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| **Comment Source: name, date, route** | **Comment** | **IICAC Draft Response** | **Change Made** |
| Dianna Chamblin MD, 9/11/2019, email | An outstanding accomplishment.1. Activity coaching hyperlinks – consider hyperlinking in body of document on pg 13 to provide brief definition then refer to pg 242. Inadequate Understanding –dx or tx options: Additional support resources – second opinion with L&I trained consultant. How about physicians/dentists? Maybe link to find medical/dental consultant on FindADoc? | 1.Adopted suggestions2. Other second opinion providers have not undergone additional L&I training and are classified differently. | 1. hyperlinked pg 132. Added medical/dental as another option. Pg13 |
| Greg Carter MD, 9/11/19, email | It is well-organized, flows nicely, and has an amazing amount of information packed in to it! | Comment supports resource | No action or change |
| Trevor Davis, PsyD,9/12/19, email | It is a rich resource. In a relatively brief review, and I've read this before or something very similar, I find it very ambitious that it is expected APs to do the following (list of “addressed by AP” on page 2)I know there is mention of referring to a Behavioral Health provider (such as on page 5), but I wish there was more of an integrative spirit to this that was clearly stated early in the document. Psychologists/Behavioral Health specialists and consults are integrated into various medical settings because we are the experts in PDIR.  | On the topic of APs doing behavioral health, we agree that what is outlined is ambitious and in many settings is solved through an AP care team with behavioral health providers. The resource tries to accommodate the variety of settings that many APs practice in which may lack collaborative teams. We believe the resource is clear that if an AP does not have expertise, time or capacity to deal with these issues they should make referrals to those who can. The goal was to leave it open to support APs having better interactions with the worker which has a strong determinant on their outcome even before the need for a referral for providers who do not have access to care teams. | Changed language to ”performed by AP care team” to include more fully a variety of settings and integrative spirit and references to behavioral health providers as part of that team. Pg 12 |
| Michael Harris, Ph.D,9/17/19, email | I think the effort and the use subsequent use of the document has been an important part of the paradigm shift that is in progress at the Department. Drs. Davis, Senske and I all have concerns about the ability, time and/or willingness of the provider to provide many of the areas currently identified as 'theirs' in the document. A number of them would be more accurately and usefully located with the behavioral health folks trained and available to use them.I general, I think THE challenge at this point is not whether to use these concepts or not but rather HOW specifically to implement them as an integrated, on-going part of early visits with injured workers. My guess is most providers are on board with the concept and need additional training and incentives to integrate them into the acute/subacute phases of their care. The next version of the PDIR or even better a follow-up document realistic and workable methods of using the concepts would be ideal. As always, I would be glad to help.Thank you. | We fully recognize the sentiments regarding the challenges in implementing behavioral health occurring not only at the Department, but statewide in the health care system. We hope this document fosters an understanding of the importance of building teams and individual capacity to deal with these issues. | Added discussion of care team to support capabilities in sections where AP is called on to deliver psychosocial services. Pg 12 |
| Jeremy Senske, Ph.D,9/17/19, email | I stand with Dr. Davis on what he said - early intervention to prevent further disability AND focusing on what the patients CAN do versus their disability conviction. Getting them a toolbox that they can use to enhance their recovery and return to work and having meaning in their social lives. Encouraging them to continue to stay active physically, emotionally and socially.  | We hear and appreciate your concern about the challenge of implementation and who should be doing the work. It is unique enough to each system that we hope our generic view of the “AP and their care team” will cover a whole range of clinic settings and how providers triage the needs of the patient.  | Enhanced the conveyance of a “care team” message. Pg 12 |
| Lee Caton, PTemail | PDIR is a critical area that needs to be screened and addressed with all injured workers.  What people’s perception of their functional work activity tolerances are will significantly affect the overall RTW rate.  If you wait for less than expected progress to be determined you have dug yourself a hole.  Proactive intervention is critical to ensure the highest functional RTW level possible.  The time constraints placed on medical providers in treating patients has limited their ability to perform screening and has little carry over to therapist providers.  Therapy providers need to be an integral part of this screening process and incorporate appropriate interventions to facilitate a functional RTW outcome.  The typical miss in treating injured workers is a focus on pain or a psychosocial issue thereby limiting functional progression.  The primary focus has to be on improving functional tolerances toward a goal/purpose.  This is how humans progress and we have seen the remarkable improvement in RTW outcomes with therapeutic interventions that focus on a RTW goal.    | Comment supports guideline | No action or change  |
| The described algorithm on page 4 works great as a flow sheet.  The actual intervention of services is lacking.  The psychological approach of talking someone through a process has its value but experiential treatment is critical.  Ex.  I can talk to someone about their fear of climbing a ladder after they have fallen off of a ladder previously.  But the ability to have this injured worker experience climbing a ladder makes a significant psychological change beyond talk/discussion therapy.   | Experiential treatment in overcoming specific movements or activities can be beneficial in treating some fear avoidant behaviors. | Added discussion on exposure and graded activity to highlight potential benefit in fear avoidance, including hyperlinked areas to highlight graded exercise and physical activation. Pg 17Added citations Rainville 2011  |
| Workflow for FRI (page 5) discussed functional scales which would be an indication of the injured worker’s subjective report of their abilities/symptoms but this is an indirect methodology of assessing actual RTW functional tolerances.   | Acknowledged – this is an indirect method that is practical within an attending provider office. It is not positioned as a substitute for more direct assessment of tolerance or goal progression. | No action or change |
| Key Recovery Messages is a great overview of areas to cover with injured workers.   | Comment supports resource | No action or change |
| Psychological Determinants Influencing Recovery Concepts- worker’s compensation benefits being constrained to the accepted work-related condition is understandable and appreciated.  An understanding of ‘work’ as a set of unique whole body activities needs to be accounted for.  Medical providers and therapists need to work at determining the limiting factors/barriers for RTW which would include injury-related and non-related areas.  As Work Hardening addresses the whole body for increasing functional tolerances it becomes critical to ‘fill in the gaps’ (potential unrelated musculoskeletal, tolerance or biopsychosocial issues) to progress a client to meet a RTW functional demand level.  A provider’s ability to communicate and possess a level of empathy for their client becomes critical to engage this injured worker to create an optimal pathway forward.   | An excellent suggestion regarding Work Hardening and it’s role with psychosocial care and return to work that we hope to explore further in the near future. | No action or change |
| Psychosocial and PRID Assessment Best Practices-  great points included in this outline.   | Comment supports resource | No action or change |
| PDIR and MH Screening and Tracking Scales- I understand the discussion of questionnaires for the client to complete but the ultimate test is functional progression towards a RTW goal.  The client may state they feel better about RTW to work but not demonstrating any advancement towards a RTW goal.  A fear would be we are trying to indirectly measure a functional outcome. | Acknowledged – this is an indirect method that is practical within an attending provider office. It is not positioned as a substitute for more direct assessment of tolerance or goal progression. | No action or change |
| Overall the Reducing Disability: PDIR was well thought out and put together in a very user friendly manner.  There is a lot of content and ultimately it encompasses a unique set of skills to deal with injured workers beyond typical patient care.  It would be intriguing to look at potential education from the state or endorsed by the state for certain level of medial/rehab practitioners to assist in delivering these concepts in a practice setting.   | Comment supports resource | No action or change |