"Ask Dr. J"

The "Ask Dr. J" columns are authored monthly by Jennifer Christian, MD, MPH, President of Webility Corporation. See previous columns at www.webility.md.

Dr. J's columns also appear in the monthly Bulletin of the Disability Management Employer Coalition (DMEC). To purchase a book of Dr. J's collected columns, go to www.dmec.org.

The columns often summarize issues discussed by the Work Fitness and Disability Roundtable, a free, multi-disciplinary e-mail discussion group moderated by Dr. Christian. Apply to join the Roundtable at www.webility.md.

February 2005 – What IS Disability Management?

Dear Dr. J:

I've just gotten into the disability management field, and have a very basic question. What IS disability management? I hear a lot of people using those same words to describe what sounds like different things.

Polly in Peoria

Dear Polly:

Polly, what great timing for your question! I'm writing to you from Australia, where I've been learning about Australia's approach to disability – which has made me see some new things about disability management in the US!

A group here in Australia asked me to speak to them about the recent evolution of the disability management model in the USA. In thinking about how to describe our model to them, I realized that there are at least seven different areas today that people could call "disability management," and most of them are in flux. They are:

1. ***Controlling indemnity costs.*** Some state legislatures have been trying to manage disability by changing the dollar amount of temporary total disability (TTD) payments, limiting the maximum possible weeks that TTD can be paid, modifying the permanent partial disability (PPD) award process, and standardizing the method by which permanent impairment ratings are performed. Since money tends to affect motivation and behavior, these changes can have a favorable effect by reducing the "attractive nuisances" that needlessly promote withdrawal from the workplace.

2. ***Finding a "permanent solution" through rehabilitation.*** Many people think disability management means helping people who have suffered a medical catastrophe (amputation, blindness, paralysis, brain injury, etc.) to learn to cope with their new and less able "self," which often means a permanent modification in the way they do their job

or even a change of career. Sadly, the perceived value of traditional vocational rehabilitation services in workers' compensation and disability insurance programs is currently low. Vocational rehabilitation services have generally been delivered on a "cost plus" basis, and both lawyers and claims managers have distorted the process for their own purposes – claimants' lawyers to drive up the cost of claims; claims adjusters to prove employability and enable closure of claims. As an example of the current perceptions, California recently simply threw out its existing voc rehab system in favor of a simple voucher for services that is driven by the injured worker rather than a professional.

That said, vocational rehabilitation can and does work miracles. A psychiatrist from Dartmouth medical school continues to dumbfound the do-gooders and the mental health community with the success of his clever and creative programs to reemploy people with chronic severe mental illness (schizophrenia, psychosis). He and some vocational rehabilitation colleagues find real jobs that are a "perfect fit" for them and their interests – and then they support them in the workplace on an on-going basis. A stunningly high proportion of those formerly hopelessly ill people are now medically-improved, stably employed, and proud as the dickens to be productive contributors to society!

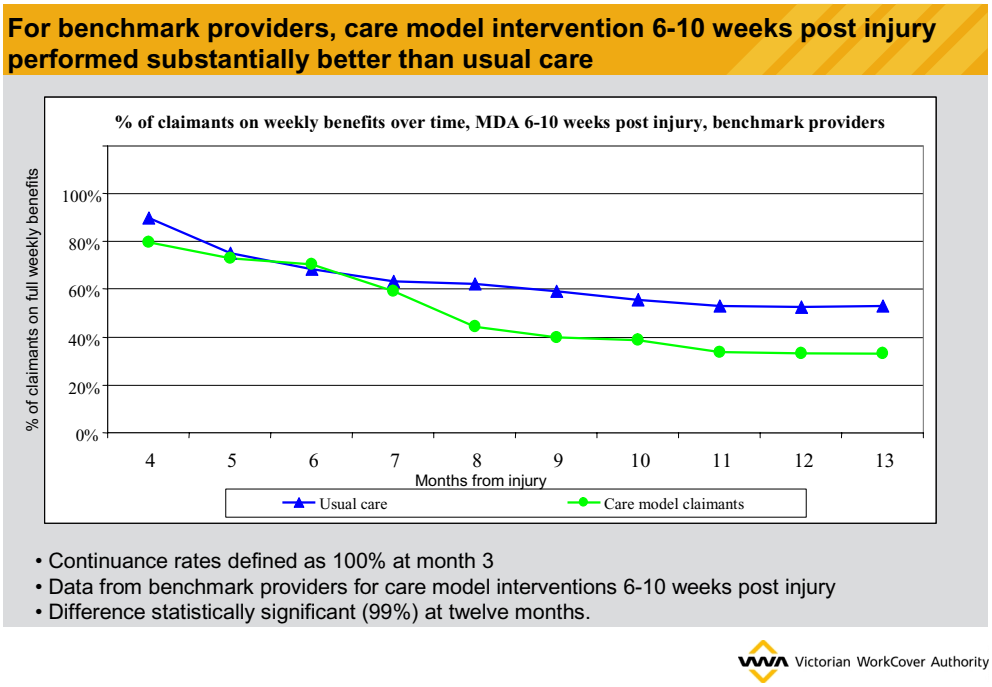
3. ***Speeding up the medical care process.*** It seems logical that speeding up recovery from a medical condition will also reduce the length of disability. Thus, many nurse case management programs that are focused on assuring appropriate medical treatment and expediting the healthcare process are called disability management programs. Recently, some cynicism has appeared in the marketplace about whether case management delivers more results than it costs. Buyers want "hard evidence" of the effectiveness of case management. Ironically, as with any preventive service, it is basically impossible to document your success, because the thing you would have compared to it didn't happen.

   In my own experience, too many well-intentioned but inexperienced nurses are thrust into case management without adequate preparation in the basic principles of disability management. And, too many case management companies are still paid on a "time and materials" basis. The best use of case management is NOT to facilitate communications and document carefully while the case goes to hell in a hand-basket. It IS to figure out whether and where there is an opportunity for case management to make a difference, and if there isn't, then to say so. The next item on the agenda is to anticipate possible contingencies and figure out a set of strategies to positively influence the outcome – and then to carry them out.

4. ***Treating delayed recovery.*** More people are becoming aware of the need for urgency in treating delayed recovery – because every week someone is away from work, the lower the chances become that they will ever go back to that or any other job. In no more than a month or so, the workers re-arrange their self-concept, and take on a new identify as "unable" or "disabled" instead of "normal" or "healthy". Once a human being gets comfortable thinking this way, it is very hard to get them to go backward.

   It is also becoming more generally recognized that people who recover way more slowly than expected, or who actually get worse when most others would be back to normal, usually have more than a physical medical problem going on. The illness or injury occurred in the context of the injured or ill worker's whole life, and the disability is the result of the interactions of factors in several dimensions.

There is a lot of current interest in figuring out how to identify people at risk for delayed recovery while there is still time to do something about it – and to identify the most effective ways to intervene. There are on-going projects in several Canadian states (Alberta, British Columbia, Ontario), in England and in Scotland. All focus on the bio-psychosocial model of disease (as opposed to the strictly medical model), and all provide both multidisciplinary assessments and interventions. Cognitive behavioral therapy, in which the patient learns to think differently – to see themselves and their situation from new perspectives – is a mainstay of many of these programs. As a very recent example, while here in Australia I heard about a pilot project on delayed recovery sponsored by the Victoria Work Cover Authority. They selected "benchmark healthcare providers" by competitive bid to participate in the project. One purpose was to see how many weeks after injury a multidisciplinary assessment (MDA) and referral for multidisciplinary services should be done. They discovered that they got the biggest "bang" from the MDA (a 20% reduction in time away from work) if the MDA was done 6-10 weeks post injury rather than 11-15 weeks – and that they got virtually no "bang" if the MDA was delayed until 15-18 weeks post injury. And, they discovered that it took a LOT of hard work to get claims adjusters (or agents as they call them) to actually refer the cases! (See figure below)



5. ***Providing opportunities for on-the-job recovery.*** Increasingly, the focus is on creating and maintaining an environment that fosters recovery, especially in the workplace. It is intuitively obvious that "acting healthy" is more likely to lead to recovery than "acting sick". The medical literature is solid and ever-expanding in support of the idea that early return to appropriate normal activity speeds healing and recovery in almost all medical conditions, from surgery to soft tissue injuries to psychiatric conditions. So, the most "modern" approaches to disability management use carefully designed work assignments as part of the therapeutic process. They spend more time and money on arranging on-the-job recovery and work-like activities and less time and

money on health care services like traditional rehabilitation. One Canadian study compared the effectiveness of intensive medical rehabilitation to worksite intervention. They found that intensive traditional rehabilitation actually INCREASED average case costs, while worksite intervention REDUCED costs compared to usual. In this case, worksite intervention included a range of possible activities ranging from ergonomic interventions to transitional work to on-site meetings. The organizations that anticipate the need for and pre-arrange on-the-job recovery opportunities can prevent disability entirely, rather than managing it.

6. ***Selecting doctors who "get it".*** Another part of creating and maintaining an environment that fosters recovery is selecting and working with doctors whose medical practice patterns demonstrate their ability to achieve good health outcomes AND functional outcomes as quickly and cost-effectively as possible. Sophisticated observers of the healthcare marketplace see the fruit of the labors of hundreds or thousands of doctors. They see that a small group of doctors are truly outstanding, a lot are medium or nondescript, and a few are really bad. There is more than one way to be bad: the doctor may be dangerously incompetent, disorganized, enabling, erratic, inattentive, neglectful, clinically or interpersonally inappropriate, corrupt, greedy, unethical, and so on. Some of these would actually qualify for the term "predatory physicians" because they take advantage of the misery their patient is in to offer unneeded or even inappropriate but profitable medical services – most commonly ineffective physical medicine services, painful injections, or spinal fusions and other mutilating surgeries – while the patient's life slides downward into domestic decay and permanent disability. In many states, a remarkably high fraction of all workers' compensation costs are generated by a few doctors who are each earning millions of dollars per year, and are notorious among insurers and employers as "bad doctors". It is not surprising but it is sad that patients who end up with delayed recovery or failed recovery have often been treated by a bad doctor. What IS surprising to me is how slowly employers and insurers have moved to put strategies in place to divert patients away from these doctors towards good ones, or to supplement care for the patients who are unlucky enough to have no other choices.

   Changes are in the wind, however. Selecting doctors to work with because of their proven record or philosophical alignment is now possible. Regulatory agencies, payers and employers have payment databases that let them create "profiles" of doctors and see who really does achieve good outcomes. (Profiling is harder than it sounds, however, and I would STRONGLY suggest you make sure you have people with real expertise on the job – physicians as well as data people – or else you will unwittingly throw away good doctors and keep the bad ones). The existing big medical networks based only on fee discounts (despite what they say) are being pressed to demonstrate that their providers actually deliver better results. California's new Medical Provider Network legislation is designed to let employers have much more control over where their employees go for care. Colorado, Texas and Florida are now requiring doctors to take basic training in workers' compensation order to treat work-related injuries or do impairment ratings. Happily, powerful organizations in both California and Texas are advocating for a requirement that doctors in those states be REQUIRED to take training in disability management as well.

   The American College of Occupational and Environmental Medicine has proposed new CPT codes that physicians could use to bill for disability management services. Personally, I believe the ability to use these codes should be a PRIVILEGE that can be earned through training and a documented track record rather than a right. As you

know, I think we'll all get better results when payers start recognizing and rewarding doctors who provide good care, so that more of them want to. Most doctors went into medicine because they want to do good and make a difference. The consolation prize for being treated with disrespect and like an expensive nuisance is to get revenge by making an even better living. Is it just money that drives you, or is it the desire to feel satisfied, acknowledged, and appreciated?

7. ***Getting employers involved.*** The Achilles heel of the workers' compensation system is the employer who says "no way" after the doctor, the claims adjuster and the case manager have reached agreement that a worker can return to work on transitional duty. What do we do then? There are millions of dollars spent on needless disability benefits because the employer says there is no temporary light duty available, or no way to permanently modify a job. It is also not clear what the best way around this roadblock is. Sometimes the problem is employer reluctance. The reluctance may be due to simple ignorance, since most employers don't know HOW to find appropriate work or supervise workers doing therapeutic work. The reluctance may be due to non-medical factors that are unacknowledged but need attention – hurt feelings, personality conflict, workplace friction, performance difficulties. Sometimes the problem is truly a matter of lack of resources, because small employers have got only a few jobs, may be in survival mode, and are already wearing too many hats.

   For several years now, many insurance companies have provided premium discounts for employers who have return to work programs. This sounds better on paper than it is in reality, because the sales force is eager to make sales, and employers who fail to actually provide transitional work are not held accountable. Only if that loophole gets closed will we start to see more real progress. The Ohio Bureau of Workers' Compensation (BWC) actually provides monetary Transitional Work support grants that allow employers to hire a professional to design and document a return to work program for them. The employers then get a discount on their premiums, and the Ohio BWC actually checks to make sure the programs conform with the law. Interestingly, employers frequently ask the professional to remain available as a contracted resource when return to work issues come up.

   Apparently, Australia has a law that requires all employers with more than 200 employees to employ an injury management coordinator, and that person is responsible for writing return to work plans for all employees out on workers compensation disability leave. This week I attended a meeting hosted by the Australia post office in Sydney for a group of local medical doctors. The line management of the post office was highly visible, in addition to the in-house injury management staff. The whole event was arranged by InjuryNet, a unique company that builds relationships with local providers and trains them on behalf of employers, and then on-goingly runs interference whenever there are service, communication, or collaboration breakdowns. InjuryNet is now working with several of Australia's largest multi-site employers, and is paid a monthly management fee. Is there anywhere in the US where this model is in place? I don't think so.

   The most dramatic experiment underway in the employer participation arena in the US is the new California "swing" on permanent partial disability (PPD) cash awards depending on whether the employer has offered temporary transitional or permanent modified duty. As I understand it, the amount of the award is INCREASED by 15% if the employer FAILED to make an offer, and is DECREASED by 15% if the employer DID make an offer and the employee failed to return to work. We are all waiting with bated breath to

see if putting this much money on the table will actually bring employers to the table as active partners in return to work.

In my opinion, it is inexcusable that neither the US government nor the workers' compensation and disability industries in the US have a research agenda and funding for high quality scientific research (from demonstration projects up through randomized controlled trials) to find the best way to clinically care for people in order to minimize work absenteeism and withdrawal from work. As a result, we have almost no scientifically (or politically) credible local evidence base upon which to decide whether any particular intervention actually pays off. The Australians, Canadians, English, New Zealanders and Scots (in alphabetical order) all have made considerably more investment in research than the United States. Canada, for example, has the National Institute for Disability Management and Research, and the individual provinces fund research projects. The Australian workers' compensation authorities fund research. Likewise, in Britain and Scotland. Why not us? And if our answer is that we prefer a private workers' compensation system, then I say it still behooves us to require the private sector to fund research.

Wow, Polly, you asked a short question, and I have given you a loooonnnng answer. Hope this is useful. Stay in touch, and let me know how you like your new career in disability management – and what it turned out to be for you, really!

Smiling,

Dr. J

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