Workers' Comp

Boosting Comp Outcomes Through Case Management-Physical Therapy Collaboration

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15 MIN READ

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Tom Kerr (TK): Recently, WCRI issued a report "Psychosocial Factors and Functional Outcomes Following Physical Therapy" which explored how certain mental health factors are strong predictors of adverse outcomes in workers' comp, especially for injured employees recovering from physical injuries such as knee and shoulder pain. It also underscored how psychosocial screenings can make a big difference in improving outcomes.

To discuss this study and topic from physical therapy (PT) and case management viewpoints, Enlyte's Kim Radcliffe and Tammy Bradly join us.

Kim, let's start with the first question here. Standardization in PT evaluations. What led to the initiative to standardize and capture psychosocial screening outcomes and PT evaluations, and what tools or frameworks are being used currently?

Kim Radcliffe: So, the standardization of psychosocial screening and physical therapy evaluations really emerged from several key developments. Obviously, first and foremost is the recognition of the biopsychosocial model.

Physical therapy, at its core, you think about muscles and joints and a purely biomechanical approach. However, we really started to understand that the psychological and social factors can significantly influence patient outcomes.

And then, of course, research evidence started demonstrating that the psychosocial factors are often better predictors of outcomes than pure physical findings alone, particularly for conditions like chronic pain or chronic conditions when it's gone on for a long time.

And then our practice guidelines started to evolve. Organizations like APTA (the American Physical Therapy Association) began incorporating psychosocial assessments into clinical practice guidelines. And we really started to emphasize measurable outcomes and evidence?based practice that really need standardized assessment tools.

So, first we recognized the need to capture it, and then we needed to develop the tools for it. So, there are a lot of tools out there. It's both a challenge and an opportunity, but one of the most recent ones is called SPARE (Screening for Pain Vulnerability and Resilience). And it assesses some of these psychosocial behaviors like, fear avoidance, catastrophizing.

This is a tool that objectively risk?stratifies but also provides some targeted intervention recommendations based on those scores that really help physical therapists evolve their practice beyond just the mechanical, but also address the psychosocial aspects as well.

TK: Kim, can you talk about the emergence of psychologically informed physical therapy and how it differs from traditional PT approaches?

Radcliffe: So, psychologically informed PT deliberately integrates psychological principles and techniques into the physical therapy practice. As I mentioned before, it recognizes that the psychological factors can influence pain recovery and function. And more specifically, it's really just teaching physical therapists to use language carefully to avoid the nocebo effect, a negative perception from patients, by employing motivational interviewing and validation techniques.

And it's really important to make sure that we are guiding patients toward feeling positive about their recovery. Some of those key things are neuroscience education, teaching patients how pain works, and emphasizing that pain doesn't always equal damage.

And physical therapy, we used to joke about, "no pain, no gain," and, you know, PTs are often called "physical torturers." However, patients who are scared of pain or nervous and guarded have catastrophizing concerns; they really have to understand that pain doesn't always equal damage. We can work through it and help to address their psychological concerns about their healing.

TK: So, let's look into the clinical impact of psychosocial risk factors. So, Kim, based on your experience and WCRI findings, how do factors like fear avoidance and negative coping influence functional recovery in PT patients?

Radcliffe: It's really important, and why this has become such a big deal is when the research started to show that these psychosocial factors often outweigh the biomedical factors in predicting disability outcomes.

And conversely, by identifying these factors, we can reduce chronic disability by 25% to 50%. When we identify workers with high-fear avoidance scores, we need to recognize that they have approximately twice as long a disability duration, and if we don't address them, health care costs can increase substantially.

TK: And, I'm going to get into challenges related to integration with these strategies. What are the practical challenges PTs face when trying to address psychosocial factors without defaulting to behavioral health referrals?

Radcliffe: Yeah, and that's the biggest challenge, particularly in workers' comp, right? We're treating, usually, a musculoskeletal injury and it's really not appropriate actually to even address a behavioral health specific diagnosis or issue.

So, the PTs are trying to incorporate these psychosocial factors without defaulting to that behavioral health, but some of the challenges are inadequate education. Initial PT training really was about the muscles and joints, pain, range of motion, strength. We weren't looking at [psychosocial] factors. So just making sure that we've added that training is important.

And then we have to factor time limitations. Psychologically informed therapy involves a lot of cognitive behavioral techniques that rely on a little bit extra time to talk through things with patients. And sometimes, a typical 45? to 60?minute session often leaves little time to address both the physical and psychological factors. That's also related to reimbursement. Insurance doesn't typically compensate for psychosocial interventions.

So, PTs really have to be creative in how they learn to communicate and talk to the patients during the normal, physical?based treatments and how to document it so that they are justifying the psychosocial interventions, but within the physical therapy billing codes, which are still very much based on manual therapy, gait training, exercise.

There's not really a defined code for it within PT, but you just have to kind of build that into your communication. And then the last one probably is the patient factors. Resistance from patients, expecting purely physical interventions may be reluctant to acknowledge their psychological factors.

Tammy Bradly: You know, Kim, I agree with all of those, and case management really can support the PT in that regard. While you probably see more injured employees across the board than those who come through case management, oftentimes, case management may be involved, hopefully, on the front end referring into PT versus the back end.

And we really can support the physical therapist because we are talking or have been talking to that person regularly. If it happens to be a field case management referral, we are oftentimes visiting these injured employees in their homes and learning so much about the whole psychosocial home environment, their family support information that would be very beneficial, I think, to the physical therapist on the front end.

Plus, the fact that we do the motivational interviewing and so we are identifying some of those barriers to recovery and sharing it with the PT could be very meaningful on the front end, when it's available.

Radcliffe: Yeah, it's a great opportunity to make sure that we connect the case manager with the physical therapist to facilitate that communication and make sure that it's an aligned partnership and communication. That's where I think going back to some of the tools that PTs are using, they're using at the start of care.

And one of our goals is identifying, at that start of PT care, if we use those tools and a flag comes up, if there's not a case manager, how do we maybe engage and identify those that might benefit from more involved engagement of a case manager?

Bradly: Yes.

TK: Great points, and thanks for that, Tammy. Kim, we were talking about training and communication, and really Tammy talked about how case managers can be helpful with that, but are PTs currently receiving training on how to communicate about psychosocial risks with patients? And if they are, what does that look like in practice?

Radcliffe: Yeah, I do believe we are seeing that added to entry?level education. Most DPT programs now include at least basic training in psychosocial factors and recognition and how to communicate.

I think it's just bringing together the old school practiced and experienced clinicians that may not have had that experience versus the entry level — bringing experience and education together.

Specialized certification programs help. There are specialized credentials like therapeutic pain specialist certifications. Those therapists that focus on, as I mentioned, chronic pain. It's very common to see these issues.

And so, learning how to communicate and incorporate those training components in particular courses or through post?professional education has been helpful.

TK: I want to bring Tammy Bradly back here to talk about the case management perspective. Tammy, early identification in case management is key. How is case management evolving to identify psychosocial risk factors earlier in the claim journey? And, what role does predictive modeling play?

Bradly: We've been using predictive analytics for many years to identify claims that can benefit from early clinical intervention. Really, those claims that are at risk of becoming complex with the idea that we intervene early and provide the support and the education that that injured employee needs, then we can successfully resolve the claim before it becomes more complex.

Evolving for us is looking at what else can we do with the data we capture from utilization review, from physical medicine, from bill review and pharmacy … even networks, so that as claims mature, we are continuing to identify any emerging risk or emerging trends that indicate the need for case management.

For instance, we're piloting behavioral health alerts, leveraging information from bill review data today. We already have some of these alerts in play, but bringing in more real?time, physical medicine data is a great example of how we could take it to the next level.

Keep in mind more injured employees go through physical medicine services than case management. So, it's a real opportunity for us to use the data that physical medicine collects to identify claims that may need a clinical resource.

Also, I know Kim mentioned this, we use motivational interviewing. Not only do we train on motivational interviewing, but we put together a series of open?ended questions that our case managers can use in their assessment, both initial and ongoing assessments with that injured employee to really understand and uncover some of those psychosocial issues You know, asking the question, knowing what to look for in their answer, and getting to the next steps, such as what do we need to help them overcome this barrier?

TK: And you had mentioned that case managers are being trained to address psychosocial factors. What does that training involve and how is it being received?

Bradly: Yeah, again, this is not new for us. We started what we call our LASER Training, which is a proprietary training that stands for locating resistance, active listening, selective reinforcement, empowering change and removing barriers. This is something that was built really on the foundation of cognitive behavioral therapy. We don't call it therapy, we call it cognitive behavioral coaching.

We started piloting LASER back in like 2013. So, we've been talking about this for many years and have had it integrated into our clinical programs. We also train on motivational interviewing skills. We, as I said earlier, developed open?ended questions because, as Kim said, oftentimes the injured employee may be reluctant to take psychological tests. They ask, "Why are you asking me that? You're my case manager. You're not my psychologist."

And when you use open?ended questions, such as we use in our motivational interviewing, it really makes it more conversational. However, at the same time, we are learning so much more about that injured employee.

And then lastly, we have incorporated health coaching and education into our case management delivery process. We use a URAC?accredited health coaching and education tool to support the injured employees holistically throughout their recovery. So, with this education comes confidence to make more informed

decisions and feel more in control of their recovery.

Let's say the person is being transitioned into physical therapy. Well, using our health coaching tool, we can actually coach that individual on what to expect when they go to physical therapy, and provide them with materials so that they are prepared for that first day when they go into that PT assessment.

TK: What about collaboration with PTs? How are case managers and PTs working together to ensure psychosocial risks are addressed holistically, and are there shared workflows or communication protocols in place?

Bradly: Sure. Case managers have historically collaborated with physical therapists. Oftentimes, we might meet the injured employee at physical therapy or drop by PT for an update.

I can remember doing that when I was a case manager. I would do my visit with the injured employee before or after PT, giving me an opportunity to see them in PT and talk with the physical therapist. Telephonic case managers certainly make these types of outreaches by phone. I know many PTs will cc the case manager on their progress reports that they send out to the accounts.

Today, when working with, like, Apricus Physical Medicine, we are typically copied on progress notes that are going to the client. So, we get that information very quickly. and the case manager has the opportunity to intervene, consult with the PT, consult with the provider if there are any issues identified. And then Apricus, when they are providing clinical oversight on the cases that they are managing, when they hit a certain visit count as recommended by certain ODG guidelines, then they're alerting the case manager of the red flags when they are identified.

We're certainly working to create more automated triggers that would alert the case manager to missed appointments, delayed recovery, any type of barrier that's been identified by that physical therapist.

TK: OK, great. And, let's talk about some of these data?driven insights that we briefly mentioned before. Kim, let me start with you. What surprised you most in the recent WCRI findings, and how are those insights shaping your respective strategies?

Radcliffe: Yeah, I think the most surprising thing was how high the percentage of negative coping was. The results showed that more than 40 percent reported negative coping, and this was in both knee and shoulder injuries.

I used to believe and used to talk about the 80/20 rule. That 20% of delayed recovery were the outliers, but it's apparent that this is prevalent enough to really invest resources to appropriately address this.

So, our strategies need to focus on becoming more systematic and consistent in screening for negative coping or other psychological factors. Because in the past, we would just kind of wait and see if they started to show problems after starting traditional therapy. But that's sometimes a little too late. The cart's already off the track. And by doing psychological screening sooner, we can help identify these factors sooner and then use the motivational interviewing and techniques that Tammy and I have been talking about to keep the patients on track and help with their outcomes.

TK: Tammy, what about you? What were your thoughts about the WCRI study results?

Bradly: Yeah, I wasn't that surprised because we've been talking about this for years. But it is so great now to have validated studies that show the need to look beyond that injured employee's physical needs alone and have

optimal outcomes to evaluate that whole person.

So, really, it's great to have a study now that supports what we've been talking about.

TK: And what policy or organizational changes do you think are needed to better support psychosocial screenings and intervention across PT and case management? Kim, do you want to start us off?

Radcliffe: Sure. I don't think it'll be surprising to say reimbursement changes. We really need to allow for more time, assessment, and treatment. Even thinking about adding more specific codes to allow for education training that's not direct hands?on care.

There's not really a code that falls in there. There's ADL training, but that's more training a patient on how to dress and cook, and so forth, and do their ADLs. This type of education and time really needs to be recognized and accounted for and reimbursed.

And then, better tools to track and report. I mentioned earlier that there's a lot of varied tools, but I do believe SPARE is coming to be more consistently used, but until we get to that standardization, sometimes you get too much information and it's really hard to stratify consistently.

Bradly: I agree, Kim. And, on the topic of reimbursement, while physical medicine is handled differently than case management, I do think we face similar issues in that it does take extra time to identify and address psychosocial barriers and then provide the ongoing coaching and education that the injured employee needs.

Sometimes billing constraints may limit the amount of time that even the case manager spends with the injured employee. But, hopefully, as studies like this one continue to come out, more people will see the need for both physical medicine and case management to have the time to have these in?depth conversations and coaching sessions with the injured employee.

TK: OK. And let's talk about future vision. We're going to have a little fun here. So, if you could redesign the physical therapy and case management integration from scratch, what would it look like to optimize outcomes for injured employees with psychosocial risk factors? Kim, you start.

Radcliffe: We've talked a lot about flagging and identifying cases when a case manager could really benefit the outcome. We initially think it's a simple case, so how do we identify those and flag for case management engagement when a case severity score goes up?

And, more importantly, notes from a physical therapy network perspective to the claims adjusters … too often, no one's looking at them until maybe further downfield. So, using AI tools to screen those notes, flag for factors, and then using the data with predictive analytics to help identify issues that could create delays even before PT. Looking at things like demographics and injury factors to determine what patients are most likely to have issues.

We mentioned that chronic pain is more common, so then we can ensure scheduling with PT, skilled and psychologically informed PT, at least until it becomes more standard and widespread.

Bradly: Yeah. I think of an agentic alert that's triggered. Let's say your PT does a screening, and it's triggered off of poor screening score, or a missed appointment or lack of progression, or exceeding the ODG guidelines for a number of physical therapy sessions.

All of these things could automatically trigger that alert that would go to the case manager, if there is case management involved, or if not, could alert the adjuster so it's at the top of their desk, not the bottom of the pile and they could then consider adding additional resources such as case management to the claim.

Radcliffe: Exactly. That’s great.

Bradly: It really is recognition of this bio?psychosocial model. The best practice is really bringing all those resources together, the nursing resource, the therapists, the physicians and claims examiners, to come together to address all these factors to get the best outcomes for the patients.

TK: Thanks, Kim and Tammy. And for those looking for more information on the WCRI study, you can check it out here. We’ll be back soon with another Enlyte Envision podcast. Until then, thanks for listening.

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