President's Message

Lorena P. Payne, PT

We welcome Chris Studebaker and Fran Kistner to the Board. They bring a wealth of knowledge and energy. You will be hearing from Chris as Membership/Communication Chair and Fran as Research Chair. The addition of their time and talents benefit every member as the SIG continues to strive to be a resource for members, regulators, the insurance industry, and corporations.

Combined Sections Meeting in Las Vegas is fast approaching. We are looking forward to sharing information and current concepts relative to prevention, wellness, and the treatment of workers. Programming is Tuesday, February 4, 8 a.m. to 1 p.m. Join us for the Occupational Health SIG Meeting from 12:00 p.m. to 01:00 p.m. Look for these sessions in "Venetian D."

Functional Job Descriptions: The place to begin and end when managing work place injury prevention and treatment. "Can I go back to work?" Answering this question with uncertainty can lead to negative consequences. Would your decision stand up to a legal challenge? What is the chance of reinjury if returned to regular duty? Answering questions related to employment, work and injury can be facilitated with an accurate, valid functional job description. Join in this session for an interactive discussion of the life and times of a functional job description.

Workforce Trends and Their Impact on PT Practice: Aging, Obesity, and Other Complications

This session will explore changing workforce trends. The speakers will offer insight into how these trends impact the health care and physical therapy industries. Implications of the increased number of aging or obese individuals wishing to remain productive in the work force will be discussed. Clinical management techniques, specific ergonomic modifications, and advanced return-to-work programs will be presented.

In the following article, John Lowe discusses the importance of recognizing the functional goals of every person that we see. Regardless of the circumstances of the injury or illness, there is an impact upon ability to perform within the context of gainful employment. Identification of essential job functions is a prerequisite to formulating appropriate treatment plans, clinically based interventions, job site intervention, and goal setting.

Occupational Health: It's Not Just Workers' Compensation

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INTRODUCTION

Occupational health is a term that to most people, health care providers included, typically connotes workers' compensation. In reality however, occupational health encompasses any patient who presents with an illness or injury that precludes returning to a desired work situation. For example, if an individual presents at your clinic for rehabilitation after falling off a ladder while cleaning the gutters at home and sustaining an injury that prevents him/her from returning to work and thereby earning a living, would not one of the treatment goals typically be progressing your patient's physical abilities to allow returning to work? The term occupational health therefore refers to an employee's overall health and ability to perform the essential physical demands of his/her job.[1] Impairments that affect this may be work related or non-work related.

Costs to individuals and employers from work time lost as the result of prolonged health-related absence run beyond merely medical costs. The employee has the physical and emotional trauma of the injury or illness, possibly combined with psychosocial issues such as financial concerns. The employer has to find someone to do the work that your patient was doing. Short-term they might use some combination of supervisors, overtime, and contract labor to cover. Prolonged absences may also require recruitment and training costs involved with hiring replacement workers.[2]

Scope of the Problem

Employee lost time and/or impaired ability to work due to illness or injury may continue to increase as a result of several factors, not the least of which is the aging of the American workforce. Demographics in the United States as well as many other countries indicate that a generation—the baby boomers—are reaching and exceeding middle age.

For a number of reasons members of this generation in many cases continue working on either a full or part time basis longer than anticipated.

The generation following the baby boomers is smaller numerically.[3] This has resulted in the average age of the workforce increasing and current or projected shortages of workers in a number of occupations. Jobs requiring advanced education and training such as health care professionals, tool and die makers, electricians, and welders often incentivize employees to continue working beyond typical retirement age in order to offset shortages of skilled and experienced labor.

Events in the financial markets, changes in the employment

marketplace, and in many cases poor planning has left many people approaching their 60s unable to afford retirement or if not unable at least concerned to the point where they elect to continue working. A survey by the American Association of Retired Persons (AARP) disclosed that 79% of baby boomers plan to work in some capacity during their retirement years and that 25% of them feel they will not be able to afford retirement.[4] The last 50 years has seen a shift from defined-benefit retirement plans (typically funded mostly if not entirely by the employer) to voluntary retirement plans (known as defined contribution plans) that are largely if not totally employee-funded such as 401ks and IRAs. Fewer workers are able to rely upon traditional pensions for a significant portion of their retirement income. Workers who rely on self-funded retirement vehicles which are often invested in mutual funds or other equity vehicles are responsible for the amount of contribution, method of investment, and for taking an overall more active role in planning their retirement. They are exposed to the market risk inherent in the stock and bond markets, resulting in fluctuating values.[5]

Aging workers have of course many of the age-related maladies we as physical therapists encounter daily in our practices. Obesity, arthritis, hypertension, diabetes, and other medical conditions can limit or even prohibit participation in an occupation.[6] For example, workers with osteoarthritis report losing up to 31% of their productive time while at work and an additional 8% resulting from absenteeism as a consequence of their disease.[7] Additionally, while statistically older workers are not necessarily more likely to be injured while working than younger workers, they may sustain more severe injuries and recover from injuries slower than younger workers.[8]

Two disturbing trends indicate that the problem is not necessarily confined to older workers. An estimated 21 million Americans were diabetic in 2005. This is projected to grow by at least 54%.[9] Additionally, 34% of Americans are currently considered to be obese, a trend that also continues a disturbing increase.[10] Chronic and acute medical conditions or injuries may of course impact an individual's occupational participation and productivity in a manner that restricts or precludes their ability to earn a living and therefore need to be addressed during the rehabilitation process.

Implications for Physical Therapists and Physical Therapist Assistants

Physical therapists work with patients to resume preinjury or pre-illness level of function, or in cases where the severity of the patient's impairments rules that out, at least maximize their physical abilities. This concept holds true regardless of who is reimbursing for treatment.

Patients enter our clinics daily for rehabilitation of orthopedic, neurological, and other assorted medical disorders. Causal factors are as diverse as strokes, work injuries, cancer, heart conditions, sports injuries, and COPD. And they may be receiving treatment in a hospital, an outpatient clinic, a rehabilitation center, or onsite at a workplace. The underlying concepts to restore physical function are the same:

- What does this person need to do physically?
- To what degree can he or she currently perform each activity?
- What are the physical impairments limiting performance of those activities?
- How do we address these impairments?

Evaluations, subsequent treatments, and re-evaluations should include asking about and planning for work-related issues in addition to ADL performance. Find out what your patient's current work status is. If the person is currently working their normal job without difficulty, treatment goals obviously would not include occupational factors. If your patient is currently unable to earn a living performing a job or is working in a light duty capacity, find out what they were doing previous to their illness or injury. What are the patient's goals regarding returning to work? Does he or she have any concerns about returning to their job? If so, what are they?

Evaluating, planning, and executing a treatment plan designed to return someone to a specific occupational situation means the treating therapist needs to know the essential functions of that job for both workers and no-workers compensation patients. Every job requires specific physical activities. These include not only factors such as lifting, pushing, and pulling forces, but also positional requirements such as standing, reaching, performing low work, and so forth. If a worker cannot perform these specific physical activities, she or he cannot do their job. Finding out what is physically essential for a patient in order to perform a job is probably best achieved by going to the workplace and analyzing the job. However many physical therapists do not have the inclination, training, experience, and/or comfort level to do functional job analysis. This doesn't mean it should be ignored any more than we would recommend releasing a patient to return to a home environment following surgery without having any knowledge of the architectural barriers present in the home. At a minimum obtain as much information as possible from the patient and by contacting the employer (often times employers can provide job descriptions).

Knowing what a patient needs to do physically in order to make a living allows the clinician to structure evaluations, treatments, and documentation to address the effect of current impairments on job performance. This requires documentation of patient current work status and their goals for returning to work. We can also do some job-related functional testing and document current demonstrated abilities vs. required physical abilities. This in turn allows us to design the treatment to specifically address demonstrated physical shortcomings that impact resuming preinjury (or other if the person plans to work at a different job than their preinjury one) work duties. This is no different than designing treatment interventions to address ADL items such as negotiating stairs, dressing, etc. The underlying thought process is the same: find what the essential physical requirements are for performance of the required tasks, evaluate the patient's current ability to perform these, document your findings, and set up a treatment program to develop your patient's ability to perform these tasks.

Occupational health also involves developing strategies for continuing work with chronic medical conditions and injuries. This involves working with the employer to find out what sort of worksite physical accommodations are reasonable. Patients with chronic physical impairments may benefit from interventions such as[1]:

- Transitional work: gradually increasing the physical stresses of the job by progressing the duration and intensity of the physical activity, thereby allowing the patient to adapt to the workload.

- Work station modification: adjusting the physical environment the patient works in to minimize mechanical stresses that might exacerbate the patient's condition.
- Work task modification: working with the patient and employer to develop ways to perform required work tasks in a manner that minimizes stress on injured joints and tissues.
- Using modified tools or other adaptive equipment: the same concept as work task modification. Examples of modified equipment include different kinds of computer keyboards and mouse, modified grips on hand tools, anti-fatigue floor mats, and spring-loaded pallets.
- Exercise programs of focused strengthening and/or stretching activities to maintain flexibility and strength gains from treatment and hopefully thereby minimize the likelihood of exacerbation.
- Wellness: general diet, exercise, and lifestyle improvement programs that improve an individual's overall health and well-being can reduce health-related work absenteeism.

CONCLUSION

Occupational health is a part of practice even for physical therapists that do not typically treat workers compensation patients. We work with our patients to restore function lost as the result of an illness or injury. If a patient is employed, and if the illness or injury incurred prevents or inhibits their ability to work, one of the goals of treatment may be resuming work. This requires specific functional restoration based on the essential physical requirements of the patient's occupation. Effective treatment requires understanding the physical requirements essential to performance of each patient's job, preparing the patient to tolerate those specific physical stresses, and effectively communicating with other medical professionals, the employer, and the payor the treatment goals, rationale and progress.

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Orthopaedic Section, APTA, Inc.

FALL BOARD OF DIRECTORS MEETING MINUTES
October 10-11, 2013

(Continued from page 59)

=MOTION 14= Steve McDavitt, President, moved that the Orthopaedic Section Board of Directors approve the Section and the Hand Rehabilitation Section collaborate and utilize their combined resources to create clinical practice guidelines Management of Distal Radius Fractures, (1) coordinated by the Orthopaedic Section ICF-based Clinical Practice Guidelines Coordinator and Advisory Panel, (2) to be published in JOSPT, (3) using the following listing in the title: Clinical Practice Guidelines linked to the International Classification of Functioning, Disability, and Health from the Section on Geriatrics and Orthopaedic Section of the American Physical Therapy Association, 4) utilizing the following copyright and permission statements: ©201_ Orthopaedic Section American Physical Therapy Association (APTA), Inc., and the Section on Geriatrics, APTA, Inc., and the *Journal of Orthopaedic & Sports Physical Therapy* consent to the reproducing and distributing this guideline for educational purposes, and 5) submit to have the guideline on www.guidelines.gov.
ADOPTED (unanimous)
Fiscal Implication: None

=MOTION 15= Steve McDavitt, President, moved that the Orthopaedic Section Board of Directors approve a one day meeting at CSM 2014 for the 9 individuals of the Neck Pain Revision workgroup to organize, review, and appraise articles for the revision. ADOPTED (unanimous)
Fiscal Implication: Total = $2,277

Steve McDavitt, President, reported on the activities of the ARSIG and the outcomes database.

=MOTION 16= Steve Clark, Treasurer, moved that the Orthopaedic Section Board of Directors approve the 2014 as revised. ADOPTED (unanimous)
Fiscal Implication: None

=MOTION 17= Steve McDavitt, President, moved that the Orthopaedic Section Board of Directors approve developing a student information packet on the benefits of membership and send via an Osteo-blast. We would then eliminate the welcome breakfast at CSM 2014. ADOPTED (Steve McDavitt, President – in favor; Gerard Brennan, Vice President – absent; Steve Clark, Treasurer – in favor; Tom McPoil, Director – in favor; Pam Duffy, Director – in favor)
Fiscal Implication: None

=MOTION 18= Joe Donnelly, Practice Chair, moved that the Orthopaedic Section Board of Directors charge the Practice Committee with reviewing the residency and fellowship residency curriculum information for clarity and consistency on what we are providing with a report back to the Board with recommendations. ADOPTED (Steve McDavitt, President – in favor; Gerard Brennan, Vice President – absent; Steve Clark, Treasurer – in favor; Tom McPoil, Director – in favor; Pam Duffy, Director – in favor)
Fiscal Implication: None

The following was brought up under closing comments -
- Reviewed meeting logistics and agreed to continue using this format for future meetings in La Crosse.
- Discussed purpose of having a Board meeting at the 2014 Annual Meeting.

ADJOURNMENT 4:30 PM CT Friday, October 11, 2013
Submitted by Terri DeFlorian, Executive Director