



Promoting the New Work Disability Prevention Paradigm for Disability Benefits & Workers' Comp Systems

Introduction to ACOEM's New Work Disability Prevention Guideline: "Preventing Needless Work Disability by Helping People Stay Employed"

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Note: This is not an ACOEM publication.

Executive Summary

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. 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 the ACOEM guideline know that much work disability is not required from a strictly medical point of view.

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 will improve outcomes. Until now, the distinct nature and importance of the stay at work and return to work process (SAW/RTW) has been overlooked. 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.

The first half of the ACOEM work disability prevention 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. Sixteen sections with observations and specific recommendations are grouped under these four general recommendations:

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.

A group of 21 physicians¹ developed the Guideline because they felt compelled to speak. The insights they had gleaned about the preventable nature of much work disability must be shared. Their primary goals 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. They invite all of you to use the Guideline and work together towards solutions.

¹ Seven medical specialties are represented in the group that developed the Guideline within ACOEM: emergency medicine, family practice, internal medicine, occupational medicine, orthopedics, physiatry, and psychiatry. Eleven have additional post-graduate degrees. They are in private medical practice, government, academia, heavy industry, as well as workers' compensation and disability insurance companies. They work in Canada and 15 of the United States. The Guideline was developed without any outside financial support.

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Background and Overview

The North American workforce has been aging. The burden of chronic disease in the population and its resulting impact on function has been rising. Episodes of prolonged disability² due to common conditions such as depression and low back pain are becoming more common. As the population is aging, the fraction of the US 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 for medical reasons.

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. It is time to broaden the scope.

The fundamental questions this paper is designed to answer are these:

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?

The focus of this 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 below, prolonged work withdrawal (disability absence) by itself can produce unfortunate consequences, and averting them is an intended outcome of this guideline.

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

² In this guideline, 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 related 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 guideline's definition, because they are at work.

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 guideline authors contend that a considerable amount of the work disability due to common everyday conditions (and an unknown fraction of the 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.

This Guideline is the end product of extensive and vigorous deliberation by the 21 physician authors, who used a collaborative and consensus-seeking process to develop the observations and recommendations.

In order to build a more profound awareness among all stakeholders that collaboration is required to make the SAW/RTW process work better, please read this introduction and the guideline in its entirety. Every stakeholder will be more familiar with some parts than others, so you should focus on the portions with which you have less personal experience.

The Guideline 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 parallel processes is described. Three are much more well-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 recommendations. Each of the 16 specific recommendation sections:

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

The major points and recommendations made in this Guideline are:

- I. 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, look for ways to prevent or reduce absence from work. 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. 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.
 - 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.

- II. 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 breeds trouble. Common courtesy may be all that is needed.
 - Rather than ignore them, investigate and address social and workplace realities. Scientific research shows that workplace factors like job dissatisfaction or poor job fit have a powerful effect on disability outcomes. Despite reluctance to intervene, some issues can be readily resolved once brought to the surface.
 - Reduce distortion of the medical treatment process by hidden financial and legal agendas. A physician who is kept in the dark is not necessarily more 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.

- III. Acknowledge the powerful contribution that motivation makes to outcomes and make changes that improve incentive alignment.
 - Pay doctors for disability prevention work in order to increase their commitment to it.
 - 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.)

- 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.
- Good faith efforts should be required of the patient / employee, the doctor, and the employer to prevent or mitigate 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 lawyers.

IV. Invest in system and infrastructure improvements.

- Programs are needed that will provide basic training to practicing clinicians on why and how to prevent disability, as well as why and when to disqualify patients from work. 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.
- Disseminate the scientific evidence regarding the benefit of staying at work and being active on recovery and preserving function. Doctors, patients and employers all need to know this.
- Improve information exchange between employers / payers and medical offices.
- 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, is described in the full paper that follows. The bibliography of literature references is arranged in groups that correspond to the sixteen specific recommendation sections.

Full implementation of many recommendations will require collaboration among all system participants, but forward progress can and is already being made by committed individuals and companies on their own.

Note to the Reader

This Guideline was developed by occupational medicine physicians who want to help meet the needs of workers, employers and insurers in the twenty-first century. Many of the authors have begun moving beyond the specialty's traditional role in preventing and treating *work-related* health problems and are already working collaboratively with all parties to keep the workforce healthy and productive. They are taking on a broader role in preventing, treating, and mitigating the impact of *all types* of health conditions on function, particularly on occupations.

For more discussion of the implications of the SAW/RTW process for the hands-on practice of medicine, please see:

- ACOEM's "*Consensus Opinion on the Attending Physician's Role in Helping Patients Return to Work After an Illness or Injury*" (see www.acoem.org / Policies & Position Statements / Consensus Opinions).
- The 2nd edition of ACOEM's *Occupational Medicine Practice Guidelines*, Chapter 5, entitled "Cornerstones of Disability Prevention and Management" (see www.acoem.org / Publications / Other ACOEM Publications).
- The American Medical Association's new book "*A Physician's Guide to Return to Work*" edited by Drs. James Talmage and Mark Melhorn, who are among the authors of this guideline (see www.ama-assn.org).
- Webility Corporation's on-line continuing medical education course entitled "Talking About Ability to Work: Basic Disability Prevention for Treating Clinicians" accredited for 3.5 CME hours under a joint sponsorship agreement with ACOEM. The author is Dr. Jennifer Christian who led the development of this guideline (see www.webility.md).

The full text of the ACOEM Guideline entitled "*Preventing Needless Work Disability by Helping People Stay Employed*" can be found at www.acoem.org under Policies & Position Statements / Guidelines.