

Occupational Medicine Newsletter

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TCOHR can help you manage your WC care costs

In Minnesota, most employees can choose where to seek care for job related injuries. Still, employers can use 'Authorization & Referral' forms and tear-off maps from our posters to point employees to TCOHR clinics.

Even if an employee seeks care somewhere else, many employers will require that the individual be assessed by a medical provider of their choosing to be sure that the employee is 'fit for duty.'

We invite you to read the article on the next column for more insights on how TCOHR can help you better achieve your W/C injury goals.

DOT Publishes Notice of Proposed Rulemaking

On February 4th, 2010 the Department of Transportation proposed changes to 49 CFR Part 40, Procedures for Transportation Workplace Drug and Alcohol Testing Programs. The proposed changes seek consistency between DOT drug testing and non-DOT Department of Health & Human Services (HHS) drug testing requirements. Recommendations include: Adding MDMA (i.e. Ecstasy), lowering cutoff levels for cocaine and amphetamines, conducting mandatory initial testing for heroin and authorizing employers to use HHS-Certified Instrumental Initial Test Facilities to conduct initial drug-testing. Public comments must be submitted by April 5, 2010. To view the Federal Register notice and directions for submitting comments, please visit:

<http://edocket.access.gpo.gov/2010/pdf/2010-2315.pdf>

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The Occupational Medicine Model: An interview with Dr. Dick Huset, MD, MPH.

When treating an injured worker, the Occupational Medicine Model assumes that:

- 1) Employers want productive and healthy employees;
- 2) Employees want and need their job;
- 3) It is usually in both parties' interest that proper healing occur while (whenever possible) keeping the injured employee at some level of productivity.

Unfortunately, outside of an occupational medicine model, these assumptions are often not shared between the medical provider, the injured worker, the employer, and indirectly with direct supervisors.

In a traditional medical model, a common view is to 'protect the injured worker from the workplace.' Lacking a clear understanding of the workplace and of the duties that the employee will return to, too often providers discount the value of having an employee heal while remaining productive and at work. Even when providers don't restrict an employee entirely from work, work restrictions are often overly general (e.g., 'unable to work outside') or overly specific (e.g., 'not allowed to use xyz tool').

The occupational medicine model communicates functional restrictions to both the employee and employer, who together determine if and how accommodations can be made. For example, 'Avoid vibrating power tools' or 'lifting less than x pounds.'

The occupational medicine model also assumes that

- 4) *Healing takes time.*
- Providers know, for example that X injury requires 2 weeks to heal and Y injury requires 6 weeks. If a patient is not making progress within those expectations, it becomes necessary to reassess the patient. Healing can be slowed by ignoring work restrictions, overdoing activities outside of work, missing therapy, not following prescribed exercises or stretches, being sedentary, etc.

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If a patient is not making progress, it is sometimes necessary to involve a specialist. Referral networks should tend to be to specialists who are both technically expert as well as supportive of the occupational medicine/return to work model.

5) Healing is psychological, social and physical.

The psycho-social-physical link is also crucial to recovery.

Take for example, a common low back strain. Maybe for the first time in her or his life, a worker is in acute pain. Pain makes them apprehensive not only about how they move and rest, but about how they begin to see the future. *Will this become a protracted disability? How will I pay my bills if I can't work? Who will hire me if I lose this job?* If sent home to 'rest' for a week, by the end of that time of isolation and inactivity (which limits range of motion and can lengthen tissue healing) the patient is often teetering on the brink both emotionally and financially.

Instead, the occupational medicine model motivates the injured worker to stay mobile and active with limitations, being both physically and psychologically therapeutic. Co-workers who surround injured workers communicate their expectation that the injury will heal, providing 'pats on the back' for making progress (e.g., "Joe, look at how well you are doing?" "You're moving better today!") The ability to continue to draw a paycheck means that economics don't become as much a factor, enabling the worker to focus on their recovery. Even when the patient arrives for follow-up exams or therapy, occupational medicine clinic staff share and reinforce their expectation that the worker is likely to get better and return to work as a fully-contributing person; something we presume most people want.

6) Using the Teachable Moment

One other distinction of the occupational medicine model involves taking advantage of the 'teachable moment.' Is it really enough to send someone home just with a prescription for meds and rest? The occ med model requires that providers take time to review injury prevention strategies with the patient and sometimes with the employer; strategies that can be applied both during and after the healing process. Failure to take full advantage of this critical opportunity destines the patient to repeat past mistakes.

In 2009, TCOHR performed nearly 10,000 drug and alcohol tests, and nearly 5,000 physicals

While under Minnesota law, most employees can choose where they want to be treated for workers-compensation injuries, there is a difference between an employer requiring or referring. Given the substantial benefits to both employees and employers, is it time for your workplace to partner with a medical service that operates within the occupational medicine model?

H1N1: Follow-up on Vaccine Safety

TCOHR still has an ample supply of H1N1 vaccine.

An FDA/CDC analysis of 3783 reports of adverse events submitted to the Vaccine Adverse Event Reporting System through November 24, 2009, showed no substantial differences between H1N1 and seasonal

influenza vaccines in the proportion or types of serious adverse events reported, nor was there any increase in Guillain-Barré syndrome or any of the other adverse events under surveillance.

To date, experience with the H1N1 influenza vaccination program has met high safety expectations, based on the track record of the licensed seasonal vaccines, including live attenuated and inactivated vaccines. *Morbidity Mortality Weekly Report*. 2010;59:1-5.

Stretch of the Day:

One of the easiest ways to stretch the hamstring is to:

- a) place the leg you wish to stretch up on a small bench or chair,
- b) lock your knee fully straight,
- c) bend the other knee just a few degrees, and
- d) bend forward reaching for your toes,
- e) hold for a count of 5 to 10 and repeat with the other leg

