

REPORT

FINAL REPORT

Establishing Accountability to Reduce Job Loss After Injury or Illness

October 2015

Jennifer Christian*

Submitted to:

U.S. Department of Labor
Office of Disability Employment Policy
200 Constitution Ave. NW
Washington, DC 20210
Project Officer: Janet Voight
Contract Number: DOLQ121A21886/DOL-OPS-14-U-0087

Submitted by:

Mathematica Policy Research
1100 1st Street, NE
12th Floor
Washington, DC 20002-4221
Telephone: (202) 484-9220
Facsimile: (202) 863-1763
Project Director: Yonatan Ben-Shalom
Reference Number: 50015.400

*Webility Corporation

Preparation of this item was funded by the Office of Disability Employment Policy, U.S. Department of Labor, Contract Number DOLQ121A21886/DOL-OPS-14-U-0087. This document does not necessarily reflect the views or policies of the Office of Disability Employment Policy, U.S. Department of Labor, nor does the mention of trade names, commercial products, or organizations imply endorsement by the U.S. government

ACKNOWLEDGMENTS

This report was prepared by Jennifer Christian of Webility Corporation for the Office of Disability Employment Policy (ODEP), U.S. Department of Labor. A group of subject matter experts (listed below) offered valuable information, insight, and advice. Although this report has benefited greatly from their input, they did not review its contents, and the report does not necessarily reflect their views or imply their endorsement. The author thanks Mathematica's Yonatan Ben-Shalom, David Stapleton, and Gina Livermore for their helpful comments on the report, Effie Metropoulos for editorial support, and Sharon Clark for production support. The author also thanks Meredith DeDona, Janet Voight, and Michael Reardon of ODEP for their guidance and support throughout the entire project.

Members of the policy work group

- Ed Corcoran, independent consultant
- Kim Jinnett, Integrated Benefits Institute
- Ann Kuhnen, The Hartford
- Jane Ryan, Mayo Clinic
- William Shaw, Liberty Mutual Research Institute
- Mary Ellen Wright, Kansas Medicaid

Other subject matter experts who were interviewed

- Stephen Bevan, The Work Foundation, Lancaster University; Fit for Work Europe
- Casey Chosewood, NIOSH Total Worker Health
- Marianne Cloeren, Managed Care Advisors
- Peter Dandelides, WorksiteRx
- Aaron Konopasky, Equal Employment Opportunity Commission
- Carolyn Langer, Massachusetts Medicaid
- Pamela Mazerski, independent consultant
- Kathryn Mueller, Colorado Department of Labor and Employment
- Peter Rousmaniere, workers' compensation consultant
- Steve Serra, Aetna
- Bruce Sherman, National Business Coalition on Health
- Hal Stockbridge, Washington State Department of Labor and Industries
- Sara Tamers, NIOSH Total Worker Health
- Richard Victor, Workers Compensation Research Institute
- Karen Wolfe, MedMetrics

This page has been left blank for double-sided copying.

CONTENTS

ABSTRACT	VII
I. INTRODUCTION.....	1
II. BACKGROUND	3
A. The affected worker	3
B. Frontline and supporting stakeholders	4
III. RECOMMENDATIONS AND A VISION FOR THE FUTURE.....	7
A. Three recommendations.....	7
B. A view from the future after a transformational change	8
IV. DETAILED SUGGESTIONS FOR IMPLEMENTING THE RECOMMENDATIONS.....	11
A. Capture and consolidate the data necessary to create credible metrics and establish real accountability	11
B. Provide federal leadership in public health, health care, and social policy	12
C. Encourage key frontline players to work for positive SAW/RTW outcomes.....	14
REFERENCES.....	17

This page has been left blank for double-sided copying.

ABSTRACT

This is one of three policy action papers prepared as part of the Stay-at-Work/Return-to-Work Policy Collaborative, an initiative funded by the Office of Disability Employment Policy in the U.S. Department of Labor.

Each year, millions of workers in the United States lose their jobs or leave the workforce after their ability to work is disrupted by a medical condition. Keeping these workers in the labor force could help them stay productive, maintain their standard of living, and avoid dependency on government programs. In this paper, we present actionable policy recommendations for keeping more people at work by (1) establishing the preservation or restoration of work and full participation in life as key outcomes and important indicators of the value delivered by medical care and other health-related services; (2) making three key stakeholders who directly influence those outcomes more accountable: health care delivery organizations, employers, and insurers; and (3) designing and implementing an array of strategies to give the accountability real teeth, disrupt the current status quo, and deliver transformational social change.

This page has been left blank for double-sided copying.

I. INTRODUCTION

Productive engagement and economic self-sufficiency are expected and desirable features of a full and satisfying adult life. But every year, millions of workers across the nation lose their jobs or leave the workforce entirely after a medical condition compromises their ability to work. In many cases, these unfortunate outcomes might have been prevented. Federal policy is currently focused on helping people get jobs after a long period of disability, but a second area of focus is needed: helping working-age individuals keep their jobs or promptly find new ones soon after they develop health problems.

Recent reviews of the evidence have documented how work promotes positive physical, mental, and social well-being for all individuals—including those with chronic health conditions (Waddell and Burton 2006)—and how worklessness does the opposite (Waddell and Burton 2006, Strully 2009). Keeping individuals in the workforce protects their health and well-being, quality of life, and standard of living. It also prolongs their years of productive contribution to society and helps them avoid dependence on Social Security Disability Insurance (SSDI), Medicare, and other federal, state, and local disability-related programs.

This paper offers three recommendations for policies that could keep more workers earning a living after their lives are disrupted by a medical condition. The three recommendations are supported by detailed suggestions for carrying them out.

The recommendations made in this paper rest on four premises:

- **Premise 1.** The criteria that define a healthy adult should include participation in human society and engagement in productive activity, whether paid or unpaid, as long as it is feasible. These criteria should apply to all adult Americans and be adjusted for each person's specific functional abilities as appropriate.
- **Premise 2.** Maximizing the number of adults who are self-sustaining taxpayers and contributors to the economy is vital to ensure continued prosperity.
- **Premise 3.** Today, individuals with a new health-related employment predicament look first for assistance from three types of frontline professionals. These professionals are in different disciplines and work in separate places: managers in the affected individual's own workplace, practitioners in healthcare delivery organizations, and administrators in the claim departments of health care, disability, and workers' compensation programs. None of these professionals feel responsible for helping affected workers keep their jobs. They are only held accountable for achieving the limited goals of their own discipline and organization. They have neither a shared definition of a good outcome, nor a common understanding of each other's roles, capabilities and responsibilities, nor a tradition of collaboration with one another to achieve shared goals.
- **Premise 4.** The current situation reflects the complex and fragmented nature of the nation's health care and welfare systems in both the private and public sectors. Those systems are also in a state of uneasy equilibrium, balancing the inertia of long-standing traditions and stakeholders' vested interests with the flux and uncertainty that characterize an era of health care reform and growing pressure on payers and public benefit programs. Despite expansion of the civil rights of disabled workers under the Americans with Disabilities Act (ADA), the

demand for taxpayer-funded disability benefits continues to grow as the rate of participation in the workforce steadily declines.¹

The paper proceeds as follows. In Chapter II, we describe the current environment and the perspective of key stakeholders. In Chapter III, we present our three main policy recommendations and our vision for the future. In Chapter IV, we present detailed suggestions for carrying out the three main recommendations.

¹ See Congressional Budget Office (2012) and U.S. Bureau of Labor Statistics (2015).

II. BACKGROUND

When a person's ability to work is threatened by a medical condition, there are four main stakeholders who affect the outcome. The worker is most important, but the outcome will also depend on the actions and decisions of three types of professionals, each in a different sector: health care delivery, employment, and insurance. Each of these professionals is directly responsible for separate and well-defined aspects of the individual's care and experience. We discuss these frontline stakeholders here and then describe others that play indirect or supporting roles.

A. The affected worker

In all but the most extreme cases, the affected person is in the most powerful position to determine the eventual outcome of his or her situation. A diagnosis that affects the ability to work can make a person feel powerless, but decisions must be made about how to handle the life predicament it has caused. Ultimately, the affected person is the only one who can choose how to respond to the health and employment challenge, how to adapt to his or her new circumstances, and how hard to work to create a satisfying "new normal" everyday life and future.

How a specific individual responds is partly a function of his or her overall health, strength, and vitality, but is also affected by personality traits, inherent capabilities, world view, cultural background, history, and environment. The environment includes families, doctors, employers, and insurers, as well as the legal, administrative, and economic context. Taken as a whole, these non-medical dynamics are an integral part of the biopsychosocial model of sickness and disability (Waddell et al. 2008; Loisel and Anema 2013). We recommend expanding the term to bio-psycho-socioeconomic (BPSE), given the powerful impact of financial considerations on the behavior of all stakeholders when a potentially disabling condition becomes manifest.

Some workers' careers are disrupted by unusual and devastating medical conditions characterized by sudden, obvious, and irreversible physiological alterations. A much more frequent scenario is job loss due to conditions with a mixture of symptoms like pain, weakness, coping difficulties, and the inability to tolerate certain activities due to hidden functional impairments. These conditions are most often low back, shoulder, and knee musculoskeletal (MSK) problems, and chronic mood disorders (CMD)—typically depression and anxiety. Roughly half of the workers now entering the SSDI rolls have MSK and CMD diagnoses.² It is important to recognize that the overwhelming majority of people diagnosed with these same conditions every year are able to stay employed—those entering SSDI have had unusually poor outcomes.

The factors that predict unusually poor outcomes (such as severe impairment and prolonged work disability) of MSK problems, especially low back pain, are not firmly related to either the specific diagnosis or the extent of the pathology (Caruso 2013; Franklin et al. 2014; Franklin and Mueller 2015; Habeck et al. 1998; Harris et al. 2008; Johnson and Fry 2002; Mahmud et al. 2000; Nicholas et al. 2011). Although less research has been done on factors that predict poor

² In 2013, 35.9 percent of SSDI's awards to disabled workers went to individuals with "diseases of the musculoskeletal system and connective tissue" and another 15.6 percent were to workers with "mental disorders" (SSA 2014).

outcomes in CMD, and diagnosis does play a more significant role, there are important non-medical factors (Arends et al. 2014; Cornelius et al. 2011; Loisel and Anema 2013). Furthermore, MSK and CMD often co-occur.

Some of the factors that predict poor outcomes are preexisting or immutable, such as age, medical history, work history, and geographic location. But the way a health-related episode unfolds over time in all dimensions—biological, psychological, social, and economic—can have a big impact on the outcome. Events can either mitigate or aggravate existing risk factors in the situation, leading to better or worse outcomes. There are usually many opportunities to actively influence the course of events immediately after the onset of a health problem—and substantially fewer opportunities later on—but today there are few resources devoted to finding and exercising these early opportunities.

Examples of negative prognostic factors that are potentially remediable include many non-medical ones (Waddell et al. 2001; Loisel and Anema 2013), especially elapsed time out of work (Caruso 2013; McLaren et al. 2010; Loisel and Anema 2013; Wickizer et al. 2011), uncertainty and distrust due to lack of communication or information (Bowling 2000; Loisel and Anema 2013), uncoordinated or inappropriate medical care and advice (Abásolo et al. 2005; Franklin et al. 2014), low expectations of recovery (Cornelius et al. 2011; Sullivan et al. 2005), excessive vigilance, catastrophic thinking, false beliefs, fear of movement, self-limitation, perceived injustice (Sullivan et al. 2005), and lack of employer support (Cornelius et al. 2011).

Today, the professionals who typically handle these situations do not look for any of the potentially remediable problems mentioned above and, as a result, do not address them. None of the professionals have been trained to try to avert job loss (ACOEM 2006), and most will never even know if it happens. As a result, it is reasonable to presume that some of the workers in this group have ended up with lost livelihoods and a future on disability benefits, even though their impairments may have been preventable or reversible, or could have been successfully accommodated in the workplace.

B. Frontline and supporting stakeholders

Three professionals typically respond when a worker's life is first disrupted by a medical condition: a healthcare practitioner, a workplace manager, and a benefits claims administrator. They each deal directly with the affected worker and have discretionary authority about how to manage the part of the worker's care or experience for which they have responsibility. In each specific case, an affected worker and these three individual professionals are in the strongest position to influence whether the worker's predicament eventually achieves an optimal resolution: the worker keeps working and participating fully in life. If each professional in each organization takes responsibility for doing his or her part well and is competent, the odds of an optimal resolution are favorable—unless a problem or uncertainty arises that requires the active cooperation of another party, such as provision of information or expertise. Today, there is little interaction among the parties due to professional traditions, social and business conventions, and organizational and infrastructure barriers.

- **Health care professionals.** The main reason why physicians and other treating practitioners interact with affected individuals is to provide healing and relief by making diagnoses and selecting therapies. They also set future expectations for recovery and work, determine work

restrictions, and sign disability forms. Typically, practitioners focus only on diagnosis and treatment, not on functional and SAW/RTW outcomes, which have not traditionally been within the purview of medicine (ACOEM 2008). They therefore tend to see SAW/RTW questions and forms as an irrelevant administrative burden. As has been amply documented, quality and outcomes vary widely from provider to provider. These professionals vary in their personal qualities, knowledge, skills, and values. They are influenced by the culture, ethical, and legal obligations of their professional specialty as well as the policies, procedures, and priorities of the organization in which they work. The average health care professional derives no economic benefit from helping patients stay at or return to work, and has no accountability for failing to do so. Physicians may randomly encourage their patients to work, passively go along with their application for disability benefits, or even tell their patients they will never work again. Like other helping professionals, physicians tend to earn more when their patients' problems continue.

- **Employers.** The main reason why employers interact with workers who have health-related work problems is to carry out the organization's policies and procedures regarding attendance, performance, and other internal programs, and to comply with applicable laws. In addition, employers control the availability of work. They decide whether recovering workers will sit home until they are fully recovered, remain on the job in a reduced capacity while they recover, or receive timely, reasonable accommodations that permit full productivity. This means employers can choose whether to support, ignore, or edge out a worker with a disabling condition. The individuals in management positions who make such decisions on behalf of a company vary in their personal qualities, capabilities, knowledge level, and priorities. Their decisions are often influenced by the environment in which their business operates. For example, small companies (which are exempt from the requirements of the Family Medical Leave Act and the ADA) typically provide neither paid sick leave nor private disability insurance. In general, many employers consider employee turnover to be normal and view their employee benefits packages plus government programs as the best solution for employees with newly disabling conditions. After a few days or weeks off work, it is common for supervisors not to ever talk to the worker directly again. Very few employers—mostly large companies or those employing highly skilled, hard-to-replace workers—consider the cost of losing an experienced employee and try to avoid that outcome.
- **Insurers.** Health plans, workers' compensation (WC) companies and private disability insurance (PDI) companies all interact directly with affected workers or with their doctors or employers for the purpose of administering benefits claims correctly, usually by telephone and/or on paper. Health plans define the services they authorize and the amounts that will be paid for them. WC and PDI companies decide what kind of rehabilitative or SAW/RTW services to offer and when to offer them. The frontline professionals who make decisions on behalf of these payers vary in their personal qualities, knowledge, skills, and priorities, and are influenced by the culture, business rules, priorities, and legal obligations of their organizations. There is a wide range of subject matter expertise and performance in these industries, within and across organizations. And although a costly claim for a poor outcome is undesirable, insurers generally remain profitable by following two principles: (1) focus on a short time horizon, because the employers may take their business elsewhere next year; and (2) cover excess losses this year by raising premiums in succeeding years. This means

that insurance companies typically have limited interest in making systematic efforts to improve long-term outcomes for individuals.

- **Supporting players.** Behind the three frontline professionals who deal directly with the affected worker stands an army of other professionals who play indirect roles—co-workers and executives in the organizations where the frontline professionals work, as well as civil and regulatory authorities, government agencies, attorneys and judges, the U.S. Congress, and state legislatures. Each of these supporting players may influence some aspect of the cultural, economic, social, and legal environment in which the frontline players operate, thus affecting their decisions and, indirectly, the outcomes.

Although there are many long-established organizations that promote the employment of people with long-term disabilities who are not currently working, those organizations are typically not involved at the outset, when a health condition has just begun to interfere with working. The factors to be considered in beginning a career or returning to work after a long absence are quite different from those that confront a person whose ability to stay on the job is newly challenged by a medical condition. The pace of preparing for and entering the workforce is often slow, taking months or even years, whereas an existing job can be lost in a matter of weeks or even a few days.

Of note, there is currently no federal entity specifically designated to take the lead in preventing job loss among workers who experience a change in their health that creates or worsens a disability.

III. RECOMMENDATIONS AND A VISION FOR THE FUTURE

Our broad recommendations for policies that would help more workers keep their jobs when they have medical conditions are based on the four premises laid out in the introduction to this paper, and take the roles of the frontline players into account. In the next chapter, we present detailed suggestions for carrying out these recommendations.

Because these recommendations are so comprehensive and varied, implementing them will require a lead federal agency to drive and coordinate an ongoing, action-oriented, multi-sector initiative. Doing so successfully means engaging many private sector organizations and various federal and state agencies in an ongoing collaboration. Natural candidates for this leadership role include the Department of Labor's Office of Disability Employment Policy or its Employment and Training Administration. The Department of Labor cannot be successful on its own, however. Relevant offices in other federal agencies should be required to cooperate with the designated lead agency in its efforts. In particular, several units within the Department of Health & Human Services and the Office of Management and Budget would play instrumental roles in implementing some of the specific suggestions that follow these recommendations.³

A. Three recommendations

Recommendation 1. Add to the list of expected positive outcomes of care for a health-related episode the preservation or prompt restoration of the affected individual's full participation in life—especially a return to paid work among those who have been working. These outcomes should be considered major indicators of the quality and practical value delivered by health care services and health-related services, including WC and PDI. Conversely, avoidable impairment, functional loss, work disability, and job loss should be considered major negative outcomes because they create an ongoing cascade of consequences that further reduce quality of life.

Recommendation 2. Develop formal mechanisms to establish and enable accountability for both positive and negative outcomes among the parties with the most direct influence on them. Separate mechanisms will be required to make the right things happen more often and the wrong things happen less often, because the forces that generate them differ in fundamental ways. Among other things, the mechanisms will need to remove or minimize operational and administrative obstacles to information sharing and teamwork among the participating stakeholders' organizations.

Recommendation 3. Design and implement an array of carefully considered strategies for how to use accountability to effectively disrupt the forces perpetuating today's suboptimal marketplace equilibrium and drive transformational social change. This will require strong leadership on social and public health policy. As described in the specific suggestions which follow, the strategies need to include public information and social marketing campaigns,

³ The scope of this project did not include an evaluation of the fiscal implications of implementing these recommendations. Some of the recommendations will require significant investment to implement. However, the expected economic benefits of reduced labor force exit and SSDI entry are likely to be even larger, including increased growth in employment, personal income, and tax revenues, and reduced rate of growth in federal and state expenditures. Nevertheless, the potential costs and benefits of each recommendation and the timeline for their realization should be carefully examined prior to implementation.

positive and negative incentives for organizations in both the private and public sectors, new legal and regulatory mandates, and different priorities for research and development. Reversing the trends working against change must be accomplished with an acceptable return on investment of time, energy, and resources.

B. A view from the future after a transformational change

In this section, we ask readers to imagine themselves transported into the future, after the recommendations made here have been carried out and transformational change has occurred. In that better future:

The expectation among Americans is that all working-age individuals—including those with chronic conditions and disabilities—will earn a living (or be otherwise productively engaged) and participate as fully in society as they can. In addition, Americans are confident that any employed people who develop a health problem will get the encouragement and help they need—from their doctor, their employer, and their insurers, all working together—to adapt to change, restore the rhythms of everyday life, and find a way to stay employed if at all possible. The nation’s workforce development strategy reflects awareness that humans naturally experience a decline in functional ability over a working lifetime. As a result, there are many avenues available that allow aging Americans to remain financially and functionally independent and continue contributing in various ways for as long as possible.

At the front line, all treating physicians and the other health care professionals they collaborate with to deliver care have been trained to see functional and employment outcomes as a practical way to gauge the effectiveness of their care and a measure by which their performance is evaluated. They know how to identify patients at risk for job loss early on and how to counsel them on realistic goals for treatment and a return to health. Ancillary professionals with special expertise in functional restoration and the SAW/RTW process are considered adjunct members of the health care delivery team and are easily accessible, so they can regularly help treating clinicians achieve the best possible outcomes for their patients. The health care team routinely coordinates with employers and insurers so patients can resume their usual responsibilities on a timely basis—as soon as it is medically safe. Patients, employers, and insurers who want to make an informed choice among possible care providers are routinely relying on published data about the SAW/RTW services and outcomes delivered by individual professionals and health care delivery organizations.

Employers know they are obliged to demonstrate that they make an adequate effort to help all qualified employees who develop disabling medical conditions to keep their jobs or find new ones—in the employer’s organization or elsewhere. To ensure compliance, employers are routinely calling on experts to assist them in the SAW/RTW process. Because poor performance in their SAW/RTW program will invite financial consequences, most employers are trying to retain affected employees and keep them productive, or try to help them find new jobs elsewhere.

To assist individuals as well as their employers, health plans and WC and PDI companies now cover a specified set of SAW/RTW services. Their marketing materials describe how those services help covered workers stay at or return to work, and help employers meet their obligations. WC and PDI companies routinely make the services of ancillary professionals with

special expertise in functional restoration and the SAW/RTW process available when an affected individual's local health care delivery team lacks that capability. Since their program outcomes are visible to potential customers, insurers have an incentive to provide as much or even more support to workers from small companies as they do to workers in large ones since the lack of internal resources in smaller organizations increases the risk of fines.

Organizations in all three sectors—health care delivery organizations, employers, and insurers—are routinely reporting data on their activities and outcomes to a designated federal agency, which makes the data publicly available to guide business-to-business purchasing decisions. The government is using the data to conduct inspections, assess penalties, and take enforcement actions when appropriate, and to shape its ongoing work in policy, programs, and research and development.

A lead federal agency has spearheaded the changes that have made all of this a reality, and has kept track of all these activities. That agency continues to drive and coordinate an ongoing multi-sector initiative that has successfully engaged many private sector organizations and various federal and state agencies by employing a public-private partnership approach, among other techniques. A different federal agency has been given primary responsibility for carrying out the corresponding research agenda. That research has produced new evidence about more effective actions the frontline players can take to prevent needless work disability and help affected individuals stay employed, as well as better tools and methods for them to use in the process. All federal agencies, in their role as employers, have been leading by example and have model programs in place. These programs incorporate accountability for keeping people involved in life and work and employ metrics to guide internal efforts at process and quality improvement as well as outside purchasing decisions in health care, workers' compensation, and disability benefits.

Happily, all of this effort means that fewer working-age people are losing their jobs. Employers have found creative ways to make good, productive use of employees whose work capacity has been altered by medical conditions. When employers cannot do so, there are other jobs available in the community, because the government has made changes in economic and employment policy that have encouraged development of more jobs that are suitable for workers in this situation. An array of new service and technology businesses have sprung up to assist health care delivery organizations, employers, and insurers in carrying out their responsibilities. The inflow of working-age people onto taxpayer-funded, disability-related income-replacement programs has been reduced, which has relieved some of the pressure on the nation's social safety net. This means that more government resources are available to help people in need of temporary or long-term supports.

This page has been left blank for double-sided copying.

IV. DETAILED SUGGESTIONS FOR IMPLEMENTING THE RECOMMENDATIONS

A. Capture and consolidate the data needed to create credible metrics and make accountability real

Today, it is not clear how many workers actually receive SAW/RTW services or lose their jobs every year because of a medical condition. Relevant statistics are neither kept nor reported at the front lines (medical offices, workplaces, and insurance companies) where these activities take place or their outcomes become manifest. Because the facts are hidden, those who might logically be held accountable cannot be. Visibility has the potential to unleash powerful forces that may promote positive action—such as professional pride, competitive marketplace pressures, administrative action, or even litigation.

Real accountability is made possible by credible metrics, which in turn depend on the availability of accurate data and data systems. Metrics are by definition imperfect representations of a more complex reality. Metrics inevitably cause technological challenges, howls of protest, delaying tactics, gaming, and disputes, especially at the outset. These issues can and must be anticipated and competently managed in a way that keeps the public purpose at the forefront and harnesses the power of accountability as a force to drive better outcomes.

To foster accountability in a way that will change the behavior of the frontline players and the organizations in which they work, the data need to be multidimensional, including information about diagnoses, treatment, and the BPSE context; and track services delivered, processes carried out, and outcomes achieved. These data will need to come from multiple sources: affected individuals, health care delivery organizations, employers, insurance companies, government entities, and possibly others. All relevant stakeholders must therefore possess the means to capture and contribute their own data accurately. Next, data from multiple sectors must be consolidated to create a complete picture that can be shared with all data contributors and other interested parties.

Most likely, many organizations will initially resist requirements to capture new kinds of data, especially if they do not suit their own purposes, citing legal requirements that protect confidentiality as well as the traditional reluctance to share potentially competitive information across organizational boundaries. These barriers to the capture, reporting, and sharing of information will need to be surmounted.

To capture and consolidate the data necessary to create credible metrics and establish real accountability, we suggest the following actions by the federal government:

1. **Designate an agency to expedite the creation and adoption of metrics that will make it possible for stakeholders to both define and allocate accountability for preventable impairment, loss of function, and job loss; these metrics will also make it easier for stakeholders to understand each other and to collaborate with respect to their responsibilities and contributions.** This includes: (1) cataloging and comparing existing metrics that employers, doctors, health plans, WC and PDI companies, and related public agencies can use to monitor processes, events, and outcomes that pertain to work and full participation in life; (2) ensuring that changes are made to federal specifications for electronic health records as well as to record-keeping by employers, insurers, and agencies,

so they each incorporate data about the portion of the process they actually deliver, manage, or see. Examples include SAW/RTW services delivered, changes in impairment, medical restrictions and functional abilities or functional status; and changes in work status, specific obstacles to SAW/RTW, days away from work, employment status, and receipt of cash benefits; (3) making it easier for multiple stakeholders to collaborate and exchange data—including those who carry out and document activities and processes, and those who observe and document the resulting work absence, benefit receipt, and employment outcomes; and (4) being at the table when the value of health care is being discussed and potentially relevant metrics are being developed by industry-specific entities and government agencies.⁴

2. **Require that outcome measures in federally funded research include, when applicable, the test subjects' ability to participate in important life activities and SAW/RTW.** This includes all health, health systems, public health, and social services research to evaluate the benefits of various kinds of treatments and interventions for populations that include working people.
3. **Require job losses caused by medical problems to be tracked and reported to the Department of Labor.** This can be done with a log similar to the one that employers are already keeping for all occupational injuries and illnesses as required by the Occupational Safety and Health Administration (OSHA). OSHA logs created both visibility and accountability—and an ongoing stream of data that has made it possible to track industry's remarkable progress at improving safety and reducing workplace injuries and fatalities over the last 40 years.⁵ Logs have also allowed OSHA to identify employers and industries that perform poorly on these measures and to take corrective action. To apply this idea to tracking job loss, employers, health plans, and WC and PDI carriers should be required to keep and report statistics to the government on how many people with health conditions lost or gained jobs while they were an employee, patient, or beneficiary. Both public- and private-sector organizations should be expected to log these outcomes.

B. Provide federal leadership in public health, health care, and social policy

To provide the leadership in public health, health care, and social policy that will be required to disrupt the status quo and deliver transformational social change, we suggest that the federal government:

1. **Modify the nation's health agenda by redefining "healthy" such that it includes full participation in work and society.** The major indicators of health status for all working-age adults—including those with chronic conditions and disabilities—should include work

⁴ Relevant entities include the National Quality Forum, National Committee for Quality Assurance, Joint Commission, URAC, Integrated Benefits Institute, Accreditation Council for Graduate Medical Education, America's Health Insurance Plans, and National Business Group on Health, among others; and government agencies such as the Centers for Medicare and Medicaid Services, Social Security Administration, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, and the National Institute for Disability, Independent Living, Rehabilitation Research, among others.

⁵ According to OSHA statistics, workplace injuries and illnesses have decreased from 10.9 incidents per 100 workers in 1972 to 3.3 in 2013, and workplace fatalities have decreased from 38 workers a day in 1970 to 12 a day in 2013 (OSHA 2015). These trends are in part the result of changes in the type of industries and occupations that are prevalent today in comparison with the 1970s.

and full participation in life. The nation's objectives for the public's health are laid out in the federal government's Healthy People (HP) initiative (Koh et al. 2014). The current version is HP 2020, which has 1,200 objectives in 42 topic areas. It does not define what "healthy" means for people living with chronic conditions and disabilities. In addition, paid work should be positioned as a major determinant of health status, because employment creates the means to avoid or compensate for many of the other social determinants of disease.⁶

2. **Convene a multi-stakeholder panel of experts to develop a strategic plan that clearly specifies how to effectively disrupt the status quo and deliver transformational social change.** A good plan will need to be preceded by a realistic assessment of the forces perpetuating the current equilibrium and those that might alter it. An essential ingredient will be sustained, expert, and committed leadership in public health, medical, and social policy, along with interagency coordination. This kind of leadership is required because an effective initiative will involve specific strategies and tactics on many fronts over a period of several years. Examples include professional education, public information, and social marketing campaigns; positive and negative incentives for the private sector marketplace and public sector agencies; a legislative agenda for new legal and regulatory mandates including reporting requirements; changed priorities for funding of research and development efforts; and expansion of some existing programs and reductions of others.
3. **Develop a set of key documents to serve as a persuasive and easy-to-read, evidence-informed foundation for effective action.** The United States has not yet made it a national research priority to study the benefits of work or the best ways to ensure that adults who develop health problems are able to stay at work. Perhaps this is because it has seemed obvious that working is a necessary part of adult life. However, we are now in an era of evidence-based policy-making. Decades of research and education about occupational health hazards funded by the National Institute of Occupational Safety & Health and similar organizations have created an imbalance between the public's awareness of the science concerning the benefits of work versus its risks and harms. Although it is true that research studies on the positive impact of preventing needless work disability and the hazards of worklessness have been rapidly accumulating in the last decade or so, that literature has not yet been comprehensively collated, catalogued, analyzed and digested in documents written for professionals in relevant fields, much less for the general public. (An example entitled *Is Work Good for Your Health & Well-Being?* was published in the UK in 2006 by Waddell and Burton. It had limited scope and needs updating.) Therefore, the U.S. government should commission a series of comprehensive reviews of existing literature, written in plain language, on key issues that are central to keeping workers employed after a challenge to their health. The reviews, to be widely disseminated, should summarize what is known about the issues and what the findings imply for real-world action, and point out knowledge gaps that need to be filled.⁷

⁶ Although the government is now developing a new area of emphasis for HP—health-related quality of life and well-being—to recognize the many social determinants of health, employment is just one in a long list of many new measures the government is evaluating in this area.

⁷ Examples of key topics that need to be reviewed include (1) the consequences of unemployment on the well-being of Americans, including its impact on morbidity, mortality, and mental health, and on family, social, and economic well-being; (2) the extent to which functional impairment, limitations on activity, and inability to work because of a

4. **Launch a strategic campaign that informs and shifts the beliefs of stakeholders who are in a position to influence the implementation of these recommendations as well as those who influence outcomes for individuals.** Social change usually occurs as the result of widespread changes in beliefs, which in turn influence behavior and then outcomes. The success of a public health campaign largely depends on whether it presents the facts persuasively to different stakeholders. Examples in the U.S. include campaigns against tobacco, drunk driving, and domestic violence, as well as campaigns promoting safe sex, immunizations, and the use of seatbelts and car seats. In this case, the messages should be evidence-informed and tailored to specific target audiences. For example, key messages suitable for educating politicians and policy-makers will be different from those aimed at health care professionals or the population at large. Social marketing techniques to consider include: (1) creating a series of short documents addressed to various stakeholders, summarizing the findings of the evidence reviews; (2) using evidence-based techniques for spreading ideas and influencing individual behavior to construct and disseminate short and effective public education messages customized to various stakeholders; and (3) reaching out to targeted groups of stakeholders with the new information and ideas.⁸
 5. **Revise federal research and funding priorities in order to bridge the critical gaps in our understanding of how to consistently achieve better functional and work outcomes.** Agencies that could potentially fund this research include the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the National Institutes of Health, the Centers for Disease Control, and the Department of Labor. Suggested priorities include (1) conducting clinical research into the development of services (including educational, instructional and treatment methods, techniques, tools and programs) that optimize functional recovery, avoid medically-induced harm, pseudo-impairment, and over-limitation, and prevent work disability and social withdrawal for health reasons; (2) conducting practical research to understand marketplace dynamics and the operational, financial, and competitive barriers to implementation, and then developing, testing, and deploying real-world techniques that facilitate widespread adoption and routine use of tools, techniques, methods, and service and payment innovations that facilitate or support functional restoration, SAW/RTW and full participation in life; and (3) conducting public health and health systems research to develop population health strategies and programs for optimizing the health, well-being, sustained social participation and productive contribution of the working age population.
- C. Encourage key stakeholders to work toward positive SAW/RTW outcomes

Below are a variety of suggestions for incentives and models that could promote positive SAW/RTW outcomes:

health condition (that is, work disability) can be avoided, eliminated, remediated, or accommodated; and (3) the relationship between health care costs and work disability (which engages the health care sector).

⁸ For certain groups, this will require more than providing written materials—it also means engaging them in dialogue by inviting them to conferences, going to the conferences they hold themselves, and meeting with them in person.

1. **Pay or otherwise reward physicians and other health care providers for specific efforts they make to restore their patients' ability to function in everyday life and for the time and expertise they devote to forwarding the SAW/RTW process.** Certain health care services that are known to improve SAW/RTW outcomes are currently available only sporadically to a limited number of individuals. In large part, this is because there is no good way for providers to document their own activities, order services for delivery by others with confidence they will be authorized, or be confident that payment will be made for them.⁹ Nearly all physicians, physical therapists, occupational therapists and other health care providers involved in the SAW/RTW process are required to use a defined set of numeric CPT codes to describe and bill for the specific services they provide.

The current list of codes, however, does not include SAW/RTW services. One way to get such services included is to direct the Centers for Medicare and Medicaid Services to collaborate with the American Medical Association, the American College of Occupational and Environmental Medicine, and other relevant medical societies to (1) create new CPT codes or modify existing ones, (2) assign relative value units to them, (3) revise fee schedules, and (4) mandate reimbursement for them if specific criteria are met. All four steps are essential. Clinicians could then document, bill, and get paid for a defined set of services that facilitate functional restoration and SAW/RTW, and/or increase their patients' engagement in work and other activities of life.

An additional strategy is to expand the list of billable activities that can be delivered by non-physician staff under codes for chronic care coordination, case management, patient education and the like in order to include best practices such as two-way communications with employers and payers about SAW/RTW issues. A third and long-overdue strategy is to make professionals in the field of disability management and vocational counselors with specified credentials and expertise part of the health care team. When they carry out physicians' orders, they should be allowed to bill using CPT codes for specific SAW/RTW services.

The billing codes used in Washington State's Centers for Occupational Health & Education program can serve as an excellent model. Research has shown that when doctors and health care coordinators perform, bill, and are paid for well-defined best practices, both short-term and long-term outcomes improve (Wickizer et al 2011).

The process of creating and modifying CPT codes usually specifies the circumstances under which each code can be used, as well as the training and expertise of professionals eligible to provide the various kinds and levels of service.

2. **Explore the possibility of funding SAW/RTW services for workers who lack access to them by fining employers who do not attempt to retain employees with medical challenges or to assist them in finding new jobs.** Whenever the EEOC investigates an

⁹ Two examples of activities that physicians could take on are (1) educating patients about the implications of their health condition for work and then counseling them on why they should try to stay at work and how they can cope with the disruption to their life, and (2) carefully considering and then providing explicit guidance to workers (and to their families, employers, and/or insurers) on what they can still do safely—including advice on whether certain tasks are within a worker's capability and suggestions for possible job modifications, whether temporary or permanent. Although CPT codes already exist for patient education, case management, and care coordination, they are new, very limited in the specific topics covered and parties involved, and not yet widely used by physicians or reimbursed by payers.

employer or a government agency awards disability benefits, they should evaluate whether the current or immediate past employer made an adequate effort to keep the worker in the workforce. Criteria must be established for what constitutes an adequate effort to help avoid job loss or help the worker find another job (which at a minimum should include involvement by professionals with relevant expertise). Penalty fees should be put in a fund that pays for services delivered to workers who lack access to SAW/RTW services due to prior job loss and/or lack of benefits coverage.

3. **Create a positive certification program for employers that is analogous to OSHA’s Voluntary Protection Program (VPP).** The VPP program showcases effective occupational safety and health programs. Employers apply for the program. Based on a set of performance-based criteria, OSHA conducts a verification process to ensure that applicants meet those criteria. Typically, employers’ performance improves during the certification process (OSHA 2015). A similar program could be created to publicly recognize employers and insurers whose SAW/RTW programs are exemplary.
4. **Design a model for a health plan that includes SAW/RTW services.** The model would incorporate existing evidence and current best practices for health plan design, health care delivery, managed care, patient education and care coordination services, and their interactions. Suggested features would include a specified set of SAW/RTW services for mental and/or physical conditions; utilization criteria; criteria for exemption from utilization review, deductibles and co-pays; defined credentials of specialists to deliver the services; and so on. The model plan would be disseminated to employers, industry groups, and health plans. Education about the financial impact of preventable impairment and work disability on total health care costs and other employer costs will need to be created along with the model itself. Likewise, incentives or mandates will be necessary for states and private exchanges that might otherwise be reluctant to offer these models due to competitive concerns about raising premiums to cover expected increases in the cost of health care.
5. **Create model curricula for physicians in training, along with incentives for educators to use the curricula.** Medical educators should teach physicians how to help minimize the impact of injury and illness on working and quality of life and work, and physicians should understand the benefits of this to patients and its value to society. These concepts should be introduced in medical school and picked up again in residency when new physicians are first being exposed to the realities of medical practice. Because medical education programs are already pressed for enough time to cover all the material they focus on now, schools will have to be given a mandate or significant incentives to adopt the model curricula.
6. **Create an interagency collaborative whose mission is to improve outcomes for federal workers.** This collaborative would make it easier for personnel at different agencies to coordinate and strengthen their own efforts to actively prevent needless work disability and minimize both lost productivity and workforce withdrawal due to disabling medical conditions—among both civil service and contract employees. Among its activities, this collaborative should jointly develop and disseminate a model SAW/RTW program in order to create more harmony and consistency of approach among the various agencies.

REFERENCES

- Abásolo, Lydia, Margarita Blanco, Javier Bachiller, Gloria Candelas, Paz Collado, Cristina Lajas, Marcelino Revenga, Patricia Ricci, Pablo Lázaro, Maria Dolores Aguilar, Emilio Vargas, Benjamín Fernández-Gutiérrez, César Hernández-García, Loreto Carmona, and Juan A. Jover. "A Health System Program to Reduce Work Disability Related to Musculoskeletal Disorders." *Annals of Internal Medicine*, vol. 143, no. 11, 2005, pp. 404–414.
- American College of Occupational and Environmental Medicine (ACOEM). "Preventing Needless Work Disability by Helping People Stay Employed." June 2006. Available at <http://www.acoem.org/PreventingNeedlessWorkDisability.aspx>. Accessed August 31, 2015.
- American College of Occupational and Environmental Medicine (ACOEM). "The Personal Physician's Role in Helping Patients with Medical Conditions Stay at Work or Return to Work." December 11, 2008. Available at http://www.acoem.org/PhysiciansRole_ReturntoWork.aspx. Accessed August 30, 2015.
- Arends, Iris, Jac JL van der Klink, Willem van Rhenen, Michiel R de Boer, and Ute Bültmann. "Predictors of Recurrent Sickness Absence Among Workers Having Returned to Work after Sick Leave Due to Common Mental Disorders." *Scandinavian Journal of Work, Environment, & Health*, vol. 40, no. 2, 2014, pp. 195–202.
- Bowling, Maddy. "The 'Halo Effect:' Measuring the Power of Intangibles in Workers' Compensation." *Journal of Workers Compensation*, Fall 2000.
- Caruso, Garson M. "Biopsychosocial Considerations in Unnecessary Work Disability." *Psychological Injury and Law*, vol. 6, no. 3, 2013, pp. 164–182.
- Congressional Budget Office. "Policy Options for the Social Security Disability Insurance Program." Washington, DC: Congressional Budget Office, July 2012.
- Cornelius, L.R., J.J.L. van der Klink, J.W. Groothoff, and S. Brouwer. "Prognostic Factors of Long Term Disability Due to Mental Disorders: A Systematic Review." *Journal of Occupational Rehabilitation*, vol. 21, no. 2, 2011, pp. 259–274.
- Franklin, Gary M., and Kathryn Mueller. Letter to NIOSH, February 15, 2015. ACOEM Public Comments: http://www.acoem.org/PrioritizingSecondaryPrevention_NIOSH.aspx.
- Franklin, Gary M., Thomas M. Wickizer, Norma B. Coe, and Deborah Fulton-Kehoe. "Workers' Compensation: Poor Quality Health Care and the Growing Disability Problem in the United States." *American Journal of Industrial Medicine*, vol. 58, no. 3, 2014, pp. 245–251.
- Habeck, Rochelle V., H. Allan Hunt, and Brett VanTol. "Workplace Factors Associated With Preventing and Managing Work Disability." *Rehabilitation Counseling Bulletin*, vol. 42, no. 2, 1998, pp. 98–143.

- Harris, Ashley M., E. John Orav, David W. Bates, and Arthur J. Barsky. 2008. "Somatization Increases Disability Independent of Comorbidity." *Journal of General Internal Medicine*, vol. 24, no.2, 2008, pp.155–161.
- Johnson, David and Tim Fry. "Factors Affecting Return to Work after Injury: A Study for the Victorian WorkCover Authority." Melbourne, Australia, 2002: Melbourne Institute of Applied Economic and Social Research.
- Koh, Howard K., Carter R. Blakey, and Allison Y. Roper. "Healthy People 2020: A Report Card on the Health of the Nation." *Journal of the American Medical Association*, vol. 311, no. 24, 2014, pp. 2475–2476.
- Loisel, P., and J.R. Anema (eds). *Handbook of Work Disability: Prevention and Management*. New York: Springer-Verlag New York, 2013.
- Mahmud, Mohammed A., Barbara S. Webster, Theodore K. Courtney, Simon Matz, James A. Tacci, and David C. Christiani. "Clinical Management and the Duration of Disability for Work-Related Low Back Pain." *Journal of Occupational & Environmental Medicine*, vol. 42, no. 12, 2000, pp. 1178–1187.
- McLaren, Christopher F., Robert T. Reville, and Seth A. Seabury. 2010. "How Effective are Employer Return to Work Programs?" Rand Corporation, prepared for the California Commission on Health, Safety and Workers' Compensation. Working paper series WR-745-CHSWC. Accessed at http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR745.pdf.
- Nicholas, Michael K., Steven J. Linton, Paul J. Watson, and Chris J. Main. "Early Identification and Management of Psychological Risk Factors ('Yellow Flags') in Patients with Low Back Pain: A Reappraisal." *Journal of the American Physical Therapy Association*, vol. 91, no. 5, 2011, pp. 737–53.
- Occupational Safety and Health Administration. "Commonly Used Statistics." Available at <https://www.osha.gov/oshstats/commonstats.html>. Accessed August 30, 2015.
- Occupational Safety and Health Administration. "Voluntary Protection Programs." Available at <https://www.osha.gov/dcsp/vpp/>. Accessed August 30, 2015.
- Social Security Administration. "Annual Statistical Report on the Social Security Disability Insurance Program, 2013." SSA Publication No. 13-11826. Washington, DC: Social Security Administration, 2013.
- Strully, Kate W. "Job Loss and Health in the U.S. Labor Market." *Demography*, vol. 46, no. 2, 2009, pp. 221–46.
- Sullivan, Michael J.L., Michael Feuerstein, Robert Gatchel, Steven J. Linton, and Glenn Pransky. "Integrating Psychosocial and Behavioral Interventions to Achieve Optimal Rehabilitation outcomes." *Journal of Occupational Rehabilitation*, vol. 15, no. 4, 2005, pp. 475–489.

- U.S. Bureau of Labor Statistics. "Labor Force Statistics from the Current Population Survey." Available at <http://data.bls.gov/timeseries/LNS11300000>. Accessed August 30, 2015.
- Waddell, G., and A.K. Burton. "Is Work Good for Your Health and Well-Being?" Report commissioned by UK Department for Work and Pensions, London. 2006.
- Waddell, G., A.K. Burton, and M. Aylward. "A Biopsychosocial Model of Sickness and Disability." *The Guides Newsletter*, American Medical Association, May/June 2008.
- Waddell, G., A.K. Burton, and C.J. Main. *Screening to Identify People at Risk of Long-Term Incapacity for Work: a Conceptual and Scientific Review*. Royal Society of Medicine Press, 2001.
- T.M. Wickizer, G. Franklin, D. Fulton-Kehoe, J. Gluck, R. Mootz, T. Smith-Weller, and R. Plaeger-Brockway. "Improving Quality, Preventing Disability and Reducing Costs in Workers' Compensation Health Care: a Population-Based Intervention Study." *Medical Care*, December 2011, vol. 49, no. 12, pp.1105–1111.

This page has been left blank for double-sided copying.

www.mathematica-mpr.com

Improving public well-being by conducting high quality,
objective research and data collection

PRINCETON, NJ ■ ANN ARBOR, MI ■ CAMBRIDGE, MA ■ CHICAGO, IL ■ OAKLAND, CA ■ WASHINGTON, DC

MATHEMATICA
Policy Research

Mathematica® is a registered trademark
of Mathematica Policy Research, Inc.