

**Incoming President Address
Ronald Zipper, D.O., FAADEP
Orlando, Florida
January 8th, 2010**

AADEP

American Academy of Disability Evaluating Physicians



Welcome to sunny Orlando!



- In 2003, AADEP President Bob Haralson III, M.D., MBA, FAADEP issued a challenge.
- *“The Activity Paradigm”*.
- He identified the **Disability Crisis**-and predicted the demise of AADEP if the **Disability Crisis** and the **barriers** to overcoming it weren’t strategically addressed.



- The **Barriers** were:
 - The *Patient*
 - The *Physician*
 - The *Employer*
 - The *Attorney*
 - The *Insurance Industry*
 - The *Union Official*
 - The *Administration Law Judge*
- The result was the iatrogenic creation of a population of **permanently disabled** workers, and the dysfunctional effects and costs on our society.
- The **#1** etiology was **Chronic Low Back Pain**.



- Has AADEP met the *Activity Paradigm Shift* challenge?

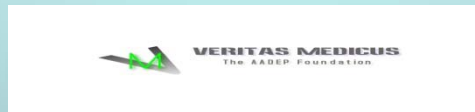
answer: ***YES!***

- Has AADEP *removed the barriers* that Dr. Haralson addressed in 2003?

answer : ***we don't have the evidence of how effective we've been!***

AADEP *Initiatives Since 2003*

- *Associate Membership.*
- AADEP is *financially solvent.*
- *PERT* - Prevention, Evaluation, Rehabilitation & Treatment.
- *CEDIR* Certification for all “Guides” editions.
- *Home Study* CME.
- CME emphasizing *Evidence Based Medicine (EBM).*
- *Society for Disability Prevention & Mgt.*
- *Collaboration* with other Associations.
- *Veritas Medicus.*
- Maintaining *ACCME accreditation for 4 more years.*





Teaches the Rationale Approach to the Early RTW of the Injured Patient

AADEP Courses Stress:

- Employee ***Safety Monitoring***.
- Providing ***Safe Job Descriptions*** within employees' capacities.
- ***Early Incident Reporting*** & Medical ***Referrals***.
- Accurate Diagnosis & Early ***Aggressive Conservative Interventional*** Physician Directed Care Based on ***EBM***.
- ***Early RTW – Transitional*** Work Facilitated by the Case Manager.
- Excellent ***Communication Between All “Players”***.
- Employer ***RTW & Wellness Programs*** Identifying ***High Risks***.
- ***Indemnity Benefits & Prompt Insurer Payments***.
- ***Attorneys Assisting*** Injured Workers' RTW Without Re-injury.
- Work Comp Boards Facilitating ***Consistent Standards & IR's*** .



***So, Has the AADEP Activity Paradigm Shift
Succeeded in Implementing Rational
Treatment of Occupational Injuries in 2010?***

Answer: NO!

Why Not?

2010 Trends in Workers Compensation

- ***Workers Compensation pays more than Group Health.***
 - ***Over-Utilization differences dominate price differences, explaining 80% of the overall cost difference.***
 - Utilization differences vary principally by type of injury, with ***all occupational injuries having higher costs than group health.***
 - Traumas to extremities (fractures) consistently have smaller cost & utilization differences, while ***chronic pain-related injuries such as bursitis, carpal tunnel and low back pain have the largest costs.***

With a “Rational” System Why Are There Still Problems?

The logo for The New York Times, featuring the name in a classic, blackletter-style font.

“A World of Hurt”

“In Workplace Injury System, Ill Will on All Sides”

Fred Willette, a former metal grinder with lung disease, says he was fired for talk of filing a claim. **STEVEN GREENHOUSE**: *April 1, 2009*.

“Exams of Injured Workers Fuel Mutual Mistrust”

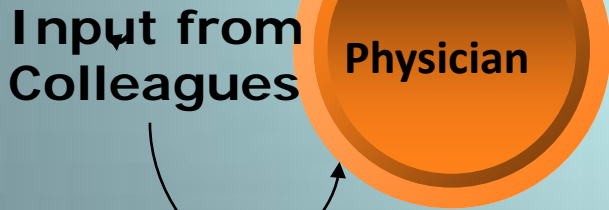
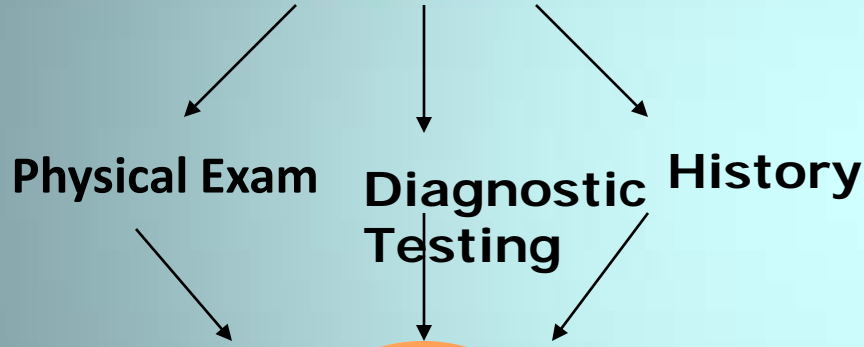
There are questions about whether doctors hired by insurers to examine injured workers are really independent. ***N. R. KLEINFELD***: *August 16, 2009*.

“For Injured Workers, a Costly Legal Swamp”

The hurt workers wait on benches at the Queens office of the New York State Workers’ Compensation Board. **KLEINFELD** and **GREENHOUSE**, *2009*.

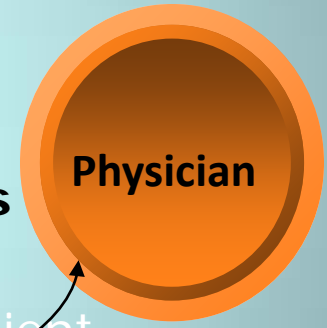
What **Barriers** Continue to Create Disability?

Private Care

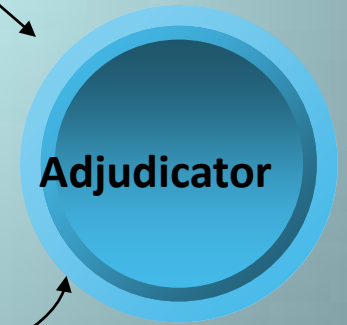


Recommendation to Patient

Occupational Injuries



Work Requirements
Accommodations?
FCE's, RTW, MMI?



Disability/ Impairment Determination = \$\$??

Barriers Still Preventing Implementing Rationale Approaches to RTW and Preventing Disability Patients in 2010

- The **employee's psychosocial status at the time of and after the injury**. The **Injury Model** rather than the **Psychosocial Model** still predominates.
- **Employer mismanagement** - unwilling to accommodate **transitional RTW** or **educating** their employees insurance benefits.
- **Insurers 'initial response assuming fraud**, resulting in defensive "I'll show them I'm really sick" attitudes.
- The **lack of family support** of prolonged rehabilitation.
- The conundrum continues to be **CHRONIC PAIN – the focus of this course!**

The **Barriers** to Rationally Approaching to the Work. Comp. Patient -2010

- The **number of IME's required** by insurers or attorneys.
- The **length of time** out of work.
- Attorneys encouraging patients to **remain inactive attempting to increase settlements.**
- The **sense of employee powerlessness** having no control over repeated exams, decisions or treatment decisions.
- The **adversarial W.C. case management by all "players", including the judiciary.**

Barriers to the Rationale Approach to the Work. Comp. Patient

- Mismanagement of initial treatment – doctors ***not identifying high risk factors, not setting goals, and not encouraging early transitional work.***
- Mismanagement by the treating doctors by ***continuing ineffective or unnecessary treatment,*** or delays in **Red Flag** referrals.

Barriers: Physician's Impact of Communication in Occupational Injuries

- Are **we** recognizing our ***inabilities in communicating*** with our patients, the OHC team, employer, case manager, insurer or attorneys?
- Do **we** realize that most complaints against us have more to do with ***our attitude*** rather than our clinical competence?
- Are we mismanaging our initial treatment by ***not: identifying high risk factors, setting goals, or encouraging early transitional work?***
- Are we mismanaging our treatment by ***continuing ineffective or unnecessary treatment, or delaying Red Flag referrals?***
- We must ask ourselves individually and as an Academy if we have any ***Professional Learning Gaps.***
- Is our care successfully, or unsuccessfully ***creating positive changes in preventing occupational disability? ACCME now requires this result from AADEP CME.***



So, Congratulations to the AADEP SELF STUDY TEAM for AADEP's New Four Year ACCME Re-Accreditation

- Marc T. Taylor, MD, FAADEP – **15** Years.
- David C. Randolph, MD, FAADEP – **12** Years.
- Douglas W. Martin, MD, FAADEP – **8** Years.
- Sandra L. Yost, MBA, FAADEP – **15** Years.
- Debbi Frigo – **16** Years.
- Mysi DeSantis, MPA – **1** Year.
- Michelle Belsey – **1** Year.



- **AADEP's 2010 Challenges:**

- ACCME now requires evidence that our **CME results in positive outcomes** in our identifying our **Professional Practice Gaps** which result in **positively altering patient and society's health outcomes.**

Can AADEP successfully be reaccredited in 2013?

- Has AADEP successfully communicated to all “players” in occupational injuries through 
- Has AADEP been successful in recruiting **Associate membership?**
- **Challenge: Your BOD needs your help for AADEP to remain viable. Please volunteer your ideas and contributions. The best minds in Disability prevention are sitting in this room!**



Thank you! See you at tonight's reception.