The Value of Evidence-Based Treatment and Return-to-Work Guidelines

By Philip L. Denniston

According to the Centre for Evidence-Based Medicine, “Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.” Once you become familiar with the term, the idea of putting that principle into practice for medical treatment seems like common sense — so much so that it is hard to believe that using evidence-based standards has not always been common practice.

Although testing medicine for its efficacy can be traced back to ancient Greece and Chinese medicine, it was not until the early 1990s that actual methodologies used to determine “best evidence” were established. These methodologies were decided by a McMaster University research group led by doctors Gordon Guyatt and David Sackett, who followed in the footsteps of professor Archie Cochrane, a Scottish epidemiologist and pioneering advocate of evidence-based practices in the 1970s.

The term “evidence-based medicine” first appeared in medical literature in 1992 in a paper by Guyatt et al. Two years later, Dr. Sackett founded the Centre for Evidence-Based Medicine (CEBM). CEBM is a not-for-profit organization based at Oxford University with the purpose of collaborating with, and assisting in, the development of evidence-based healthcare training programs internationally.

Setting a Standard

In 1998, the U.S. Department of Health and Human Services’ Agency for Healthcare Research and Quality (AHRQ) decided to create a clearinghouse with specific inclusion criteria so that the public could sort through the growing number of evidence-based guidelines by using the AHRQ’s quality-control benchmarks. Inclusion criteria would require that, among other things, “Corroborating documentation can be produced and verified that a systematic literature search and review of existing scientific evidence published in peer reviewed journals was performed during the guideline development.”

What resulted is the National Guideline Clearinghouse (NGC) (www.guidelines.gov), an Internet-based free public resource that contains summaries of evidence-based clinical practice guidelines and related documents. NGC’s mission is, “To provide health care professionals with an accessible mechanism for obtaining objective, detailed information on evidence-based clinical practice guidelines and to further their dissemination, implementation and use.” As of May 2009, this database contained 2,400 clinical practice guidelines from hundreds of organizations.

There are different types of evidence-based guidelines, and the focus here is on return-to-work and treatment guidelines. Return-to-work guidelines provide durations for time out of work for an illness or injury. Treatment guidelines recommend treatments and treatment pathways. As with both types of guidelines, choosing an evidence-based guideline ensures that the recommendations come from actual experience data and clinical trials, and that they are not biased by contributors who may have a vested interest in promoting a particular treatment.

It is important to note that the advent of the evidence-based guideline does not mark the decline of the clinical practitioner. While evidence-based medicine defines the likelihood of a specific outcome, real world cases do not take place in a vacuum, and users of the guidelines must take into account the case at hand, including any extenuating circumstances and co-morbidities. In using one’s own experience in conjunction with evidence-based guidelines, the practitioner can help ensure that he will be able to back up decisions with the references and statistics on which the guidelines are based, whether in a discussion with the patient, employer, insurance company, or court of law.

The Benefits

The Official Disability Guidelines (ODG), published by Work Loss Data Institute, have been accepted for inclusion by the AHRQ in the National Guidelines Clearinghouse. They were accepted in 2005 and were the first national workers’ compensation guideline to be included. ODG uses an aggregate of over 10 million cases from the CDC and OSHA, and additionally maps out best practices for time out of work depending on treatment pathways.
It is unique among workers’ compensation guidelines in that it takes evidence-based guidelines to their logical end point; the recommendations are linked directly to the evidence in the studies and references, which have been compiled through a comprehensive and ongoing medical literature review with preference given to high-quality systematic reviews, meta-analyses and clinical trials.

Data from the Ohio Bureau of Workers’ Compensation collected in a pilot study by CompManagement in 2005 provides an example of how the use of ODG has led to cost savings, reduced treatment delay, and faster return to health. Following program adoption in 2003, workers’ compensation medical costs were reduced by 64 percent and lost days were reduced by 69 percent. Most importantly, treatment delay was reduced by 77 percent.

The success in Ohio was reaffirmed in a $7 million comprehensive Deloitte Consulting study of Ohio’s workers’ compensation system completed in April 2009, where one of Deloitte’s major recommendations was to further strengthen Ohio’s adoption of ODG, saying, “The bureau should be prescriptive and mandate the use of ODG... ODG is the emerging standard for UR decisions and expected disability duration.” www.ohiobwc.com/deloitte.

About 20 states and provinces have adopted or approved ODG as an authority for use in their workers’ compensation systems and have found that using evidence-based guidelines has had a substantial and positive impact on time and cost of claims.

North Dakota adopted the program in 2005, and since then its workers’ compensation premiums — already the lowest in the nation — dropped another 44 percent, and $52 million in premium dividend credits were returned to North Dakota companies. The state’s House Majority Leader Rick Berg commented, “This is one of the largest direct cash infusions into North Dakota’s economy that the state has seen.”

Texas adopted ODG as the standard for all non-network medical care administered for workers’ compensation claims in 2006. Recently, the Texas Division of Workers’ Compensation reported that since the adoption of ODG, the average cost per claim has gone down, the number of disputes has declined by 44 percent and, in one specific example, the number of spinal fusions decreased by 71 percent in the first year of adoption. At an average cost of over $100,000 each, based on the number of fusions that had been performed, this alone represents an annualized savings of $211 million. The benefit is not just in the cost savings. For the workers, the use of an evidence-based treatment guideline means that they are finally getting the right treatment and, as demonstrated in Texas, preventing unnecessary procedures.

In Summary

Using evidence-based guidelines benefits all the stakeholders — the employer, employee, insurer, and provider — by setting a standard for proven quality and timely care and by taking the guesswork out of treatment and disability duration. Injured workers return to health, and therefore to work, faster by benefiting from the least invasive, most effective treatment today’s science offers. Though not the focus, a significant byproduct of using evidence-based treatment guidelines is cost savings across the board for all.

In addition, providers using evidence-based guidelines are assured of timely payment in states that have adopted the guidelines. They also have a wealth of research, studies and unbiased peer-reviewed conclusions at their fingertips, not only for their own use in making treatment decisions, but also as a backbone for their personal defense if ever a treatment decision is questioned.

Although the scientific studies are based on one main question: “What is most successful in getting the patient better,” time has shown that what benefits the injured worker also benefits the employer, insurer and the provider. Since the dawning of the first documented use of the term “evidence-based” in 1992, the effectiveness of using such guidelines has demonstrated itself repeatedly. We have come a long way in improving treatment, reducing costs, and getting employees back to health and productivity thanks to the use of evidence-based guidelines. ▲

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