IT'S INSIDE—AND OUTSIDE—THE BOX

BY E.J. BROWN

"Industrial rehabilitation" is a hard term to pin down in an occupational therapy context.

It has historically covered a mixture of environment and task evaluation and modification, clinical treatment after on-the-job injuries, and even safety and prevention at job sites. Clients may be not only individuals who are covered under their companies' insurance policies, but companies themselves that have chosen to work with particular health and safety program providers.

Last fall, the Representative Assembly actually changed the name of AOTA's former Work Programs Special Interest Section (WPSIS) to Work and Industry, trying to broaden its scope to reflect the many roles OTs are playing and hope to play in this setting in the future. But many unpredictable factors are at play here, including the march toward evidence-based practice—something AOTA and industrial rehab practitioners are scrambling to keep up with.

The Problems

Unless an OT is actually employed and on staff at a particular company, payment in this arena often comes from Workers' Compensation claims. That complicates the matter; Workers' Comp is administered by the states, and its reimbursement rules differ in each one.

AOTA is currently in the process of developing a set of guidelines for using evidence-based

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KYLE KIELINSKI

treatment protocols in Workers' Compensation. Occupational therapy has been battling changing reimbursement regulations in this setting for at least the past three years as these agencies try to determine who should be "qualified" to treat in this arena.

Late in March 2005, a crisis surfaced in California, where interim Workers' Comp regulations that had gone into effect in December 2004 had effectively cut occupational therapy off the industrial rehab team because the profession wasn't listed in the practice guidelines of the American College of Environmental and Occupational Medicine. A study jointly undertaken by AOTA and the Occupational Therapy Association of California asserted that $56 million worth of Workers' Comp claims had been denied in the first six months of 2004, and it seemed likely that Texas and other states would pick up similar changes in their Workers' Comp guidelines.

Contrast that with what has happened in Ohio, and you see how unpredictable the winds are.

The Ohio Bureau of Workers' Compensation (OBWC) adopted a program called "transitional work" (TW). It just so happens that the OBWC's definition of TW is a near-mirror image of the OT practice act in the Buckeye State in the way it describes "how occupationally based tasks are the preferred interventions for injured workers who wish to return to full-duty status," therapist Bill Benoit reported to us in 2006. "It is through these 'functional work tasks,' or therapeutic occupations, that occupational therapists are gaining a strong foothold in Ohio as a vital link to recovery from work injuries." ("Ohio's Model for Industrial Rehab," Jan. 23, 2006)

In a study done in 2002, the OBWC found that TW cut the average number of days absent from work due to an injury by 46 percent, lowered medical costs by 11 percent, and cut indemnity costs by 22 percent. It also sped up claim filing by 37 percent.

Benoit called the significant reimbursement for TW a "prime example" of what the AOTA Centennial Vision describes as a "Wild Card" event: something that you just cannot predict ahead of time when envisioning the future of OT in any particular arena.

California may come around. At a hearing in 2006, AOTA requested that the California Division of Workers' Compensation add an occupational therapist to the panel that would be reviewing medical treatment guidelines for the system. Last year former AOTA President Mary Foto, OT, FAOTA, CCM, was appointed to serve in the post. Foto has long had a successful industrial rehab practice in California and is currently co-chair of the health care professionals' advisory committee to the American Medical Association.

Getting more OTs into decision-making positions like these is highly important to the future viability of the profession.

'Don't set up your treatment program to go from intake to discharge. You need to go all the way to return-to-work.'

—Jim Mecham, MS, OTR/L

Current Issues

According to the National Institute for Occupational Safety and Health (NIOSH), an average of approximately 9,000 workers will be injured at work every day this year, badly enough to go to the emergency room. About 6,000 of them will require job transfers, work restrictions or time away from their jobs after the injuries. Sixteen of them will die. Another 137 workers and retirees will die from diseases they developed at their current or former jobs.

The question, in the eyes of Workers' Comp boards, is how to recognize quality practice that will reduce these injuries and speed recovery. Four years ago, California vested its trust in the already-established standards set by a medical organization with which it was familiar; and so it identified certain professions as ones whose practitioners were "qualified" to treat.

Ohio, meanwhile, chose to try a new plan to reduce costs and increase efficiency based on a standard that is fast evolving in the industrial setting: *function*, not just measurement.

Jim Mecham, MS, OTR/L, an associate ergonomics professional (AEP) certified through the Board of Professional Certified Ergonomists (BCPE), is the developer of online assessment applications for OccuCare in Kenosha, WI. "I've been getting calls over the past few months from people who tell me their compensation boards want the goals to be functional now," he said. "It looks like Arizona will ask to have functior documented soon."

Mecham trains people in the use an modification of functional capacity evaluations in the clinic. "I am telling them now 'don't set up your treatment program to g from intake to discharge. You need to go al the way to return-to-work.'"

What compensation boards want to se is that people who come out of outpatien industrial rehab are really going back t doing the jobs they were doing. How the scored on strength and endurance tests i the clinic may be invalid if the tests di not examine the worker doing actual job related tasks.

The bottom line is, the boards have had to do something. In 2004, the year of California's fateful decision, employers in the United States were already spending $87 billion in Workers' Compensation costs.

What Is 'Evidence'?

Current evidence behind today's treatment protocols in industrial rehab comes mostly from literature reviews of what tools have undergone clinical research and are accepted by most of the industry as "standard." So go back and look up what has been written about the tools you are currently using and keep it near at hand, Mecham says, in case you are asked to justify your approach.

Meanwhile, Mecham says, if you are adding to the clinical research base, try to have your research meet the Daubert standard, set by the Supreme Court in 1993. In *Daubert vs. Merrill Dow Pharmaceuticals*, the Supreme

Court ordered federal trial judges to be the "gatekeepers" of scientific evidence. In order for testimony to be considered reliable, the expert must have derived his conclusions using the scientific method.

That method, according to the court, would require that:

- a tool or technique has been tested as to whether it actually contributes to the patient's progress;
- the tool or technique has been subjected to peer review;
- it has a known or potential rate of error; and
- it is accepted practice in the scientific community.

Most of today's accepted treatment tech- ques do not meet the Daubert standard, cham said. But, "the FCE is the main l in your rehab program," he reminds leagues. "If you can make sure that all tests in your FCE are evidence-based erature-backed), it's going to make them nd up better in a court of law."

There are several kinds of FCEs available r use in today's clinic, and clinicians often odify them to test more specific move- ents. The trick in function-based research ill be to maintain standardized reliability hose factors in testing that all people can o the same way, thus providing accurate, measurable results) and to increase validity tests that measure the individual client's ability to do actual job tasks, either simulated or at the work site).

Doing the Research

According to Jeff Clinger, MS, OTR/L, one of the best ways is to partner with the research arms of universities to create tools that better quantify the ongoing progress of patients using particular interventions in particular cases.

Clinger is manager of the occupational rehabilitation program at Midwest Health Strategies in Muncie, IN. The clinic has added motion analysis to its work conditioning and work hardening with the help of a biomechanics lab. Motion analysis assesses the movement of a particular body part with a standardized protocol that ensures consistent measurements.

At Midwest, Clinger worked with a biomechanist to establish a protocol for shoulder movement, because Midwest's occupational medicine providers wanted to learn how functional outcomes differed among groups of surgical patients. This would aid Midwest clinicians in making more precise data comparisons to document and adjust treatment under specific conditions—concrete evidence in the eyes of payers.

The project required him to select the right software program for this task, because different programs offer different features. Once that was done, he involved all his team members in developing the protocols. They had to agree on the critical data to be obtained and how to go about getting it.

"My team met bi-weekly for two months to problem solve and analyze data collection, migration into reports and storage," Clinger reported in the January 2007 issue of the WPSIS newsletter. Once the system was in place, they expanded it to cover low back, hip and knee due to referral interest "and staff interest in analyzing the aging workforce."

Clinger believes industrial rehab clinics need to find ways to set their services apart from what others can provide by moving to more research-oriented protocols.

The Right Time

Right now is a good time to put some effort into all of this. Most U.S. industries are completely unorganized in getting a grip on their musculoskeletal problems.

Paula Bohr, PhD, OTR/L, FAOTA, associate professor and director of the Maryville University Occupational Therapy Program in St. Louis, has been active in work-related practice and research for more than 30 years. A study she published in 2004 with

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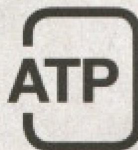

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co-author Nora E. Barrett looked at the musculoskeletal work safety education programs offered by 10 nationally based companies to determine whether their evaluation methods, parameters measured and methods of data collection were adequate.

The authors found that "overall, there was a profound lack of comparison of parameters measured over time. In particular, behavior, which has been identified as the key to continuous injury prevention, was not evaluated over time by any of the respondents. Even if current programming incorporated good prevention strategies, their efficacy cannot be demonstrated without more clearly defined ...methods of data collection and analysis."

Bohr is one of eight experts who will participate in an evidence-based literature review of OT interventions for individuals with work-related injuries/clinical conditions at the AOTA conference in Long Beach, CA, in April.

Credentialing

Payers' cries for nuts-and-bolts protocols in work injury rehab is in part a reaction to the competing standards in the industry created by people with deeply divergent skill sets. Throughout the 1990s, ergonomics was the new kid on the block, and nobody seemed to know who it "belonged" to. So everyone took a piece of the pie. The idea of fitting the job to the worker was right up OT's alley. Ergonomics principles fit in easily to the industrial rehab scene.

But it wasn't long before groups of professionals were fighting over what those principles really were. Since the turn of this century, the BCPE has opened its umbrella to people working at various levels in the ergonomics industry and sets the "gold standard" in ergonomics credentialing, Mecham says.

But payers have learned that certification can be confusing. That's why they want evidence.

Part of the information that will under gird AOTA's guidelines in evidence-based practice under Workers' Compensation will come from two online Zoomerang surveys of therapists working in industrial rehab settings that were completed late last fall. One focuses on upper-extremity conditions, and the other on lower-back conditions. AOTA's surveys on Workers' Comp protocols in use today have confirmed that the work and industry practice arena is hard to pin down, with people who classify themselves under that category working in many different places and under several payment structures.

Mecham feels that too many of his colleagues in work and industry are "not involved with AOTA as much as they should be." He estimated that there were only about 700-800 people in the WISIS. "This is a niche practice area," he said, but he added that the number of industry-related courses at national conference is growing significantly each year.

Meanwhile, he urges clinicians to continue doing research on the tools they are now using.

In their personal research models, Mecham said, "therapists will need to balance 'reliability,' which is 'inside the box,' and validity—'outside the box'—in order to meet the desires of today's payers."

But balancing is an old OT art. Let's hope it works in the research arena. ■

E.J. Brown is ADVANCE *editor.*

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