OCCUPATIONAL HEALTH

SPECIAL INTEREST GROUP

GREETINGS OHSIG MEMBERS!

We have had a very active past couple of months! Hopefully you had the opportunity to respond to one or more of the initiatives we let you know about. Here are the activities we have been engaged in on your behalf these past months!

ANNOUNCEMENT OF OHSIG BULLETIN BOARD

In the last issue of *OPTP*, Vol 23, No 3, 2011, we announced the OHSIG Electronic Bulletin Board on the Orthopaedic Web site. This is an active communication link for OHSIG members only! It is a great place to ask questions of your colleagues and share ideas. As of this writing, there have been 15 various topics discussed.

The link is https://www.orthopt.org/message_boards.php. Login is required.

For those of you who have not used an asynchronous communication (not all users have to be online at the same time) platform before, you can use the Online Bulletin Board whenever:

- you want to mail a single message to other OHSIG members, or
- you want to brainstorm or communicate ideas to foster discussion.

GUIDELINES:

1. All members will see your messages.
2. Be courteous.
3. Keep messages clear and goal directed.
4. Messages should be related to Occupational Health.
5. We will be unable to accept postings pertaining to advertisements or employment opportunities.

Please make every effort to use correct grammar, punctuation, spelling, and sentence structure. Most of all have fun! This is a benefit of belonging to the OHSIG. We hope you will use it!!

UPDATE: PETITION FOR SPECIALIZATION IN OCCUPATIONAL HEALTH PT

We received a response from the ABPTS regarding our Petition for Specialization in Occupational Health. Many questions were posed and clarifications were requested. A call was held with the Orthopaedic Section President, Jay Irrgang, OHSIG Liaison to the Orthopaedic BOD; Bill O'Grady, ABPTS representative; Lorena Pettit, OHSIG VP; and myself. It was determined that OHBOD would hold a face-to-face meeting mid September to respond to questions posed by ABPTS. Our goal is to continue the path toward Specialization in OHPT.

WCPT

Dee Daley, past OHSIG VP/Education Chair and current Content Expert for Occupational Health PT Specialization, attended the World Confederation of Physical Therapy Conference in Amsterdam, The Netherlands. Here is her report. It sounds like there were very collaborative and informative presentations!

Moving Forward - Occupational Health at WCPT by Dee Daley

Forty-eight physical therapists from Australia, Brazil, Canada, Finland, Germany, Japan, Netherlands, Nigeria, Norway, Puerto Rico, Sweden, Thailand, Uganda, United States, and Zimbabwe participated in a WCPT satellite program related to current practice and future trends related to occupational health physiotherapy practice related to work injury prevention and management. The program titled *"Moving Forward - Occupational Health"* was a collaborative presentation of physical therapists from 4 WCPT regions.

The full day of programming included programming on risk management and ergonomic tools as well as the practical application of ergonomic tools, evaluation of work capacity, job analysis, and the implications of biopsychosocial aspects of musculoskeletal disorders for rehabilitation and return to work. Emerging research, updates, and regional perspectives on material handling, safe patient handling, work stress, progress, and barriers in the areas of work injury/illness prevention and successful rehabilitation/return to work were also topics covered in the various sessions

Faculty included: Paul Rothmore (AUS), Rose Boucaut (AUS) (co-chairs), Martin Mackey (AUS), Dee Daley (US), Mike Fray (UK), Gunvor Gard (Sweden), Elisabet Schell (Sweden), and Venerina Johnston (AUS).

In addition to an occupational health networking session on Tuesday of WCPT, an abstract session in occupational health included the following:

- Physiotherapists use of a guideline for reducing work related musculoskeletal disorders *(Inger Helene Gudding, Norway)*
- The development of a cumulative psychosocial risk index for problematic recovery following physical therapy for work-related musculoskeletal injuries *(Timothy Wideman, Canada)*
- Physical and mental workload in computer tasks: effects on cervical muscle activation, cardiovascular response, and perceived stress in computer users *(Yuling Wang, China)*
- Effectiveness of exercise on work disability in patients with non-acute nonspecific low back pain: a meta-analysis of randomized controlled trials *(Peter Oesch, Switzerland)*
- Biofeedback is more effective than exercise and electrotherapy in managing work-related neck pain in office workers *(Pui Yuk Grace Szeto, Hong Kong)*
- Physical profile of professional orchestral musicians: a national cross-sectional study *(Bronwen Ackermann, Australia)*

***** On behalf of the OHSIG, a special thank you to Dee for her participation at WCPT and for representing the United States and the OHSIG! *****

OHSIG ACTIVITIES--MEMBER PARTICIPATION

- APTA requested CMS to add a new Place of Service code for "work-site" to identify services that are delivered at the workplace when the practitioner does not maintain an office at that work-site. Karen Jost, Associate Director Payment Policy & Advocacy, APTA, informed the OHSIG that this request was being considered, and she requested additional information from OHSIG members. OHSIG members responded, providing her with the information she needed.
- OHSIG provided evidence for the efficacy of work hardening and work conditioning procedures with clinical examples for the Regulatory and Payment Counsel of APTA.
- OHSIG members participated in an International Multi-stakeholder Return-to-Work (RTW) Survey.
- OHSIG submitted feedback to the Massachusetts HCSB Chronic Pain Treatment Guideline draft.
- OHSIG was asked to review the Employment Services Standards related to CARF's Employment and Community Services customer service unit. They convened a series of International Standards Advisory Committees and focus groups to review and revise standards in the area of Employment Services. Anita Bemis-Dougherty, Associate Director, Department of Practice, APTA, asked for our review and comments to proposed standards.

As a reminder, be sure to watch for E-mail blasts from the OHSIG. If you do NOT receive E-mail blasts from us and you are an OHSIG member, please contact Tara Fredrickson at the Orthopaedic Section office (800-444-3982 x203) or contact any of the OHSIG BOD. These E-mail blasts are usually time sensitive, so E-mail blasts are the best method of communication for us. Also, we will use the OHSIG Bulletin Board when we can.

NEED AUTHORS

If you are interested in submitting an article for OPTP, please let us know.

MEMBER INVOLVEMENT

If you have suggestions, questions, or comments, contact any of the BOD members. We'd love to hear from you! You can find the officer listing on the Orthopaedic Section Web site, under Special Interest Groups.

Professional Regards,

Margot Miller, PT
OHSIG President

CLINICAL CORRELATION OF EVIDENCE TO FORM A FUNCTIONAL CAPACITY EVALUATION OPINION

By Sandy Goldstein, PT, CDMS

Often, the results of imaging studies (x-ray, CT, ultrasound, or MRI, among others), require clinical correlation. When a radiologist comes across a finding that may mean multiple things, they say "please correlate with clinical findings" or "clinical correlation requested." In medicine, "clinical findings" are observable signs of a particular condition or disease, along with symptoms as reported by the patient. A test, as explained above, is "correlated" or "compared to" or "compared with" the observable signs and reported symptoms before a final diagnosis is made. Clinical findings can be made any time a physician examines and interviews a patient; most often, this occurs in a doctor's office or while a patient is in the hospital.

In the Functional Capacity Evaluation (FCE), our findings and subsequent opinions are based on a combination of historical, medical, and clinical findings. When we put our name on the dotted line and assert that our "opinion is accurate and complete to a reasonable degree of occupational health or ergonomic probability," we are offering an opinion that is reflective of our clinical expertise together with the objective data collected before, during, and after the FCE.

The purpose of this article is to clarify that opinions offered following a well-performed FCE will include a summary of our subject's medical history, vocational history, objective diagnostics, medication regimen, recent lifestyle activities, as well as the results of what they were willing to do on test day balanced with an assessment of their effort and consistency of performance.

COLLABORATING EVIDENCE TO FORM OPINION: MEDICAL HISTORY, EXAMINATION & EVALUATION, FUNCTIONAL TESTING & OBSERVATION OF THE SUBJECT

As the American Physical Therapy Association (APTA) *Guidelines for Evaluating Functional Capacity* identify, components of an FCE should include but are not limited to appropriate administration, documentation, and consideration of the following when providing an opinion regarding an individual's functional ability:

Medical history including:

- Mechanism of injury
- Treatment to date
- Objective diagnostic tests
- Surgeries
- Other relevant claims/medical history

- Report of current symptoms and work/leisure limitations
- Current medications

Examination and evaluation of:
- Cardiovascular/pulmonary tests and measures
- Integumentary tests and measures
- Musculoskeletal tests and measures
- Neuromuscular tests and measures

Functional testing including:
- Static strength tests to evaluate consistency of effort (eg, grip, pinch, pull)
- Dynamic balance/agility
- Finger dexterity tests
- Manual dexterity tests
- Cardiorespiratory endurance tests
- Postural tolerance tasks
- Lift/carry strength and endurance tests
- Simulated or actual work tasks

Observation of the subject:
- Cooperation during participation
- Consistency and level of effort
- Behaviors that interfere with physical performance
- Body mechanics/safety
- Physiological responses and clinical findings

The results of the above are considered in combination with the evaluation of history, medical records, and test performance to recommend safe work abilities. Moreover, a comparison of the individual's safe work abilities to their job or task demands (if known) is provided.

IN SUPPORT OF CLINICALLY CORRELATING FCE RESULTS

Historically, return-to-work decisions were based upon "clinical findings" including diagnoses and prognoses of physicians, but did not include objective measurements of worker functional abilities and job match demands. There were no tools for physicians to use to correlate their opinions or clinical findings.

The FCE emerged to elevate the available information used to provide objective assessment of an individual's safe functional abilities compared to the physical demands of work or leisure tasks.

Functional examination/evaluation, combined with diagnoses and prognoses by physical therapists has emerged as a valid and effective tool to support safe return to work or lifestyle activities after an injury or illness.

In Chapter 16 of the *Guide to the Evaluation of Functional Ability*, Genovese & Galper 2009, the chapter authors clearly make the case that an FCE is a clinical evaluation used to answer questions about a person's abilities (and limitations) relative to a medical condition.

The discussion points out that many FCE evaluators do not produce reports that clinically correlate medical findings (found during the FCE or from review of medical records) with the functional findings of the FCE. In fact, the authors point out that reports they have reviewed provide evidence that some evaluators believe that:

1) all the clinician has to do is gather data and input it into their computer;
2) the FCE protocols are stand-alone and that the scoring procedures allow an individual's physical abilities to be determined independent of any clinical judgement;
3) the evaluator's role is more technical than clinical, simply observing performance and recording results.

These points could not be further from the truth. Clinical judgment within the functional testing process is a must in order for the findings of an FCE to be valid and practical.

CASE IN POINT: AN EXAMPLE OF CLINICAL CORRELATION DURING FCE TESTING

Tony –

- Diagnosis: s/p C4/5, C5/6, C6/7 disc herniations with associated radiculopathy and myelopathy.
- Surgical intervention: anterior cervical partial vertebrectomies, diskectomies, spinal cord nerve root decompression at all three levels with interbody fusions.
- Target Job: Parking Lot Cashier (considered within the Light physical demand classification according to the Dictionary of Occupational Titles, 1991 definition).
- Limiting Health Conditions (per self-report): "I fall 2-3X per month," and "I drop objects out of my hands."
- Pertinent Self-report of Activities of Daily Living:
    - "use a chair for showering;"
    - "don't cook, never know when the shocks are coming;"
    - "standing/walking, legs get wobbly;"
    - "stairs, can't do-keep falling."
- Current Complaints: Intermittent neck stiffness, left sided low back pain, and bilateral lower extremity pain, tightness, and numbness.
- Assistive Device: Uses a quad cane for community or home based ambulation assistance and a scooter for distance.
- Neuromusculoskeletal Exam Summary:
    - Moderate decreased cervical ROM and lumbosacral ROM
    - Bilateral sustained (> 5 beats) ankle clonus
    - Upper extremity and lower extremity strength testing WFL throughout
- Standardized Functional Test Results Scores:
    - Very low aptitude for ambulation agility and dynamic balance
    - Low aptitude for ambulation stamina
    - Very low aptitude for climbing
    - Low aptitude for finger dexterity
    - Low aptitude for manual dexterity
    - Occasional standing tolerance
- Performance Results
    - Cooperative and provided good consistent effort
    - No unusual or inconsistent symptoms
    - No superficial tenderness or non-anatomic tenderness

- No inconsistent weakness or strength
- No inconsistent movements with distraction
- No unusual pain behaviors or overreaction
- No abnormal function in unaffected regions
- No refusal to attempt specific tests
- No overestimation of safe-work abilities

In considering Tony's case, the combination of his medical history and diagnoses, self-report of limitations and performance of his daily activities, neuromusculoskeletal findings combined with the functional testing, it was clearly shown that he would be unable to perform the ambulation demands of work as a Parking Lot Cashier.

Tony's sustained clonus reaction was present throughout all weight bearing functional tests and was supported by the examination, medical history, and self-report. In other words, his low tolerance for standing and low aptitude for walking, climbing, and endurance were well supported by considering all the available evidence.

Prior to the FCE, the veracity of his limitations were in question, following the FCE, the case was settled.

IN SUMMARY

A skilled FCE evaluator must demonstrate that the underlying health condition(s) have an effect on the individual's functional performance, or visa versa. It is for these reasons that the FCE can only be properly performed by professionals knowledgeable in anatomy, physiology, pathology, and kinesiology; have skills in clinical and functional evaluation methods; and the ability to draw conclusions by considering the person's injury or illness in the context of all other findings.

REFERENCES

1. American Physical Therapy Association. *Occupational Health Guidelines: Evaluating Functional Capacity*. Alexandria, VA: American Physical Therapy Association; 2010.
2. Gambert SR. The importance of clinical correlation and impact of testing choices on clinical care and outcome. *Clin Geriatr*. 2006;14(5):6.
3. Genovese & Galper. *Guide to the Evaluation of Functional Ability*. USA: American Medical Association; 2009:1-17.
4. US Department of Labor, Employment, and Training Administration. *Revised Dictionary of Occupational Titles*. Vol 1 and 2. 4th ed. Washington, DC: US Department of Labor, Employment and Training Administration; 1991.

Sandy Goldstein is Proprietor and General Manager of Sandy Goldstein & Associates. He originally trained as a physical therapist, and later advanced his postgraduate skills with training and certifications in Social Security disability law, life care planning, disability management, return-to-work program development, and functional testing. He has built a foundation of broad expertise during his 13+ year career. Mr. Goldstein has performed hundreds of functional capacity evaluations and other forms of stay-at-work/return-to-work assessments and has designed programs that simultaneously align incentives, improve outcomes, and reduce costs. He holds the position of Communications Chair for the OHSIG.