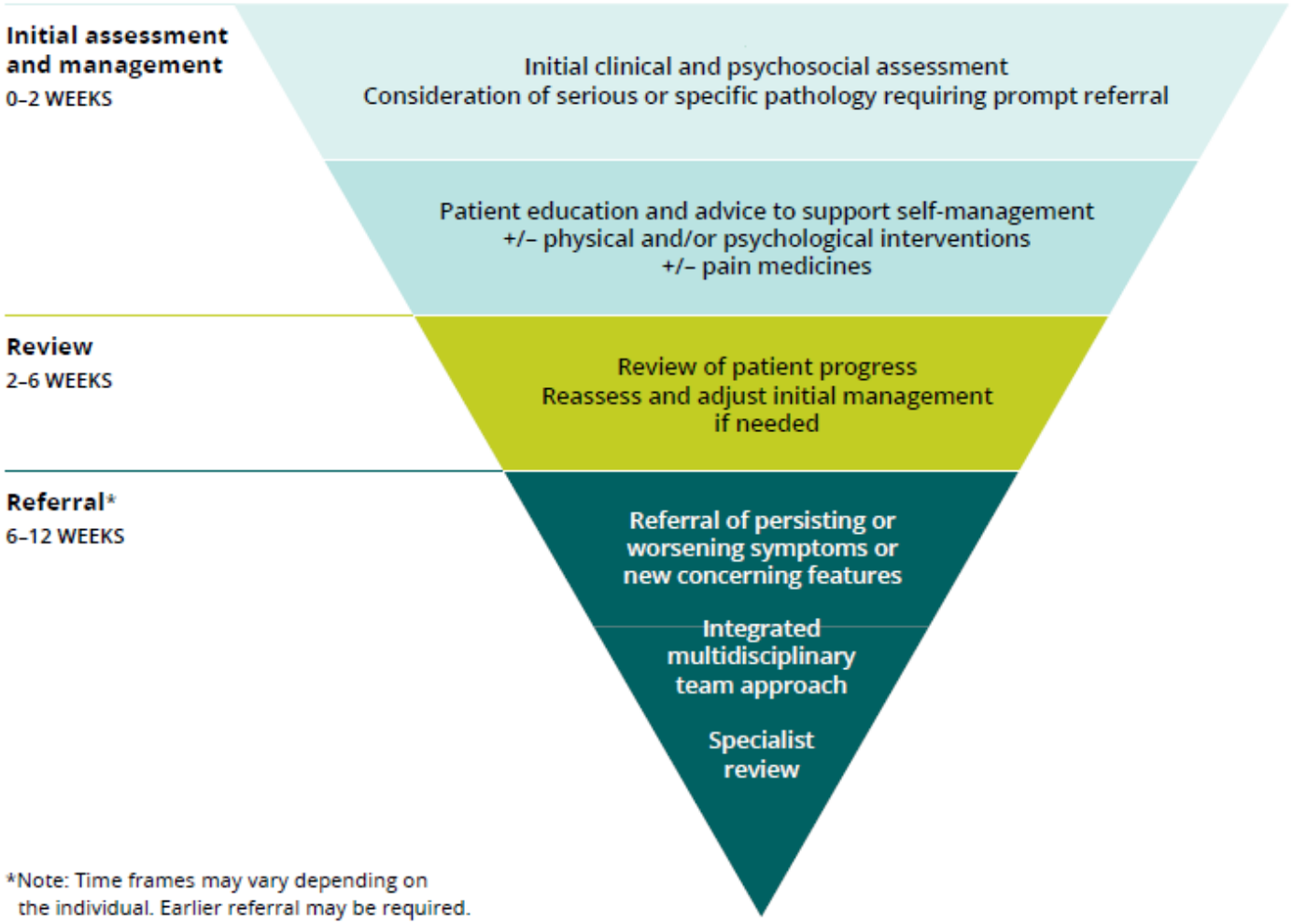
NSW GOVERNMENT | AGENCY FOR CLINICAL INNOVATION

NSW GOVERNMENT State Insurance Regulatory Authority

Health Professions seem to be onboard

General summary

Figure 1: General overview of care – *Low Back Pain Clinical Care Standard*



*Note: Time frames may vary depending on the individual. Earlier referral may be required.

General agreement on how to respond to new injury

Model of care for the management of low back pain – Summary December 2022

Key principles

Principle 1: Assessment – history and examination [4,5]

But unlikely to be enough unless there is a plan for integration of assessment findings into a treatment plan, supported by case managers and other stakeholders

questionnaires, stratify patients into low, medium or high risk groups, determining the amount and type of treatment that they require.

If high risk case identified by the Orebro Scale:

Örebro Musculoskeletal Pain Screening Questionnaire (Short-form)(Linton et al, 2010)

Name: _____ **Date:** _____

1. How long have you had your current pain problem? Tick (√) one.

☐ 0-1 weeks [1] ☐ 1-2 weeks [2] ☐ 3-4 weeks [3] ☐ 4-5 weeks [4] ☐ 6-8 weeks [5]
☐ 9-11 weeks [6] ☐ 3-6 months [7] ☐ 6-9 months [8] ☐ 9-12 months [9] ☐ over 1 year [10]

2. How would you rate the pain that you have had during the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10 [ ]
No pain *Pain as bad as it could be*

For items 3 and 4, please circle the one number that best describes your current ability to participate in each of these activities.

3. I can do light work (or home duties) for an hour.

0 1 2 3 4 5 6 7 8 9 10 (10-)[ ]
Not at all *Without any difficulty*

4. I can sleep at night.

0 1 2 3 4 5 6 7 8 9 10 (10-)[ ]
Not at all *Without any difficulty*

5. How tense or anxious have you felt in the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10 [ ]
Absolutely calm and relaxed *As tense and anxious as I've ever felt*

6. How much have you been bothered by feeling depressed in the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10 [ ]
Not at all *Extremely*

7. In your view, how large is the risk that your current pain may become persistent?

0 1 2 3 4 5 6 7 8 9 10 [ ]
No risk *Very large risk*

8. In your estimation, what are the chances you will be working your normal duties (at home or work) in 3 months

0 1 2 3 4 5 6 7 8 9 10 (10-)[ ]
No chance *Very Large Chance*

9. An increase in pain is an indication that I should stop what I'm doing until the pain decreases.

0 1 2 3 4 5 6 7 8 9 10 [ ]
Completely disagree *Completely agree*

10. I should not do my normal work (at work or home duties) with my present pain.

0 1 2 3 4 5 6 7 8 9 10 [ ]
Completely disagree *Completely agree*

SUM:_____

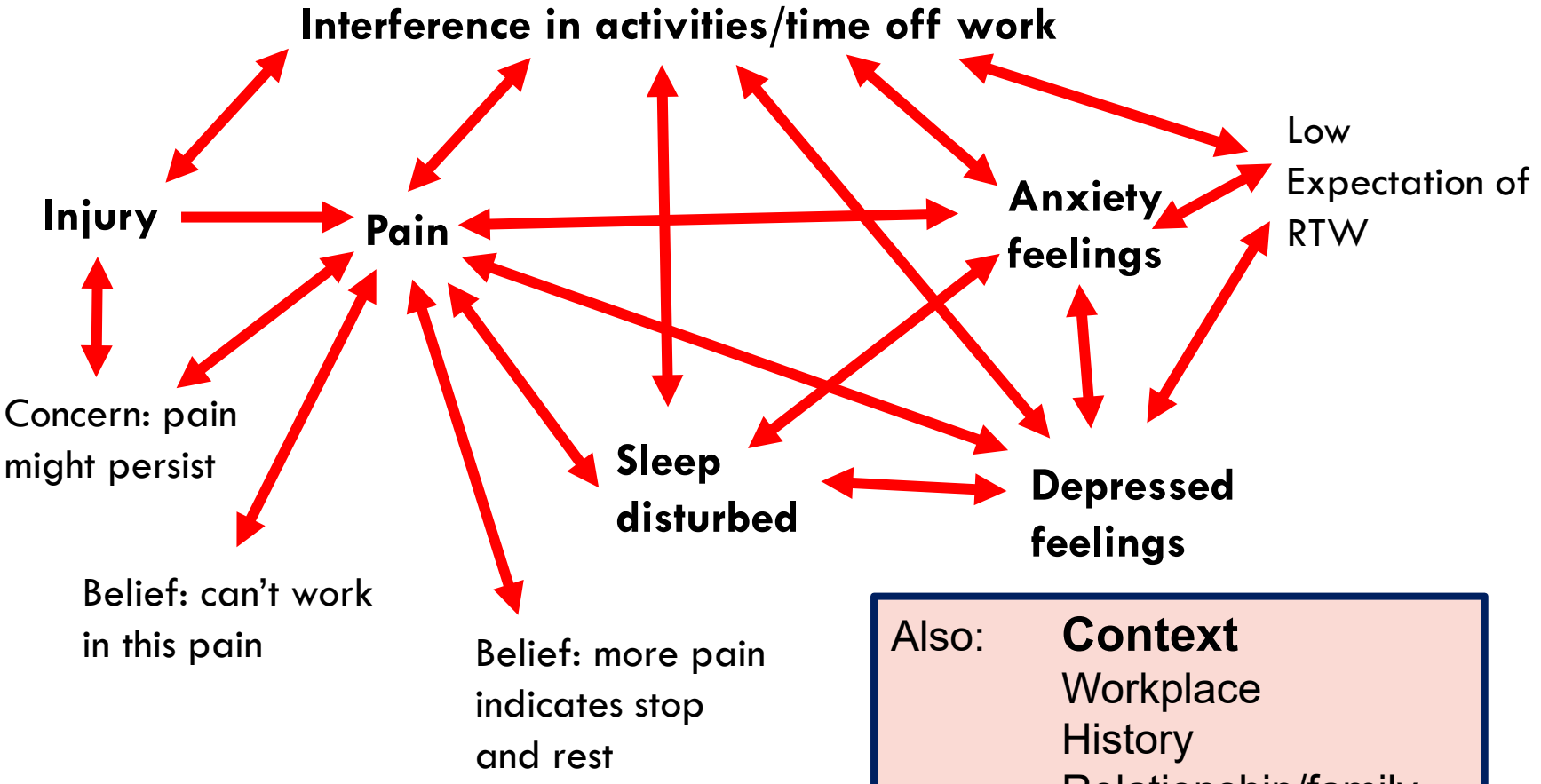
2
8
8
7
8
7
4
8
9
10
71

Total score:
71 (>49/100)

Next step?

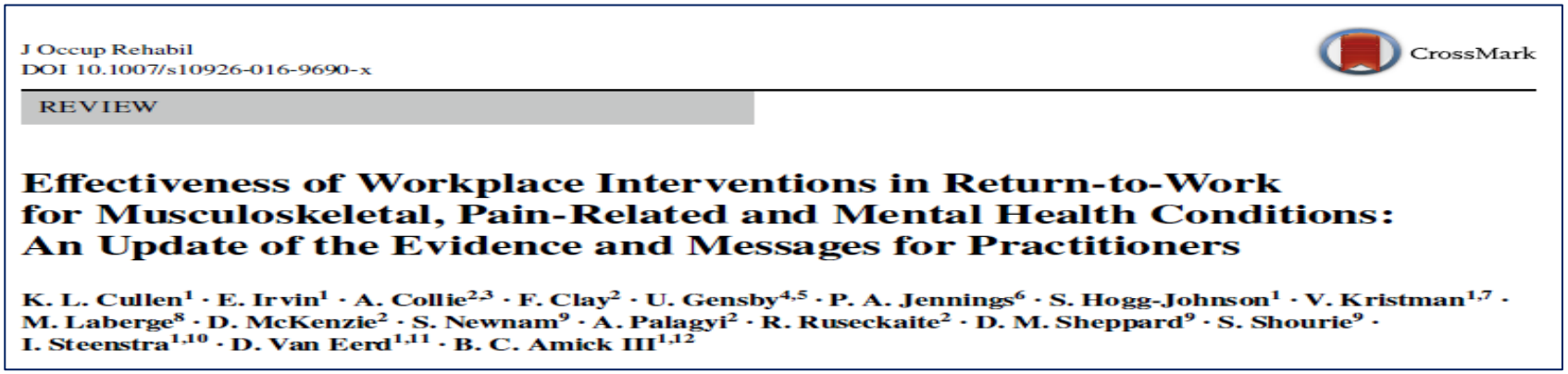
Interview worker to understand their responses

Case formulation: after OMPSQ-SF + interview



Also: **Context**
Workplace
History
Relationship/family
Compensation status

Intervention negotiated with the worker, employer, case manager, other health care providers



J Occup Rehabil
DOI 10.1007/s10926-016-9690-x

CrossMark

REVIEW

Effectiveness of Workplace Interventions in Return-to-Work for Musculoskeletal, Pain-Related and Mental Health Conditions: An Update of the Evidence and Messages for Practitioners

K. L. Cullen[1] · E. Irvin[1] · A. Collie[2,3] · F. Clay[2] · U. Gensby[4,5] · P. A. Jennings[6] · S. Hogg-Johnson[1] · V. Kristman[1,7] · M. Laberge[8] · D. McKenzie[2] · S. Newnam[9] · A. Palagyi[2] · R. Ruseckaite[2] · D. M. Sheppard[9] · S. Shourie[9] · I. Steenstra[1,10] · D. Van Eerd[1,11] · B. C. Amick III[1,12]

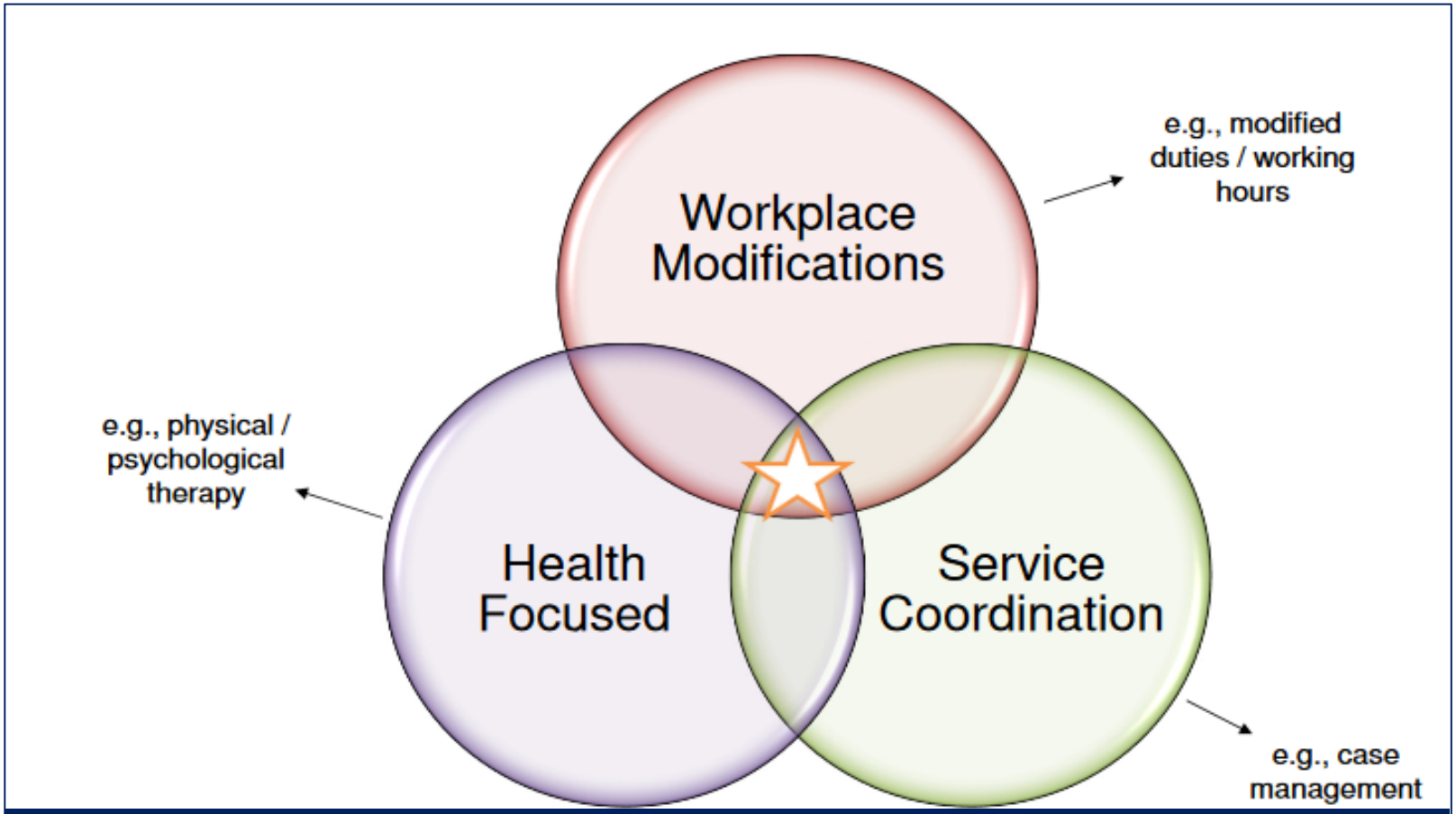
Strong level of evidence for **multi-domain interventions** (service coordination, work modification and improving worker health) for reducing lost time from injuries.

Recommendation:

Implementing a multi-domain intervention to help reduce lost time for MSK and pain-related conditions.

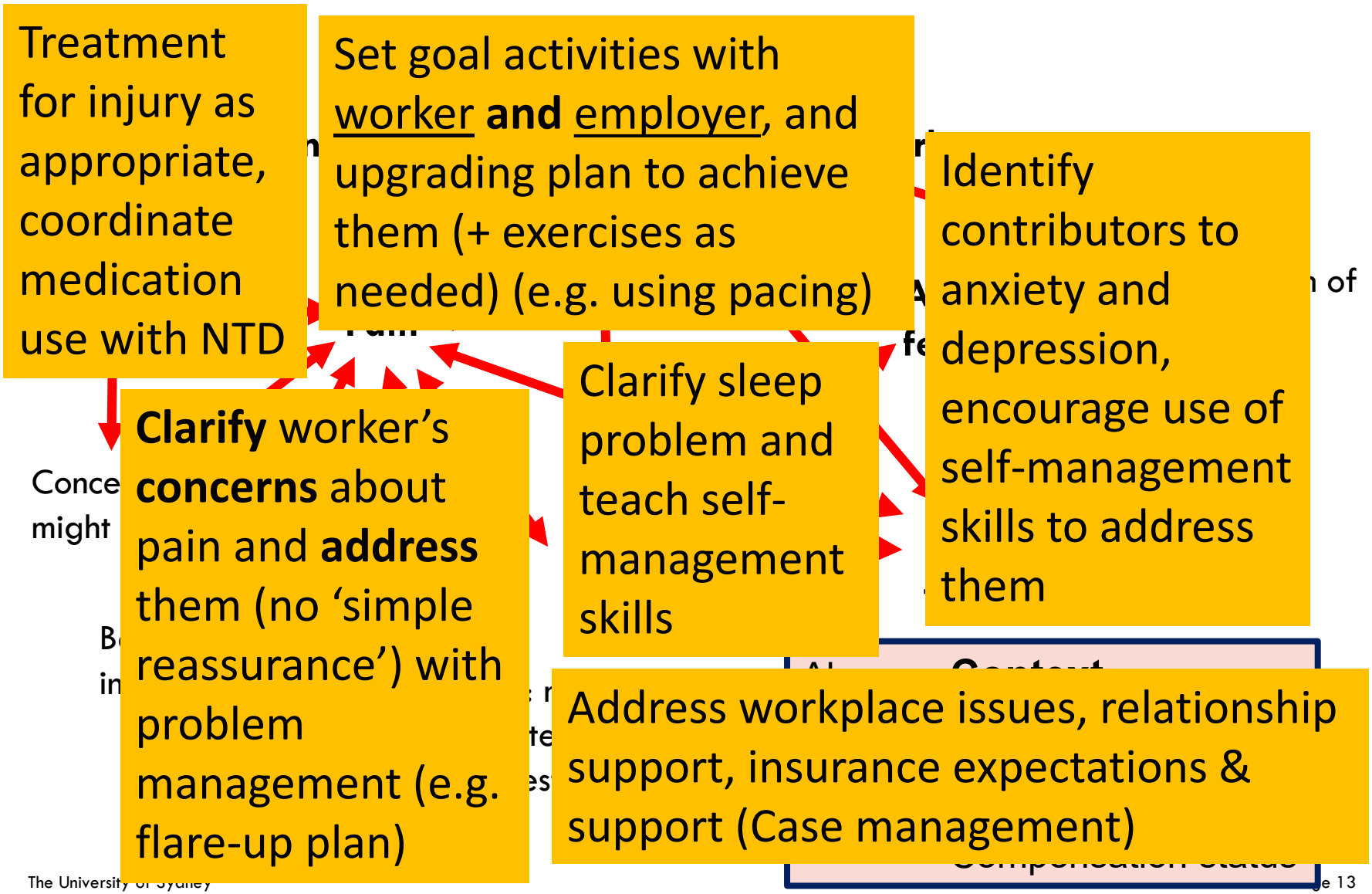
What might that look like?

Using framework from Cullen, Irvin, Collie, et al. JOOR 2017.



Key Point: intervention is not about a treatment done in isolation

Case formulation to match treatment to case: <u>after</u> OMPSQ-SF + interview



Sounds good, but can it be done in the real world?

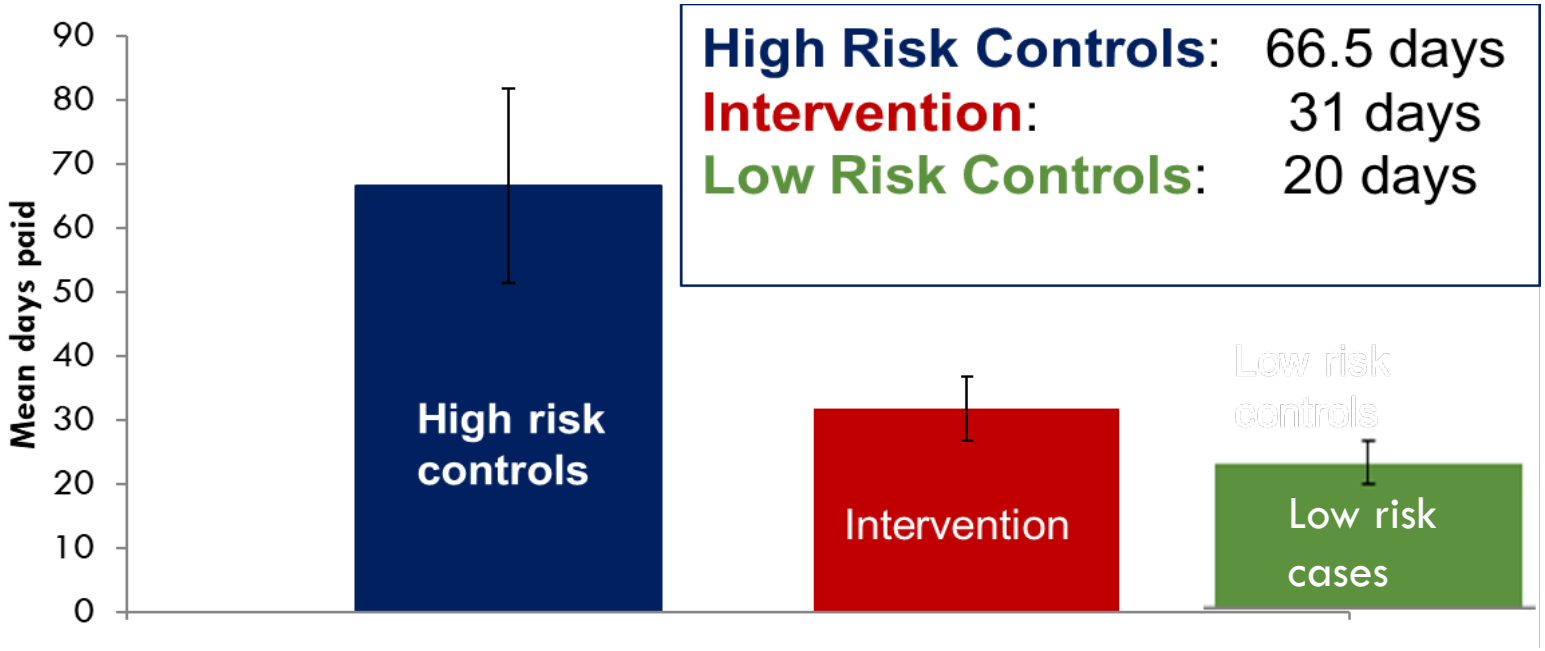
Example of Early Matched Care: WISE Study (Nicholas et al., J of Occ Rehab 2020)

WISE Study – awarded 'Best Paper in 2020' by Editorial Board of JOOR

icare Award for Excellence, 2016.
Winner: Frameworks & Systems
M, Gleeson, M. Nicholas, G. Pearce

WISE: Ave. Days to Pre-Injury Duties (PID) (2 yr f/u)

Using injured health workers with soft tissue injuries, all had medically-approved 5 days off work initially



>90 Days to PID (for high risk cases)

- **Intervention: 3/54 (5.5%)**
- **Control: 11/57 (19.3%) - 'Tail' still wagging**

NEW STUDY

Early Matched Care at Australia Post (EMCAP) Study

Replication of WISE protocol

- 1 yr follow-up, but so far, results very similar to WISE
- Industry awards already

2022 AUSTRALIAN HR AWARDS
EXCELLENCE AWARDEE

Winner
Recovery at and Return to Work Award
2021 Comcare National Work Health and Safety Awards

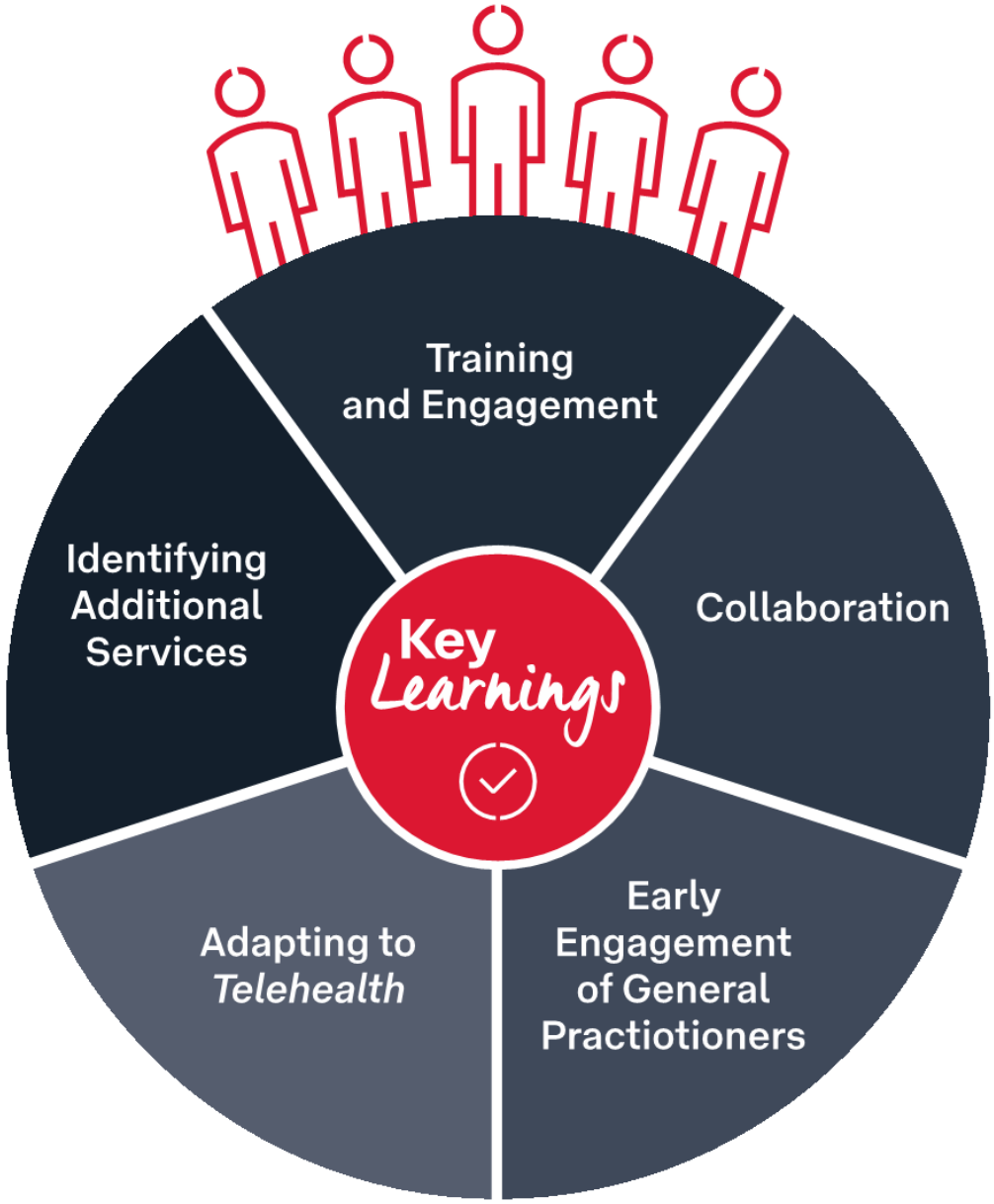
WE ARE WINNERS IN THE
28TH ANNUAL NATIONAL SAFETY AWARDS OF EXCELLENCE
ANSCA GIO

Australia Post

Obstacles to better outcomes despite proven protocol

- Implementation drift – needs **oversight** and **commitment** (vertically, and across the business)
- Short-cuts (to 'save time')
- New staff (onboarding issues)
- Lack of training of stakeholders in protocol
- Institutional "hardening of arteries", lack of willingness to change

- Look at what Mel Iannsen and the Aust Post Group learnt



Australia Post

Summary

- **Psychological and social** risk factors present from **Day 1** (if not before)
- Can be **identified** by screening within days of the injury
- Targeting **identified** risk factors ASAP = better outcomes
- **Usual care (stepped care)** risks delays in treating **high-risk cases**
- **Bio-psycho-social approach from start is critical**
- **All key stakeholders** need to contribute = treatment providers + the employer + scheme agent + worker
- Success requires these contributions to be **coordinated**
- "If we want outcomes to change, we must do things differently"

To describe it graphically

But, if one player doesn't do their bit ….???