



Healthy Worker 2020: A collaborative care plan for injured workers

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Kari A. Stephens, PhD

Psychiatry and Behavioral Sciences

University of Washington

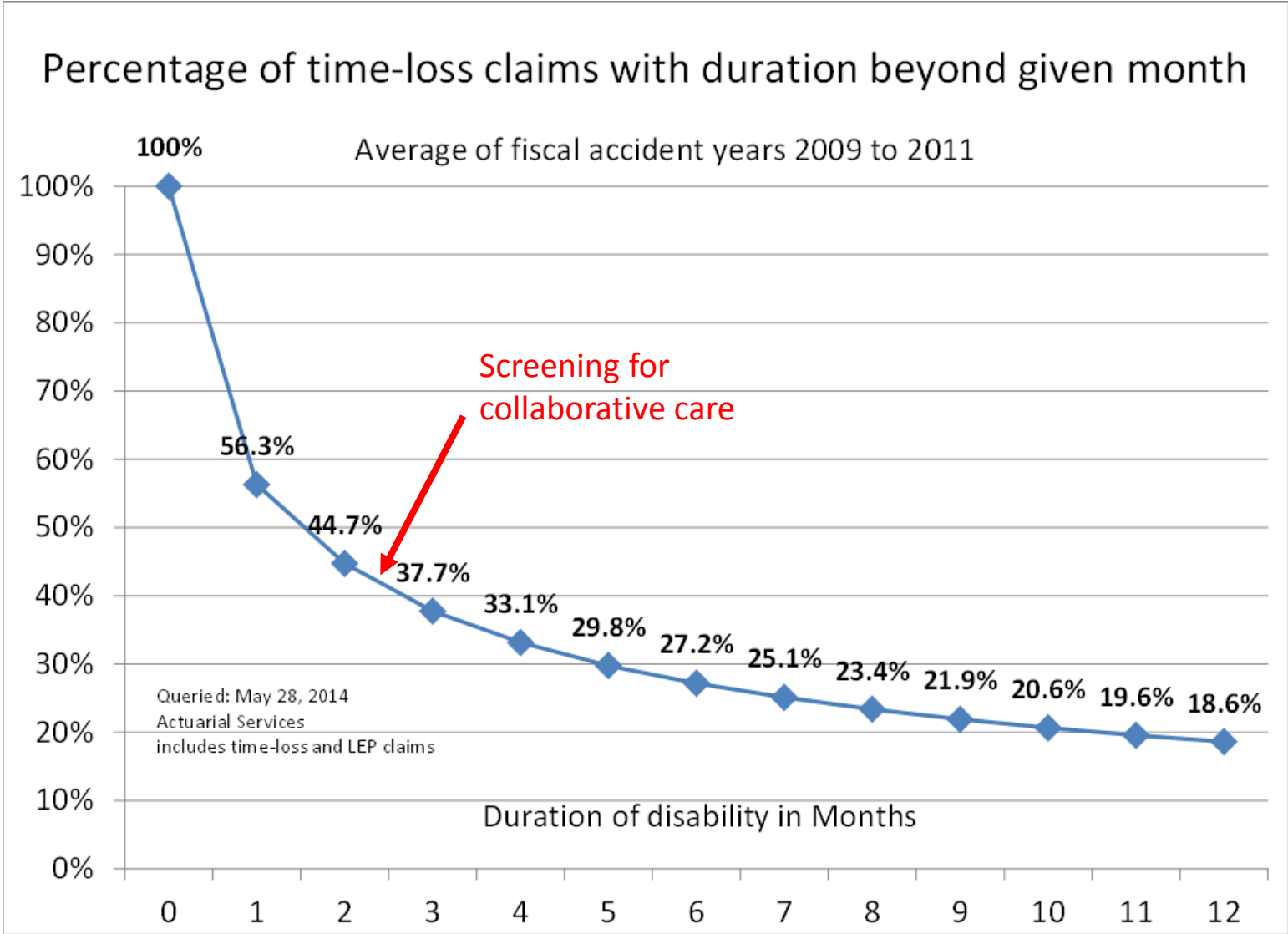


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Disclosures – none.

Duration of time-loss



Pain & Behavioral Health Collaborative Care Program

Target Population

Injured workers with pain and/or behavioral health issues – at risk for time loss and disability

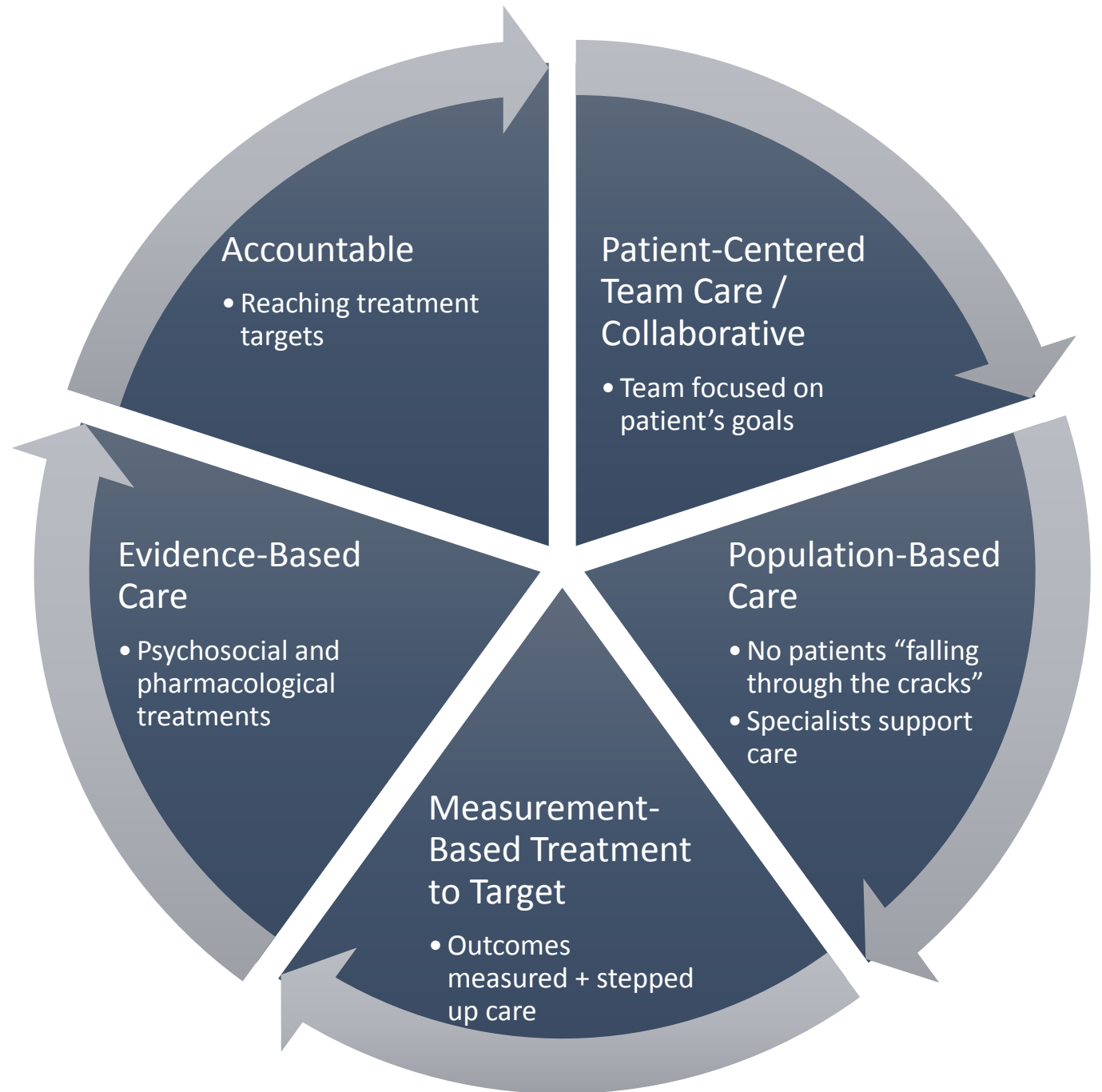
- *Preventing long term disability*
- *Addressing a critical gap in care for injured workers*
- *Targeting engagement in treatment early in their claim process*
- *Brief, targeted treatment → stepping up care as needed*
- *Using an evidence based model of team-based care*

Collaborative Care

- A type of ***integrated healthcare*** developed to treat common behavioral health conditions
 - Originally mental health conditions
 - Used now for cancer, diabetes, cardiovascular disease, pain & other conditions
- Team-based system of care
- Based on 5 core principles
- Cochrane Review 2012: 79 trials and 24,308 patients

<https://aims.uw.edu/collaborative-care>

Principles of Effective Collaborative Care



Treatment formats

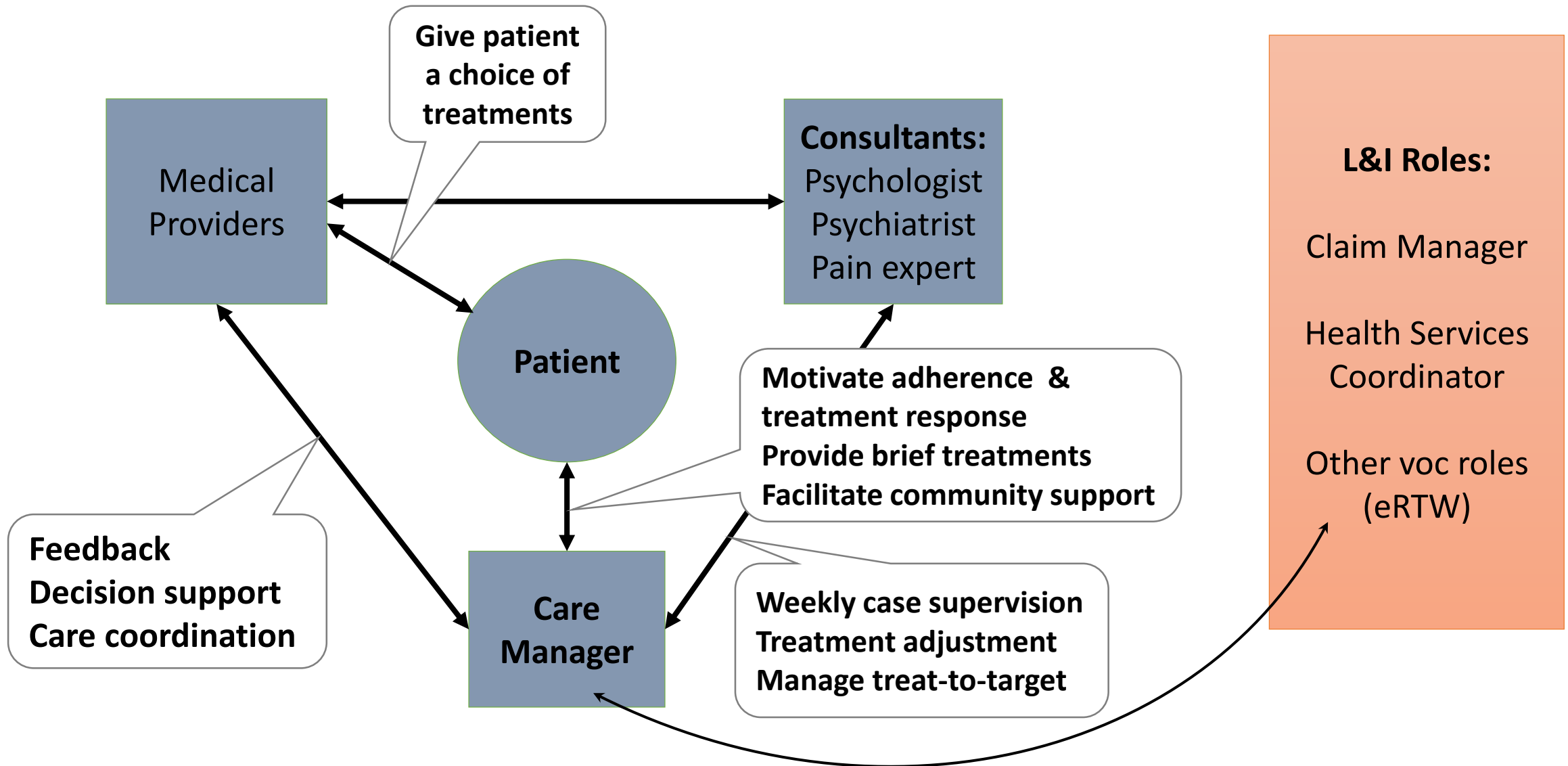
Traditional Behavioral Health (treatment as usual)

- Single behavioral health expert
- Psych assessment
- Typically address a very targeted problem
- Costly training
- Rigid protocols
- Limited population generalizability
- Time consuming treatments - Typically delivered face-to-face
- Point of care treatment, no outreach
- Limited population reach

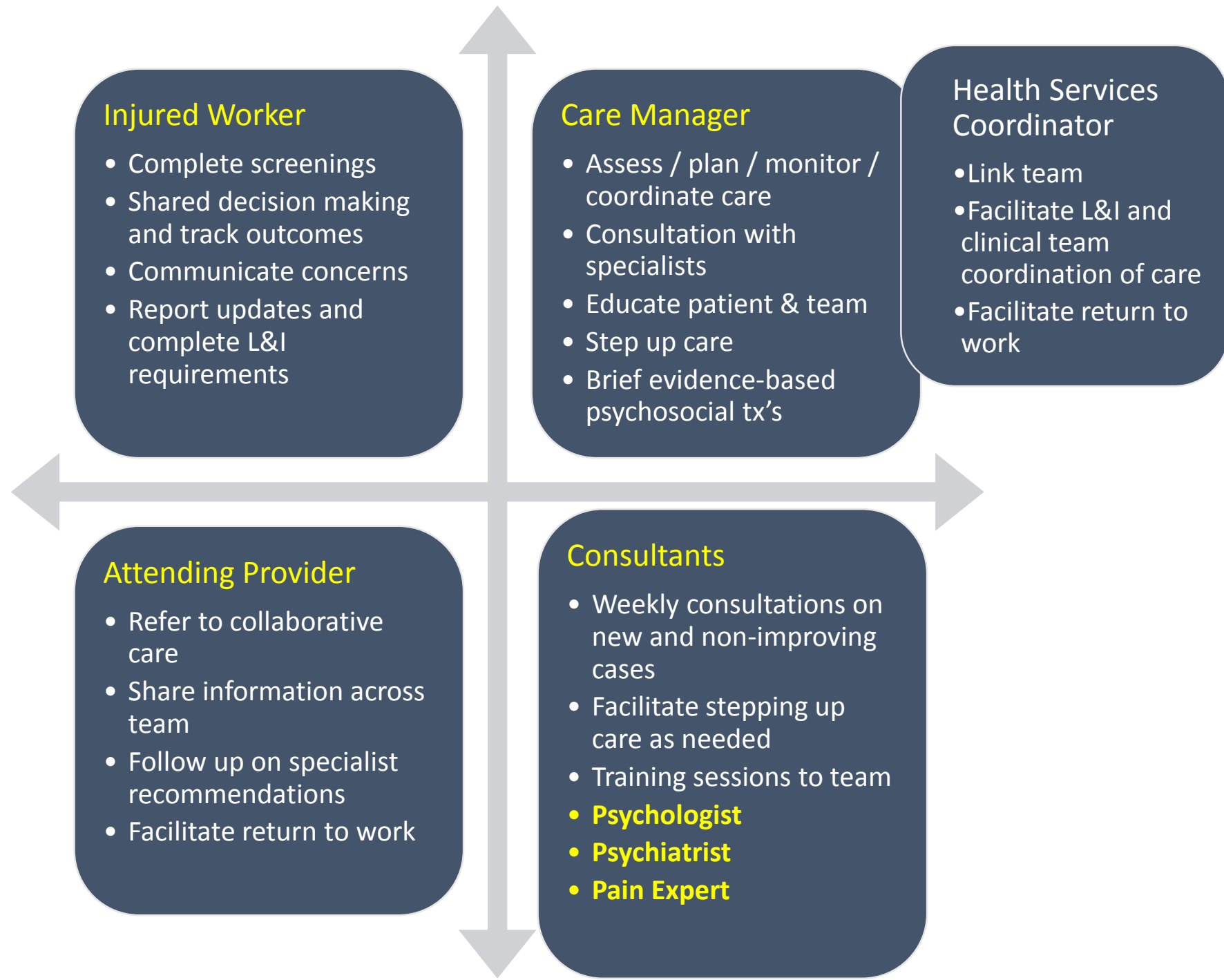
Collaborative Care

- Care manager (specialist consultants)
- Systematic screening
- Brief evidence based treatments
- Interdisciplinary team care
- Medication management and consultation
- Utilizes telehealth to reach patients
- Flexible
- Focus on patient engagement
- Increased intensity in treatment as needed
- Lower cost than traditional treatments
- Broad population reach

L&I Collaborative Care Model

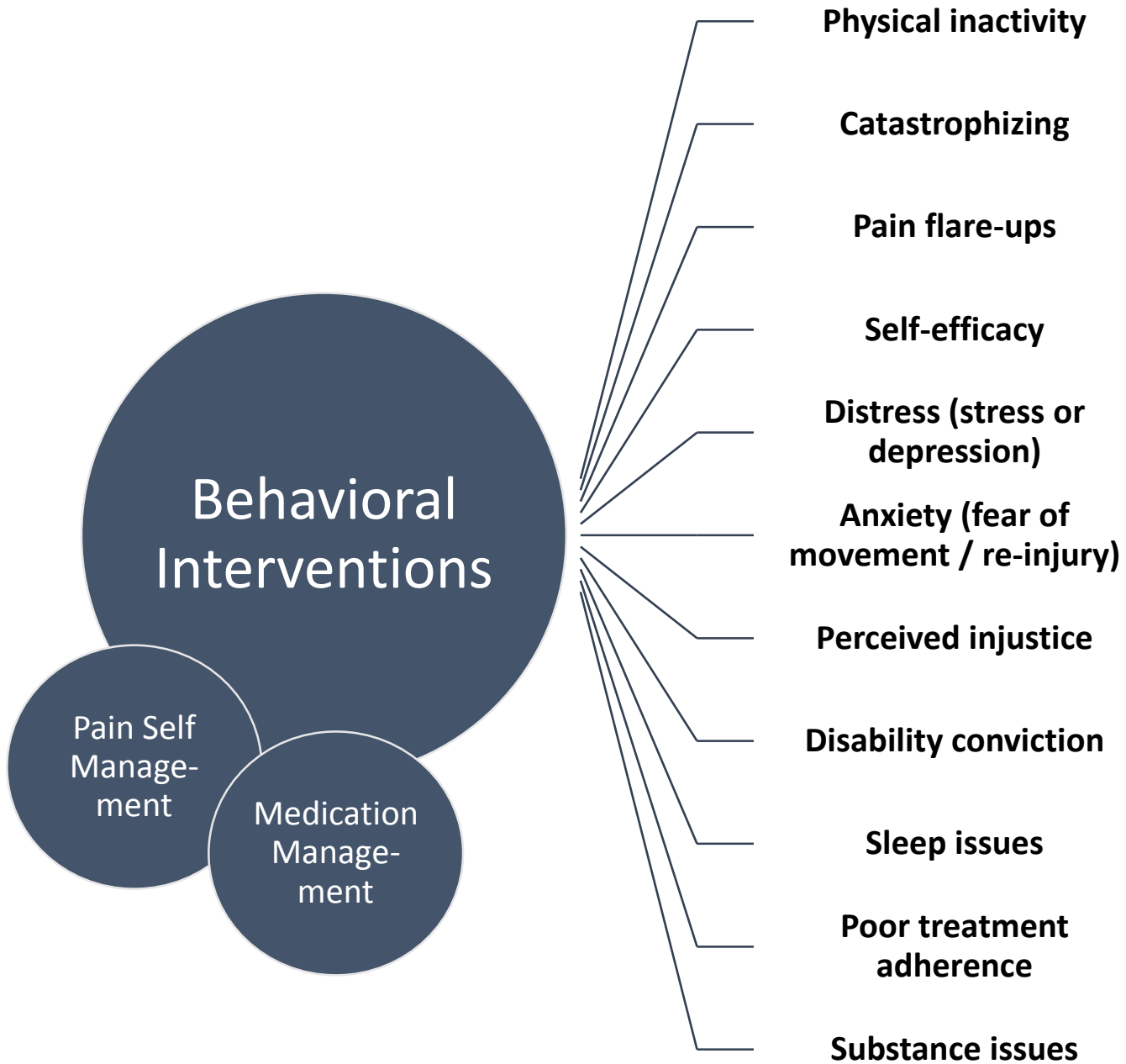


Roles for Collaborative Care Team Members



Core Behavioral Interventions





Chronic Pain Psychosocial Risks / Symptoms

Episode of Chronic Pain & Behavioral Health Care

2-6 months

Standard clinical symptom measures

- Depression - PHQ-9
- Anxiety - GAD-7
- Pain intensity and interference
- PROMIS
 - Pain Self efficacy
 - Sleep
 - Pain catastrophizing

Session /Activity	Content
Care Manager & Injured Worker	
Session 1	Patient-centered assessment & care planning: <ul style="list-style-type: none"> • Assessment • Self-management & care • Set recovery expectations • Develop initial treatment plan
Sessions 2 to # Session frequency will range from 1/week to 1/month & typically decreases over time	Ongoing sessions: <ul style="list-style-type: none"> • Monitor outcomes & response • Monitor adherence, self-management, & work status • Coordinate medical management • Provide brief behavioral interventions • Provide support for pain self-management & maintenance of gains • Intensify/step up treatment
Final Session	<ul style="list-style-type: none"> • Relapse prevention plan • Provide resources to maintain gain
Specialist weekly consultation	<ul style="list-style-type: none"> • Discuss new patients • Discuss non-responding patients • Review progress, barriers, plan • Monitor outcomes • Recommend treatment adjustments
Other Activities	<ul style="list-style-type: none"> • Inform L&I staff as needed • Facilitate referrals (i.e., PGAP, voc services)

Case example: treatment as usual in L&I

- 34 year old mother of 4
- Works nights as nursing assistant
- Injured back transferring patient, seen in urgent care, referred to occ med
- 2 weeks later – meds not working, prescribed NSAIDS and referred for PT
- Released to light duty, but employer has no light duty available
- 3 months after injury - no improvement
- 6 PT sessions, home exercises, no benefit from meds, switched meds
- Referred to different PT and to PGAP (PHQ9 score of 20)
- Declines PGAP because of childcare

Challenges

- Remote versus co-located deployment of care managers
- Integration with existing care across numerous settings with small populations of injured workers
- Sustainable work force development for care managers, psychologists, and psychiatrists in chronic pain
- Electronic tracking system solutions
- Cross setting successful collaboration (i.e., care settings, L&I, employers)

Recommendations

- Train workforce with clinical core competencies that will get refined under guidance of psychologist/psychiatrist specialty consultants
- Work directly with clinical care setting champions to collaborate on adaptations needed to be successful as early as possible
- Start simple with electronic tracking (e.g., Excel spreadsheets) to avoid complicated hurdles to getting started
- Try to avoid payor/plan specific customizations within the clinical team to allow for utility to broader populations of patients

Thank you

Questions/Contact:

Dr. Kari Stephens – kstephen@uw.edu