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REPORT

FINAL REPORT

Steps States Can Take to Help Workers Keep Their Jobs after Injury, Illness, or Disability

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ABSTRACT

This is one of three policy action papers prepared in Year 3 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 because of 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 identify promising early-intervention options for states that wish to help workers keep their jobs after injury, illness, or disability.

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I. INTRODUCTION

Millions of American workers leave the labor force every year, at least temporarily, because of the onset of conditions that could end up creating a long-lasting or permanent challenge to their ability to work (Hollenbeck 2015). These conditions may or may not have been caused or worsened by their work. Without steady earnings, affected workers and their families often must turn to public programs such as Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, and Medicaid.

The resulting costs to state and federal governments are steep, but they are potentially avoidable. It is likely that state governments could gain substantial net benefits from implementing successful programs designed to help an increasing number of affected workers find a way to stay at or return to work rather than rely on disability benefits (Ben-Shalom and Burak 2016). The net benefits to states would come primarily from increased tax revenues from workers able to retain their jobs as well as from reduced costs associated with Medicaid coverage and other public assistance programs. The federal government would also reap the benefits of increased tax revenues, although most of its net benefits would result from avoiding public assistance costs. Perhaps most important, more workers would be able to remain in the labor market and realize the benefits that come from employment, such as higher earnings and improved social and emotional well-being (Waddell and Burton 2006).

Currently, many workers who experience injury, illness, or disability fall through the cracks of a fragmented system. They are too often left to navigate, on their own, various uncoordinated service providers and programs that are generally poorly equipped to deal with their situations or are accessed when it is too late to help. If a medical condition is job-related, the worker is typically eligible for cash benefits and medical care through workers' compensation (WC). However, the level of benefits and quality of care provided under WC vary widely across states (Sengupta and Baldwin 2015, Workers' Compensation Research Institute 2016). Furthermore, the types of job-retention services and supports and their effectiveness vary by employer. For workers not covered by WC, the scenario is often more dire. In 2014, only 39 percent of private sector workers had short-term private disability insurance for off-the-job conditions, and only 33 percent had long-term coverage (Monaco 2015). Here, too, provision of job-retention services and supports varies widely. Workers without private disability insurance are disproportionately employed in low-skill, low-wage positions and are the most likely to apply for SSDI benefits.

In this paper, we identify promising early-intervention options for states interested in helping workers keep their jobs after injury, illness, or disability. States can take a variety of steps—and some states are already doing so—to fill the gaps in the fragmented system described above, improve the well-being of affected workers, and enhance state government's bottom line. States regularly interact with employers and workers through their workforce, vocational rehabilitation (VR), WC, health, and other agencies. These agencies have the tools to promote better outcomes, though the most appropriate tools vary from state to state depending on agencies' capabilities and structure and the program-specific features in any given state.

In the remainder of this chapter, we briefly describe some of the challenges that stand in the way of states' efforts to implement successful job-retention programs as well as some recent developments that could help overcome those challenges. In Chapter II, we describe several

critical junctures where states may identify and engage with workers who could benefit from such programs and then present a conceptual framework that can help states decide where and how they can intervene early to improve outcomes; we also provide some prominent examples of promising state-run job-retention programs to help illustrate the conceptual framework. In Chapter III, we outline types of interventions for states' consideration. We conclude in Chapter IV with recommended action steps.

A. Challenges

States face several significant challenges that hinder their ability to provide timely job-retention services to workers who could benefit from them. We highlight a few of those challenges here.

First and perhaps foremost, states evidence a general lack of awareness and leadership regarding the problem of job loss following injury, illness, or disability, despite the large number of workers who leave the labor force and subsequently receive SSDI because of a disability. Each year from 2002 through 2014, between 700,000 and 1 million individuals were awarded SSDI disabled-worker benefits. In 2014, the number of awards in each state ranged from just over 1,100 in Alaska to roughly 50,000 in Florida and Texas and over 65,000 in California (SSA 2015). State-level awareness of and leadership on the issue of job retention are both limited for several reasons: the issue's lack of visibility, lack of recognition that job loss and workforce withdrawal have substantial negative consequences, and limited understanding that job loss and workforce withdrawal are often preventable. Nonetheless, ample evidence points to the adverse impact of worklessness on the physical, mental, social, and economic health of affected individuals and families (Waddell and Burton 2006; Strully 2009). In parallel, the financial impact of avoidable worklessness on government-funded programs has failed to draw the attention of leaders and policymakers. To complicate matters, states are somewhat insulated against issues of worklessness related to injury, illness, or disability because of the misalignment of the costs and benefits associated with workers' departure from the labor force. Even though state agencies are best positioned to provide job-retention services, the large share of the savings in public assistance would accrue to programs run by federal agencies—primarily the Social Security Administration (SSA) and the Centers for Medicare & Medicaid Services (CMS).

Another challenge is that relevant state agencies have not traditionally focused on workers at risk of losing their job because of an injury, illness, or disability. To be certain, state workforce agencies invest varying degrees of effort into helping unemployed workers find new jobs, but the agencies do not focus on the hundreds of thousands of workers who are struggling to *keep* their jobs as they face a range of medical conditions. Such efforts also do not address workers whose current employer cannot accommodate them but who might be able to transition quickly to a new job more suited to their current circumstances. By the time affected workers have been out of the workforce long enough to redefine themselves as persons with a disability (and thus meet formal eligibility criteria for receiving long-term disability benefits), they find that the process of securing a new job has become significantly more difficult.

State VR agencies have limited capacity to serve already employed individuals with disabilities. Per the provisions of the Rehabilitation Act of 1979 (Pub. L. 93-112), which authorizes formula grant programs for state VR agencies, VR agencies are obligated to focus

first on the employment of those with the most significant disabilities. Hence, the agencies mostly serve individuals with significant disabilities who either have never worked before or have been out of the labor force for some time. As a practical matter, this means that workers in need of immediate assistance to retain a job or secure a new one are typically ineligible for VR services at the time when such services are most likely to help workers succeed. Further, the workers with the most common causes of entry into SSDI—musculoskeletal and mental disorders—are rarely eligible for services before SSDI entry because, from the perspective of VR agencies, their disabilities are not considered sufficiently severe.

A third challenge is that a state interested in dealing directly with the problem of job loss after injury, illness, or disability would have to make difficult funding decisions regarding competing priorities. In addition, the state would face constraints in terms of the current fragmentation of state agency responsibilities; the capacity of those agencies, alone or in combination, to provide—or facilitate the provision of—effective job-retention services; and the entrenched status quo in which lawyers, physicians, and worker advocates often guide workers toward applying for disability benefits rather than remaining in the labor force. These parties may be concerned with meeting the immediate financial and medical needs of the affected workers and believe that applying for benefits is in the worker's best interest; however, misaligned financial incentives also likely play a role (for example, lawyers stand to gain from a successful SSDI application).

B. Opportunities

Despite the above challenges, several fairly recent developments enhance states' ability to provide timely job-retention services to workers who could benefit from them. One such development is enactment of the Workforce Innovation and Opportunity Act (WIOA), which in July 2015 superseded the Workforce Investment Act (WIA). WIOA authorizes state workforce development programs to provide a wide range of federally supported employment and training programs through American Job Centers and requires states to develop unified strategic plans across several agencies to better align federal investments to support the needs of employers and workers (DOL 2016).

In addition to including amendments to the workforce development system, WIOA includes amendments to Title I of the Rehabilitation Act, which authorizes funding to state VR programs. One amendment authorizes the use of VR funds for job retention of current employees, a departure from longstanding policy. Before WIOA's enactment, Title I of the Rehabilitation Act limited the use of VR funds to cover services needed by current or former clients, and, when a state lacked the resources to serve all individuals with disabilities eligible for VR services, the state was allowed to serve only individuals with the most significant disabilities in accordance with an "order of selection." Under Title I of the Rehabilitation Act, as amended by WIOA, VR agencies may now serve employed workers "who require specific services or equipment to maintain employment" regardless of whether they were formerly VR clients and regardless of any order of selection established by the state (DOL 2015). The VR agencies may use the new authorization to launch or enhance programs designed to help workers retain their jobs following injury, illness, or disability. One VR agency, the Florida Division of Vocation Rehabilitation, has recently cited the WIOA authorization in its decision to "provide job retention services to

eligible individuals, regardless of order of selection, who require specific services or equipment to keep their job."[1]

A second significant development is the 2013 issuance by the U.S. Department of Labor's Office of Federal Contract Compliance Programs of a revised rule implementing Section 503 of the Rehabilitation Act, which prohibits businesses contracting with the federal government from engaging in discrimination on the basis of disability and requires the development of affirmative action program plans (41 CFR Part 60-741). Among its other provisions, the revised rule now requires federal contractors and subcontractors to aspire to increase to 7 percent the percentage of their employees with disabilities and to track and report on progress toward that goal (ADA National Network 2015). One potential effect of these new rules is that, in attempting to satisfy the 7 percent aspirational goal by retaining current workers with chronic conditions and impairments, federal contractors will increase demand for the range of job-retention services provided by states and other entities.

Another relevant development is the enactment of the Affordable Care Act (ACA) in 2010. The expansion of Medicaid coverage under the ACA means that Medicaid might cover more workers in need of job-retention services. With the expanded coverage, state Medicaid programs could potentially play an important role in job retention by promoting best job-retention practices among physicians treating Medicaid patients and providing health services that may, in general, support job retention. Other workers in need of job-retention services now obtain health insurance coverage under the ACA health insurance exchanges, another potential avenue for introducing mechanisms to promote favorable retention outcomes (Christian 2015).

Finally, the concept of "states as model employers" for people with disabilities has gained significant traction in recent years, with many state agencies "leading by example" in hiring individuals with disabilities (Krepcio and Barnett 2013). According to the National Governors Association (2013) and the National Council of State Legislatures (2016), several states have set forth "policies that direct the state to be a model employer," "'fast track' provisions to recruit and appoint qualified people with disabilities into state jobs," and explicit "hiring preferences for people with disabilities." The concept of "states as model employers" could similarly apply to the *retention* of workers with newly acquired disabilities, which is the focus of this paper.

[1] http://www.rehabworks.org/.

II. WHERE STATES CAN INTERVENE EARLY: A CONCEPTUAL FRAMEWORK

States interested in providing—or facilitating the provision of—timely job-retention services to workers who could benefit from such services first need to be able to identify and engage with those workers. Here, we describe a few places where such identification and engagement could take place. We then present a conceptual framework that can guide states in deciding where and how they can intervene in a more timely fashion to improve outcomes for the target population.

To help illustrate the conceptual framework, we provide some prominent examples of existing state-run job-retention programs that fit within the framework. While all of these programs have shown considerable promise, the extent of evidence regarding their success is quite limited. To our knowledge, only the Centers of Occupational Health and Education program in Washington State's WC system has undergone a rigorous evaluation proving its success.

A. Points of identification and engagement

In Table II.1, we show four primary places—and the respective target populations—where states may intervene early to improve job retention. We then provide further details on these and other potential points of intervention.

Table II.1. Primary points of identification and engagement for job-retention interventions

Point of identification/engagement	Target population	Availability
State-regulated WC systems	Workers with job-related injury/illness	All 50 states and the District of Columbia
State short-term disability insurance programs	Workers with off-the-job injury/illness	California, Hawaii, New Jersey, New York, Rhode Island
State VR agencies	Employed workers meeting VR eligibility criteria	All 50 states and the District of Columbia
State/local employee benefit programs	Covered state/local employees	In 2007 (see Stoltzfus 2009) - 23 percent of state/local employees covered by short-term disability insurance - 34 percent of state/local employees covered by long-term disability insurance - 72 percent of state/local employees covered by employee assistance programs

1. State-regulated WC systems

Early identification and engagement of individuals at risk of job loss because of disability is relatively straightforward in state-regulated WC systems. To receive any benefits, a worker is required to file a claim. State-regulated WC systems provide both income replacement and

medical benefits to workers who experience job-related injury, illness, or disability. Furthermore, the WC system provides all related medical care. In 46 states and the District of Columbia, employers may either purchase WC insurance in a competitive marketplace or self-insure. Four states—North Dakota, Ohio, Washington, and Wyoming—rely exclusively on state WC funds that solely provide WC insurance (Sengupta and Baldwin 2015).

The four states with exclusive state funds have access to detailed data for most, if not all, WC claims in their state and therefore enjoy a particular advantage with respect to identifying workers who could benefit from job-retention services. Three of the four states—North Dakota, Ohio, and Washington—have implemented promising job-retention initiatives for workers with job-related conditions (described below). Other states have adopted various laws, regulations, and programs to promote job retention in WC cases. Below, we highlight a notable WC reform implemented in Colorado but otherwise do not feature such initiatives in this paper because of the wide variation across states and the prominent role played by private WC carriers and self-insured employers in the promotion (or lack thereof) of job retention.

2. State short-term disability insurance programs

In the five states with mandatory short-term disability insurance (STDI) programs, early identification and engagement of affected individuals at risk of job loss due to disability is also relatively straightforward. As with the case of WC, workers seeking STDI benefits must file a claim in order to receive cash benefits; unlike the case of WC, however, STDI does not cover medical care. In Hawaii and New York, nonexempt employers are required to provide STDI benefits for their employees by either purchasing private insurance or self-insuring.[2] California, New Jersey, and Rhode Island operate public STDI programs that cover the vast majority of the workforce; the states' workforce agencies administer the programs. To our knowledge, only the Rhode Island STDI program has implemented changes specifically targeted at improving job-retention outcomes among claimants.

3. State VR agencies

The state VR agency presents another opportunity for early state intervention to improve job retention. As noted, under Title I of the Rehabilitation Act, as amended by WIOA, VR agencies may now serve employed workers "who require specific services or equipment to maintain employment" regardless of whether they were formerly VR clients and regardless of any order of selection established by the state. However, for several reasons, early identification and engagement of affected workers through the VR system is more challenging than through the WC and STDI systems. First, state VR agencies have not traditionally focused on workers who are employed but at risk of losing their jobs because of injury, illness, or disability. Second, many states lack the resources to serve all individuals eligible for VR services and are subject to the "order of selection" process that traditionally required VR programs to serve individuals with the most significant disabilities before serving other individuals. Further, VR agencies seeking to serve employed workers who are at risk of job loss would have to shift funds away from other priorities or obtain additional funds in order to expand support for such workers. Third, workers

[2] The STDI programs in California and Rhode Island are financed wholly by employee payroll contributions; the STDI program in New Jersey is financed by both employee and employer payroll contributions; in Hawaii and New York, employers may partially finance disability insurance coverage through employee contributions.

who may be eligible for VR services—and their employers—may not be aware of either their eligibility for services or the job-retention services offered by VR and therefore do not apply for services.

Despite these challenges, many VR agencies throughout the country are building programs or offering services that address job retention. Alabama and Arkansas are two examples of states whose VR agencies operate long-standing programs that work with businesses on job retention. Furthermore, as we describe later in this chapter, the Council of State Administrators of VR (CSAVR) has implemented a national initiative to offer a coordinated approach to supporting employers who seek to hire and/or retain individuals with disabilities, including those with newly acquired disabilities.

4. State and local employee benefit programs

States and localities may intervene early with their own employees through their administration of health insurance, disability insurance, and other benefits such as employee assistance programs (EAPs). A substantial minority of state and local employees have short- and long-term disability insurance coverage (23 and 34 percent in 2007, respectively) (U.S. Bureau of Labor Statistics 2008). To our knowledge, however, Delaware is the only state with a legislated return-to-work program for state employees. The state's appointed return-to-work coordinator is tasked with helping workers return to work after injury, illness, or disability. Most state and local employees (72 percent in 2007) have access to EAPs. Although they originally developed as a confidential resource for employees with substance abuse problems, EAPs have expanded their reach and now provide assistance to employees with a wide range of personal, family, or work problems (Attridge 2015). Research has shown that some EAPs have positive impacts on both clinical and job-related outcomes (Younger 2015).

5. Other options

Several other avenues offer opportunities for states to identify and engage workers at risk of job loss for health reasons. Workforce and social welfare agencies, to which workers turn for cash assistance (such as unemployment benefits, Temporary Assistance for Needy Families, and the Supplemental Nutrition Assistance Program), could identify workers with chronic medical problems or long-standing disabilities in need of return-to-work services and refer them to available resources. State Disability Determination Services (DDSs), which make initial determinations regarding the disability status of individuals who apply for SSDI and/or SSI benefits, could divert some applicants to services such as VR services that would help them remain in the labor force. State health care system regulators could require private insurers to cover health services that support job retention, adopt public health goals for job retention, and hold health care providers accountable for job-retention performance (Christian 2015).

B. A conceptual framework and prominent examples

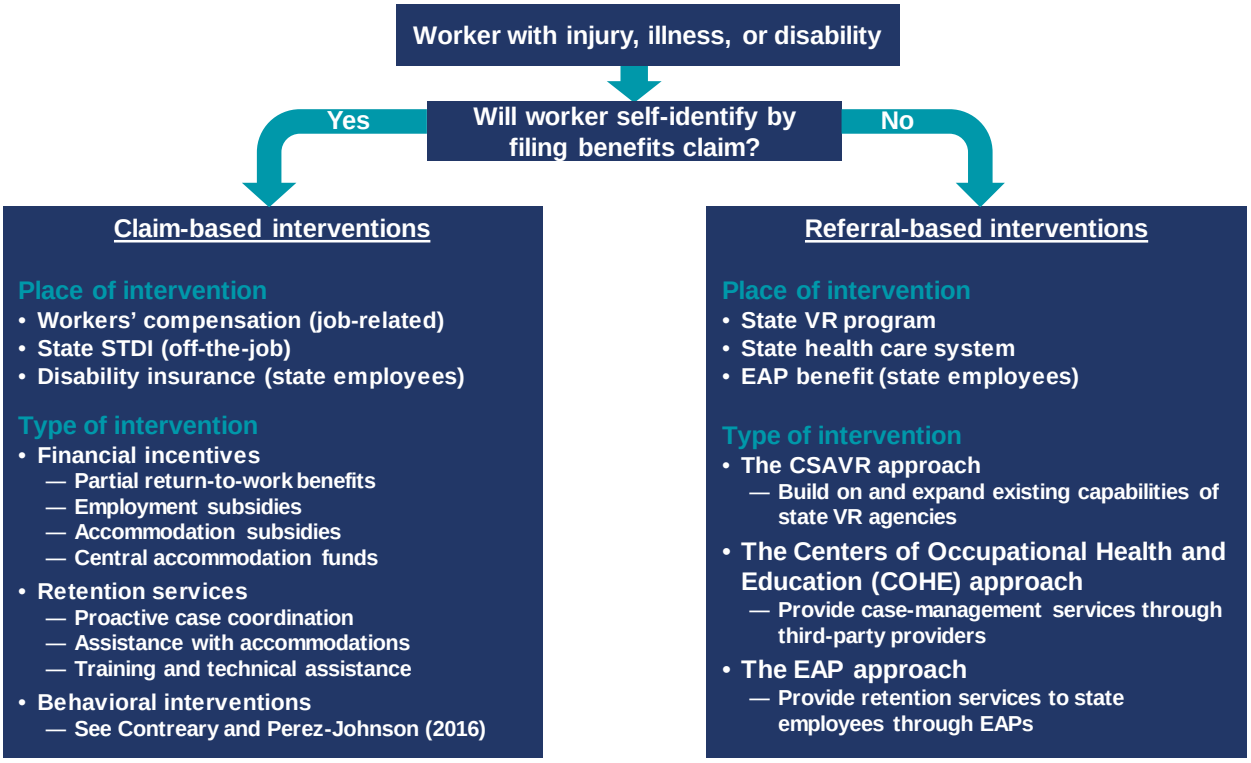
According to the points of identification and engagement described above, it seems reasonable to divide states' early-intervention expansion options into two general categories based on the method of early identification of the problem and engagement with the affected worker. In instances where the worker self-identifies by filing a benefits claim (that is, in WC

and state STDI and in disability insurance programs that cover state employees),[3] the claims data provide a method for accurately capturing detailed information about those who may need help. We call interventions triggered by the filing of a benefits claim "claim-based interventions" (Figure II.1).[4] A larger group of workers consists of millions of workers who do not file a claim for cash benefits to replace income lost because of a medical condition because they are ineligible for either workers' compensation or short- and long-term disability insurance (other than SSDI). The associated category of interventions includes those instituted by state VR and health care programs and by EAPs for state employees. We call such interventions "referral-based interventions" because either workers must self-refer or other stakeholders (such as employers and service providers) must refer those in need of supports to the organization offering the needed job-retention services. Below, we provide some prominent examples of existing state-run job-retention programs that fit within this framework. In the next chapter, we describe the types of interventions that are possible under each category.

[3] This paper does not consider intervention options for private sector disability insurance because states have little leverage with respect to job-retention services in that market.

[4] Identification and engagement based on claims is also possible at DDSs when affected workers apply for SSDI. However, any intervention targeting SSDI applicants will be hindered by the amount of time that has passed since the onset of the medial condition; the worker's already reduced attachment, if any, to his or her employer; and the various stakeholders—such as health care providers, lawyers, private insurers, and state agencies—that have some level of involvement in the SSDI or SSI application process. For example, states might have an incentive to encourage SSDI entry because Medicare benefits—for which SSDI beneficiaries are eligible after a two-year waiting period—are paid by the federal government, whereas states share responsibility for Medicaid with the federal government; hence, entry of a Medicaid beneficiary into SSDI eventually reduces state Medicaid expenditures.

Figure II.1. A conceptual framework for where and how states can intervene to help workers keep jobs after injury, illness, or disability



1. Claim-based interventions

When a worker files a claim to receive disability-related benefits, the state agencies responsible for the relevant benefit program (WC, STDI, or disability insurance for state employees) are on notice that the worker may need help. The agencies are therefore in the best position to help the subset of workers most at risk of job loss and workforce withdrawal and most likely to benefit from some type of support for workforce retention. Nonetheless, many challenges can stymie the provision of needed services. For example, some claimants—or their representatives—may perceive certain early-intervention initiatives as an attempt to deny them the benefits to which they are entitled—the same benefits that their co-workers, friends, or family members may have received in the past. Physicians may be reluctant to allow or even encourage return-to-work before a claimant has completely recovered his or her functional capacity. Employers may see return to work as risking additional injury or contrary to the employer's best financial interest, perhaps because employers are unable to quantify all the associated benefits or see their turnover costs as relatively low (Ben-Shalom 2015).

Nonetheless, some promising examples of state programs that have instituted job-retention strategies fall under the category of claim-based early intervention. We briefly describe them below.

Example 1: Rhode Island's Temporary Disability Insurance (TDI) program

Rhode Island's TDI program provides financial protection to workers who are unable to work because of illnesses and injuries that are not job-related and therefore not covered by WC. The program, financed entirely by workers through a payroll tax, pays for up to 30 weeks of benefits at approximately 60 percent of base-period wages. It covers all employees of private companies in Rhode Island as well as employees of state and local government entities that choose to participate in TDI. In 2015, the program administered 340,435 weekly payments across 34,015 claims, with an average weekly benefit of $455 and average duration of 11 weeks (Rhode Island Department of Labor and Training 2016).

To our knowledge, Rhode Island's TDI program is the only STDI program that has implemented changes targeted at improving return-to-work outcomes for claimants. In 2005, prompted by requests from employers to initiate a review of the TDI system, the Rhode Island TDI Task Force issued a report recommending, among other things, that the TDI program (1) inform Qualified Healthcare Providers about medical duration guidelines to help them determine appropriate return-to-work dates and (2) offer a partial-return-to-work option that would allow claimants to collect partial TDI payments when they return to work on a part-time basis (Rhode Island Department of Labor and Training 2005). Reliance on medical duration guidelines can shorten the period of time that individuals are out of work, thus helping them maintain their attachment to the labor force. A partial-return-to-work option encourages workers who are able to do so to return to work sooner than they would have done in the absence of such benefits. In short order, Rhode Island instituted both medical duration guidelines and the partial-return-to-work option. State law now provides for a Partial Return to Work Program, in effect since January 1, 2006 (RI Gen L §28-41-5).[5] In addition, medical disability duration guidelines are used to determine the appropriate duration of benefits for each claimant based on his or her illness or injury.[6]

Example 2: Delaware's Return-to-Work Program

Delaware's Return-to-Work Program assists state employees who need help staying at or returning to work after (or in lieu of) claiming short-term or long-term disability insurance benefits. Delaware enacted the program in January 2006, when the state transitioned from providing employees with disability pensions to enrolling them into a self-insured disability insurance plan (29 Del.C. § 5256). The state has assigned a designated return-to-work coordinator to the Statewide Benefits Office to work with insurance carrier staff, physicians, and supervisors and help affected workers return to work. We are not aware of any other state with a similar job-retention program. In fact, in 2007, fewer than 25 percent of the nation's 18 million state and local government employees were covered by short-term disability insurance, and only

[5] More recently, New Jersey legislators have tried to pass a bill, based on the Rhode Island program, implementing a partial-return-to-work program in the state's TDI system (NJ Senate Bill 1770). The bill cleared both chambers of the New Jersey legislature late in 2014 but has since died.

[6] The two most commonly used disability duration guidelines in the U.S. are Reed Group's MDGuidelines (https://www.mdguidelines.com/) and the Work Loss Data Institute's Official Disability Guidelines (ODG) (http://www.worklossdata.com/). Both sets of guidelines are based on millions of lost-time cases and are proprietary. The Rhode Island TDI program initially used the MDGuidelines but has since switched to the ODG.

about a third of such workers were covered by long-term disability insurance (U.S. Bureau of Labor Statistics 2008).

Example 3: WC initiatives

Three states with exclusive state WC funds have implemented promising job-retention initiatives for workers with job-related conditions. Washington's Centers of Occupational Health and Education (COHE) program is the most notable of these. The COHEs are independent community-based entities affiliated with health care delivery organizations. The state enters into contracts with the COHEs to work with medical providers, employers, and injured workers in the first three months after injury (or six months, if needed) to improve medical and return-to-work outcomes and reduce costs. The COHEs train physicians, provide financial and other incentives for them to follow best practices, assign telephonic care coordinators to assist the physicians with care planning and return-to-work communications for their patients, and provide ready access to board-certified occupational medicine consultants. The COHE model was first implemented as a pilot in western Washington and then, in response to the pilot's success, introduced to the entire state (Wickizer et al. 2004; Wickizer et al. 2011).[7] Another innovative program in Washington is Stay at Work, which incentivizes employers to help workers stay on the job by paying employers 50 percent of injured workers' base wages (up to a $10,000) as well as the costs of certain accommodations (Washington State Department of Labor & Industries 2015).[8]

North Dakota's Preferred Worker Program, which is less ambitious than Washington's Stay at Work program, is designed to encourage the re-employment of injured workers by providing them with benefits such as a work search allowance, moving expenses, and reimbursement for new tools and equipment (North Dakota Workforce Safety & Insurance 2013).[9] Ohio operates two programs designed to encourage transitional work for injured workers. The Transitional Work Grants Program provides eligible employers with funds to develop a work-site program that helps injured workers perform transitional work as they recover from their injury (Ohio Bureau of Workers' Compensation 2016a). The Transitional Work Performance Bonus Program rewards employers who successfully provide their injured employees with transitional work (Ohio Bureau of Workers' Compensation 2016b).[10]

[7] Wickizer et al. (2011) found that over the 12-month evaluation period, the COHE pilot intervention led to a 20 percent reduction in lost work days, a 21 percent reduction in the number of claimants out of work and receiving cash benefits as of the end of month 12, and a 12 percent reduction in the average costs per claim. The reductions in lost work days and the number of claimants out of work and receiving cash benefits at month 12 were even larger for those with back sprains (30 percent and 37 percent, respectively).

[8] The Stay at Work program was launched in 2012. In a 2014 survey, 69 percent of employers reported they were aware of the program, 3 percent reported participating in the program, and 82 percent said they are fairly or very likely to participate in the future. According to the Washington Department of Labor and Industries, for every $1 spent on the program $2.40 is saved in disability cost (WorkComp Strategies 2015).

[9] Only 23 Preferred Worker Program claims were filed from 2010 to 2014 (North Dakota Workforce Safety & Insurance 2015).

[10] The Transitional Work Grants Program and Transitional Work Performance Bonus Program were both launched on July 1, 2012. According to data we obtained from the Ohio Bureau of Workers' Compensation, more than 300 employers participated in the grants program between July 1, 2012, and June 30, 2016. More than 1,900 employers participated in the bonus program between January 1, 2015, and June 30, 2016.

Among the other states without exclusive state WC funds, Oregon and Colorado stand out for their proactive stance in promoting positive return-to-work outcomes in their WC systems. Oregon's Employer-at-Injury Program (EAIP) is similar to Washington's Stay at Work program and provides employers with wage subsidies, reimbursement for work-site modifications, and other accommodation costs to help workers stay at work (Oregon Division of Workers' Compensation 2016a).[11] Oregon's Preferred Worker Program (PWP) is similar to its EAIP but targets employers who hire previously injured workers (Oregon Division of Workers' Compensation 2016b).[12] Worker and employer contributions to Oregon's Workers' Benefit Fund underwrite both the EAIP and PWP. In 1992, Colorado reformed its workers' compensation system by mandating that physicians treating workers with injury or chronic pain follow evidence-based "best practice" medical treatment guidelines. These guidelines, which were developed by the Colorado Division of Workers' Compensation with help from expert panels that reviewed the available science, include from the outset a focus on rehabilitation coupled with a timely assessment of complicating biopsychosocial factors if recovery extends beyond six weeks. According to Bruns et al. (2012), the reform, which includes several other major features, has led to improved quality of care while controlling costs.

2. Referral-based interventions

In cases where workers are not claiming WC, STDI, or disability benefits for state employees, two reasons explain the challenges associated with the early identification and engagement of workers in need of job-retention services. First, in these cases, workers do not file a claim for benefits and thus do not signal a potential need for services. Second, no state agency is a natural candidate for assuming responsibility for assisting the affected workers. In other words, workers, employers, or other stakeholders must make a considerable effort to connect those in need of services to the required job-retention services. Relative to the category of claim-based interventions, fewer promising state programs have implemented strategies that fall under the category of referral-based early interventions. The latter programs are characterized by proactive outreach but are reactive at the service delivery level—they are highly dependent on their referral sources and provide services to individuals only on request. Below, we briefly describe a few relevant examples.

Example 1: Job-retention services provided by the Alabama and Arkansas VR agencies

Many states operate programs within their VR agencies that are dedicated to helping retain employees who need assistance to stay at work.[13] Alabama and Arkansas are two examples of

[11] The EAIP was launched in 1993. In 2013, the program had 9,085 placements across 2,143 employers. Employment and wage recovery rates for EAIP participants as measured at the 13th quarter after injury have been consistently higher among program participants that among other workers (Oregon Department of Consumer and Business Services 2015).

[12] The PWP was launched in 1990. In 2013, 431 workers used PWP benefits. Employment and wage recovery rates for PWP participants as measured at the 13th quarter after injury have been substantially higher among preferred workers who used the program as compared to preferred workers who did not (Oregon Department of Consumer and Business Services 2015).

[13] Personal communication with Kathleen West-Evans, director of business relations at CSAVR.

states with agencies that operate long-standing programs that work with businesses on job retention.

The Alabama Department of Rehabilitation Services (ADRS) administers a program called Retaining a Valued Employee (RAVE), which provides employers (including some state agencies) with services such as "problem-solving for return-to-work and performance of essential tasks," "identification of accommodations," "counseling and education about medical and emotional issues," and "modified duty and transitional work options" (ADRS 2016).[14] RAVE offers employers and employees in Alabama a single point of contact—the RAVE coordinator—who rapidly assesses an individual's needs and arranges for assistance accordingly. Referrals to the RAVE program come from a variety of sources: human resource managers, occupational health and safety personnel, disability insurance and workers' compensation carriers, third-party administrators managing occupational and non-occupational claims, and the employee or his or her family. The Alabama RAVE program has recently launched a new marketing campaign in an effort to attract more referrals from businesses and is in negotiations with the State Employee Injury Compensation Trust Fund to be the lead provider of services for state employees whose job is affected by illness, injury, or disability.[15]

The Arkansas Rehabilitation Service (ARS), a division of the Arkansas Department of Career Education (ACE), administers a program similar to Alabama's RAVE. The Arkansas program was first launched in 2010 and until recently was also called RAVE. The agency's accommodation specialists evaluate a worker's functional limitations and compare them to the essential job functions of the employee's job and then collaborate with the employer and employee to provide work-station, assistive technology, and other modifications to the work environment that help the worker perform his or her duties. ARS also assists the employer in job matching for transitional or light-duty work, if needed. In 2016, the Arkansas program changed its name from RAVE to Stay-at-Work/Return-to-Work (SAW/RTW). The program now focuses on providing retention services for state agency employees and has developed client service delivery processes for that purpose.[16]

Similar programs in other states include South Carolina's Job Retention Services (JRS) program (South Carolina Vocational Rehabilitation Department 2016) and Georgia's Retain and Support Valuable Personnel (RSVP) program (Georgia Vocational Rehabilitation Agency 2016).

[14] Alabama's RAVE program was first launched as a pilot program in 1998.

[15] Personal communication with Peggy Anderson, administrator of ADRS's business relations program.

[16] In 2000, ARS, along with the Arkansas Workers' Compensation Commission and the Public Employee Claims Division of the Arkansas Insurance Department, undertook several initiatives to introduce the concepts of integrated disability management into state government. These initiatives focused on state government employees for three reasons: (1) the idea of ARS serving as a resource to other state agencies regarding the accommodation of state employees with disabilities was introduced as part of Governor Mike Beebe's Employment First Task Force in 2011; (2) there was opportunity to take advantage of previously developed partnerships to introduce integrated disability management in state government; and (3) the new administration put an emphasis on the state being a model employer (Personal communication with Alan McClain, commissioner of ARS).

Example 2: CSAVR's National Employment Team

CSAVR's National Employment Team (NET) consists of 80 business consultants, one for each VR agency, who serve as the designated point of contact for businesses seeking assistance with the hiring and/or retention of individuals with disabilities. CSAVR created the NET in 2005 in order to meet the hiring and retention needs of VR agencies' large business customers through a united (or "one company") approach. Under this approach, a national VR team provides businesses with no-cost services at the national, state, and local levels. One component of the NET's services to businesses is assistance with the retention of employees who experience the onset or deterioration of a medical condition that challenges their ability to work (CSAVR 2016). When businesses operate in several states and want to address job retention with VR assistance across state lines, CSAVR draws on the expertise of NET members in the relevant states to assist companies by simplifying the process of connecting to the appropriate VR point of contact in each state. In addition, the NET creates opportunities for VR agencies to leverage their job-retention resources, training, and special initiatives across state lines regardless of which businesses are seeking their assistance.

Example 3: Vermont's Invest EAP

Vermont's Invest EAP, initiated in 1986, and is administered by the state's Division of Vocational Rehabilitation (Vermont Division of Vocational Rehabilitation 2016). The program covers all state employees in Vermont and a large minority of workers in the private sector. It provides employers with comprehensive employee assistance services, including 24/7 telephone access to counselors, in-person counseling, and help with disability accommodations. The services are available to both employees and their family members. Notably, Invest EAP is self-sustaining, with services covered by capitated payments made by employers. Even though most other states provide their employees with access to EAP services, the Vermont model is unique in the comprehensive scope of its services.

III. OPTIONS FOR EXPANDING EARLY-INTERVENTION SERVICES IN STATES

In this chapter, we describe the types of interventions that are possible under the claim-based and referral-based categories, building on the examples presented in Chapter II.

A. Claim-based intervention

In this section, we consider three types of claim-based interventions that could promote better job-retention outcomes in instances when the worker must file a claim in order to receive benefits: (1) financial incentives, (2) retention services, and (3) behavioral interventions.

1. Financial incentives

Financial incentives that could encourage job retention among workers filing claims to receive disability-related benefits include partial-return-to-work benefits, employment subsidies, accommodation subsidies, and central accommodation funds. Partial-return-to-work benefits, such as those introduced by the Rhode Island TDI program in 2006, incentivize workers who are able to do so to return to work sooner than they would have done in the absence of such benefits. Employment subsidies, such as those provided in Washington's and Oregon's WC systems, help reduce employers' costs that may stem from reductions in worker productivity. Accommodation subsidies, which are also available in the Washington and Oregon WC systems, help reduce employers' costs of providing the accommodations that can help restore a worker's productivity. Centralized accommodations funds, made available by businesses (Hastings 2008), state governments (Krepcio and Barnett 2013), and the federal government (U.S. Department of Defense 2015), can help alleviate managers' concerns about the cost implications to their specific business unit of providing accommodations.

Partial-return-to-work benefits is the one incentive that is fully dependent on workers' filing of claims in order to receive cash benefits. Clearly, employment and accommodation subsidies are easier to implement in programs in which workers file claims to receive cash benefits, but the subsidies may still be available in other circumstances; for example, the federal Work Opportunity Tax Credit (WOTC) (DOL 2016) and similar programs in certain states (NCSL 2016) provide tax credits to assist employers in the hiring and retention of workers with disabilities. In theory, centralized accommodation funds should encourage the provision of accommodations to workers who need them whether or not employees file a disability claim; however, workers who need help but do not file any type of claim may be reluctant to ask for accommodations, and the managers of some workers may not be aware of their employees' needs.

2. Retention services

Various types of services could help improve retention outcomes among workers who file claims to receive disability-related benefits. Such services include proactive case coordination, assistance with workplace accommodations, and training and technical assistance for workers, employers, and physicians. (WC benefits include health care benefits; here, we focus on services other than usual health care services.)

Proactive case coordination can take many forms, with the common understanding that some level of coordination between various parties can facilitate a more rapid recovery and return to

work for workers after injury, illness, or disability. One example is Washington's COHE model, in which trained health service coordinators work directly with medical providers, employers, and injured workers to coordinate care and return-to-work activities. Another example is Delaware's Return-to-Work Program, in which the return-to-work coordinator works with insurance carrier staff, physicians, and supervisors to place return-to-work candidates back at work.

Even though we included centralized accommodation funds in the section above as a financial incentive, we recognize that the funds play a role in direct assistance with accommodations. Washington and Massachusetts are two states with established central accommodation funds for their employees (Krepcio and Barnett 2013). Other states operate programs that help with assistive technologies more broadly; two such examples are the Maryland Technology Assistance Program (MDTAP) (Maryland Department of Disabilities 2016) and the Delaware Assistive Technology Initiative (DATI) (DATI 2016).

Several states provide various forms of training and technical assistance for workers, employers, and physicians, with the aim of educating them in, and helping them implement, best return-to-work practices. Such training and technical assistance are a feature of the Washington COHE model. In addition, Ohio's Bureau of Worker's Compensation (BWC), for example, provides training and accreditation to case managers and physical and occupational therapists who can then help employers develop customized transitional work plans that may qualify for grants from BWC (BWC 2015). California's Division of Workers' Compensation commissioned a return-to-work handbook that provides guidance for small business employers who wish to establish effective return-to-work programs for injured employees (Institute for Research on Labor and Employment 2010). North Dakota's WC state fund, called Workforce Safety & Insurance (WSI), provides VR services aimed at helping injured workers find a new job if they are unable to return to their pre-injury employer (WSI 2011).

3. Behavioral interventions

Behavioral interventions, which are the focus of a companion SAW/RTW policy action paper (Contreary and Perez-Johnson and 2016), also have the potential to help improve job-retention outcomes. Such interventions draw from psychology and other social sciences to alter the environment in which decisions are made to help stakeholders such as workers, employers, physicians, and insurers avoid common pitfalls that result in unnecessary time off from work or even job loss. The filing of a disability-related claim triggers several interactions and decision points where behavioral interventions might promote job retention. For example, claims for short-term disability could be used as a trigger for multi-party dialogues that bring together the worker, employer, and physician to discuss options for supports that enable full or partial return to work.

B. Referral-based intervention

When there is no claim to trigger the provision of job-retention services and no state agency assigned to help workers who need such services, it is crucial that the state charge an agency with responsibility for providing such services. The same agency would also need to conduct outreach to generate service referrals from the target population. Below, we present three possible approaches to achieving these objectives: the CSAVR approach, which builds on and

expands the existing capabilities of state VR programs; the COHE approach, which relies on case-coordination services provided by third-party providers—adapted to off-the-job cases; and the EAP approach, which focuses on the retention of state employees.

1. The CSAVR approach: Build on and expand existing capabilities of state VR agencies

The CSAVR approach, exemplified by its NET and the employee-retention services available in Alabama, Arkansas, and other states, relies on the existing capabilities of state VR agencies. This approach emphasizes outreach to, and referrals from, employers. In Alabama, the retention rate among workers referred to RAVE services is very high;[17] however, the number of workers referred to RAVE services (about 200 in 2014) represents only a tiny fraction of Alabama workers who eventually receive SSDI—in 2014, more than 18,000 Alabama residents were awarded SSDI disabled worker benefits. The numbers suggest that many more workers in Alabama could benefit from RAVE's job-retention services.

In Alabama (and probably in other states), the contrast between the number of workers who could potentially benefit from job-retention services and those who receive them underscores the critical need for effective outreach to increase referrals, along with the need for funds to improve outreach efforts and increase access to services for those who would benefit from them. According to our policy work group discussions, the RAVE programs in Alabama and Arkansas apparently have the capacity to provide job-retention services to many more workers than are currently referred to the programs, and both programs are in the process of revamping their outreach strategies.

One promising option for effectively increasing referrals to retention services is to conduct outreach focused on increasing referrals from physicians and other health care providers (such as physical therapists and company nurses) to VR retention services. Many, likely most, workers first seek health care services to address their medical condition, even those with limited health benefits. Currently, however, physicians and other health care providers are rarely aware of VR retention services. Thus, providing information to them about making referrals to VR retention services, where they exist, could help encourage workers to seek the help they need. Other potential sources for referrals to VR retention services include human resource managers, EAP providers, worker advocates, American Job Centers, and state DDSs.

Other intervention options that may help increase employer referrals to retention services and that the NET already emphasizes to some degree include state VR agencies' ability to help employers comply with the reasonable accommodations requirements of the Americans with Disabilities Act (ADA) and the Section 503 requirement for federal contractors.

2. The COHE approach: Provide case-coordination services through third-party providers

A COHE-like intervention for off-the-job injuries and illnesses, which is the focus of a companion SAW/RTW policy action paper (Stapleton 2016), would operate primarily through the state's health care system. Any outreach would first target physicians for recruitment into the COHE network; the physicians would in turn refer their patients in need of help to other COHE

[17] Personal communication with Peggy Anderson, administrator of ADRS's business relations program.

service providers who would work with the relevant physicians, employers, and workers to maximize the chances of workers' job retention.

3. The EAP approach: Provide retention services to state employees through EAPs

The EAP approach, which also relies on referrals rather than on claims, would depend on the participation of a state's human resources office, with services delivered by third-party vendors. All covered employees may voluntarily seek EAP services through self-referrals, but, typically, supervisors also refer employees to EAP services through informal, formal, and sometimes even mandatory processes. Many workers already have access to EAP services, especially if they are full-time employees; in 2008, 76 percent of full-time public sector workers had access to EAP services (Stoltzfus 2009).

Compared to the CSAVR approach, whereby all the state VR points of contact coordinate their efforts through the NET, a myriad of companies offers EAPs for state employees, with large variation in the types and quality of programs they provide. According to a recent paper commissioned by the Employee Assistance Professional Association (Bennett et al. 2015), the evidence base for many of the services is lacking. Therefore, states interested in increasing the potential of EAP services to improve job-retention outcomes for their employees should consider (1) talking to their EAP provider about how their program can assist with the retention of workers following injury, illness, or disability, including mental illness, and (2) holding the EAP provider accountable by setting clear expectations for improvements in productivity and job retention.

IV. RECOMMENDED ACTION STEPS FOR STATES

Here, we present a menu of options for specific steps that states may take to increase access to job-retention services among workers who need them but who are currently unlikely to receive them. The most appropriate course of action will vary from state to state, depending on the capabilities and structure of the agencies and programs in a given state. In view of states' limited resources and competing demands, we identify some specific locations that seem most suitable for the introduction of claim-based and referral-based interventions. We provide examples of existing state programs that do not yet offer such interventions but are primed to do so (Table IV.1). At least from an operational perspective, these programs represent "low-hanging fruit ready for picking" by states interested in improving job-retention outcomes for workers.

Table IV.1. Recommended action steps for states

State system	Intervention type	Relevant state(s)
Claim-based interventions		
State WC systems	COHE model; behavioral interventions	North Dakota, Ohio, Wyoming
	Employment and accommodation subsidies; technical assistance and incentives for employers	All states
State STDI programs	Partial-return-to-work program	New Jersey, New York, Hawaii
	Proactive case coordination; duration guidelines; behavioral interventions	California, New Jersey, New York, Rhode Island, and Hawaii
	Introduce state STDI	45 states and the District of Columbia
Disability insurance programs for state employees	Partial-return-to-work program; proactive case coordination; disability duration guidelines; behavioral interventions; central accommodation fund	Any state with disability insurance coverage for employees
	Introduction of disability insurance for state employees	Any state without disability insurance coverage for employees
Referral-based interventions		
State VR agencies	Increase referrals, capacity, and outcomes reporting	States in which VR agencies provide job-retention services
	Require VR agency to take lead on job-retention services	States in which VR agencies do not provide job-retention services
State health care systems	Build on COHE model for off-the-job cases	All states
EAP benefits for state employees	Enhance EAPs' job-retention capabilities	Any state with EAP benefits for employees
	Introduce EAP benefits for state employees	Any state without EAP benefits for employees

Although the above intervention options have strong potential to improve job-retention outcomes for workers, most of them have not been rigorously evaluated. Hence, we recommend to accompany the introduction or expansion of any new intervention with a carefully designed pilot test of its effectiveness. When well designed, such tests provide information that can help a

state maximize its return on the resources invested. The results can also help other states make informed decisions about implementing similar programs.

A. Claim-based interventions

1. State WC systems

- Three states with exclusive public WC funds (North Dakota, Ohio, and Wyoming) are natural candidates for pilot-testing a COHE-like program or promising behavioral interventions such as those recommended by Contreary and Perez-Johnson (2016).
- Any state WC system, whether monopolistic or competitive, could pilot-test employment and accommodation subsidy programs similar to those in Oregon and Washington or follow the Ohio BWC model of providing training and incentives to encourage employers to develop and implement transitional work programs.

2. State STDI programs

- New Jersey's Temporary Disability Insurance (TDI) and New York's Disability Benefits (DB) programs are natural candidates for pilot-testing a partial-return-to-work program—ideally before enacting a statewide program. The New Jersey TDI program shares many similarities with the Rhode Island program and could potentially replicate, perhaps with some adjustments, the partial-return-to-work program already implemented in that state. The New York DB program differs from those in New Jersey and Rhode Island in that employers must purchase an insurance policy from a private disability insurer or self-insure their employees. While the insurance purchase complicates the piloting of a partial-return-to-work program in New York, it is still theoretically feasible to do so, potentially by requiring DB policies to provide a partial-return-to-work option.
- All five states with STDI programs (California, Hawaii, New Jersey, New York, and Rhode Island) could pilot-test proactive case coordination and behavioral interventions.
- The other 45 states and the District of Columbia could consider the merits of introducing an STDI program. Such programs, whether financed by workers or employers or a combination, could give states more claim-based tools for promoting improved job-retention outcomes.

3. Disability insurance programs for state employees

- Delaware and any other state government that provides its employees with disability insurance coverage could pilot-test any or all of the following: a partial-return-to-work program, proactive case coordination, disability duration guidelines, behavioral interventions, or a centralized accommodation fund, if they do not already offer these options.[18]

[18] Some states already provide some of these services to their employees with job-related injury or illness, and can consider options for expanding them to employees with off-the-job conditions.

- The state governments that do not currently provide disability insurance coverage to their employees—the majority—could consider the merits of offering such coverage and the options for funding it (i.e., through employee or employer contributions or some combination thereof). States that obtain disability insurance coverage for their employees will be able to consider claim-based intervention options, in coordination with their disability insurance carrier, similar to what Delaware has done.[19]

B. Referral-based interventions

1. State VR agencies

- States with VR agencies that already provide job-retention services should carefully consider their options for increasing the number of referrals to their services and for ensuring that they have the capability and capacity to provide services to more workers.
- Other states should consider the merits of relying on their VR agency to take the lead in identifying and engaging with workers in need of job-retention services and how best to implement the CSAVR approach in their state.

2. State health care systems

- All states should consider the merits of pilot-testing the COHE approach—adapted for off-the-job cases—within their health care systems.

3. EAP benefits for state employees

- States that already provide EAP benefits to their employees should consider consulting with their EAP provider about how their program can assist with retention of workers following injury, illness, or disability, including mental illness.
- Other states should consider the merits of offering EAP benefits to their employees and how best to provide job-retention services through those benefits.

[19] In addition to providing disability insurance coverage to state employees, states can consider policies to expand private disability income protection to a greater proportion of state residents in the private sector. For example, states could target tax incentives to encourage small- and medium-size employers to establish disability income protection plans and/or to enroll employees in disability income protection plans. States could also offer disability income security information resources to educate and empower working state residents.

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