Introduction to the New Work Disability Prevention Paradigm

"Preventing Needless Work Disability by Helping People Stay Employed"

A blueprint for process improvement from the American College of Occupational and Environmental Medicine (ACOEM)

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Abstract

This article describes a new model for preventing needless work absence and withdrawal following injury or illness. This model is embodied in a guidance statement from the American College of Occupational & Environmental Medicine. Subsequent to the publication of ACOEM's guidance statement, a separate initiative called The 60 Summits Project began

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to propagate this new model and drive its implementation across North America. In the traditional benefits processing model, the focus is on processing and adjudicating a person's claim for disability benefits or workers' compensation accurately and then paying the benefits promptly – while leaving the claimant alone to manage the impact of their injury on their life and work situation. In contrast, the point of ACOEM's new work disability prevention model is to anticipate and assess the impact of illness or injury on the whole situation (person + work), and to actively drive the real-world situation towards the best achievable overall outcome. This article first reviews the history and development of ACOEM's guidance statement, then provides a conceptual overview of the new model and 16 specific recommendations for process improvement, and concludes with a brief history of The 60 Summits Project which will be described in more detail in the next article in this two-part series.

Introduction and Background

This is the first article in a two-part series whose purpose is:

1. In Part I, to offer a new conceptual model to stakeholders in workers' compensation systems the work disability prevention paradigm – along with a set of recommendations that constitutes a blueprint for improvement of the stay-at-work and return-to-work process (SAW/RTW) and that are laid out in a paper by the American College of Occupational & Environmental Medicine (ACOEM) entitled "Preventing Needless Work Disability by Helping People Stay Employed."
2. In Part II, to describe some initial and largely grassroots multi-stakeholder efforts now underway in several jurisdictions as part of The 60 Summits Project described later in this document to disseminate the work disability paradigm – and then to move beyond exhortative discussion to making concrete plans for how to implement the changes recommended by ACOEM, and begin to carry them out.

Most of the changes recommended by ACOEM[1] and espoused by The 60 Summits Project focus on increasing collaboration among stakeholders in pursuit of a shared vision of how the SAW/RTW process should function within and between medical offices, workplaces and insurance companies. The overall goal is to improve the way the SAW/RTW process usually operates across North America, and thus to improve the outcomes of health-related employment situations. If needless work disability is prevented, both workers and their employers will benefit, as will society.

Although I am lead author of the ACOEM work disability prevention paper, chaired the group that developed it, and remain active in the College, I am neither representing nor speaking on behalf of ACOEM in this article. I am speaking as founder and chair of the 60 Summits Project, now a separate non-profit corporation that has no formal relationship with ACOEM. ACOEM is a professional society for physicians and other highly trained professionals. The 60 Summits Project advocates for positive social change and may be best classified as a community development effort.

History

In 2002, the elected all-physician Board of the American College of Occupational & Environmental Medicine (ACOEM) decided to form a committee that became known as the Stay at Work and Return to Work Process Improvement Committee. Appointed as the first chair of that committee, I proposed that our inaugural project be a review of the current state of the SAW/RTW process across North America which would include recommendations for improvement. The proposal was accepted, and we began work.

Committee members were carefully recruited to ensure that readers in a variety of audiences would believe that the report had been produced by

[1] ACOEM is the pre-eminent professional society of physicians and other highly trained professionals involved in the practice of occupational & environmental medicine. See www.acoem.org

experts on the topic. So, members were chosen who represented a broad array of specialties and work settings, and had deep familiarity with the workers' compensation and disability benefits systems from a variety of perspectives. The physicians who agreed to join the committee had a passion for achieving better outcomes of health-related employment episodes, and agreed that the committee should share with as broad an audience as possible the insights its members have gleaned about the preventable nature of much work disability.

Seven medical specialties are represented among the 21 developers: emergency medicine, family practice, internal medicine, occupational medicine, orthopedics, physiatry, and psychiatry. Eleven have additional post-graduate degrees. At the time, they were working in private medical practice, government, academia, heavy industry, as well as workers' compensation and disability insurance companies. (No physician affiliated with a union was available.) The members were located in Canada and in 15 of the United States. The paper was developed without any outside financial support.

The committee, all members of ACOEM, worked together for two years to develop a white paper that was subsequently shortened for publication in its current guidance statement format. (Some of the explanatory and background material in this article was originally included in the white paper, but eliminated by ACOEM during editing process.) The guidance statement was formally adopted by ACOEM in May 2006.

That same month, the first multi-stakeholder Summit in The 60 Summits Project was held in Portland, Oregon. Since then, a total of 15 Summits in 9 jurisdictions—Oregon, New Mexico, North Dakota, Minnesota, Ohio, Montana, Arizona and Florida— have been held. Three more jurisdictions (Wisconsin, British Columbia and Michigan) are scheduled to hold Summits in the next several months. Multi-stakeholder groups of volunteer professionals have planned and produced most of the Summits. Multi-stakeholder coalitions or consortiums have been formed following the Summits in California, Minnesota, Ohio, Arizona and Florida.

Rationale for and Intended Uses

The fundamental precept for physicians is "first, do no harm." However, physicians in practice see daily the contrast between well- and poorly-managed health-related employment situations and the harm that results from poor management. Identical medical problems end up having very different impacts on people's lives. The differences in impact cannot be explained by the biology alone. Physicians see devastating psychological, medical, social, and economic effects caused by unnecessarily prolonged work disability and loss of employability. They also see wasted human and financial resources and lost productivity.

The physicians who developed "*Preventing Needless Work Disability by Helping People Stay Employed,*" the ACOEM paper summarized below, wanted others to know that much work disability is not required, from a strictly medical point of view. The primary goals of the committee were to draw attention to the SAW/RTW process and to shift the way many people think. Their intent was to open a dialogue with all stakeholders in the workers' compensation and non-work-related disability benefits systems: employers, unions, working people, the insurance industry, policymakers, the healthcare industry, lawyers and healthcare professionals, especially all physicians.

Finding better ways of handling key non-medical aspects of the process that determines if an injured or ill person will stay at work or return to work can improve outcomes. Until now, the distinct nature and importance of the SAW/RTW process has been largely overlooked in American jurisdictions. Improvements to that process will support optimal health and function for more individuals, encourage their continuing contribution to society, help control the growth of disability program costs, and protect the competitive vitality of the North American economy.

Everyone is invited to use "*Preventing Needless Work Disability by Helping People Stay Employed*" as a framework for discussion about how to work together towards solutions. It can be referred to as ACOEM's Work Dis-

ability Prevention (WDP) paper or guidance statement[2].

The full text of ACOEM's WDP paper can easily be found and downloaded for free on The 60 Summits Project's homepage at www.60summits.org. It is also available at no charge at www.acoem.org. (Go to Web heading Policies & Position Statements and then go to Guidance Statements.)

Structure

The 20-page ACOEM WDP paper is addressed to all stakeholders and provides no specific guidance about the management of individual cases. (In contrast, the several hundred pages of the 2nd edition of the ACOEM Occupational Medicine Practice Guidelines are intended for that purpose. The Practice Guidelines lay out recommended diagnostic and treatment choices for common work-related medical conditions. Some basic concepts and definitions that appear in chapter 5 of the Practice Guidelines

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[2] The words "guideline" and "guidance" have caused some confusion. The 20-page paper entitled "*Preventing Needless Work Disability by Helping People Stay Employed*" **is not the same as** ACOEM's much better known treatment or practice guidelines.

- The guidance statements section on ACOEM's website has a series of six short papers that are available to the public at no charge, including the one on preventing needless work disability. Others focus on topics such as protecting health care workers from tuberculosis, use of contact lenses in an industrial environment, HIV and AIDS in the workplace, and so on.
- The publications section on ACOEM's website offers for sale a document entitled Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers. The practice guidelines are addressed to treating physicians, and make specific recommendations on how to diagnose and select treatments for the most common work-related medical conditions based on ACOEM's assessment of the best currently-available medical evidence. They were adopted by the State of California as the interim presumptively correct standard of care for workers compensation in 2004.

entitled "Cornerstones of Disability Prevention and Management" also appear in the WDP paper.)

The first half of "*Preventing Needless Work Disability by Helping People Stay Employed*" provides the groundwork for readers to understand the second half. Most importantly, the first half describes the SAW/RTW process, how it works and how it parallels other related processes. The second half discusses factors that lead to needless work disability and what can be done about them. In all, 16 sections with observations and specific recommendations are grouped under four general headings:

1. Adopt a Disability Prevention Model
2. Address Behavioral and Circumstantial Realities that Create and Prolong Work Disability
3. Acknowledge the Powerful Contribution that Motivation Makes to Outcomes and Make Changes that Improve Incentive Alignment
4. Invest in System and Infrastructure Improvements

Societal Context

The average age of the North American workforce has been increasing. The burden of chronic disease in the population and its resulting impact on function has been rising. Episodes of prolonged work disability[3] due to common conditions such as depression and low back pain are becoming more common. As the population is aging, the fraction of the U.S. population now receiving social security disability payments is also rising. Although the incidence of work-related injuries and illnesses has been falling steadily for the last several decades, the length of disability following work-related injury has been climbing, as have the number of medical services and their costs. Paradoxically, employers are paying for more – and more expensive – medical services but people are nevertheless losing more time from work attributed to medical reasons (U.S. Department of Commerce, 2003).[3]

The fundamental questions the ACOEM WDP paper is designed to answer are:

1. Why do some people who develop common everyday problems like backache, wrist pain, depression, fatigue, and aging have trouble staying at work or returning to work?
2. How can employers and insurers work more effectively with healthcare providers to reduce the disruptive impact of injury, illness and age on people's daily lives and work, and help them remain fully engaged in society as long as possible?

[3] In ACOEM's WDP paper, the word "disability" is employed the same way that employers use it in their benefits programs and employment policies, and the same way that insurance laws, regulations, and policies do. In this context, "disabled" means someone who is absent from work or not working at full productive capacity for reasons attributed to a medical condition. Please note that confusion is common regarding the word "disability" since it is sometimes used to describe physical or functional impairments. For example, a person who has an impairment that affects one or more life functions is considered to have a disability under the Americans with Disabilities Act (ADA). However, people with ADA-qualifying impairments who are working at full productive capacity would NOT be considered disabled according to the WDP paper's definition, because they are at work. We prefer the phrase "work disability".

The focus of the WDP paper is on the surprisingly large number of people who end up with prolonged or permanent withdrawal from work due to medical conditions that normally would cause only a few days of work absence. Many of those who end up receiving long-term disability benefits of one sort or another have conditions that began as common everyday problems like sprains and strains of the low back, neck, shoulder, knee and wrist, or depression and anxiety. As will be discussed later, prolonged work withdrawal (disability absence) by itself can produce unfortunate consequences, and averting them is an intended outcome of the WDP paper.

On the other hand, many of the people who receive disability benefits have severe illnesses like a major cancer or schizophrenia or have suffered catastrophic injuries such as amputations, blinding, major burns, or spinal cord injuries, or have had major surgery. These people, too, are susceptible to the influences described in this paper, although the effects may be overshadowed by the obvious difficulties of coping with medical problems of this magnitude, and the need to learn skills and methods to deal with any resulting impairments. In these cases, a prolonged period of work absence is often unavoidable. The traditional rehabilitation approach delivered by an array of professionals was designed to meet the needs of these people. The question still arises: what amount of this work disability could be prevented?

The WDP paper's developers contend that a considerable amount of the work disability due to common everyday conditions (and an unknown fraction of the work disability that follows more serious conditions) is avoidable, as are its social and economic consequences. They believe that a lot of work disability can be prevented or reduced by finding new ways of handling important non-medical factors that are fueling its growth. Full implementation of many of the recommendations made in the WDP paper will require collaboration among stakeholders, regulators and policy makers, but forward progress can and is already being made by committed individuals and companies on their own.

Until now, mitigating the impact of illness and injury on everyday life and work – with the goal of preventing needless disability, preserving function,

and protecting quality of life – has not been within the traditional purview of medicine[4], nor has it been within the perceived scope of workers' compensation policy or systems. It is time to broaden the purview, expand the scope and shift the paradigm.

By observing how things usually operate today, one can infer the basic assumptions underlying the prevailing (traditional) paradigm of disability management:

1. Work absence or disability is necessary after illness and injury.
2. Work avoidance assists in recovery from illness or injury, so it is good.
3. 3Duration of work absence reflects the severity of the illness or injury.
4. Most people don't need any help because they will receive appropriate medical care and support in managing their health-related employment disruption.
5. Tragic situations and "bad people" cause most loss costs.

The "new" disability paradigm rests on different assumptions, which are:

1. Much of today's work disability could be foreshortened or averted entirely because work absence is not medically required for more than a few days after illness and injury.
2. Being active during convalescence speeds recovery, while extensive work avoidance and "rest" tend to delay it.
3. Prolonged absence or permanent withdrawal from work is bad for people's well-being – mental, physical, social and economic.
4. Prolonged withdrawal from work is usually being driven by non-medical factors instead of medical ones, most commonly the inaccurate perception that work avoidance is medically

[4] ACOEM also has a position statement on the Attending Physician's Role in Facilitating Return to Work after Illness or Injury. It is available on line at: http://www.acoem.org/guidelines.aspx?id=744.

required, is beneficial or an entitled benefit; the lack of suitable work; unfortunate discretionary decision-making; poor or delayed communications; administrative and bureaucratic delay; incentive misalignment; flabby management processes; and weak individual, organizational and system accountability for real-world outcomes.

5. In today's complex world, many people need pro-active instruction, advice, or even one-on-one assistance in:
   - how to navigate the healthcare system;
   - how to select doctors who will provide the most effective treatments; and
   - how to cope best with a health-related employment situation.

6. The majority of problematic high cost claims begin as innocuous appearing medical problems, and "go south" because of the way non-medical aspects of the situation are handled.

Content Summary

ACOEM's work disability prevention paper begins with a brief description of how the SAW/RTW process works by using a simple case example. There are two tables: one that shows how the process can escalate and increase in complexity through a series of iterations due to circumstances; and a second one with examples of different kinds of medical conditions that have very different impacts on function and work over time.

Next, the relationship of the SAW/RTW process to four other concurrent processes is described. Three are better known and studied; the other has been studied in academia but largely ignored by disability benefits programs. The failure to distinguish among these separate processes underlies much current system dysfunction. These four other processes are:

- The ill or injured individual's personal adjustment (coping) process

- The medical care process
- The benefits administration process
- The reasonable accommodation process under the ADA

The second half of the paper consists of observations and recommendations about the current status of and potential improvements to the SAW/RTW process in North America today. Sixteen specific recommendations are described in groups under the four general headings. Each of the16 specific recommendation sections:

- Identifies specific challenges and non-medical factors that now combine to create needless work disability and its negative consequences;
- Recommends ways that many of the issues can be addressed; and
- Points out initiatives underway and best practices in preventing needless work disability among working people who are faced with injury or illness.

Recommendations

The major points and recommendations made in the WDP paper are summarized below.

Adopt a Disability Prevention Model

Legislators, regulators, policymakers, and benefits program designers should address the reality that much work disability is preventable, and that successful SAW/RTW requires collaboration among several parties.

Shift the focus of the SAW/RTW process away from certifying or evaluating work disability towards preventing it. Unless complete work avoidance is medically-required for healing or for protection of the worker, co-workers or the public, those involved in the SAW/RTW process should try to prevent or reduce absence or complete withdrawal from work. As

demonstrated by studies by the Rand Corp. (Reville, Boden, Biddle, & Mardesich, 2001) and others, wage replacement from indemnity benefits does not leave North American workers whole. Moreover, replacing lost wages or giving cash awards for permanent impairment is not the preferred solution; getting life back to normal is. Expecting and allowing people to contribute what they can at work and keeping them active as productive members of society is good for them – and that includes each of us.

Instill a sense of urgency to normalize daily routine, because prolonged time away from work is often harmful. The period of fluidity is short. In only a few weeks, most people make adjustments and adopt a new view of themselves and their situation. Some people begin to think they are permanently disabled regardless of the medical facts. Once that idea is implanted, it is hard to shake (Strang, 1985, pp. 247-258).

Employers, unions, and insurance carriers should devote more attention and resources to preventing disability by focusing on the "front end" of disability episodes while the window of opportunity to make the most difference is still open. In practice, this means ensuring that the right things happen during the first few days and weeks of work absence. Injured/ill workers should routinely receive the support and services they need to get their daily lives back to normal as soon as possible.

Address Behavioral and Circumstantial Realities that Create and Prolong Work Disability

- Acknowledge and address people's normal human reactions to illness and injury. Life disruption may be significant and hard for some to cope with. Failure to acknowledge this distress, or offer help, often breeds trouble. Common courtesy or an expression of concern from the employer may be all that is needed.
- Investigate and address social and workplace realities, rather than ignore them. Scientific research shows that workplace factors like job dissatisfaction or poor job fit have a powerful effect on disability outcomes (Clark &

Oswald, 1994; Ensalada, 2000; Gard & Sandberg, 1998; Melamed, Ben-Avi, Luz, & Green, 1995; Stansfeld, Rael, Head, Shipley, & Marmot, 1997). Some issues can be readily resolved once brought to the surface.

- Reduce distortion of the medical treatment process by the hidden financial and legal agendas of patients, employers, insurers, lawyers, and any other involved parties. A physician who is kept in the dark and then unknowingly provides answers to loaded questions or requests is not necessarily independent, and is vulnerable to manipulation.
- Find a way to effectively reduce disability due to psychiatric conditions, whether occurring in isolation or in combination with physical ailments. Do so in a manner that avoids creating more harm and pouring resources into ineffective physical or mental health treatment.

Acknowledge the Powerful Contribution that Motivation Makes to Outcomes and Make Changes that Improve Incentive Alignment

- Pay or otherwise reward doctors for disability prevention work in order to increase their commitment to it. There is ample empirical evidence from progressive employer and payer programs that such services can be very cost effective.[5] This will require regulators and policy makers, who are often tied to an outside source for their payment systems (such as the CPT codes or RBRVS fee schedules) to obtain or create mechanisms that allow payment for these atypical services. It is illogical to justify inaction in these areas by insisting on traditional but ill-fitting definitions

[9] COHE program Washington State – prior articles published in Millbank quarterly, University of Washington School of Public Health and Community Medicine Department of Environmental and Occupational Health Sciences Occupational Epidemiology and Health Outcomes Program Task 3 Long-Term Follow Up of Original COHE Cohorts Principal Author: Thomas Wickizer, PhD Prepared for: Occupational Health Services Project Washington State Department of Labor and Industries Submitted 19 March 2008.

of "reasonable and necessary" medical services or pointing to the cost and administrative effort of adapting inflexible billing code systems designed for other purposes.

- Support appropriate patient advocacy by getting treating doctors out of a loyalties bind. Stop asking treating doctors to "certify" disability or to set a return to work date. Instead ask them about functional ability (unless there is a clear reason why it would be medically-inappropriate for the worker to do all work of any kind.) Florida[6] has instituted a policy that moves a long way in this direction, and the results in that state have been encouraging.
- Increase availability of on-the-job recovery and transitional work programs. Make it faster and easier to arrange permanent job modifications since workers who stay active during recovery have better outcomes. Requirements or incentives for employer participation will be required to move employers out of old habits.
- Require good faith efforts of the patient / employee, the doctor, and the employer to prevent or mitigate work disability.
- Reduce cynicism and improve customer service to injured and ill employees by being more rigorous, more authentic and helpful, fairer, and kinder.
- Restore integrity to programs rife with minor abuse. Make people aware how minor benefits abuse breeds still more abuse and cynicism that in turn leads to negative and prejudicial treatment of innocent people.
- Devise better strategies to deal with bad faith behavior/ exploitation/fraud. In particular, provide workers who believe they need help with alternatives to an adversarial or legalistic model for handling certain types of problems. Examples might include customer service representatives,

[6] See Florida Workers Compensation Uniform Medical Treatment/ Status Reporting Form at: http://www.fldfs.com/wc/pdf/DFS-F5-DWC-25.pdf.

ombudsmen, or escalation mechanisms that allow the worker to obtain assistance from an expert resource whose income is not tied to a financial resolution of the problem.

Invest in System and Infrastructure Improvements

- Establish programs that will provide basic training to practicing clinicians on why and how to prevent disability, as well as why and when it is appropriate to medically disqualify patients from work vs. provide information about functional ability to those who should make employment decisions. This education should encourage physicians and other healthcare professionals to broaden the focus of their care to include disability prevention and to develop clinical skills in this arena. Policy makers could create incentives or require that health care providers who participate in the workers' compensation system receive such training, preferably with periodic updates.
- Disseminate the scientific evidence regarding the benefit of staying at work and being active on recovery and preserving function. Doctors, patients, unions, claims handlers, employers, lawyers, judges, regulators and legislators all need to know this. Anyone unfamiliar with this evidence may very likely make decisions that harm the parties they are intending to help.
- Improve information exchange between employers/payers and medical offices. SAW/RTW cannot happen in an information vacuum, because the involved parties often don't know what they don't know about realities at the other end. A single exchange of information may not be enough. A collaborative problem-solving approach is necessary. Where necessary, remove barriers to the mutual sharing of information with appropriate protection of patient information that is not required for SAW/RTW decision-making. (Diagnostic and treatment information is rarely relevant in this setting.)

- Improve and standardize the methods and tools that provide data for SAW/RTW decision-making.
- Increase the study of and knowledge about the SAW / RTW process. Policymakers, government agencies, labor organizations, employers, insurance carriers, and interested citizens should underwrite efforts to learn more about how the SAW/RTW process works and to understand its outcomes, and should support research to develop methods that prevent disability more often or more effectively.

The basis for each recommendation, along with suggestions for how to implement it and examples of current best practices, is described in the full WDP paper. A bibliography of literature references is arranged in groups that correspond to the sixteen specific recommendation sections.

Moving Beyond Pontification: Disseminating and Implementing the Recommendations

As soon as the WDP paper was adopted by ACOEM in May 2006, the question arose "what next?" The 21 doctors who had spent years developing the white paper did so because they wanted to draw the public's attention to the SAW/RTW process and to shift the way many people think. Their intent was to for the paper to open a dialogue with all stakeholders in the workers' compensation and non-work-related disability benefits systems: employers, unions, working people, the insurance industry, policymakers, the healthcare industry, lawyers, and healthcare professionals, especially all physicians. Simply putting the paper on ACOEM's website did not seem like an effective way to accomplish that goal. ACOEM is a specialty society for physicians, not a social change advocacy organization.

It seemed like someone should convene multi-stakeholder summits in every U.S. state and Canadian province on the subject of "*Preventing Needless Work Disability by Helping People Stay Employed*" and offer them the WDP paper as a framework for discussion about how to work together towards

solutions. On an impulse one afternoon, I decided to see what I could get started by myself. Without any funding or institutional support, it seemed like the only way to actively propagate this new paradigm across North America would be to take a grassroots approach and see if local groups of volunteer professionals would step up to plan and produce those Summits. The answer was yes, and thus, The 60 Summits Project was born.

The next article in this series will discuss The 60 Summits Project – and the 16 Summits that have been held in 10 states so far – in more detail.

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