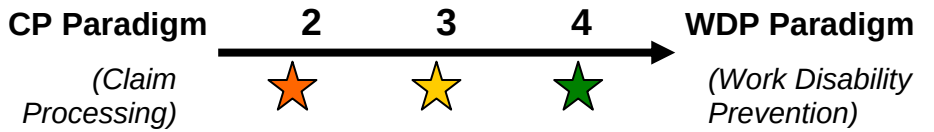
A Catalyst for Positive Change in Workers' Compensation and Disability Benefits Systems

SHIFTING THE PARADIGM – STARTING POINT SELF-ASSESSMENT

WHERE ARE YOUR PROGRAMS NOW – IN THE PARADIGM SHIFT?

Steps on the continuum of a paradigm shift:



KEY:

CP = Status quo = the traditional claims processing paradigm

2 = Realizing / recognizing problems, diagnostics; global planning

3 = Detailed planning & designing; starting the change process

4 = Change initiatives fully underway

WDP = Best practice = the work disability prevention paradigm, although improvement activities continue

As you complete this assessment, you will look at 20 areas in which the ACOEM Work Disability Prevention report provides recommendations. You will be able to see where your programs lie, overall, on the continuum between the traditional claim processing paradigm and the new work disability prevention paradigm. As you work, you will find yourself noticing what specifically is missing, and may discover you want to start putting together a roadmap for change. The right-hand column will help you build a list of specific places where you want to make changes.

Webility Self-Assessment — Paradigm Shift

INSTRUCTIONS:

1. In the table below, read the description in the Traditional (CP-Claims Processing) Paradigm column, and then the one in the ACOEM's New Paradigm column. Which one is your situation most similar to now? Or, are you somewhere in the middle, making the transition between paradigms? Make an X in the column that indicates the position on the continuum that best describes your current situation.

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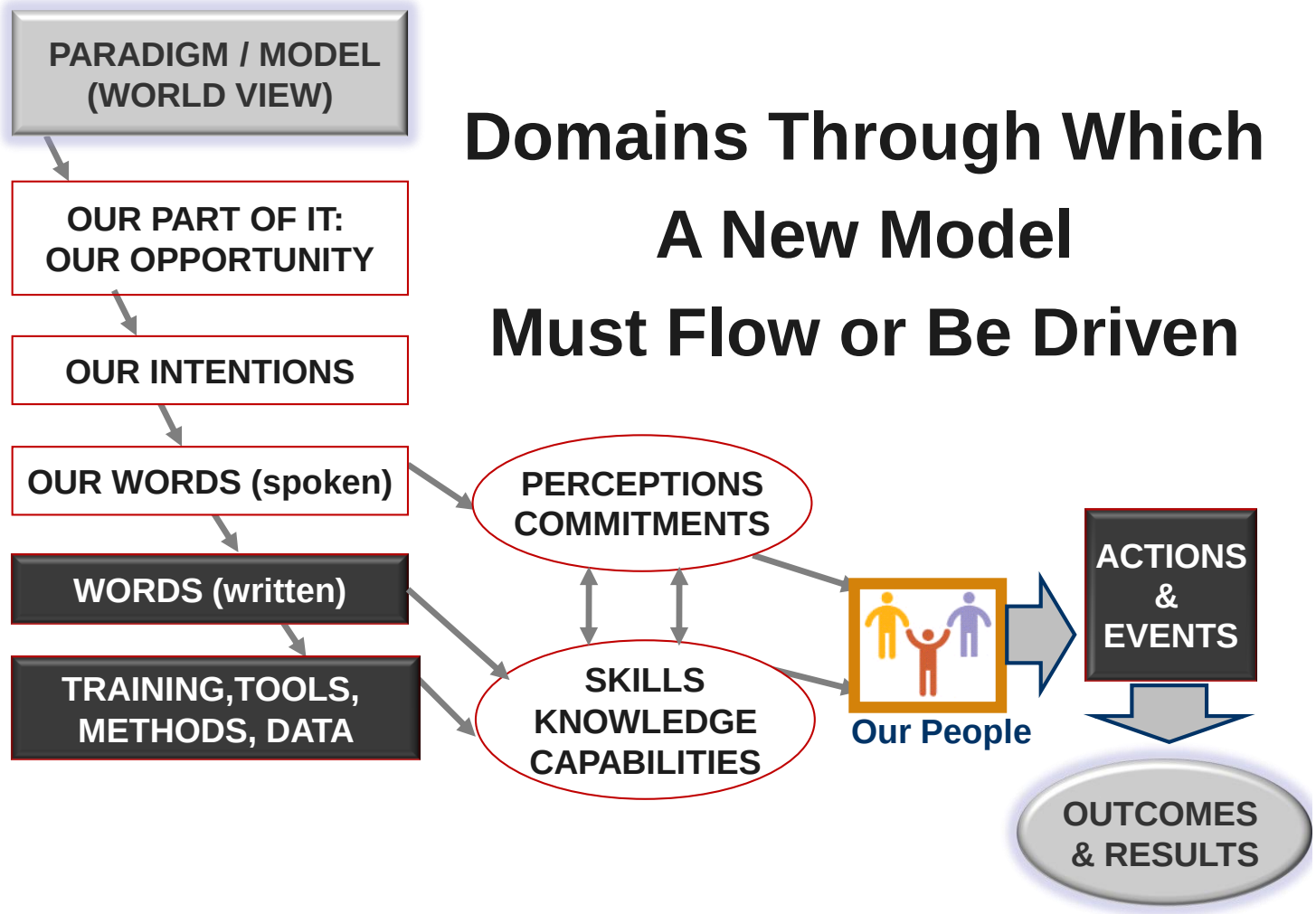
2. The diagram on the next page *[Domains Through Which a New Model Must Flow or Be Driven]* will help you:

   a. Decide where you want to begin the change process and start building your roadmap for change.

   b. Identify all the domains that will need attention in order to implement the recommendations.

In the diagram, the white domains are intangible; the black domains are tangible. In order to produce better outcomes and results, new ideas must become established in intangible domains (people's thoughts and decisions, their perceptions and commitments, their spoken conversations) and be embodied in tangible domains (written materials, training courses, tools, methods, data, observable actions and events).



	TRADITIONAL PARADIGM: CLAIMS PROCESSING	WHERE ARE WE NOW? (on the continuum?) ⟷					ACOEM'S NEW PARADIGM: WORK DISABILITY PREVENTION	DOES THIS APPLY TO US? WHAT IS MISSING HERE NOW? WHAT WOULD WE HAVE TO DO OR CREATE? HOW DO WE GET STARTED?
		CP	**2**	**3**	**4**	**WDP**		
I	**Use the claims processing model or the disability <u>management</u> model.** The most common current models or paradigms focus on (a) certifying or evaluating work disability in order to process claims -- rather than preventing work disability and actively working to assure the best possible outcome and (b) reacting to cases that have gotten off track by trying to get them back on track.						**I. Adopt a disability <u>prevention</u> model** *Recommendations*: **Make the decision to:** • Stop assuming that absence from work is medically required and that only correct medical diagnosis and treatment can reduce disability. • Educate employers about their powerful role in determining SAW/RTW results. • Pay attention to the non-medical causes that underlie discretionary and unnecessary disability. • Reduce discretionary disability by increasing the likelihood that employers will provide on-the-job recovery. • Reduce unnecessary disability by removing administrative delays and bureaucratic obstacles, strengthening flabby management, and by following other recommendations in this report.	

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1	Presume that work avoidance is medically necessary (beneficial) for injured and ill people. • Most people (including workers, their supervisors, employers, insurers, judges, legislators, the press) are unaware that work disability is only RARELY medically required.						1. Increase awareness of how rarely work disability is medically required, and the negative consequences of life disruption and worklessness. *Recommendation:* • Instruct all participants about the nature and extent of preventable disability.	

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2	Manage by "the system's" calendar; Pay no attention to how long the employee's life/work is being disrupted. • Most people (including workers, their supervisors, employers, insurers, judges, legislators, the press) are unaware that with every additional day away from work, the odds of a person's ever returning to work are falling. • Most programs do not pay systematic attention to time at all; those that do so start counting when the responsible person "got the ball", rather than when the injured/ill person first started missing time from work.						2. Instill a sense of urgency because prolonged time away from work is harmful. *Recommendations*: • Shift the focus from "managing" disability to "preventing" it and shorten the response time • Revamp disability benefits systems to reflect the reality that resolving disability episodes is an urgent matter, given the short window of opportunity to re-normalize life. • Emphasize prevention or immediately ending unnecessary time away from work, thus preventing development of the disabled mindset. • Disseminate an educational campaign supporting this position. • Whenever possible, incorporate mechanisms into the SAW/RTW process that prevent or minimize withdrawal from work. • On the individual level, the health care team should keep patients' lives as normal as possible during illness and recovery while establishing treatments that allow for the fastest possible return to function and resumption of the fullest possible participation in life.	

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II	**Ignore behavioral and circumstantial realities -- and pay the costs of it. It is too risky to acknowledge the "elephant in the room."**						**II. Address behavioral and circumstantial realities**	
3	Pay no attention to people's feelings and reactions; assume this has no impact. • Current processes do not acknowledge human realities. • Workers are typically left alone to cope regardless of their situation and their coping skills. • Little effort has been devoted to reducing uncertainty and other sources of stress. • Individuals caught up in stress that they cannot handle alone are not identified and offered extra support.						3. Acknowledge and deal with normal human reactions *Recommendation:* • Encourage all participants to expand their SAW/RTW model to include appropriate handling of the normal human emotional reactions that accompany temporary disability to prevent it becoming permanent. • Encourage payers to devise methods to provide these services or pay for them.	

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4	Stay on the surface by focusing only on what the policy or the law says or what the medical issues are. • Common issues include: inauthentic communication, lack of curiosity, and the failure to take a problem-solving approach. • Supervisors and workers often use the disability benefit system to sidestep difficult workplace issues that are obvious to them, but not disclosed to third parties. • When key parties to the SAW/RTW process do not know what is actually happening because they lack "inside information," any effort expended on SAW/RTW may be misguided or futile and a waste of resources and time.						4. Investigate and address social and workplace realities *Recommendation*: The SAW/RTW process should: • routinely involve inquiry into and articulation of workplace and social realities; • establish better communication between SAW/RTW parties; • develop and disseminate screening instruments that flag workplace and social issues for investigation; • and conduct pilot programs to discover the effectiveness of various interventions.	

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5	In health related employment situations with slower then expected recovery, continue to pay extra medical and disability costs for claims where psychiatric conditions remain undiagnosed, untreated, or ineffectively treated. • Maybe the psychiatric issues will go away if you ignore them. • Because you have spent a lot of money on ineffective treatment in the past, there is nothing you can do.						5. Find a way to address psychiatric issues effectively. *Recommendation:* • Adopt effective means to acknowledge and treat psychiatric co-morbidities; • teach SAW/RTW participants about the interaction of psychiatric and physical problems and better prepare them to deal with these problems; • make the performance of psychiatric assessments routine in people with slower-than-expected recoveries; • make payment for psychiatric treatment dependent on evidence-based, cost-effective treatments of demonstrated effectiveness.	

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6	Expect doctors and employees to ignore financial agendas despite disparities of benefit program designs. Make decisions based on key words only. • In disability cases, the medical treatment process is often distorted by non-medical factors, with patients often seeking particular diagnoses or treatments to obtain or maximize benefits. • Distortion also occurs when employers or benefits claims administrators ask naive physicians precise questions and elicit particular language that that later becomes the basis for benefit, claim, or employment determinations.						6. Reduce distortion of the medical treatment process by hidden financial agendas. *NOTE: This recommendation refers mainly to attempts by the payer, the employee or the employer to manipulate the doctor for financial purposes. A provider's agenda to earn a living is not hidden.* *Recommendation:* • Develop effective ways and best practices for dealing with these situations. • Acknowledge the problem. • Instruct clinicians on how to respond when they sense hidden agendas. • Educate providers about financial aspects that could distort the process. • Procedures meant to ensure independence of medical caregivers should not keep the physician "above it all" and in the dark about the actual factors at work. • Limited, non-adversarial participation by impartial physicians may be helpful. • Where possible, reduce the differences between benefit programs that create incentives to distort. Employers are in a better position to do this than other payers.	

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III	**Continue to complain about employees and physicians who do not do "the right thing" because of "perverse" incentives – and continue to pay the costs of it.**						**III. Acknowledge the contribution that motivation makes to outcomes and align incentives**	
7	There's nothing that can be done about slow, incomplete, & inadequate information from physicians. • Physicians seldom receive extra compensation for their time and effort in the disability prevention and management aspects of the SAW/RTW process. As a result, they may give those aspects low priority, believing they have no market value. In more complex situations that could benefit from the physician's initiative or active participation, the monetary disincentive reflected by lack of payment often deters the physician from responding quickly or making the extra effort, often delaying SAW/RTW. • Because most physicians don't consider disability prevention their responsibility, their passivity does not represent a failure to carry out their perceived duty. Although employers and insurers may assert that disability management should be included in the price of the medical visit, such assertions have little impact on physician behavior.						7. Pay [or otherwise reward] doctors for disability prevention work in order to increase their professional commitment to it. *Recommendations:* • Develop ways to compensate physicians for the cognitive work and time spent evaluating patients and providing needed information to employer and insurers as well as on resolving SAW/RTW issues. • Make billing for these services a privilege, not a right, for providers; • Make that privilege contingent on completion of training and an ongoing pattern of evidence-based care and good-faith effort to achieve optimal functional outcomes.	

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8	Put doctors on the spot by asking them questions in a way that makes the doctor feel "caught in the middle" between the employer and the employee. • Government agencies, insurers, and employers expect physicians to provide unbiased information that verifies what their claimants/employees have said about their medical conditions and ability to work. • The medical profession does not acknowledge any duty to play this role as corroborator of fact for third parties, especially because negative financial consequences for patients may result. In fact, the physician must advocate for the patient and consider the patient's interest first.						8. Support appropriate patient advocacy by getting doctors out of a loyalties bind. *Recommendations:* The SAW/RTW process should: • recognize the treating physician's allegiance; reinforce the primary commitment to the patient/employee's health and safety avoid putting the treating physician in a conflict-of-interest situation; • focus on reducing split loyalties and avoid breaches of confidentiality; • use simpler, less adversarial means to obtain corroborative information; and • devise creative ways for treating physicians to participate in SAW/RTW without compromising their loyalty to their patients.	

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9	Tolerate (and justify) line management's lack of support for on-the-job recovery (OJR) in your organization, and the reasons why it takes time to arrange transitional work assignments/reasonable accommodations. Currently, there are three problems that can prevent workers from recovering on the job: • Failure to provide temporary modified work. • The bad reputation of "light duty." • Long lag times due to the lack of an anticipatory approach.						9. Increase "real time" availability of on-the-job-recovery, transitional work programs, and permanent job modifications *Recommendations:* • Encourage or require employers to use transitional work programs; • adopt clearly written policies and procedures that instruct and direct people in carrying out their responsibilities; • hold supervisors accountable for the cost of benefits if temporary transitional work is not available to their injured/ill employees; • consult with unions to design on-the-job recovery programs; • require worker participation with ombudsman services available to guard against abuse; • make ongoing expert resources available to employers to help them implement and manage these programs.	

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10	Turn a blind eye to minor benefits abuse. After all, "everyone" does it; we don't want to appear too "tough," and we need to choose our battles. • Disability benefit programs are often used inappropriately to solve other problems – for example, taking sick leave to stay home and care for a child. • Rules also are stretched to receive benefits without medical justification. • If these minor abuses continue unchecked, more people assume everyone engages in such behavior. • Eventually, anyone filing a claim is treated with cynicism or suspicion.						10. Be rigorous, yet fair and kind in order to reduce minor abuses and cynicism *Recommendations:* • Encourage programs that allow employees take time off without requiring a medical excuse; • learn more about the negative effect of ignoring inappropriate use of disability benefit programs; • discourage petty corruption by consistent, rigorous program administration; • develop and use methods to reduce management and worker cynicism for disability benefit programs; • train all parties to face situations without becoming adversaries; and • be fair and kind to workers in the SAW/RTW process.	

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11	Explain why your hands are tied and you can't do anything about really "bad apples". • Some individuals in each group (workers, doctors, supervisors, TPAs) manipulate the SAW/RTW process to the point of serious abuse or clearly fraudulent activity. • Most workers seeking legal counsel do so only after a problem arises. People who feel they have been ill-served and retain lawyers get involved in an adversarial system that hardens and polarizes positions, prolongs needless disability, and increases the likelihood of poor functional outcomes.						11. Devise better strategies to deal with bad faith behavior *Recommendations:* • Devote more effort to identifying and dealing with employers or insurers that use SAW/RTW efforts unfairly and show no respect for the legitimate needs of employees with a medical condition; • make a complaint investigation and resolution service – an ombudsman, for example – available to employees who feel they received poor service or unfair treatment. • When faced with a serious problem, intend to win: take the time, collaborate, devise a strategy, and do the rigorous careful work required.	

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IV	Continue to operate in isolation; do not cooperate or collaborate with others on community-wide solutions. • Given the importance of the SAW/RTW process to system outcomes, remarkably little investment has been made to improve the system at the community level, and to enhance infrastructure necessary to develop and carry timely and accurate SAW/RTW data and other communications among the parties.						**IV. Invest in system and infrastructure improvements**	

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12	Keep complaining about doctors who don't know what to do or how to do it -- and keep paying the associated costs. Medical schools/residency programs neither educate physicians about the key role that patients, employers, and insurers expect them to play in the SAW/RTW process, nor teach them how to evaluate suitability for work or formulate RTW guidance.						12. Educate physicians on "why" and "how" to play a role in preventing work disability *Recommendation:* • Educate all treating physicians in basic disability prevention / management and their role in the SAW/RTW process; provide advanced training using the most effective methods; • make appropriate privileges and reimbursements available to trained physicians; • focus attention on treatment guidelines where adequate supporting medical evidence exists; • make the knowledge and skills to be taught consistent with current recommendations that medicine shift to a proactive health-oriented paradigm from a reactive, disease-oriented paradigm.	

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13	Keep complaining about how people "don't get it" -- and keep paying the associated costs. • It can take 20 years for new scientific evidence to percolate through a population. There is a growing body of evidence that being active and keeping life as normal as possible fosters recovery and improves outcomes. • Based on this evidence, the ACOEM Practice Guidelines recommend exercise, active self-care, and the earliest possible safe return to work. Despite this evidence, inactivity, work avoidance, and passive medical rehabilitation programs are often prescribed as treatment.						13. Disseminate medical evidence re: recovery benefits of staying at work and being active to everyone who needs to know it. *Recommendations:* • Undertake large-scale educational efforts so that activity recommendations become a routine part of medical treatment plans and treating clinicians prescribe inactivity only when medically required; • specify that medical care must be consistent with current medical best practices; • or preferably, adopt an evidence-based guideline (such as ACOEM's medical practice guidelines) as the standard of care.	

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14	Keep complaining about how everyone uses different forms and the poor decisions doctors seem to make. . • Each employer and insurance company has its own RTW form and communications process. So does each medical provider office. In any community, there may be 200 or more forms in use. • Although physicians play an important role in the SAW/RTW process, they are typically given too little information to act effectively. • Employers usually do not send any information to the physician about an employee's functional job requirements, their SAW/RTW programs, their commitment (or lack of it) to employee well-being, how to quickly answer questions or address problems.						14. Simplify/standardize information exchange methods between employers/payers and medical offices *Recommendations:* • Encourage employers, insurers, and benefits administrators to use communication methods that respect physicians' time; • shift the focus to include more than benefits questions and talk about getting life back to normal and preventing more work disability; • spend time digesting, excerpting and highlighting key information so physicians can quickly spot the most important issues and meet the need for prompt, pertinent information; • encourage all parties to discuss the issues – verbally and in writing – in functional terms and mutually seek ways to eliminate obstacles.	

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15	Be content with current poor methods and tools for obtaining, displaying, and analyzing data for SAW/RTW decision-making. • Existing methods and tools are nonstandard and often crude. Few of them have been rigorously scientifically tested.						15. Improve/standardize methods and tools that provide data for SAW/RTW decision-making *Recommendations:* • Help physicians participate more effectively in the SAW/RTW process by standardizing key information and processes; • persuade employers to prepare accurate, up-to-date functional job descriptions (focused on the job's maximum demands) in advance and keep them at the benefits administrator's facility; • send them to physicians at the onset of disability; • teach physicians practical methods to determine and document functional capacity; • require purveyors of functional capacity evaluation methods and machines to provide published evidence in high-quality, peer-reviewed trials comparing their adequacy to other methods.	

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16	Why spend time and money on research? The government or medical schools must be doing it. • The SAW/RTW process has not been systematically and formally studied in sufficient detail. Little solid methodological foundation or medical evidence exists to support or improve commonly used methods and tools. • Compared to other specialty populations (such as children, migrant laborers, the elderly and poor, little investment has been made in research on what methods and tools produce the best outcomes for the population of injured/ill workers overall.						16. Increase the study of and knowledge about SAW/RTW *Recommendations:* • complete and distribute a description of the SAW/RTW process with recommendations on how best to achieve desired results in disability outcomes; • establish and fund industry-specific, broad-based research programs, perhaps in the form of independent institutes or as enhanced university programs; • collect, analyze, and publish existing research; • formulate research to better understand current practices and outcomes, determine best practices and test alternative solutions to problems; • develop a way to effectively communicate the findings of completed research to all decision makers; and solicit needs for future research.	