Social Security Administration

"Use of Functional / Vocational Expertise" Project - Final Report

Supplemental Report

Transmittal Note

August 27, 2007

This document is part of the final report for a project commissioned by the Social Security Administration. The purpose of the project was to obtain expert advice on how to best use functional and vocational expertise in SSA's disability programs. The project was conducted by Webility Corporation and SSDC. It involved extensive input from a panel of twenty experts in relevant professions.

The entire final report was recently accepted by SSA, which also granted permission to release it to the public. These materials will be of interest to a wide variety of audiences. We hope that readers will find them useful.

IMPORTANT NOTE: The opinions, findings, and recommendations expressed in this report reflect the professional expertise and recommendations of Webility Corporation, SSDC, and the expert panelists. The report should not be interpreted as representing the viewpoints or philosophy of SSA, nor should it be interpreted as representing any present or future changes to vocational or occupational policy administered by the Social Security Administration.

Other components of the Final Report and additional project documents can be found at www.webility.md. While the project has officially concluded, we welcome dialogue with interested readers. Questions about Social Security's program policy should be directed to them, however.

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Social Security Administration
"Use of Functional / Vocational Expertise" Project

Supplemental Report

(See Core Report for panel recommendations.)

Final Report

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Supplemental Report

SSA Use of Functional / Vocational Expertise Project

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Introduction

This document contains supplemental materials from a project commissioned by Social Security Administration (SSA) in January 2006 to obtain expert advice on how to best utilize functional and vocational expertise in administration of SSA's disability programs.

The recommendations from that project appear in the companion document labeled the "Core Report," which should in most cases be read before reading these supplemental materials.

This Supplemental Report contains four items:

- Design Details for the Multi-Dimensional Assessment (MDA) describes in detail how the panel's cornerstone recommendation would work – a program for obtaining face to face assessments of certain applicants by mFV experts in order to more fully understand their situation.
- The Nature of Functional and Vocational Expertise defines these, describes why they exist and the tasks that require them, identifies who has them, and describes where to find those people.
- Use of Functional and Vocational Expertise in Other Systems briefly describes how several related disability systems use functional and vocational expertise today, and which practices would be useful for SSA to emulate.
- Project History presents a brief summary of the project's timeline and methodology.

Social Security Administration
"Use of Functional / Vocational Expertise" Project
Contract # SSOO-06-60072

Supplemental Report

I. Design Details For The Multi-Dimensional Assessment (MDA)

October 23, 2006

Design Details for the Multi-Dimensional Assessment (MDA)

- A key element in the mFV Expert Panel's report is a face-to-face multi-dimensional assessment (MDA) of the functional status of applicants and beneficiaries, when pertinent. The mFV professionals among the panelists agreed that this is the cornerstone of the recommendations.
  - (See Core Report sections D-3 and D-4).
- An earlier version of this presentation was generally endorsed by the Expert Panel. This version is shorter and reflects changes in the recommendations as approved by the panel, but otherwise presents the same material.
- This presentation provides a preliminary blueprint for an MDA program.

Outline of Topics Covered

- Summary of Idea
- Purpose of Program
- The Multi-Dimensional Assessment (MDA)
  - Nature and Expected Impact
  - Final Reports
  - Approach and Design
  - Process, Method & Tools
  - Additional Functional Testing
  - Report and Follow-up
- The MDA Evaluators and Functional Testers
- Training and Quality Management
- Financial and Operational Considerations

Summary of the MDA Idea

- In addition to CEs, the DDSs will rely on community-based mFV experts in the mFV Registry to perform MDAs, whenever pertinent.
- Standard preparation for hearing an appeal will also include an MDA, whenever pertinent.
- DDS staff will rely on internal mFV experts and protocols (triaging, claims complexity levels, and evaluator selection criteria) to determine which cases need MDAs.
- The MDA is a face to face (or video) evaluation performed in 1-2 sessions.
- mFV experts will conduct the evaluation, request additional CE or detailed functional testing if needed, analyze the results, and write a 2-part MDA report (one part for SSA, and the other part for the applicant/beneficiary as an option).

Purpose of MDA Program

- The multi-dimensional assessment process and the 2-part MDA reports are designed to:
  - Provide value to SSA – richer data and a more solid basis for disability determination in many cases.
  - Provide value to the applicant –
    - an expansion upon previously available data that will clarify the applicant's situation and improve chances of an award if it is warranted
    - a personalized expert evaluation and plan of action for removing barriers to employability, where possible.
  - Create a database of actual barriers to work faced by SSA applicants that will support multi-organizational policy and program improvements.

The Multi-Dimensional Assessment

- Nature
- Expected Impact and Credibility
- The Set-Up and Selection
- Approach and Design
- Process, Method & Tools
- The Final Report
- Follow-up

Nature of The MDA

- An independent professional evaluation of:
  - The impact of a medical condition on multiple domains in applicant's life
  - Causal links between the medical condition, functional limitations, and lack of gainful work activity
  - Barriers to employability in a variety of life domains and the feasibility of reducing them.
- Consists of 1 or 2 face-to-face sessions, occasionally by video.
- Includes observation of function and may lead to additional CEs or functional tests if required.
- Work-product will be a final written report.
- Performed by community-based mFV experts using a specific method established by SSA.
- mFV experts, through their professional training and work experience, already employ this type of multi-dimensional approach to evaluation.

Expected Impact of MDAs

- Impact will be apparent in the DDSs, at the appellate level, by applicants, and on the national level.
- On the SSA disability evaluation process, both in the DDS and on appeal:
  - Increase breadth and level of detail available and provide a more solid basis for accurate decision-making.
  - Improve credibility of basis for findings re: RFC, ability to work, eligibility for benefits, etc.

Expected Impact of MDAs - 2

- On Applicants:
  - Enhance likelihood of a benefit award if it is warranted.
  - Take a new look at their life situation through the eyes of an expert professional and see a pathway back to work (where feasible).
  - Learn about options for obtaining services.
  - Improve likelihood of accessing needed services and returning to work.
  - Increase their confidence in the adequacy of SSA's evaluation.
  - Increase their satisfaction through a more personalized process and the value they get out of it.
  - Discourage non-meritorious / fraudulent applications.

Expected Impact of MDAs - 3

- At the national level:
  - Create a database of the actual barriers to employability now facing people who are turning to SSA for help.
  - The database could provide a factual basis for policy and program changes that could be designed to improve availability of and access to needed services, or to track whether services are actually delivered and their impact.

MDA Reports in Two Parts – Part A

- Part A: Sent to SSA (and Applicant /Beneficiary upon request)
  - Documents current functional status in domains in which key barriers to employability often exist: medical, physical, mental, socio-economic, environmental.
  - Documents results of observation and testing, along with applicant's behavior and comments.
  - Explicitly addresses causal chain and consistency/credibility of findings.
  - Identifies specific barriers to work in any life domain.

MDA Reports in Two Parts – Part B

- Part B: Sent only to Applicant or Beneficiary (upon request)
  - When feasible, lays out a general strategy for removal of barriers to employability, including potential solutions and timeline.
  - When appropriate, suggests options for needed services.

Credibility of MDA Reports

- Credibility will be enhanced by:
  - The expertise and neutrality of the MDA evaluator.
  - The scope and level of detail of the information developed.
  - The individualized and realistic picture of the applicant’s situation.
  - Careful exploration of the causal association between medical condition, impairment, residual functional capacity and ability to work.
  - Explicit differentiation between factors that do and do not constitute the legal basis for a benefit award.
  - The use of standardized methodology and consistency among MDA evaluators.

Selecting The Claims That Will Receive an MDA

- In general, MDAs will be done when there is lack of clarity, low quality data, uncertainty, inconsistencies, or potential for competing causes of work withdrawal.
- All claims that do not meet the Listings in Step 3 of the sequential process will be triaged and assigned to one of three claim complexity classes
  - Class A = Straightforward
    - (e.g., amputation; congenital condition)
  - Class B = Mid-Range
    - (e.g., asthma, heart disease, arthritis)
  - Class C = Difficult
    - (e.g., depression, fibromyalgia, migraine)
- Protocols for each claim complexity class will determine whether or when an MDA will be required.

Selecting The mFV Expert Who Will Perform the MDA

- A mFV provider in the DDS selects the desired profession and Expertise Tier of the MDA evaluator.
- Community-based providers in the mFV Network will do MDAs:
  - Nurse case managers, nurse practitioners, occupational therapists, physical therapists, physicians, psychologists, social workers, vocational rehabilitation professionals.
- All mFV providers will have been assigned to Tiers based on the extent of their mFV expertise:
  - Tier I = mFV practitioner (inside SSA; do not do MDAs);
  - Tier II = mFV Expert (do Class B MDAs)
  - Tier III = mFV Senior Expert (do Class B and C MDAs)
  - Tier IV = mFV Subspecialist Expert (do Class B and C MDAs)

Logistics for the MDA

- User-friendliness for applicants should be paramount – emphasis on courtesy, clear instructions, with convenient location, transportation, and hours for MDAs – but with clear consequences for no-shows.
- SSA staff schedules appointment for the applicant with an appropriate MDA evaluator (who must be a member of the mFV Network)
- SSA staff creates a request for MDA that succinctly outlines the key issues of concern for the MDA
- SSA makes all application data available to MDA evaluator

Which Applicants Get an MDA?

- Protocols should drive the decision to obtain an MDA.
- Prior to making benefits award decisions, MDAs will be done when more detailed information is needed.
- After a denial decision has been made, MDAs should be done when the clinical situation warrants it, for example, when an MDA may:
  - Avert the need for subsequent reapplication by an applicant who was denied based on current income or length of disability.
  - Provide an expert assessment and suggestions for people who may be uncertain what to do next.
  - Provide a basis to turn an initial denial into an award.
- MDAs should also be performed on a random sample of qualifying benefit denials as part of SSA's quality management program.

During the MDA – How the MDA Evaluator will BE

- Professional, neutral, unbiased as to the facts and the outcome.
- Observant; listening for the spoken words as well as the communication beneath the words.
- Trustworthy, authentic, on the level – and focused.
- Interested, courteous, warm, and empowering.
- Committed to delivering value to each applicant, and to their health, safety, fullest possible participation in life, and highest possible level of self-sufficiency.

During the MDA –
What the MDA Evaluator will <u>DO</u>

- MDA evaluator collects and creates better data through interview, observation, basic testing.
- 1-2 sessions -- face-to-face, home visit, or video (last choice):
  - (A) 90 to 120 minute face-to-face initial appt.
  - (B) 30 or 60 minute follow-up appt only if needed.
- Follows interview guide and protocols for observation and testing.
- Employs well-known and professionally-designed tools (e.g., SF-36) and elicits simple physical maneuvers.
- Uses template and specifications to document and analyze results and make findings / recommendations.

MDA Protocols / Tools

- SSDI / SSI application data
- Checklist that documents completion of all elements of MDA and selection of functional testing tools
- Interview guide
- Functional testing inventory and materials
- Medical reference material, e.g., disability duration guidelines, etc.
- Worksheets to record data
- Template for final report (with specifications)

1st MDA Appointment: Interview

- In collaboration with applicant:
  - Explores applicant's current status in multiple domains of life (medical, physical, mental, socio-economic, environmental) including desires, intentions and goals.
  - Explicitly identifies barriers to function or employability and their source.
  - Investigates efforts that applicant has already made to overcome them, results, and reasons for any inaction.
  - When feasible, devises possible ways to remove each barrier.
- Evaluates availability, accessibility, duration, cost & likelihood of technical success for removing barriers.
- If indicated, sends applicant for additional CE or targeted functional assessment to answer a specific question.
  - Offers second appointment to discuss results if needed.

1st MDA Appointment: Observation and Testing

- Observes:
  - function and behavior in “natural” activities and social interactions before, during, and after appointment.
  - relationship between medical impairments and functional ability.
  - details: eye contact, affect, level of engagement, thought process, alcohol on breath, fidgeting, grooming, use of functional aids, etc.
- Selects and conducts simple functional screening test(s) or elicits demonstration of pertinent physical / mental capabilities.
- Decides whether additional CE or functional testing will be required.
- Documents all results.

Referral for More Detailed Functional Testing

- When uncertainty remains about a medical issue or particular functional ability, MDA evaluator recommends further evaluation, and the type of clinician to do it
  - Self-referral prohibited
- DDS arranges appointment with a CE or another member of mFV Network
  - MDA evaluator may do testing only if no other qualified mFV expert is reasonably available
- Test results are sent to MDA evaluator and SSA

MDA Evaluator's Development of MDA Report

- Completes worksheets. Analyzes data from interview, observations and initial testing as well as any additional evaluation/testing by others.
- For Part A: Summarizes findings using report template.
- For Part B: If barrier removal seems feasible,
  - Formulates a strategy for barrier removal, a list of potential solutions and a timeline for applicant's use.
  - Considers what services are likely to be effective, available and accessible, and makes appropriate suggestions and referrals.
- On occasion (see Panel of Peers below) presents proposed findings to a panel of peers or supervising professional or both for critique, input, and suggestions prior to completion of report.

Optional 2nd MDA Appointment: Closure

- Observes behavior before, during, and after appointment. Further evaluates any issues identified as key in the interim.
- Reviews results of 1st appointment with applicant. Asks for additional input.
- Where feasible, counsels applicant about strategy for removal of barriers to employability, potential solutions and timeline.
- Asks for initial reactions, suggestions. Asks applicant what they intend to or want to do with these results.
- Refers to public sector or non-profit agencies for services if appropriate AND if applicant agrees.

Applicant / Beneficiary Role in MDA

- Be available for MDA; show up for the appointment.
- Cooperate with interview, act “normal” and give full effort in testing.
- Help identify barriers to employability and, where realistic, explore possible ways of removing them.
- If feasible solutions are identified by MDA evaluator, decide whether to take action and follow through with any referrals.

Follow-up

- Adjudicators use the MDA report in making their determination.
- SSA staff enters data into the Barriers Database about specific barriers to employability that were identified in all MDAs.
- On an on-going basis, mFV quality management staff calls a random sample of applicants 1-2 weeks after the MDA appointment to determine applicant's satisfaction with the MDA process and evaluator and to answer any questions.
  - Results of this call are captured in the mFV quality management database.
  - Results are sent to the evaluator as quarterly / semi-annual performance feedback.
  - Results are used to drive MDA process improvement.
- If claim decision is appealed, MDA evaluator may be called on to testify.

Training of MDA Evaluators and Quality Management of Work Products

- Initial and periodic training of MDA evaluators will be essential.
- On-going quality management will:
  – provide essential performance feedback and coaching to evaluators, and
  – ensure system-wide reliability and consistency of the MDA reports they produce.

MDA Quality Management Tools

- Use panels of peers to achieve and maintain quality
- Calibrate and “tune” MDA evaluators to keep them consistent
- Do routine quality audits of MDA reports
- Enforce other training and quality management requirements

Use Panels of Peers To Harness Professional Pride and Increase Quality

- Weekly telephone conferences of MDA evaluators provide forum for on-going training, motivation, and performance improvement
- Regular presentation of MDA findings to panel of multi-disciplinary peers
  - New MDA evaluators or evaluators on probation present findings of their first several MDAs (5 to 10)
  - Experienced MDA evaluators present a case monthly or quarterly
  - Peers comment and make suggestions to improve report.

How the Panel of Peers Works

- Coordinated by “lead” MDA evaluator in the area
- Provides incentive to look good to peers by doing good work
- Panel provides feedback and additional resources or insights that improve MDA reports
- Assures adequacy of work by new evaluators
- Multi-disciplinary approach cross-fertilizes among professions and cross-trains evaluators
- Reinforces professional discipline and ethical independence
- Maintains professional satisfaction and morale

Calibrate and “Tune” MDA Evaluators To Keep Them Consistent As a Group

- Videotaped MDA appointments can be used:
  - To train new evaluators
  - To calibrate and “tune” existing evaluators
- Several MDA evaluators watch video, fill out worksheets, and analyze results of the same videotaped interview.
- Analyze data and assess level of consistency.
- If results are not acceptable, the lead MDA evaluator (or an SSA trainer) conducts a “tuning” session. This involves working with evaluators as a group, asking questions, providing information, suggestions and direction until they come up with similar results.

Audits of MDA Reports

- mFV Quality Management staff audits MDA reports and gives feedback and suggestions and offers coaching to evaluators:
  - Frequently for new evaluators (first 6 reports)
  - Randomly (1% sample)
  - After a complaint by an applicant, DE, or ALJ
- MDA reports from MDA evaluators with a low score on a prior audit will be re-audited every 2 weeks until report quality becomes satisfactory. Failure to improve is grounds for removal.
- Aggregate audit results will drive quality performance improvement program plans.

Other Training and QM Needs

- mFV experts in DDSs will need to be taught a consistent approach to triaging, assigning claims to complexity classes, and selecting which mFV expert is most appropriate to do each MDA.
- DEs need to be taught how to assess the adequacy of functional information supplied by treating sources, and assess the level of expertise of the source in evaluating that information.
- Periodic audits of randomly-selected triage, claim complexity classes, and mFV assignments results will make sure DDSs are ordering MDAs appropriately.
- Aggregate analysis of audit results will track system- wide referral performance and point out training needs.

New Responsibilities & Costs for SSA

- Someone must manage the quality of the work done by providers in the mFV Medical Registry (both Unit & Network) as well as the providers themselves.
- Establish, maintain and enforce:
  - Eligibility and performance standards for individual mFV providers and multi-provider vendors
  - Performance specifications for MDA process and reports
  - A national fee schedule (with local adjustment possible for cost-of-living, state laws, etc.)
- Negotiate national, regional or local contracts with network management companies and / or large multi-provider vendors.
- Lead, manage and perform the functions required to operate:
  - Training programs for mFV experts
  - The Quality Management program

New Responsibilities & Costs for DDSs

- mFV Network Management
  - Provider recruiting, contracting, credentialing.
  - Response to complaints about service, access, quality, billing, etc.
  - Selection of training & continuing education offerings
- MDA Program Support
  - Training delivery for DEs and MDA evaluators
  - Local quality management programs
- MDA Operational Support
  - DE triage for whether MDA will be done
  - MDA scheduling and transportation
  - Cost of MDA assessments (estimated $150-$500 each)
  - Cost of additional functional assessments (estimated $75-$500 each)

Making This Change SUCCESSFULLY

- Commit to finding a way to make the big ideas work, and stick with it until they do, rather than “giving this design a try.”
- Get the individual elements ready.
  - Design, pre-test, listen, analyze, refine, re-test.
- Make sure the whole process works operationally at very low volumes before large-scale operations begin.
  - Test, listen, analyze, refine, re-test.
- Roll-out at a speed that doesn’t overwhelm the system’s capacity to implement change successfully.
  - Provide extra support to each unit as it adopts the new process.

Design Phase

- Allow mFV experts to contribute existing knowledge and help develop prototypes for MDA program.
  - Triaging, claim classification, and selection criteria for MDA evaluators
  - The MDA “toolkit” – protocols, methods, tests, checklist, worksheet, reference materials, templates for reports.
  - mFV network development materials – recruitment, credentialing, contracting, training.
  - Quality management processes.
  - Support and operational processes
  - Policies and procedures
  - MDA-related training materials for all other involved parties

Pre-Testing and Refinement

- Discuss and pre-test MDA toolkit with a hand-picked group of MDA experts.
  - Listen to feedback; analyze results. Refine and retest until it is easy-to-use and produces useful results.
- Pre-test the effectiveness and operational feasibility of the whole operational design at very small scale.
  - Listen to feedback; analyze results. Refine as necessary and re-test until it works smoothly.
- Discuss and pre-test protocols for triage, claims classification, and criteria for selecting MDA evaluators with a hand-picked group of DDSs.
  - Listen to feedback; analyze results. Refine and retest until it is easy-to-use and works well.

Implementation:
Full Scale Field Test, Phased Roll-Out

- Roll-out new MDA process in one state's DDS and with one FRO. Provide extra support during roll-out.
  - Operational issues? Effectiveness? Impact?
  - Refine as necessary and re-test if needed.
- Proceed with full nationwide roll-out. Provide extra support to each unit as it adopts the new process.

Reprise: Summary of the MDA Idea

- In addition to CEs, the DDSs will rely on community-based mFV experts in the mFV Registry to perform MDAs, whenever pertinent.
- Standard preparation for hearing an appeal will also include an MDA, whenever pertinent.
- DDS staff will rely on internal mFV experts and protocols (triaging, claims complexity levels, and evaluator selection criteria) to determine which cases need MDAs.
- The MDA is a face to face (or video) evaluation performed in 1-2 sessions.
- mFV experts will conduct the evaluation, request additional CE or detailed functional testing if needed, analyze the results, and write a 2-part MDA report.

Anticipated Results of MDA Program

- The multi-dimensional assessment process and the 2-part MDA reports will:
  - Deliver value to SSA – richer data and a more solid basis for disability determination in many cases.
  - Deliver value to the applicant –
    - an expansion upon previously available data that will clarify the applicant's situation and improve chances of an award if it is warranted
    - a personalized expert evaluation and plan of action for removing barriers to employability, where possible.
  - Create a database of actual barriers to work faced by SSA applicants that will support multi-organizational policy and program improvements.

II. The Nature of Functional and Vocational Expertise

Overview

The Social Security Administration (SSA) uses a combination of medical, functional and vocational expertise in its formal administrative determinations of medical impairment, functional ability, and ability to work. However, SSA's use of expertise is only a small part of the universe where medically-related functional and vocational expertise is needed and supplied.

Knowing more about the issues that call for medically-related functional and vocational expertise, the people who possess it, and the marketplace in which it is bought and sold will provide a solid basis for developing practical recommendations for SSA about how to best obtain and make better use of this expertise.

This paper creates a foundation of understanding about the need for and use of medically-related functional and vocational expertise (hereinafter referred to as mFV expertise) in America today – and the people who are called upon to provide it. Key questions addressed are: what is this expertise, how and where is it needed and delivered, how is it paid for, who has it and to what degree, how many experts are there, who do they work for, and so on.

The paper is divided into the following major content areas:

- Definition, background, key concepts
- Providers and uses of mFV expertise, uses of mFV expertise by SSA today
- Detailed description of tasks involved in providing mFV expertise.
- Considerations for obtaining mFV expertise
- Implications and Conclusions

Definitions, Background, Key Concepts

A. Expertise and Experts

In this paper, the word “expertise” means the knowledge and skill required to do well what a situation calls for. Obviously, the demands posed by different situations require different kinds and amounts of expertise. Some situations call for a person who possesses basic factual information about a general subject; some require in-depth knowledge about a particular detailed aspect, some need a person who is really a master in the whole matter.

Expertise is a relative term, but expert is not. An expert is defined by the American Heritage Dictionary as *a person with a high degree of skill in or knowledge of a certain subject* – in other words, a person with a lot of expertise. The opposite of an expert is a beginner or an amateur. In the middle are people with a modest or moderate level of expertise in a particular domain – sufficient for easy tasks but not for hard ones.

Definitions:

In order to distinguish levels of mFV expertise among those who possess it, we use specific terms throughout this paper, as follows:

- “mFV provider” describes someone with some amount of mFV expertise – from basic to world-renowned.
- “mFV practitioner” describes someone with a basic or modest amount of mFV expertise.
- “mFV expert” describes those with higher levels of expertise – from substantial to specialized to world-renowned.

In order to distinguish the providers from their clientele, we often use the word “person” to mean an individual whose life situation calls for mFV expertise to be brought to bear, whether:

- an applicant for disability-related benefits,
- an existing beneficiary of disability-related benefits,
- a client or a patient seeking assistance from an mFV expert.

Whenever the question arises whether a person’s medical condition is disabling and what can be done about that, medical, functional, and vocational expertise are all called for.

- Medical expertise is required because of the need to understand the current and future impact of the underlying pathology on a person’s state of health, vitality, and anatomical or physiological integrity – and how to minimize that impact.

- Functional expertise is required in order to understand the person's current level of self-sufficiency – their ability to function in daily life and accomplish particular things or tasks independently – and how to improve that ability.

- Vocational expertise is required in order to understand the current impact of functional limitations on global ability to work or employability – and how to minimize that impact.

The boundaries between the three kinds of expertise are often blurred because there is often an interplay and overlap between the three domains. Full understanding of the functional aspects of a situation may require information or judgment about the medical or vocational aspects, and vice versa.

The most common use of mFV expertise is to help people whose medical problems have impaired their ability to function normally to restore their abilities or find alternative ways of performing the fullest possible range of activities of everyday human life. These include taking care of themselves, fulfilling family, social, and community roles, and working.

Less often, mFV expertise is used in administrative or judicial proceedings in order to provide an objective assessment of the extent of damages (specifically disability in SSA's case) as a basis for accurate and fair determinations regarding eligibility for benefits or financial awards.

B. Historical Background

Ever since Hammurabi's code in the earliest days of human civilization, societies have had laws that provide for justice in the form of financial or other consequences when one person has been hurt (lost an eye, a hand, the ability to walk, their life) at the hands of another. Early societies set up lists of specific impairments as well as methods to permit administration of these laws. Someone had to be the official determiner of how much loss had actually occurred, and someone had to interpret the law and mete out the justice that was due. Once justice was done, the parties went their separate ways.

In today's society, the impairment evaluation process is the modern day descendent of these early justice systems. That lineage is most direct in workers' compensation. Because the employer "hurt" the worker, the employer owes the worker benefits. A physician disability examiner is asked to determine the extent of anatomical or physiological impairment. The expertise required is both medical and administrative (knowledge of the rules and conventions of the justice system). The worker receives a cash award that is proportional to the extent of permanent impairment, often in an amount set out in a "schedule of awards." Once the award is made, the worker exits the workers' compensation system.

The disability determination approach used today by the Social Security has roots in that same ancient method. The sole purpose of the process is to determine eligibility for a cash benefit. A medical professional is in charge of determining the extent of impairment and someone else decides what benefits are due. The Social Security system delivers justice in the form of money. However, there are four big differences between the ancient method and the SSA process:

1. There is no injuring party, and the government is the source of payment.
2. The size of the award does not vary with the extent of impairment.

3. Benefits are awarded not because of the impairment itself but because of its impact on ability to work.
4. And, most importantly, if benefits are awarded, that begins rather than ends the relationship between the parties.

Distinct from the idea of delivering one-time justice to people is the idea of providing them with expert assistance to improve their lot in life when it has been disrupted by illness or injury. This idea that people can be helped and it is worthwhile to do so is much more recent – it arose in the late 1800's. Most of the professions described in this paper – social work, case management, occupational and physical therapy, vocational rehabilitation, and so on – are relatively new and have their roots in the early decades of the 1900's.

C. What Constitutes Functional and Vocational Expertise

An important initial step in the project was deciding on a clear and useful definition of functional and vocational expertise. To do this, the project team inventoried the disability determination tasks requiring this expertise, and studied the professions appearing best prepared to do those tasks. Three clusters of expertise types emerged that will powerfully help distinguish professionals on whom SSA should rely from those it should not. The expertise types are medical, functional, and vocational. (Caution: these expertise types do not correspond to individual professions. Many professions have expertise of more than one type.)

This report uses the acronym **"mFV"** to mean "medical-functional-vocational." The terms are combined because a mixture of these three expertise types is commonly found among individual experts in the disability-related professions. The "m" is lower case to indicate that the "medical" portion of the expertise may simply be familiarity with medical issues – it does not signify the deep technical knowledge required for diagnosis and treatment. Some "medical" must be included because virtually all functional and vocational evaluations in the SSA disability programs benefit when involved experts have had substantial professional experience working with people with disabling medical conditions – physical and/or mental – and therefore can fully understand and anticipate the effects of medical conditions and resultant issues. Furthermore, many evaluations require that experience.

Expertise is more than knowing facts; it is cumulative and develops over time. Growing in expertise also means accumulating more personal experience and becoming more wise. It is reasonable to ask what specifically entails mFV expertise – what is it that these experts can do that others cannot?

"**Medical expertise" is defined as the knowledge, education, skills, experience, perspective and judgment required to**

(1) diagnose physical and/or mental health ailments, devise treatment plans, provide hands-on treatment, understand the pathologic process and make prognoses, assess impairment of body structures as well as of physiological and mental processes

(2) anticipate the current and future implications of a medical condition for function, and determine work restrictions required due to medical risks posed by employment.

"Functional expertise" is defined as the knowledge, education, skills, experience, perspective and judgment required to:

(1) ascertain a person's current ability (or lack thereof) to perform activities of daily life and work and to do particular activities such as component parts of a given job or carry out social and workplace roles

(2) develop plans and deliver services to enhance those abilities (though the Social Security Act precludes SSA from delivering these services to applicants).

Expertise in this realm enables a professional to anticipate, determine, understand, assess, and describe a given person's functional abilities, both generally and in the context of specific potential requirements, as well as to envision and carry out plans to improve those abilities. This includes an ability to understand the probable course of progress and events, to predict difficulties and problems, and to develop creative solutions to address problems. Functional expertise is generally applied in situations where a problem of some sort exists. The problem may be lifelong and stable (such as congenital problems) or the result of a disruptive event that will evolve over time (such as a new injury or a progressive illness).

"Vocational expertise" is defined as the knowledge, education, skills, experience, perspective and judgment required to:

(1) be familiar with the nature and requirements (functional abilities, skills, aptitude, education, etc.) of the universe of jobs in the economy, and the patterns of availability of those jobs;

(2) estimate the likelihood that a person will be able to select, find, and successfully pursue gainful work

(3) identify and create the best fit between a given individual and potentially available jobs and career paths, including general identification of and general planning for any preparation and development required, such as education and training, improvements to functional abilities, adaptive equipment, etc. (though again, the Social Security Act precludes SSA from delivering these services to applicants).

This expertise enables a practitioner to know both about jobs and careers (what they are, where they are, their requirements, what they pay, how to train and prepare for them) and about matching people with jobs (what people need and want and are good at, critical factors for job success, and how to anticipate difficulties), and then to help fit given individuals to jobs that suit them.

Vocational expertise is usually called for in several types of situations:

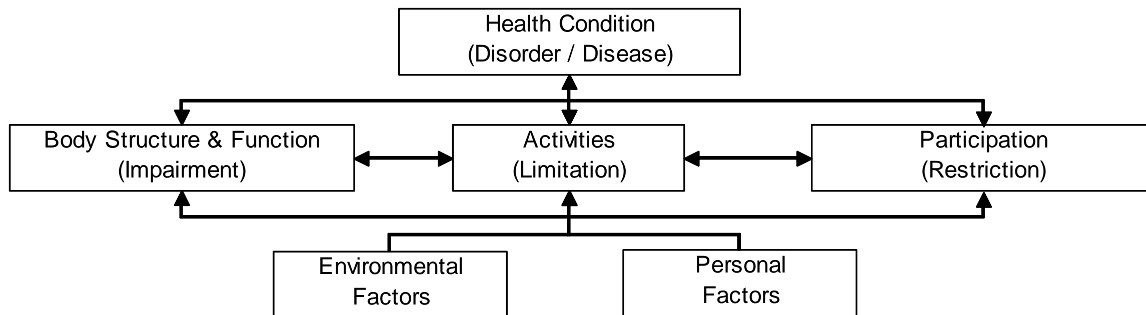
- in the normal course of people's career development (e.g. graduating from college, deciding to change careers),
- in adapting to stable but challenging life situations (e.g. dealing with mental retardation, spinal cord injury, or blindness),
- in adapting when vocational disruption occurs due to an unstable problem (e.g. coping with the consequences of multiple traumatic injuries, degenerative or progressive conditions such as arthritis or multiple sclerosis, unpredictable or intermittent conditions such as some cancers and bipolar disorder, or the collapse of local industry).

NOTE: In this paper **"vocational expert"** means someone who has substantial expertise with a broad range of vocational issues. This term is distinct from the capitalized term "Vocational Expert (VE)" used by SSA to describe someone who testifies at hearings.

D. Functional and Vocational Expertise is Multi-dimensional

Those who get involved in medical impairment, functional, and vocational issues must be prepared to assess and address the factors actually driving outcomes in the portion of the process they are considering. Failure to do so can create the appearance of inadequate mastery of the facts, of inaccuracy, of unfairness, or of irrationality.

The International classification of Functioning, Disability and Health (ICF) model of disability presented by the World Health Organization describes the major issues:



Multi-dimensional models of disability have been proposed by many, beginning with Nagi (see endnotes 1 & 2), and including the Institute of Medicine (3,4), the National Center for Medical Rehabilitation Research (5), and the World Health Organization (6-8). These models describe the concept of disability broadly. Models of disability have been developed that focus on the person as a worker (9-11). A model of work disability for industrial rehabilitation has been proposed (12), as has a model to measure work disability for benefit entitlement as defined by the US Social Security Administration (13).

If one looks successively at the factors determining (1) how impaired an ill or injured person is vs. (2) what activities and functions they are performing vs. (3) the extent to which they are participating in social or work activities, it becomes clear that the medical condition has progressively less impact and other factors have progressively more impact on determining that person's status.

Since medical factors frequently contribute much less to work status than they do to impairment status, a reality-oriented disability determination process acknowledges the importance of the other factors by explicitly and appropriately documenting their existence and considering their relative contribution.

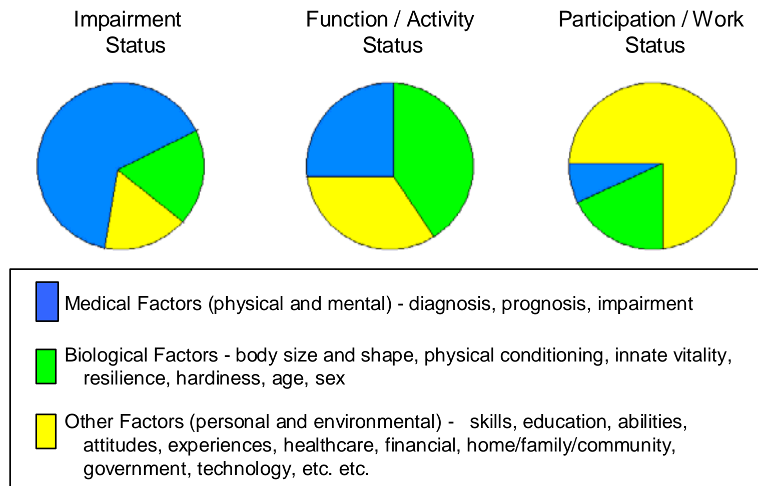
The following set of diagrams depicts this point graphically. Three colors show the relative contributions made by medical, personal and other factors to each of the major status questions in disability determination. A simplified overview appears first and is followed by more detailed versions of each of the three status charts.

Overview

The diagram below depicts the relative contributions made by medical, biological and other factors to each of the major status questions in disability determination. As is shown, medical

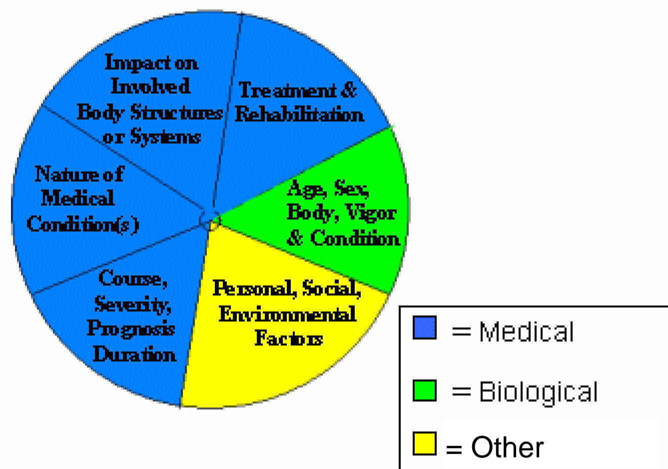
factors exert progressively less influence as the question shifts away from impairment status to functional status and then to work status.

NOTE: The proportions shown are typical but illustrative only. The relative contribution made by the three types of factors will shift with the actual circumstances, especially with the nature of the medical condition.



Impairment Status

The diagram below depicts the main factors driving medical impairment status. Impairment is a description of a perturbation in a body structure or function. "Frozen shoulder" is a statement of impairment, while "unable to lift objects above shoulder height" is a statement of functional or activity limitation.

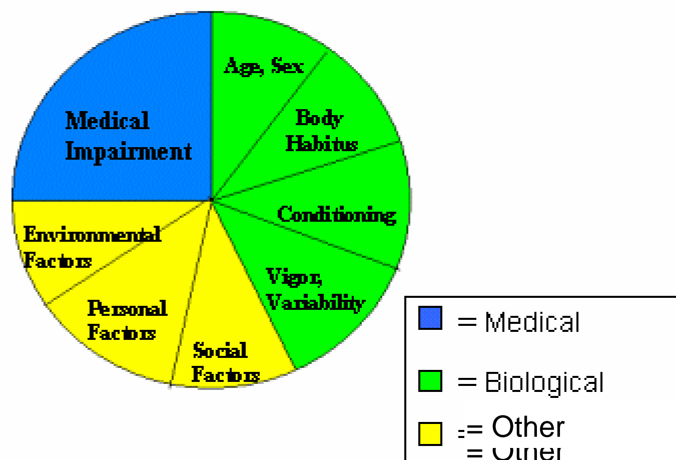


The assessment and description of impairment follows fairly directly from the medical facts in most cases, although there will often be uncertainty over how much impairment there actually is.

In disability determination systems that hinge on extent of impairment, the issue often arises as to what is causing the impairment, so it becomes important to be able to tease apart multiple causes. In particular, an individual may have impairments from other biological causes unrelated to the medical condition claimed, such as obesity or poor physical conditioning. Or, other factors can worsen medical impairments such as lack of access to treatment, non-compliance with treatment due to simple refusal, or non-compliance due to misunderstandings caused by language barriers or lack of information.

Functional / Activity Status

The next diagram depicts the drivers of functional and activity capabilities. This is a description of the person's ability to do specific things that are part of everyday life – to engage in typical daily activities as well as specific tasks that are required for working. This question is deceptively simple to pose, but often requires complex investigation and reasoning to answer appropriately.



Each human being is capable of doing thousands of different physical or mental activities – but which ones are important in their particular situation? The activities of relevance differ somewhat from person to person, especially activities related to specific jobs, and are essentially unlimited in number. For example, a cashier will need vision capable of differentiating between different coins, but a day care assistant may not need not to have such fine close-up vision.

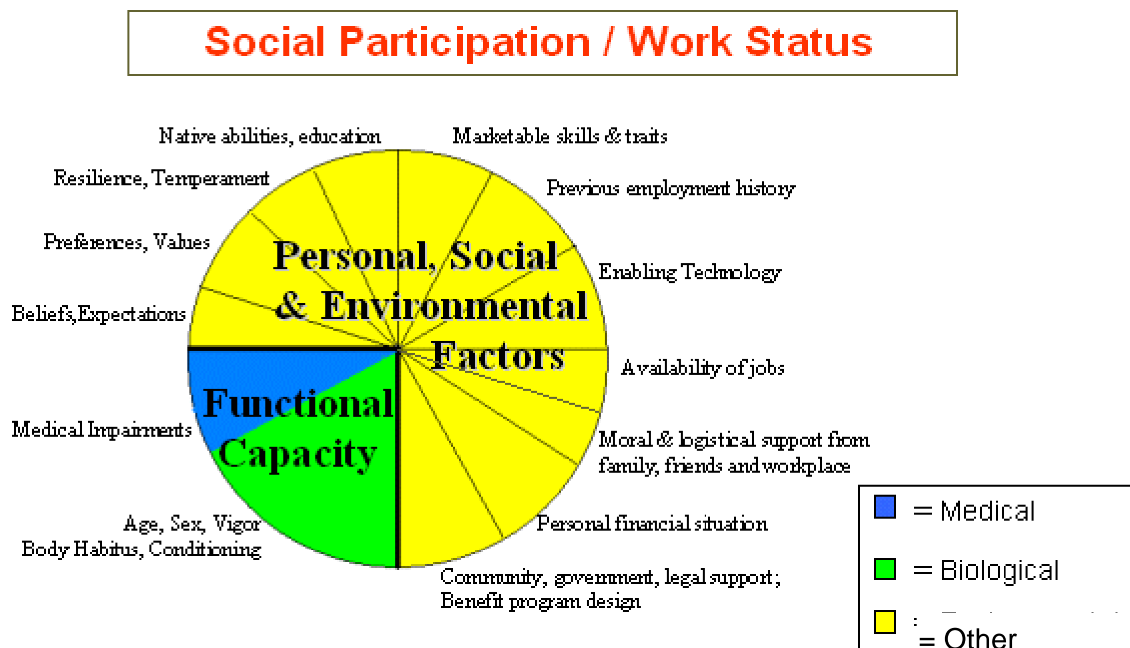
The factors influencing a person's functional abilities certainly include medical impairments, but equally important are biological realities (such as size and strength, physical conditioning, age) and personal and social factors. Most 50-year old 110 pound slightly built women cannot lift 25

pound bags of fertilizer all day long – but that is not the result of any medical impairment they might have.

It is unwise for a disability benefit program to limit the inquiry to medical issues, since functional ability is so clearly driven by things other than impairment. If a formal assessment is to accurately, usefully, and appropriately reflect what the person can do, it must include an assessment of the relative contribution of biological and other factors.

Social Participation / Work Status

The final diagram, below, shows the factors that drive work status and the level of participation in social and community life.



A multitude of factors in the real world influence whether people in fact are able to find gainful employment and participate actively in society. Most of these are not medical in nature. The ADA was enacted because even people with profound congenital handicaps, terminal illnesses and devastating conditions want the opportunity to be included in society and in the workplace.

Evaluating the relative contribution of these non-medical factors is a rightful part of assessing why someone is not working today, with an eye on whether there is a practical chance of them doing so in the future.

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11. Matheson, L., et al., *Improving the validity of the impairment evaluation process: A proposed theoretic framework.* Journal of Occupational Rehabilitation, 2000. **10**(4): p. 311-320.

12. Matheson, L., et al., *Work hardening: Occupational therapy in industrial rehabilitation.* American Journal of Occupational Therapy, 1985. **39**(5): p. 314-321.

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E. Overlap and Transitions Between Needed Areas of Expertise

The interrelationship between medical, functional and vocational expertise is of particular importance to this project and must be discussed before describing the various types of expertise and experts in more detail. The kinds of expertise required in order to fully cover the issues needed in a given case overlap, and as a result, experts must collaborate and exchange information back and forth in order to achieve a full understanding of a situation.

Frequently the expertise required to take a case from beginning to end will not reside in one expert. Ideally, single experts would exist who know everything required for a specific case, but the fields of knowledge and experience are too broad for that to happen except in very simple cases or with very rare experts. In order to respond appropriately to non-obvious situations, either cross-trained experts or collaboration between different experts with appropriate individual expertise will be required if the best result is to be obtained.

Two critical transitions between expertise domains

There are two main handoff points where the need for information exchange between experts is particularly pronounced: the transition from medical to functional issues and from functional to vocational ones.

At the beginning of the disability evaluation process, the evaluator asks "What is this person's medical problem and how much impairment has it caused?" (Outside the benefits adjudication arena, clinicians also are asked whether anything can be done to ameliorate the situation and if so to formulate and carry out a treatment plan.) The focus is on conventional medical and psychological issues: diagnosis, treatment, prognosis, understanding impairment of body structures / mental capacity, body systems, bodily functions. The key professionals who

possess the required expertise are clinical: physicians, psychologists, physician-assistants, nurse practitioners, nurse case managers and nurses, as well as other clinicians such as podiatrists, optometrists, and speech-language pathologists.

Transition from the medical to functional domain

The next question is "What are the effects of the medical condition on this person's ability to do things in everyday life?" This is the transition from a medical to a functional domain. The key issues here are:

1. anticipating the practical impact of impairments on function – activity limitations, areas of reduced capacity or tolerance – quantifying them, and then reducing them to writing;
2. anticipating risks to the patient, co-workers or the public posed by being at work, quantifying them, and then reducing them to writing.

Although it requires medical expertise to perform these tasks, they are not within the traditional purview of medicine. Most clinical practitioners have had no formal training and very little experience in doing them. They simply do not know how to make these assessments, and have scant professional interest in doing so. If pressed to provide medical restrictions or functional limitations, they generally will come up with some, but often the information is sketchy and intuitive, not based on a deep understanding.

Conversely, strictly functional experts are unlikely to have the depth of medical expertise to be able to anticipate issues with the same ability as a clinician.

A collaborative dialogue between experts in both domains is one way to reach a well-informed conclusion about the functional implications of the medical condition on this person's life.

An alternative way to handle this transition point is to find or create experts that can span the medical and functional domains. These can be medical people trained in the functional domain or vice versa. Health professionals that might have the required expertise to fill this role (or are best able to learn it) include physicians, psychologists, nurse practitioners, nurse case managers; occupational therapists, physical therapists, and licensed clinical social workers.

Transition from the functional to vocational domain

The second major transition is between functional and vocational expertise domains. The question is "What is the impact of the medical condition on this person’s ability to work?" (Outside the benefits adjudication arena, the expert would also be asked if anything can be done to ameliorate the situation, and if so to formulate a plan for doing so and then see that it is carried out.) The key issues here are:

1. anticipating the practical impact of medical restrictions and functional impairments on ability to participate in work;
2. assessing relative occupational disadvantage;
3. identifying potential appropriate occupations or actual open positions.

Again, professionals with expertise in the functional arena usually do not have a practical knowledge of the current labor market, and experts in job placement are not trained to assess functional capacity.

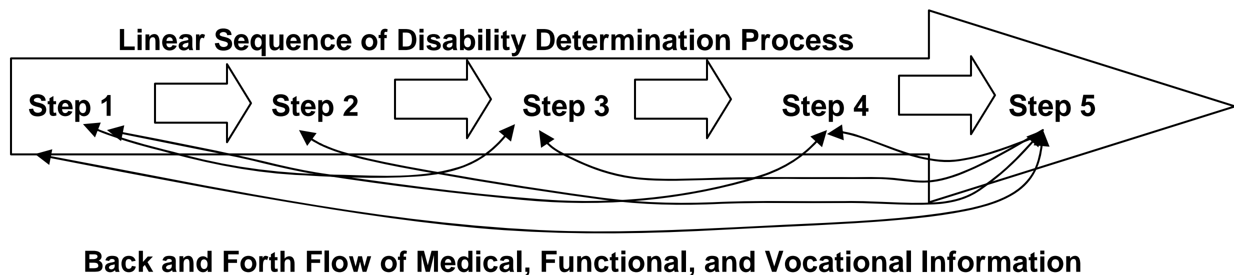
Perhaps most importantly, the need to understand a medical or functional issue more thoroughly sometimes becomes apparent only when the suitability of a specific occupation or job is being considered.

Although the core disability determination process may proceed in a sequential and linear fashion, the medical, functional and vocational expertise should flow back and forth until a satisfactory understanding of key issues has been developed. Again, there are two solutions: (a) collaboration/conversation among experts, or (b) finding experts whose expertise spans more than one domain.

As an example of how collaboration works:

- Medical resource: “Initial assessment of this applicant’s impairments reveals that visual ability is only 20:100, corrected.”
- Vocational resource: “Some people with visual problems are able to work as cashiers, but they need to be able to recognize denomination of bills and change. Is this possible?”
- Medical resource: “Unsure. Refer for functional evaluation.”
- Functional resource: “We have requested a field test of visual recognition of bills and coins, and will determine whether this applicant actually has this capability.”

Graphic Depiction of Information Exchange Among Experts That Is Required to Build Shared Understanding of Critical Issues



Providers and Uses of mFV Expertise

F. Who Provides (vs. Who Possesses) mFV Expertise?

This section lists the types of professionals that are commonly relied upon to provide mFV expertise today, both by SSA and by other parties in the United States. Some professions are better suited to do so than others.

Most of the individuals within the professions have gone through prescribed education and other professional preparation, credentialing, certification, and licensing processes that ensure they meet minimum standards for education and training for their particular core discipline.

However, both within and across professions, individuals possess mFV expertise in different areas and to varying degrees. Some of the variability is due to differences in the nature and scope of their professional discipline; some of the variability is due to differences in career focus, work experience, personal interests, and native ability. Detailed information about each of the professions that are best suited to provide a subset of professionals who are prepared to serve as formal sources of mFV expertise appears in the Appendix, including those aspects of mFV expertise that each is most qualified to provide.

Other informal sources of mFV expertise are individuals in other occupations, such as disability examiners, claims examiners and adjusters, and employers who have usually developed their expertise because of frequent involvement in disability program management or employment processes, either directly or tangentially. They typically possess basic or delimited expertise.

Professions Formally Relied on Today as Sources of mFV Expertise

Physicians and Surgeons (MDs, DOs) of all kinds – (Given highest standing)

Clinical and Counseling Psychologists – (Given highest standing)

Mid-level treating clinicians

- Physician Assistants (PAs)
- Nurse Practitioners (NPs),
- Licensed Clinical Social Workers (LCSW)
- Mental Health Counselors

Nurse Case Managers (NCMs)

Occupational Therapists (OTs)

Physical Therapists (PTs)

Career and Vocational Counselors (CCs)

(Vocational) Rehabilitation Counselors (VRs)

Professions Informally Relied on Today as Sources of mFV Expertise

SSA Disability Examiners

SSA Vocational Specialists

Private Sector Claims Examiners and Adjusters

Employers – Human resources and benefits staff, return-to-work coordinators, line managers

Despite their being relied on by some to provide input, a few of the professions listed above were not considered further in this paper due to limitations that make them sub-optimal sources of mFV expertise for SSA. Examples are:

(a) Physicians other than those in occupational medicine, physical medicine and rehabilitation, and rheumatology. Physicians in general lack training and interest in assessing and promoting function.

(b) Career and Vocational Counselors, most of whom who lack the specialized medical expertise required to work with a disabled clientele.

(c) Nurses, Physician Assistants, and Mental Health Counselors, whose less extensive basic professional education does not in general prepare them to do the kind of thinking, multidimensional analysis and complex problem-solving described later.

(d) Counseling Psychologists, Podiatrists, Optometrists, Speech/language Therapists, because the subset with expertise that aligns well with the mFV expertise clusters (described below) is perceived as very small.

Lastly, since this project focuses on SSA, there is no further description of informal sources in use outside SSA.

In the discussions that follow, some smaller professions have been grouped with others to which they are very similar. Vocational Evaluators and Work Adjustment Specialists are grouped with Vocational Rehabilitation Counselors; Life Planners are grouped with Nurse Case Managers, and Neuropsychologists have been grouped with Clinical Psychologists.

G. How SSA Uses mFV Expertise Today

To set the starting context for exploring functional and vocational expertise in America, this section presents a list of the ways that SSA uses that expertise today. A subsequent section discusses the differences between how SSA uses mFV expertise and how it is employed elsewhere.

The use by SSA of mFV expertise is currently fairly unstructured except at the hearing level, and qualifications have not been established for those providing services in this realm. Comprehensive training has neither been developed nor deployed.

The SSA benefits determination process currently relies on mFV expertise in two main ways: (1) in making decisions about individual claims both upon initial application and during CDRs, (2) in designing and administering the disability evaluation process system-wide. In both cases, there are specific tasks involved that require mFV expertise.

1. In processing individual applicant's claims, and in reviewing existing beneficiaries in a Continuing Disability Review, mFV expertise is required in order to:

a. Evaluate the reasonableness of any functional limitations that have been established by treating sources, and their relation to the claimed medical condition and related impairments. Estimate limitations when not provided in sufficient detail by treating sources.

b. Evaluate the reasonableness of any functional capacity estimates received from treating sources and their relation to the claimed medical condition and related impairments; then determine and document the residual functional capacity (what remains after subtracting the diminutions due to impairments, restrictions, and limitations).

c. Determine whether a person is able to do any of the work they have done in the past (because they have already demonstrated they are otherwise qualified to do it) given their residual functional capacity.

d. If unable to do past work, determine whether a person is capable of doing other work that will provide gainful employment within a reasonable pool of potential occupations available within a reasonable distance.

e. When claims go into the dispute resolution process, provide expert advice on the above topics to reviewing and hearing officials. (SSA generally relies on fee for service outside experts for this expertise.)

f. Understand the applicable rules, regulations, and procedures by which the SSA disability programs are governed, and perform all the above tasks in compliance with those constraints.

g. Perform all the above tasks in a professional manner, based on objective data as much as possible, using methods that provide a basis for fair, consistent, and defensible decisions.

2. In designing and administering Social Security disability programs on an aggregate basis and at the system level, mFV expertise is required in order to:

a. Design processes, procedures, methods, metrics, forms, training and professional development programs, quality assurance and quality improvement programs that reflect the worldview and knowledge of functional and vocational experts.

b. Manage programs and personnel utilizing the items developed above.

H. Aspects of mFV expertise That Others Employ Today but Social Security Does Not

Although both functional and vocational expertise are useful in disability benefit eligibility decision-making, their primary application is not in the adjudicatory realm. The main difference between the way mFV expertise is used by SSA (and other disability determining organizations) and the way that most mFV experts spend their time lies not in the nature of the work, but in the purpose for which the work is done as well as the context.

The specific knowledge, tools and methods that constitute mFV expertise were originally developed for the purpose of helping people achieve the most possible self-sufficiency or get their lives back to normal to the maximum extent possible. The context is expected to be a face to face or hands-on therapeutic process, most often in a healthcare or social services setting. Direct delivery of services is the norm for most of these professions, although often services are planned or ordered by one provider and carried out by another. A provider-patient or provider-client relationship is to be established, within which trust is intended to be present. The person can rely on the provider to keep the person's best interests paramount. The SSA disability determination process has a different purpose than this.

Another difference is that mFV experts expect to spend most of their time in the everyday world of biological systems where a fact is more often a point on a continuum rather than a binary black/white variable. In this world, things are not obvious all at once, tests must be done, experiments must be tried and discoveries will be made. What is true and what is possible tend to become clearer over time. The focus of the work is not on "yes" or "no" decisions, although the purpose of a professional assessment is to make decisions for action. Typical statements are: "let's make a plan" and "here is how I suggest we handle this" or "let's see if we can make this work" or "that's the best we can do for now." The SSA disability determination process sets a different context than this.

Another important difference is the concreteness, specificity and purposefulness of the plans and interventions made outside SSA. The manner of thinking and problem-solving is hands-on and neither general nor theoretical. Artificially constraints due to benefit availability have an influence, but the focus is on solving the person's practical everyday problems.

I. Trends in the mFV Expert Marketplace

Things are not static in the professions best-suited to provide mFV expertise. On-going trends have been changing the availability and nature of mFV experts.

Within the medical profession, the specialties of occupational medicine, PM&R and rheumatology – whose training is specifically directed towards functional and vocational expertise – have traditionally been among the smallest in terms of number of physicians. Moreover, the production of new physicians in these specialties with functional and vocational interests and expertise has slowed. The number of slots in all three types of residency programs has been static or declining for the last twenty years due to a variety of factors.

Over the last thirty years, mid-level clinicians have appeared and gained increasing credibility and popularity while the geographical mal-distribution of physicians continues to exacerbate,

and the comparative cost of physician salaries continues to rise. The professions of nurse-practitioner and physician assistant have evolved along with their legal status, educational programs, and licensing/certification operations. In many more rural areas of the country, mid-level practitioners are the only providers available; and in overstressed medical practices in low-income urban areas, the reliance on mid-levels is also heavy.

Due to the widespread unavailability and limited engagement of psychiatrists, mid-level mental health professionals such as mental health counselors and licensed clinical social workers have also appeared as the workhorse of mental health practices. They provide the bulk of counseling therapy, both in community mental health centers and private practices, while psychiatrists are increasingly doing medication management only.

The relative stature of some of the other professions is in flux. Professions commonly called "ancillary" (such as PT and OT) and thus considered secondary are becoming more expert. Higher academic degrees are becoming the norm (for example, both PT and OT professional societies have moved to require a master's degrees as the basic level of preparation although many of the most experienced still have bachelor's level preparation). The legal status of some professions is evolving, with legislative variability in independence of practice. In many states, NPs, OTs and PTs can now practice without a physician's order or supervision. Psychologists have prescribing authority in a few states.

Nurse case management as a profession has also appeared and flourished over the last twenty years. Professional societies and ever more rigorous certificate programs continue to appear. Some vocational rehabilitation counselors and social workers are also case managers. The knowledge and worldview of case managers often differs from their original professional focus because of the case manager's emphasis on involvement with the patient/client across the continuum of care, communication and coordination of services, attention to issues in other domains, and longitudinal planning.

The helping profession of vocational rehabilitation has suffered a steady decline over the last thirty years, possibly due to its deadly embrace with benefit eligibility. Both claimants and insurers have become wary. Vocational rehabilitation services have been accepted and then misused by claimants who play along but have no real intention to find a job that might foreshorten benefits by restoring economic independence. Vocational rehabilitation services have also been frequently misused by insurance companies who employ them as a way to cut off benefits the moment that employability has been established. Unfortunately, VR providers have been willing to provide extensive ineffective services on a fee for service basis under these circumstances. These factors have combined to produce distrust and cynicism about the effectiveness of vocational rehabilitation counseling. Also, withdrawal of federal funding from rehabilitation began in the late 1970's and accelerated in the '80s. The rollback in workers' compensation is now complete; there are no more mandatory vocational rehabilitation programs in state statutes. California recently eliminated nearly all vocational rehabilitation counseling services from its workers' compensation statute by creating a voucher that can only be used for specific re-training services such as tuition, equipment, etc.

Detailed Components of mFV expertise

J. Task Clusters Requiring Functional and Vocational Expertise

To provide a useful conceptual framework for understanding what mFV expertise really is we have created several clusters of the detailed tasks that require mFV expertise. To place this into the proper context, the list of clusters begins with the assessment of medical impairment, which does NOT usually require mFV expertise but which is the starting point for the tasks that do require it in a potential work disability situation.

Some of the task clusters below are not part of the SSA disability determination process. Responding to the needs of a person with a potential work disability generates a lot more tasks that require mFV expertise than those involved in the processing of a SSA disability claim.

Also, the list below covers only the tasks that require mFV expertise in individual cases – when a person has developed a potentially disabling medical condition – as opposed to the system-level uses of mFV expertise for program design, training, quality management, research, etc.)

Listed in rough temporal order of their application to situations, the task clusters are:

Cluster 0: Determine Impairments Due to Medical Conditions

Cluster 1: Assess the Situation to Determine What mFV Expertise Is Required

Cluster 2: Establish Medical Restrictions and Functional Limitations

Cluster 3: Determine Functional Capacity

Cluster 4: Assess Extent of Vocational Disruption or Disadvantage

Cluster 5: Envision Feasible Solutions

Cluster 6: Assess Reasonable Availability of Suitable Jobs/Opportunities

Cluster 7: Make a Vocational Plan and Implement It

Cluster 8: Navigate and Utilize Administrative Programs

Cluster 9: Utilize Methodological Rigor

A description of each of these task clusters follows below. This model is intended to be generic, and can apply equally well to private disability insurance or workers' compensation, and to situations where there are no insurance benefits involved, for example.

Though functional and vocational expertise can be useful in situations where substantial vocational disruption has not yet occurred, most of the task clusters assume that the person is not working.

Cluster 0: Determine Impairments Due to Medical Conditions

[This expertise cluster is called on in the Social Security disability determination process.]

This task cluster does not demand much mFV expertise, but the tasks produce the starting material that triggers the subsequent need for mFV expertise.

Performing the tasks in this cluster primarily requires traditional medical expertise. Based on knowledge about a medical condition in general and a person's actual circumstances, an assessment is made of the physical or mental impairments that have resulted from the medical condition as well as from other causes. "Impairment" is a description of damage to tissues or perturbations of bodily functions, usually in comparative or quantitative terms. Impairment generally follows fairly straightforwardly from the medical condition or conditions at issue.

Examples of impairments: Cardiac function (ventricular ejection fraction); pulmonary function (FEV1); kidney function (creatinine clearance); musculoskeletal function (spinal range of motion, absence of amputated limb, atrophy, limb circumference); cognitive function (IQ, mental status exam findings; psychological test results).

Prominent Tasks / Skills Required

- Medical expertise is required to:
  - Assess the likely accuracy of the claimed diagnosis based on the clinical facts presented. Based on the clinical facts, spot alternate or additional diagnoses that may not have been claimed.
  - Know the physiological, anatomical, and pathological facts of the condition, its usual natural history, the prognosis under this set of circumstances, commonly available treatment, and the likelihood of effective treatment.
  - Anticipate or discern which body structures and functions are most likely to be impaired as a result of the existing medical condition, and make a reasonable prediction of the typical extent, nature, and duration of the resulting impairment.
  - Know what objective medical tests exist that can document impairment, and provide a solid basis for impairment determinations. Know what specific additional tests might be required to resolve any uncertainties in a particular situation. Be familiar with normal vs. abnormal results.
  - Clearly communicate the findings about impairment, plus any uncertainty that remains about extent, duration, etc., and potential future changes.
- Combined medical and functional expertise is required to:

- Infer or indirectly determine the presumed level of impairment of body structure or function by observing the condition's impact on everyday function when accepted objective medical tests or evidence have not yet been developed. (Examples include: migraine headache, depression and other psychiatric conditions, chronic fatigue syndrome.)

Known Issues / Difficulties

- Uneven medical knowledge and technology: Objective and even incontrovertible indicators of disease severity that track tightly with impairment exist for some conditions but not for others. Measurement issues abound. Thus, clinicians are better prepared to determine and document the medical impairments that result from some kinds of medical situations than others.

- Highly-technical skilled experts may be required to estimate impairment for unusual or hard-to-assess conditions.

- If impairment is estimated while the medical condition is changing, the estimate will become inaccurate over time.

- Sometimes there is considerable uncertainty over what the impairment will turn out to be in fact, based on uncertainty of treatment results, the natural course of the condition, and existence of complicating factors.

- Teasing apart and apportioning among multiple sources of impairment can be difficult and feel arbitrary, but is more accurate than leaving the issue undistinguished.

Cluster 1: Assess the Situation to Determine What mFV Expertise Is Required

[This expertise cluster will be called on more heavily in the Social Security disability determination process if SSA accepts the Expert Panel's recommendations regarding triaging and classification of claim complexity that are described elsewhere in this report.]

Prominent Tasks / Skills Required

- Combined medical and functional expertise is required in order to briefly survey and sort out the key facts in in-coming cases in order to triage them. Triage is the process of dividing cases into categories (most often three, thus the name). The categories are based on severity, complexity or urgency. Triage also involves determining which type of professional should provide a more definitive evaluation and response. Triaging requires the ability to:

    - Sort out important from less important facts, and identify the domains in which key functional issues may lie, e.g. vision, balance, pain, stamina, mobility, dexterity, potential violence, and so on.

- Predict how difficult it is going to be to determine the condition's actual impact on those functional domains and the resultant impact on ability to work.

- Specify the type of professional(s) most likely to be prepared to address the functional and vocational issues in the domains affected by this type of clinical situation.

- Specify the level of expertise within that profession that will be required to properly and fully assess and then appropriately respond to the situation.

Known Issues / Difficulties

- Triage must be fast and efficient, or else it slows up the subsequent process. It also must be accurate, or else the purpose is defeated

- Organizations tend to put relatively unskilled or even administrative people in these positions because there are so many simple situations and the work appears routine, and they want to use their experts for the "hard" cases. In fact, triaging requires the broadest possible knowledge base because the task at hand is to recognize potential problems across a wide array of situations. The person doing triage must also be able to spot what is missing or unsaid -- issues that have been overlooked by others but that may be critical to the outcome.

Cluster 2: Establish Medical Restrictions and Functional Limitations – What the Person Should Not or Cannot Do

[This expertise cluster is called on in the Social Security disability determination process.]

mFV expertise is required, in combination with medical expertise, when the practical everyday impact of the structural or physiological (organ system) impairments on the person's ability to function in the real world must be identified. These can best be expressed as medical **restrictions** and functional **limitations**. Medical restrictions are things the person should not do for medical reasons due to risks to self or others. Functional limitations are theoretically things the person cannot do even if they wanted to. As a practical matter, functional limitations are also often statements of tolerance – what the person can cope with from a comfort point of view.

Examples of medical restrictions: May not associate with young children (risk of harm to others due to predatory behavior). May not work rotating shifts (due to risk of diabetic complications).

Examples of functional limitations: Cannot reach above shoulder height (due to frozen shoulder). Cannot grasp with right hand (due to deformity and muscle atrophy). Cannot lift > 10 pounds (intolerance due to pain).

Prominent Tasks / Skills Required

- Medical expertise is required to:

- Devise, formulate, and communicate medical restrictions.

- Functional expertise is required to:
  - Gather and elicit the information necessary to determine as accurately and quickly as possible the actual functional status of an individual with a given condition.
  - Perform tests that reveal the functional abilities an individual possesses and document the results. Perform the tests in a way to ensure adequacy of effort and that no "gaming" occurred. Set up special structured circumstances (usually following a standardized protocol) to elicit, observe and document activities and responses.

- Combined medical and functional expertise is required to:
  - Anticipate medical concerns or hazards posed by certain tasks and environments to workers with certain medical conditions – or to the co-workers/public.
  - Know which everyday activities or tasks are typically most affected by certain impairments in body structure or function due to medical conditions, and anticipate what to look for in a particular case.
  - Be familiar with the range of functional impact created by particular medical conditions, as well as the non-medical factors that also affect the impact, and anticipate what to look for in a particular case.

- Combined medical, functional and vocational expertise may be required to:
  - Have a sufficiently deep fund of technical information and perspective to provide correct and wise answers to unusual, difficult, specific, detailed or complex functional, or vocational questions and to provide workable solutions to problems regarding particular medical conditions, body parts or functions in a particular context (e.g. inferring the functional limitations/medical restrictions due to an unusual medical condition, devising a reasonable accommodation for a particular job setting).

Known Issues / Difficulties

- Most treating clinicians (physicians and psychologists, as well as mid-level practitioners) have little or no training or skills in devising medical restrictions and functional limitations in a way that is useful for vocational decision-making.

- For efficiency's sake, seat of the pants guesses are typically used to roughly estimate an individual's medical restrictions and limitations, even if more information or tests are available and could provide a better basis for decisions. Those who receive these preliminary guesses then treat them like they are precise and immutable facts.

- If a list of functional limitations is being used to help someone find a job rather than adjudicate a disability decision, then the level of imprecision due to initial guesses

and first estimates described here may have little impact. But in the one-shot rule-bound processes of determining eligibility for lifelong disability benefits, this level of imprecision can have major inappropriate consequences.

- Like impairments, there can be more than one source combining to create a specific functional limitation. Teasing apart the causes of the limitations can be difficult. But **not acknowledging** that there are multiple causes of a person's limitations is even worse.

Cluster 3: Determine Functional Capacity

[Some elements in this expertise cluster are currently required by the Social Security disability determination process. Additional elements of this expertise cluster are required to perform the multidimensional assessment (MDA) that the Expert Panel has recommended to SSA and that is described elsewhere in the Core Report.]

Determining functional capacity means figuring out what a person can do. Functional capacity is the term usually used to describe what a person has to offer in the working world. It is usually used in the context of describing the impact of a medical condition on ability to do the things that most human beings can do. Residual functional capacity means figuring out what a person can still do after taking into account the diminishment caused by medical restrictions and acquired limitations in ability. Outside SSA, the word “residual” is most often left unstated, and the term “functional capacity” is used alone.

Inside SSA, the term Residual Functional Capacity (RFC) is a theoretical construct – an estimate of what the person could do **if it were not for the medical conditions** (ignoring any limitations contributed by age, sex, body habitus, physical conditioning or other personal or environmental factors). The counter-intuitive and easy-to-confuse use of this term has led to many inconsistencies and other difficulties both inside and outside SSA.

Examples of functional capacity: May walk and stand up to 8 hours per day; may lift up to 40 pounds frequently, may do repetitive fingering for 4 hours per day with a 5 minute stretch break every hour, may work in a manufacturing environment, may work alone or in small groups, may do structured and routine work only.

Prominent Tasks / Skills Required

- Combined medical and functional expertise is required to:
  - Anticipate or discern which key activities/tasks are most likely to be affected by impairments due to a particular illness/injury from a functional point of view in general, as well as in a particular case.
- Functional expertise is required to:
  - Gather and elicit the information necessary to determine as well as possible the functional status of an individual with a given condition. Depending on the circumstances and the nature of the medical condition, an awareness of and ability to explore the multidimensional nature of impediments and enablers of function may be required.

- Perform tests that reveal the functional abilities an individual possesses and document the results. Perform the tests in a way to ensure adequacy of effort and that no "gaming" occurred. Set up special structured circumstances (usually following a standardized protocol) to elicit, observe and document activities and responses.

- Combined functional and vocational expertise is required to:

  - Anticipate or discern which specific functional limitations/medical restrictions are most likely to be limiting from an employability point of view in general.

- Combined medical, functional, and vocational expertise may be required to:

  - Have a sufficiently deep fund of technical information to provide correct and wise answers to unusual, difficult, specific, detailed or complex functional, or vocational questions and to provide workable solutions to problems regarding particular medical conditions, body parts or functions in a particular context, (e.g. inferring the functional limitations/medical restrictions due to an unusual medical condition, devising a reasonable accommodation for a particular job setting).

Known Issues / Difficulties

- Most treating clinicians have little or no training or skills in assessing functional capacity. With little factual or intellectual basis for their decisions, they tend to make them using other tools – habit, hearsay, personal philosophy, values, and so forth.

- The popular admonition to "tell me what the person CAN do, not what they cannot do" is useful in the political realm and the workplace, but not useful in this context. The universe of all potential human capabilities is enormous and it is completely impractical to list every possible activity.

- Those who are estimating functional capacity often simply anticipate what some typical job demands would be in broad categories and make correspondingly broad statements about capabilities. This is NOT individualized assessment, but merely a rough cut or starting point.

- For economy and efficiency's sake, seat of the pants guesses are typically used to roughly estimate an individual's functional capacity, even if more information or tests are available and could provide a better basis for decisions. Unfortunately, those who receive these preliminary guesses then treat them like they are precise and immutable facts.

- Forms that purport to comprehensively describe functional capability often do so in terms that are too general or imprecise to be useful when trying to match up a person's specific abilities with a specific job. A description of someone's ability as "may lift 40 pounds frequently" or "can tolerate limited stress" is actually only a rough cut and a starting point for a discussion about capabilities, but the description is usually regarded as a definitive statement of precise and immutable fact.

- Often a conversation – a series of questions and answers between experts with different areas of expertise – is required in order to accurately assess the ability of a

particular person to do a particular occupation or job. During the conversation, the experts develop an ever-more-precise understanding of the key issues in the situation through successive approximations.

- If a functional capacity assessment is being used to help someone find a job rather than adjudicate a disability decision, then the level of imprecision due to initial guesses, rough cuts, and first estimates described here may have little impact. But in the one-shot rule-bound processes of determining eligibility for lifelong disability benefits, this level of imprecision can have major inappropriate consequences.

- Disability determinations made on the basis of a theoretical RFC will seem irrational and unfair to outsiders if the way the RFC was calculated is neither explained nor perceived as realistic.

Cluster 4: Assess Extent of Vocational Disruption or Disadvantage

[Some elements in this expertise cluster are currently required by the Social Security disability determination process. Additional elements of this expertise cluster are required to perform the multidimensional assessment (MDA) that the Expert Panel has recommended to SSA and that is described elsewhere in this report.]

Based on an understanding of the person's current and presumably diminished functional capacity, an assessment must be made of how much vocational disruption has been caused. This assessment begins with an approximation of how much the person's residual functional capacity has limited the kinds of work they can now do and ends with an assessment of how much reduction in the potential pool of occupational opportunities they are now facing.

Prominent Tasks / Skills Required

- Functional and/or vocational expertise may be required to:
  - Anticipate or discern which specific functional limitations/medical restrictions are most likely to be limiting from an employability point of view in general for a specific person. In particular, begin by honing in on the question of whether critical abilities that constitute essential functions of previous occupations have been lost.
  - Be able to assemble a comprehensive picture of a person's situation and all the driving factors that are influencing their ability to function, participate, and work.
  - Identify the essential, modifiable, and critical (most difficult from a performance point of view) demands of potential jobs and careers.
  - Comprehensively evaluate the nature and extent of skill and knowledge of people with disabilities (their qualifications/eligibility as well as their ability to perform and compete – transferable skills analysis).

- Be able to broadly predict whether a person is employable, and if so which jobs a person is likely able to do based on their physical and mental capabilities, education and skills, and ability to learn.

- Be able to specifically discern whether a given individual with all their abilities and conditions is likely able to do one or more specific jobs. Research and resolve any open questions. Be able to document a detailed match-up of job requirements to personal capabilities, and to describe any uncertainties or risks.

Known Issues / Difficulties

- For applications of mFV expertise outside the disability arena, this step boils down to developing a sense of the careers and jobs the person might be interested in, qualified for, or potentially qualified for if education or training occurred. Most processes and tools that support this step are designed to find reasonable alternatives for a person to investigate, alternatives that will be feasible and not waste their time pursing. In contrast to this, in the disability determination process the process and tools can be required to support a definitive determination of whether someone is capable of performing a particular job or any jobs. This is a very different matter, and different tools and approaches are required.

- As a matter of practicality if not efficiency, rough guesses are often used to estimate the functional capabilities required for a given job or group of jobs.

- The "bible" for supporting this step, the Dictionary of Occupational Titles (DOT), clusters multiple jobs and even careers together in reaching their statements of functional capabilities required. This masks details that may be quite important for individual disability determination cases.

- When considering the vocational options of someone with impairments, seldom will there be advance knowledge of all the functional requirements of all jobs that wind up being considered in the assessment of vocational disruption. New estimates of functional capability will at least occasionally need to be created as additional jobs or careers are considered as possible feasible work alternatives.

- In many cases, it is not practical to seek one individual who possesses both the expertise needed to determine functional capabilities based on the impairments involved and to determine functional requirements of specific potential jobs and careers.

- Especially with a fluid economy and the rapid pace of change in employment patterns in today's labor marketplace, it is unrealistic to assume that very accurate job description and availability information can be maintained in a database or reference document. Such attempts will always be rough approximations, of excellent utility for career counseling, but poor for the more precise fact finding needed in disability determinations

Cluster 5: Envision Feasible Solutions

[Some elements in this expertise cluster are currently required by the Social Security disability determination process. Additional elements of this expertise cluster are required to perform the multidimensional assessment (MDA) that the Expert Panel has recommended to SSA and that is described elsewhere in this report.]

Envisioning feasible solutions means identifying a realistic strategy or route by which the person could resume or achieve gainful work. It must take into account:

1. the person's medical prognosis and residual functional capacity,
2. the person's education, skills, native abilities, interests, and motivation,
3. the person's resources, life constraints, ongoing health needs, etc.
4. the availability of training, support resources, employment-seeking activities, accommodations, adaptive equipment, etc., and
5. the universe of available occupations that the person could qualify for.

Thus, a core part of this cluster includes an identification of barriers and likelihood of the successful implementation of the potential solution for the person, given their circumstances. If the solution costs too much, or the services are not available or accessible, or the plan requires an unreasonable level of effort by the person, the solution is not actually feasible.

Prominent Tasks / Skills Required

- Vocational expertise is required to:
  - Anticipate or discern the impact of the functional constraints that a particular person has on their employability – what types of occupations and working situations are now excluded and which are not.
  - Identify the person's aptitudes, interests, commitments in addition to their capabilities, and know which jobs will call on them.
  - Have a rich understanding of available occupations and careers along with their requirements in all relevant dimensions: physical, mental, educational, skill levels, etc.
- Functional and/or vocational expertise is required to:
  - Be able to inventory functional demands of various occupations and specific jobs using a systematic approach to assessing, cataloging, measuring, articulating, and describing them.
- Combined medical, functional and vocational expertise may be required to:
  - Be able to assemble and digest all the relevant factors in a person's situation, including the potential employment opportunities that are feasible.
  - Inquire into the person's view of the situation and how the options look to them. Assess the person's willingness to trust the process and do the work to create a better future for themselves.

- Predict changes in the person's medical condition and adaptation to it, ability to cope over time, attitude and motivation, based on prior experience with people in similar situations.

- Envision the alternate futures and best feasible outcome for a given individual, medically, functionally, and vocationally. Identify potential interventions required to deliver that outcome, and project what the future will look like with and without them.

- Know about available interventions and how to best use them.

- Know about support resources that are available and how to engage them.

- Know about the emotional adjustment factors that accompany return to work attempts, and know how to deal with them.

- Plan a potential course of action to achieve the best possible outcome. Identify potential alternatives, obstacles and barriers, each with contingency plans.

- Be able to evaluate the feasibility of a plan from multiple perspectives: cost, risk, level of effort required by all parties, willingness of the person to participate, likelihood of success, upside potential, reasonableness, etc.

- Recommend / decide what to do.

Known Issues / Difficulties

- Especially in the realm of disability determinations, this step is often done informally or unconsciously, and either not documented well or at all.

- A person's wishes, interests and intentions must be considered in envisioning a realistic potential solution. Unless there is personal contact, either face to face or over the phone, obtaining a true picture of these things is virtually impossible.

- People in despair and depressed people often change their minds once they regain hope. Oftentimes, the helping professional's role is to plan for and stand for and push forward towards a better future than the person can imagine for themselves until things start to improve.

- Decisions in disability determination are often made in ignorance of the key situation drivers at play. If the full set of relevant drivers affecting a person are not discovered, understood and considered, it is unlikely that a potential solution will in fact be workable or implemented.

Cluster 6: Assess Reasonable Availability of Suitable Jobs/Opportunities

[Note: At present, this expertise cluster is the main one that the Social Security disability determination process asks outside Vocational Experts to provide.]

The reasonable availability of solutions must be considered in addition to their feasibility. Taking the potential occupations that have been identified and combining that with an understanding of the actual job market in the area or region where the person lives, the question is whether there are enough potential jobs in those occupations so that the person has a reasonable chance of getting one? If not, the solution is not reasonably available because the person has a very limited chance of finding gainful employment.

Prominent Tasks / Skills Required

- Vocational expertise is required to:
  - Develop a list of potentially feasible occupations or jobs and know how to estimate the size of the available job market for a particular individual with a particular functional capacity, or for a hypothetical person with a similar set of characteristics.
  - Have a grasp of the practical opportunities, difficulties and risks for a person getting back to full participation and gainful employment in their region.
  - Based on prior experience, accurately predict the probability of successful performance of those occupations or jobs, given the nature and size of the job market and the person's diminished ability to work.

Known Issues / Difficulties

- The tool currently in use by SSA (and many others) is the *Dictionary of Occupational Titles* (DOT) which is widely agreed to be obsolete. However, no clearly superior substitute exists today. The DOT creates a universe of possible occupations within which to identify possible solutions for people with disabilities, but the mix of occupations portrayed is the US labor market in the 1970s, not the labor market of today. Also, the domains in which job demands are expressed are crude and limited to exertional issues. Job demands in the environmental, cognitive and interpersonal realms are not described, for example.

- In most communities and regions, there is an enormous and unknown variety of specific positions and jobs within occupations. For administrative convenience, the complex realities of the job market are reduced to broad categories and rough estimates made. A coarse and broad brush estimate of likelihood makes it easier to make benefit determinations, but is inadequate for actually finding someone a job. A person doesn't find a job because the probabilities are good; they do it because they find a match.

- Apparent inconsistencies in decision making arise when the real factors at play in a situation are not identified and made explicit. The opinions and decisions of information providers, fact-finders, and decision-makers alike will be unconsciously and variously influenced by all kinds of background factors unless they are explicitly accounted for.

Cluster 7: Make a Detailed Vocational Plan and Implement It

[Note: This expertise cluster is NOT called on in the SSA disability determination process.]

In order for a person with a problematic medical condition to get back to work or achieve an optimal level of independence, hands-on and on-going expert assistance is often required.

Prominent Tasks / Skills Required

- Functional and/or vocational expertise are required to:
  - Have the necessary skills to make the solution happen: the ability to generate trust, people skills, "emotional IQ", understanding of human behavior, skill at motivational counseling, knowing psychological aspects of disability and adjustment.
  - Know how to develop a therapeutic alliance with the individuals in need and deliver services in a way that makes a difference in what happens. Enroll people in the idea of retaining / regaining function.
  - Provide coaching / case management / care coordination services to people to connect them with needed services and support them in restorative / rehabilitative / RTW efforts.
  - Know how to evaluate current status in terms of specific capabilities and skills, and know how to restore, improve, or work around them.
  - Know what kind of adaptive equipment is needed and where to find it; know what kind of specific accommodations will work, and how to make the request.
  - Know ways to find current and potentially appropriate job openings in the local area. Have relationships with supportive employers.
  - Wade in and provide hands-on therapy, services, and regular on-going support to make sure the plan is implemented.

Known Issues / Difficulties

- If a return-to-work plan is devised, but the person is not ready and willing to return to work, return-to-work services are unlikely to succeed.
- Non-medical issues may intervene and foil return-to-work efforts: the need for healthcare coverage, lack of transportation, lack of self-confidence, fear of the unknown, etc.
- Vocational rehabilitation programs have a poor record of success in many venues where their use has been mandated, though there are many individual success stories as well.

- Trust, hands-on assistance, very well-conceived interventions, support across a multi-dimensional realm of issues, and support over some period of time appear required to succeed in implementing return-to-work programs.

- It takes an extraordinarily creative and persistent practitioner to have the patience and persistence necessary to deal with people who have difficulty imagining themselves returning to work.

- Lack of a current employer or a willing new employer generally makes return to work initiatives much more difficult.

Cluster 8: Navigate and Utilize Administrative Programs

[Note: Although local staff in the Social Security Field Offices may make incidental referrals to other agencies, this expertise cluster is NOT called on in the Social Security disability determination process.]

In order to work within the administrative programs that support delivery of functional and vocational services, knowledge of the programs themselves is necessary. Many functional and vocational services are delivered at no cost, low cost, or subsidized cost through programs administered by governments, educational institutions, insurers, and other organizations. The rules and procedures to follow for many of these programs are complex and varied. Most potential individual recipients of functional and vocational services are unaware of, or at least inexperienced with, the details of these programs, and so rely on experts to assist them.

Prominent Tasks / Skills Required

- Be familiar with and have the facility to apply accurately those specific distinctions, definitions, applicable laws, regulations, and policies that apply to the programs of relevance.

Known Issues / Difficulties

- With so many different programs available, each with precisely defined terms and provisions, it is difficult if not impossible for anyone to master them all.

- Any one practitioner probably learns the programs they deal with regularly well, but knows others much less well.

- Fine or counterintuitive distinctions can trip up even an experienced practitioner. For example, within the SSA system, the definition of residual functional capacity does not appear to be uniformly understood.

K. Assessment of Fit: mFV Providers to Task Clusters

Table II-1 below shows the match between the task clusters above and the typical level of proficiency of the subset of mFV providers within each of the best-suited professions.

Individual mFV experts vary in the extent and scope of their personal expertise, so this table should be viewed as a general guide rather than a statement of fact . It estimates how proficient a typical member of each profession (assuming they have mFV expertise) will be at each particular task. For example, the table shows that:

- a typical nurse case manager with mFV expertise is likely to be more proficient at estimating impairments and triaging claims than a typical vocational counselor with mFV expertise will be;
- a typical vocational rehabilitation counselor is likely to be more proficient at assessing availability of work opportunities and developing/implementing a vocational plan than a typical nurse case manager will be;
- both types of professionals are likely to be equally proficient at assessing and testing functional limitations or work capacity.

Table II-1 – Matching mFV Providers with Task Clusters

The rows of this table show the major task clusters involved in providing functional and vocational expertise, including some tasks not now performed for SSA but which are part of the multidimensional assessment (MDA). (The MDA and the task clusters are more fully discussed elsewhere in the project reports.) The X's in the table show the typical proficiency of the subset of individuals who are mFV Registry-qualified within each profession at doing each task cluster.

Key:
- **X** = typically proficient at simple versions or limited portions of the task
- **XX** = typically very proficient at doing simple and moderately complex versions of the task
- **XXX** = typically extremely proficient at all levels of the task

PROVIDER TYPE (assumes provider has specific training and experience that meets eligibility criteria listed elsewhere in this report) → **TASKS** ↓	Physicians	Psychologists (Clinical)	Nurse Practitioners	Social Workers	Nurse Case Managers	Occupational Therapists	Physical Therapists	Voc Rehab Counselors	SSA Vocational Specialists	SSA Disability Examiners
MEDICAL EXPERTISE: 0: Determine Impairments	**XXX**	**XXX**[a]	**XX**	**XX**[a]	**XX**	**XX**	**XX**[b]			
FUNCTIONAL/VOCATIONAL EXPERTISE:										
1: Assess Situation and mFV Expertise Required	**XXX**[c]	**X**	**XX**	**X**	**XX**	**XX**	**X**			
2: Establish Medical Restrictions and Functional Limitations	**XX**	**XX**[a]	**XX**	**XX**[a]	**X**	**XX**	**XX**[b]			
3: Assess or Test Functional Limitations / Work Capacity	**X**	**XXX**[a]	**X**	**XX**[a]	**X**	**XXX**	**XXX**[b]	**X**		
4: Assess Extent of Vocational Disruption		**XX**[a]		**X**	**X**	**XXX**	**XXX**[b]	**XXX**	**X**	**X**
5: Envision Feasible Functional & Vocational Solutions	**X-XX**[c]	**X**	**X**	**XX**	**XX**	**XXX**	**XXX**[b]	**XXX**	**X**	**X**
6: Assess Availability of Work Opportunities				**X**		**X**	**X**	**XXX**	**X**	**X**
7: Make / Implement a Vocational Plan				**X**		**X**	**X**	**XXX**		
8: Navigate Healthcare and Social Service Programs	**X**	**X**	**X**	**XXX**	**XX**	**XX**	**XX**	**XXX**		**X**

[a] – For claims with primarily mental health diagnoses

[b] – For claims with primarily physical diagnoses

[c] – Level of proficiency is **XXX** for preferred medical specialties only; all other specialties are usually **XX** unless specially trained

Implications and Conclusions

1. The contribution to work status made by medical factors is often swamped by the contribution of biological and other factors. Biological factors include age, sex, body habitus, and physical conditioning. Other factors include those in the personal domain such as self-concept, worldview, beliefs, ambition, motivation, education and training, discipline, talent and skill as well as the environmental domain such as access to services and assistive technology, financial resources, as well as family, social, community and workplace support and accommodations.

2. A disability determination approach that focuses only on diagnostic and medical impairment issues and fails to explicitly acknowledge the relative contribution to disability being made by powerful factors in other domains will appear to be inconsistent, unjust, and irrational. Personal and environmental factors are usually more important than strictly medical ones in determining whether a person with a medical condition stays at or returns to work. The relative contribution of medical, biological, personal and environmental factors would need to be explicitly apportioned in order to portray the situation in the most realistic way possible to an adjudicator who wants to understand a case in order to interpret the law appropriately.

3. With some exceptions, the professions of medicine and psychology upon which SSA now relies for mFV expertise are not the best source of functional and vocational expertise because most of them are neither trained nor interested in these issues, and they are not committed to preventing needless work disability. Unfortunately, many of the professions that do have a deep commitment to and more expertise in functional assessment, restoration, and rehabilitation and workplace realities lack deep medical knowledge. Those professionals who possess a combination of medical, functional and/or vocational expertise are in very short supply. Thus, cross-training or collaboration among these experts may be required.

4. The professionals who possess significant mFV expertise are in the "helping" professions. They chose their life's work because they wanted to make a positive difference in people's lives. They went to the trouble of developing expertise so they could help find solutions, not describe problems more accurately. Most but not all of them feel uncomfortable in neutral, forensic, or adversarial roles, especially if they are asked to play those roles much of the time.

5. The most valuable thing that professionals with mFV expertise have to offer Social Security's applicants and beneficiaries is the know-how to help them identify their abilities as well as their impairments, to adapt to their new life situation, to figure out how to make life work on a daily basis and achieve the highest possible level of self-sufficiency, including gainful employment whenever possible. Given Commissioner Barnhart's commitment to foster return to work at all stages of the process, the full range of their expertise is not currently being optimally utilized by SSA.

6. The logical process of determining eligibility for disability benefits reasonably follows a linear sequence, but the information flow among experts with medical, functional and vocational expertise should not be unidirectional. Back and forth exchange of questions and answers

between professionals with medical and mFV expertise should be the norm rather than the exception in complex cases. The goal is to collaboratively create a detailed, deep, and precise enough understanding of the critical aspects of each applicant's situation to fully answer the questions at each step in the disability determination process.

APPENDIX: Detailed Information About the Professions Best-Suited to Provide mFV Experts

Nurse Practitioners (NPs), Nurse Case Managers (CNCMs), and Rehabilitation Nurses (CRRNs) .... I - 38

Occupational Therapists (OTs) .... I - 46

Physical Therapists (PTs) .... I - 52

Physicians / Surgeons (MD, DO) .... I - 58

Psychologists .... I - 65

Social Workers .... I - 71

Vocational Rehabilitation Counselors .... I - 80

Nurse Practitioners, Certified Nurse Case Managers, and Certified Rehabilitation Nurses

Overall Description

Certified nurse case managers (CNCMs) generally do not deliver hands on care but focus on ensuring that the process of care and the situation created by the healthcare condition are managed well. For example, CNCMs assess situations, educate patients, develop care plans, facilitate communications among healthcare providers, the patient and family, employers and insurers, arrange specialist referrals, and expedite care and return to work where appropriate.

Nurse practitioners (NPs) are mid-level healthcare practitioners who function as primary healthcare providers in a manner similar to physicians, with the ability to diagnose and treat disease and prescribe medications. Some of them are also case managers.

Certified rehabilitation nurses (CRRNs) base their practice on rehabilitative and restorative principles by managing complex medical issues, consulting with specialists, providing ongoing patient education, setting goals for maximal independence, and establishing plans of care to maintain optimal wellness. Some of them are also case managers.

Essence of the Professions

CNCMs assist patients and payers by acting as advocates for the efficient and appropriate delivery of healthcare and the achievement of optimal medical (and sometimes functional) outcomes for the patient. Their patient population consists mostly of people who need special assistance in navigating the healthcare system.

NPs focus on prevention, wellness, patient education and diagnosis and treatment of uncomplicated illnesses. Their patient population represents a broad cross section with heavy representation of well children and adults, or those with stable chronic illnesses.

CRRNs have a rehabilitative and restorative focus and usually work with patients with disabling conditions.

Relative Emphasis on Functional / Vocational Expertise

An estimated 20% of all nurse case managers have experience in workers' compensation or disability management settings. The majority of medical case managers are almost exclusively oriented to traditional healthcare issues and do not usually even consider functional or vocational issues.

Those nurse case managers who do work in workers' compensation and disability benefits programs are often used as a go-between between physicians and employers. They are often expected to extract work releases from physicians, and sometimes to translate the restrictions and limitations set by the physician into information the employer can understand – what tasks the employee can do. Some have more experience and exposure to functional or vocational issues than others.

Similar to physicians and physician assistants, NPs are occasionally asked by employers and insurers to assess whether their patient can work or to set limitations and restrictions and work capacity. Like their colleagues, only a very few NPs have had any training in how to do perform these tasks.

The rehabilitation nursing specialty sets measurable, functional outcome goals for patients, which rehabilitation nurses use in planning and evaluating the effectiveness of patient care. Rehabilitation nurses have strong functional assessment skills and take a comprehensive approach to care. They act as multisystem integrators and team leaders, working with physicians, therapists, and others to solve problems and promote patients' maximal independence. Rehabilitation nurses act not only as caregivers but also as coordinators, collaborators, counselors, and case managers. Rehabilitation nurses are particularly skilled at working with others to adapt ongoing care to the resources available.

Alignments / Motivations / Allegiances / Potential Conflicts

Nurses originally chose a helping profession because they want to help people and take care of them. Most nurses will not be particularly enthusiastic about or comfortable in a neutral or forensic role.

Similar to other helping professions, nurses, especially case managers and rehabilitation nurses, commonly make an assessment regarding the need for services and then provide and bill for them. It is often in their economic self-interest to declare that services are warranted.

Comments Relating to Use by SSA

NPs are probably already serving as "treating sources" for SSA applicants since they are sometimes the only available treating practitioner.

Certified nurse case managers (CCM or similar) are now not involved in SSA, but could serve as multi-dimensional assessors.

CNCMs may need to be taught to adhere to a highly-structured assessment process, but their nursing background has prepared them for it. Similar to the other helping professions, they will need professional reinforcement from peers and regular scrutiny of the quality of their work and the independence of their assessments.

Distinctions Among Groups of Practitioners Within the Profession

CNCMs, NPs, and CRRNs are initially trained as nurses. Nursing as a profession has multiple areas of specialty and multiple levels of advancement. Nurses may have diplomas, associate, bachelors, masters or doctorates in nursing. They can be certified in any of several specialty areas after specialized training. Informally, nurses develop expertise in areas in which they have been working such as emergency room, obstetrics, mental health, school health, public health, and so on. Because of variability in the level of educational attainment and specialized experience and training, the worldview and expertise of nurses varies widely.

Differences From Other Professions in this Paper

People in other industries and professions sometimes call themselves case managers. For example, in the disability and workers' compensation insurance industries, some people who in previous days would have been called claims examiners or claims adjusters are now called case managers.

In the helping professions, nurses, social workers and vocational rehabilitation professionals (VRs), OTs and PTs can all be called case managers in different settings. The roles of CNCMs and CRRNs overlap to some extent with social workers and vocational rehabilitation professionals.

Although the CCM certification can be awarded to nurses, social workers, VRs, OTs and PTs, the overwhelming majority (90%) of the members of the Case Management Society of America are nurses, with about 9% social workers and 1% vocational rehabilitation counselors.

Nurse practitioners perform similar work to physicians, but on less-complex cases, and usually under a physician's direction. Like physician assistants, they can prescribe some medications in most states.

In contrast to physician assistants who often entered their profession after experiences as medics in the armed services and tend to be acute-care oriented and more interventionist, NPs began their careers as registered nurses, have more training, and tend to have a more holistic wellness and preventive services orientation.

Professional Preparation / Education / Core Curriculum

"There are three major educational paths to registered nursing: A bachelor's of science degree in nursing (BSN), an associate degree in nursing (ADN), and a diploma. BSN programs, offered by colleges and universities, take about 4 years to complete. In 2004, 674 nursing programs offered degrees at the bachelor's level. ADN programs, offered by community and junior colleges, take about 2 to 3 years to complete. About 846 RN programs in 2004 granted associate degrees. Diploma programs, administered in hospitals, last about 3 years. Only 69 programs offered diplomas in 2004. Generally, licensed graduates of any of the three types of educational programs qualify for entry-level positions as staff nurses.

Many RNs with an ADN or diploma later enter bachelor's programs to prepare for a broader scope of nursing practice. Often, they can find a staff nurse position and then take advantage of tuition reimbursement benefits to work toward a BSN by completing an RN-to-BSN program. In 2004, there were 600 RN-to-BSN programs in the United States. Accelerated master's degree programs in nursing also are available. These programs combine 1 year of an accelerated BSN program with 2 years of graduate study. In 2004, there were 137 RN-to-MSN programs.

Accelerated BSN programs also are available for individuals who have a bachelor's or higher degree in another field and who are interested in moving into nursing. In 2004, more than 165 of these programs were available. Accelerated BSN programs last 12 to 18 months and provide the fastest route to a BSN for individuals who already hold a degree.

….. [S]ome career paths are open only to nurses with a bachelor's or master's degree. A bachelor's degree often is necessary for administrative positions and is a prerequisite for admission to graduate nursing programs in research, consulting, and teaching, and all four advanced practice nursing specialties—clinical nurse specialists, nurse anesthetists, nurse midwives, and nurse practitioners. Individuals who complete a bachelor's receive more training in areas such as communication, leadership, and critical thinking, all of which are becoming more important as nursing care becomes more complex. Additionally, bachelor's degree programs offer more clinical experience in non-hospital settings. In 2004, 417 nursing schools offered master's degrees, 93 offered doctoral degrees, and 46 offered accelerated BSN-to-doctoral programs.

All four advanced practice nursing specialties require at least a master's degree. Most programs last about 2 years and require a BSN degree and some programs require at least 1 to 2 years of clinical experience as an RN for admission. In 2004, there were 329 master's and post-master's programs offered for nurse practitioners, 218 master's and post-master's programs for clinical nurse specialists, 92 programs for nurse anesthetists, and 45 programs for nurse midwives. Upon completion of a program, most advanced practice nurses become nationally certified in their area of specialty. In some States, certification in a specialty is required in order to practice that specialty. ..." [1]

Certified Rehabilitation Nurses (CRRN) Rehabilitation nurses base their practice on rehabilitative and restorative principles by managing complex medical issues, consulting with specialists, providing ongoing patient education, setting goals for maximal independence, and establishing plans of care to maintain optimal wellness. A registered nurse with at least 2 years of practice in rehabilitation nursing can earn distinction as a Certified Rehabilitation Registered Nurse (CRRN) by successfully completing an examination that validates expertise. A registered nurse with a CRRN and a master's degree or doctorate in nursing can earn certification as a Certified Rehabilitation Registered Nurse -Advanced (CRRN-A).

Licensing

"In all States and the District of Columbia, students must graduate from an approved nursing program and pass a national licensing examination, known as the NCLEX-RN, in order to obtain a nursing license. Nurses may be licensed in more than one State, either by examination or by the endorsement of a license issued by another State. Currently 23 States participate in the Nurse Licensure Compact Agreement, which allows nurses to practice in member States without recertifying. All States require periodic renewal of licenses, which may involve continuing education." [1]

Certifications / Certifying Agencies / Associations

Numerous special certifications are available to nurses in general, most not of relevance to the area of functional and vocational expertise.

Nurse case managers may hold many different kinds of certifications. The Case Management Society of America lists the following: [5]

ABDA - American Board of Disability Analyst
CASWCM - Certified Advanced Social Work Case Manager

CCM - Certified Case Manager
CDMS - Certified Disability Management Specialist
CMC - Care Manager Certified
COHN - Certified Occupational Health Nurse
CPDM - Certified Professional in Disability Management
CRC - Certified Rehabilitation Counselor
CRRN - Certified Rehabilitation Registered Nurse
CSWCM - Certified Social Work Case Manager
RCNCM - Registered Nurse Case Manager

Typical Practice Settings / Employers / Clients

Case Managers. The 25,000 certified case managers active today work in various settings, including hospitals, insurance companies (group health, workers' compensation, short- and long-term disability) private practice, specialty facilities, home health, skilled care, and physician groups.

Some nurse case managers focus on both medical and disability issues; they tend to be employed by employers or workers' compensation insurers. Disability nurse consultants are employed by disability insurance companies but often focus primarily on medical issues.

Case managers may be full or part-time employees, contract workers, or independent contractors. A substantial number of case managers are in private practice either solo or in small groups.

Nurse Practitioners. Advanced practice nurses, who often are considered primary health care practitioners, work independently or in collaboration with physicians. Nurse practitioners provide basic preventive health care to patients, and increasingly serve as primary and specialty care providers in mainly medically underserved areas. They work in settings similar to those of physicians and physician assistants.

Certified Rehabilitation Nurses. Nurses with special training and experience who help individuals affected by chronic illness or physical disability to adapt to their disabilities, achieve their greatest potential, and work toward productive, independent lives. They take a holistic approach to meeting patients' medical, vocational, educational, environmental, and spiritual needs.

Rehabilitation nurses begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness. They continue to provide support in the form of patient and family education and empower these individuals when they go home or return to work or school. The rehabilitation nurse often teaches patients and their caregivers how to access systems and resources.

Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. Rehabilitation nurses base their practice on rehabilitative and restorative principles by

- managing complex medical issues

- collaborating with other specialists
- providing ongoing patient/caregiver education
- setting goals for maximal independence
- establishing plans of care to maintain optimal wellness.

Rehabilitation nurses practice in all settings:

- freestanding rehabilitation facilities
- hospitals (inpatient rehabilitation units)
- long-term subacute care facilities/skilled nursing facilities
- long-term acute care facilities
- comprehensive outpatient rehab facilities
- private practice
- home healthcare agencies
- clinics and day rehabilitation programs
- community and government agencies
- insurance companies and health maintenance organizations
- schools and universities

Population and Employment

"As the largest health care occupation, registered nurses held about 2.4 million jobs in 2004. About 3 out of 5 jobs were in hospitals, in inpatient and outpatient departments. Others worked in offices of physicians, nursing care facilities, home health care services, employment services, government agencies, and outpatient care centers. The remainder worked mostly in social assistance agencies and educational services, public and private. About 1 in 4 RNs worked part time." [1]

In 2000, there were over 58,000 employed nurse practitioners, 22 percent of whom practiced in rural areas (Hooker, 2002). Approximately 85 percent of nurse practitioners practice in primary care (Hooker, 2002).

In 2006, the Association of Rehabilitation Nurses' website reported that there are more than 12,000 CRRNs. [6]

Pay Rates

"Median annual earnings of all registered nurses were $52,330 in May 2004. The middle 50 percent earned between $43,370 and $63,360. The lowest 10 percent earned less than $37,300, and the highest 10 percent earned more than $74,760. Median annual earnings in the industries employing the largest numbers of registered nurses in May 2004 were as follows:

Employment services	$63,170
General medical and surgical hospitals	53,450
Home health care services	48,990

Offices of physicians	48,250
Nursing care facilities	48,220

" [1]

Case manager salaries averaged $57,000 in the 2005 Case Management Society of America survey.

Nurse practitioner salaries averaged $75k in a current salary survey (2006) - with 50% between $69,000 and $80,000.
[http://swz.salary.com/salarywizard/layouthtmls/swzl_narrowjob_HC03.html]

Buying Arrangements / Economics

Since many CNCMs and CRRNs are salaried employees, arrangements for their services must be made through the employing organization. CNCMs and CRRNs in independent practice can be contracted with independently.

Current and Future State of the Profession

The Occupational Outlook Handbook predicts much higher job growth than average for the nursing profession in the next ten years. [1]

Detailed Career Description

"Registered nurses (RNs), regardless of specialty or work setting, perform basic duties that include treating patients, educating patients and the public about various medical conditions, and providing advice and emotional support to patients' family members. RNs record patients' medical histories and symptoms, help to perform diagnostic tests and analyze results, operate medical machinery, administer treatment and medications, and help with patient follow-up and rehabilitation.

RNs teach patients and their families how to manage their illness or injury, including post-treatment home care needs, diet and exercise programs, and self-administration of medication and physical therapy. . . ..

RNs can specialize in one or more patient care specialties. The most common specialties can be divided into roughly four categories—by work setting or type of treatment; disease, ailment, or condition; organ or body system type; or population. RNs may combine specialties from more than one area—for example, pediatric oncology or cardiac emergency—depending on personal interest and employer needs.

RNs may specialize by work setting or by type of care provided. . . . RNs specializing in a particular disease, ailment, or condition are employed in virtually all work settings, including physicians' offices, outpatient treatment facilities, home health care agencies, and hospitals. . . . . Most RNs work as staff nurses, providing critical health care services along with physicians, surgeons, and other health care practitioners. However, some RNs choose to become advanced practice nurses, who often are considered primary health care practitioners and work independently or in collaboration with physicians. Nurse practitioners provide basic preventive health care to patients, and increasingly serve as primary and specialty care providers in mainly medically underserved areas. The most

common areas of specialty for nurse practitioners are family practice, adult practice, women's health, pediatrics, acute care, and gerontology; however, there are many other specialties. In most States, advanced practice nurses can prescribe medications.

Some nurses have jobs that require little or no direct patient contact. Most of these positions still require an active RN license. Case managers ensure that all of the medical needs of patients with severe injuries and illnesses are met, including the type, location, and duration of treatment. Forensics nurses combine nursing with law enforcement by treating and investigating victims of sexual assault, child abuse, or accidental death. …. Legal nurse consultants assist lawyers in medical cases by interviewing patients and witnesses, organizing medical records, determining damages and costs, locating evidence, and educating lawyers about medical issues. …." [1]

Standard Protocols and Practice Methodologies Employed

A hallmark of the nursing profession is standardized assessment and careful documentation. Case managers typically reply on highly structured assessment process, to identify a clinical path or make decisions regarding coverage and services.

Sources and References

[1] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2006-07 Edition, Registered Nurses, on the Internet at http://www.bls.gov/oco/ocos083.htm (visited June 13, 2006).

[2] American Nurses Association
http://nursingworld.org/

[3] American Nursing Credentialing Center
http://nursingworld.org/ancc/

[4] Commission for Case Manager Certification
http://www.ccmcertification.org/

[5] Case Management Society of America
http://www.cmsa.org/

[6] Association of Rehabilitation Nurses
http://www.rehabnurse.org

Occupational Therapists

Overall Description

Occupational therapy is a unique combination of hands-on treatment, education, and counseling that helps individuals maximize participation in life. Occupational therapy assists people in developing the "skills for the job of living" necessary for independent and satisfying lives.

"Occupational therapists (OTs) help people improve their ability to perform tasks in their daily living and working environments. They work with individuals who have conditions that are mentally, physically, developmentally, or emotionally disabling. They also help them to develop, recover, or maintain daily living and work skills. Occupational therapists help clients not only to improve their basic motor functions and reasoning abilities, but also to compensate for permanent loss of function. Their goal is to help clients have independent, productive, and satisfying lives." [1]

Essence of the Profession

Help people fully participate in life, with an emphasis on assessing and restoring the person's ability to function in their life situation, and solving practical problems encountered in everyday life.

Relative Emphasis on Functional / Vocational Expertise

The entire focus of occupational therapy is on assessing the practical impact of medical impairments on function and devising strategies to improve function as well as enable the fullest possible participation in activities at home, in the community, and in the workplace. In the context of vocational rehabilitation, OTs work with patients to restore whatever kind of function has been identified as essential for working.

Alignments / Motivations / Allegiances / Potential Conflicts

Occupational therapists chose a helping profession and most of them will not be particularly enthusiastic about a neutral or forensic role. Similar to the other helping professions, they will need professional reinforcement from peers and regular scrutiny of the quality of their work and the independence of their assessments.

Similar to other helping professions, OTs commonly make an assessment regarding the need for services and then provide and bill for them. It is often in their economic self-interest to declare that services are warranted.

In many states, OTs can take direct referrals for therapy without an order from a physician. Since occupational therapists are most commonly employed in complex organizations, they can be expected have loyalties to their home organization for referral purposes.

Comments Relating to Use by SSA

Currently, OTs are not commonly utilized by SSA either as internal resources or as external consultants. This group of practitioners is well-suited to provide assessment services to SSA due to their professional expertise in functional assessment, restoration,

and adaptive techniques, as well as their multi-dimensional approach. For example, if a physician or disability examiner is wondering about the vocational implications of a particular physical or mental limitation, an external consultant OT could see the applicant and assess functional ability, or an internal consultant OT could discuss potential ways to work around that particular problem.

Contracting for services with individual occupational therapists may be difficult to the low number in private practice. However, the agencies and institutions that employ them may be willing to provide the services of OTs to SSA.

Distinctions Among Groups of Practitioners Within the Profession

Most occupational therapists have the same basic professional preparation, but tend to informally develop special expertise as a result of their work experience, either in spinal cord rehabilitation programs, mental hospitals, geriatric or pediatric programs, and so on. AOTA does provide formal specialization in a number of areas including neurological, pediatric and geriatric service provision. The recognition of an additional specialty area in Work Rehabilitation and Ergonomics will go before the AOTA Representative Assembly this year.

Differences From Other Professions in this Paper

OTs and PTs are very similar in their approach to working with adults whose ability to function at home, in the community and at work has been altered by illness or injury. OTs have more training and expertise in assessing and dealing with the psychosocial and mental health aspects of disability. They are more often relied on by other health professionals for functional rehabilitation of the hand and upper extremity, on assessing abilities to perform instrumental ADLs, and on finding/teaching new ways to perform them. For example, OTs will provide hand therapy, arrange for a hand rail to be installed, teach someone to balance a checkbook, or assess someone's ability to cook a meal or drive a car. As a rule, OTs are likely to remember to assess a client from multiple perspectives, to take a broader view of the client's situation and needs, and to focus interventions on mental and social as well as bio-mechanical issues.

OTs differ from clinical social workers and counselors in the fact that they have more knowledge about physical medical conditions, they provide hands-on treatment, and they have had less formal training in counseling.

Typical Practice Settings / Employers / Clients

(See Population and Employment below)

Standard Protocols and Practice Methodologies Employed

Occupational therapists assess each patient's situation in a holistic manner which may involve a variety of standardized protocols, and then take a problem-solving approach to treatment. Occupational therapy services typically include:

- Assessment of performance skills and needs in multiple domains – physical, cognitive, emotional, social, environmental, and so on.
- Comprehensive home and job site evaluations and recommendations

- Selection of adaptive equipment and training in its use
- Customized treatment programs to improve one's ability to perform daily activities of living (ADLs) or participate in work / social activities in the community.
- Guidance to family members and caregivers

Education / Core Curriculum

"Occupational therapy coursework includes the physical, biological, and behavioral sciences, as well as human growth and development, with specific emphasis on the social, emotional and physiological effects of illness and injury and the application of occupational therapy theory and skills. The completion of 6 months of supervised fieldwork also is required.

Currently, a bachelor's degree (BA or BS) in occupational therapy is the minimum requirement for entry into the field. Beginning in 2007, however, a master's degree or higher will be the minimum educational requirement. As a result, students currently in bachelor's-level programs must complete their coursework and fieldwork before 2007. In 2005, 122 master's degree programs offered entry-level education, 65 programs offered a combined bachelor's and master's degree, and 5 offered an entry-level doctoral degree. Most schools have full-time programs, although a growing number are offering weekend or part-time programs as well. Bachelor's degree programs in occupational therapy are no longer offered because of the requirement for a master's degree or higher beginning in 2007." [1]

Licensing

"All States, Puerto Rico, Guam, and the District of Columbia regulate the practice of occupational therapy. To obtain a license, applicants must graduate from an accredited educational program and pass a national certification examination. Those who pass the exam are awarded the title Occupational Therapist Registered (OTR). Another recognized designation is OTR/L, meaning Occupational Therapist Registered and Licensed." [1]

A listing of all licensing requirements and agencies is located at http://www.nbcot.org/WebArticles/articlefiles/FORM_OTRegBody_ContactList041306.pdf

Certifications / Certifying Agencies

The National Board for Certification in Occupational Therapy, Inc. (NBCOT) administers the national certification examination that results in the designation Occupational Therapy Registered (OTR). http://www.nbcot.org/

A description of the certifications handled by NBCOT is located at: http://www.nbcot.org/webarticles/anmviewer.asp?a=113&z=16

Population and Employment

"Occupational therapists held about 87,430 jobs in 2005. About 1 in 10 occupational therapists held more than one job. More than a quarter of occupational therapists work part time. The largest number of jobs is in hospitals. Other major employers were offices of other health practitioners (including offices of occupational therapists), public and

private educational services, and nursing care facilities. Some occupational therapists were employed by home health care services, outpatient care centers, offices of physicians, individual and family services, community care facilities for the elderly, and government agencies. OTs in these settings may be independent contractors, part-or full-time employees.

A small number of occupational therapists were fully occupied in private practice. These practitioners saw clients referred by physicians or other health professionals or provided contract or consulting services to nursing care facilities, schools, adult day care programs, and home health care agencies." [1]

Additionally, a small number of OTs consult to businesses and insurance companies, most often the ones in private practice.

Pay Rates

Median annual earnings of occupational therapists were $59,100 with median hourly wages of $27.34 in May 2005 [4].

“[In 2004,] the middle 50 percent earned between $45,690 and $67,010. The lowest 10 percent earned less than $37,430, and the highest 10 percent earned more than $81,600. Median annual earnings in the industries employing the largest numbers of occupational therapists in May 2004 were

Home health care services	$58,720
Offices of other health practitioners	56,620
Nursing care facilities	56,570
General medical and surgical hospitals	55,710
Elementary and secondary schools	48,580

" [1]

Buying Arrangements / Economics

Contracting for services with individual occupational therapists may be difficult to the low number in private practice. However, the agencies and institutions that employ them may be willing to provide the services of OTs to SSA.

Current and Future State of the Profession

The *Occupational Outlook Handbook* indicates that there will be growing demand for OTs over the next ten years. "Demand for occupational therapists is expected to increase much faster than the average through 2014. The impact of proposed Federal legislation imposing limits on reimbursement for therapy services may adversely affect the job market for occupational therapists in the short run. However, over the long run, the demand for occupational therapists should continue to rise as a result of growth in the number of individuals with disabilities or limited function who require therapy services. The baby-

boom generation's movement into middle age, a period when the incidence of heart attack and stroke increases, will spur demand for therapeutic services in outpatient rehab programs. Growth in the population 75 years and older – an age group that suffers from high incidences of disabling conditions – also will increase demand for therapeutic services. Driver rehabilitation and fall-prevention training for the elderly are emerging practice areas for occupational therapy. In addition, medical advances now enable more patients with critical problems to survive – patients who ultimately may need extensive therapy." [1]

Detailed Career Description

"Occupational therapists assist clients in developing the skills to perform activities of all types, ranging from using a computer to caring for daily needs such as dressing, cooking, and eating. Physical exercises may be used to increase strength and dexterity, while other activities may be chosen to improve visual acuity and the ability to discern patterns. For example, a client with short-term memory loss might be encouraged to make lists to aid recall, and a person with coordination problems might be assigned exercises to improve hand-eye coordination. Occupational therapists also use computer programs to help clients improve decision making, abstract-reasoning, problem-solving, and perceptual skills, as well as memory, sequencing, and coordination . . . .

Some occupational therapists treat individuals whose ability to function in a work environment has been impaired. These practitioners arrange employment, evaluate the work environment, plan work activities, and assess the client's progress. Therapists also may collaborate with the client and the employer to modify the work environment so that the work can be successfully completed. . . .

Occupational therapists in mental health settings treat individuals who are mentally ill, mentally retarded, or emotionally disturbed, and individuals who are dealing with alcoholism, drug abuse, depression, eating disorders, or stress-related disorders. To treat these problems, therapists choose activities that help people learn to engage in and cope with daily life. Activities include time management skills, budgeting, shopping, homemaking, and the use of public transportation. Where appropriate, they also provide work-related skill training and intervention.

Assessing and recording a client's activities and progress is an important part of an occupational therapist's job." [1]

Sources and References

[1] Materials from Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2006-07 Edition*, Occupational Therapists, on the Internet at http://www.bls.gov/oco/ocos078.htm (visited *June 11, 2006*)

[2] The American Occupational Therapy Association (AOTA). Among other things, this organization accredits educational programs to grant degrees in occupational therapy. http://www.aota.org/

[3] National Board for Certification in Occupational Therapy, Inc. http://www.nbcot.org/

[4] Bureau of Labor Statistics, U.S. Department of Labor, National Occupational Employment and Wage Estimates, May 2005
http://www.bls.gov/oes/current/oes_nat.htm#b29-0000 (as of October 17, 2006)

Physical Therapists

Overall Description

Physical therapists (PTs) evaluate and treat patients to help them restore strength and functional abilities. Their work is hands on and their goal is to increase independence, restore or maintain function, reduce discomfort, and reach goals of increased life or work capacity. They typically do their working in settings with specialized equipment, but work wherever their patients are including home, work, sporting or other specialized facilities.

The American Physical Therapy Association's website describes PTS as "licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations." [2]

Essence of the Profession

Help people regain or maximize their physical abilities and teach them self-care techniques and how to use adaptive equipment as necessary.

Relative Emphasis on Functional / Vocational Expertise

The entire focus of physical therapy is on assessing the practical impact of medical impairments on function and devising strategies to improve function especially for moving the body through space, doing physical work, and ambulation/locomotion.

Alignments / Motivations / Allegiances / Potential Conflicts

Physical therapists chose a helping profession and most of them will not be particularly enthusiastic about a neutral or forensic role. PTs may need to be taught to adhere to a highly-structured assessment process. Similar to the other helping professions, they will need professional reinforcement from peers and regular scrutiny of the quality of their work and the independence of their assessments.

Similar to other helping professions, PTs commonly make an assessment regarding the need for services and then provide and bill for them. It is often in their economic self-interest to declare that services are warranted.

In most states, PTs practice independently and take direct referrals for therapy. They do work cooperatively with the rest of the medical team and may need a physician referral to assist in obtaining reimbursement for treatment. They may have loyalties to their home organization for referral purposes.

Comments Relating to Use by SSA

Similar to OTs, social workers, and vocational rehabilitation professionals whose professional ethos is wound up in the assessment of the "whole person" in their entire life situation.

If PTs were to be used as face-to-face generalist assessors of applicants' entire situations, the PTs would need more training and supervision with regard to interviewing techniques than would those other groups.

Currently, PTs are not commonly utilized by SSA either as internal resources or as external consultants. This group of practitioners is well-suited to provide assessment services to SSA due to their professional expertise in musculoskeletal functional assessment and restoration, and adaptive techniques. For example, if a physician or disability examiner is wondering about the vocational implications of a particular physical limitation, an external consultant PT could see the applicant and assess functional ability, or an internal consultant PT could discuss potential ways to treat or otherwise work around that particular problem.

A large number of PTs are in private practice, either full- or part-time, and should be available for contracting with SSA.

Distinctions Among Groups of Practitioners Within the Profession

Some PTs and PT facilities specialize by type of client or type of ailment handled. The vast bulk specialize in neuromusculoskeletal rehabilitation.

Differences From Other Professions in this Paper

PTs and OTs are very similar in their approach to working with adults whose ability to work has been altered by illness or injury. Usually, PTs have had more training than OTs have in musculoskeletal diagnosis and therapy, and tend to focus on biomechanical issues particularly in the lower extremities and spine. PTs have less extensive training in mental health assessment and intervention than do OTs. However, PTs often work with patients with both mental and physical disorders, and apply their expertise in neuromusculoskeletal or biomechanical issues to assisting people to cope with all of their combined problems and be more functional in their environment.

Typical Practice Settings / Employers / Clients

"Physical therapists practice in hospitals, clinics, and private offices that have specially equipped facilities, or they treat patients in hospital rooms, homes, or schools." [1] They may also provide services in facilities attached to health fitness centers and other sports facilities.

The work of most PTs requires specialized space and exercise equipment, much like a gym. In practices that administer functional capacity exams, specialized test equipment often is also required.

PT's clients are typically people that have incurred some kind of musculoskeletal stress or injury, or need to recover strength or body tone after periods of disuse.

The cost of PT services typically will be covered by the treated individual (for sports injuries, for example), by a group health plan, by a workers' compensation insurer, or by an employer directly.

Standard Protocols and Practice Methodologies Employed

PTs are taught standard assessment protocols. When they do functional capacity examinations, they may either use their own personal method or one of several commercially-available testing protocols and reporting formats.

Education / Core Curriculum

"According to the American Physical Therapy Association, there were 205 accredited physical therapist programs in 2004. Of the accredited programs, 94 offered master's degrees, and 111 offered doctoral degrees. All physical therapist programs seeking accreditation are required to offer degrees at the master's degree level and above, in accordance with the Commission on Accreditation in Physical Therapy Education.

Physical therapist programs start with basic science courses such as biology, chemistry, and physics and then introduce specialized courses, including biomechanics, neuroanatomy, human growth and development, manifestations of disease, examination techniques, and therapeutic procedures. Besides getting classroom and laboratory instruction, students receive supervised clinical experience. Among the courses that are useful when one applies to a physical therapist educational program are anatomy, biology, chemistry, social science, mathematics, and physics. Before granting admission, many professional education programs require experience as a volunteer in a physical therapy department of a hospital or clinic." [1]

Licensing

All States require physical therapists to pass a licensure exam before they can practice, after graduating from an accredited physical therapist educational program. [1]

Certifications / Certifying Agencies

The basic credential required of PTs is completion of an accredited education program in physical therapy and holding of a valid license to practice. Further certification is not common or required. At present, a bachelor's degree is sufficient for licensure in most states, but the physical therapy training programs are in the midst of shifting to a curriculum that awards a master's degree.

The American Board of Physical Therapy Specialties, part of APTA, offers a program for members to become certified as specialists in particular areas. They report that as of 2005, there are 5,943 individuals who have been certified as clinical specialists. The breakdown by specialty areas is as follows: [2]

Specialty Area	Number of Certified Specialists
Cardiopulmonary	110
Clinical Electrophysiologic	115
Geriatric	684
Neurologic	458
Orthopaedic	3404
Pediatric	670
Sports	502

Note that these certified specialists comprise a small fraction of the PT jobs currently filled.

Population and Employment

Physical therapists held about 151,000 jobs in 2005. [5] The number of jobs is greater than the number of practicing physical therapists, because some physical therapists hold two or more jobs. For example, some may work in a private practice, but also work part time in another health care facility.

Nearly 6 out of 10 physical therapists worked in hospitals or in offices of physical therapists. Other jobs were in home health care services, nursing care facilities, outpatient care centers, and offices of physicians.

Some physical therapists were self-employed in private practices, seeing individual patients and contracting to provide services in hospitals, rehabilitation centers, nursing care facilities, home health care agencies, adult day care programs, and schools. Physical therapists also teach in academic institutions and conduct research." [1]

Pay Rates

Median annual earnings of physical therapists were $65,350 with a median hourly income of $30.33 in May 2005. [3]

"[In 2004, t]he middle 50 percent earned between $50,330 and $71,760. The lowest 10 percent earned less than $42,010, and the highest 10 percent earned more than $88,580. Median annual earnings in the industries employing the largest numbers of physical therapists in May 2004 were:

Home health care services	$64,650
Nursing care facilities	61,720
Offices of physicians	61,270
General medical and surgical hospitals	60,350
Offices of other health practitioners	60,130

" [1]

Buying Arrangements / Economics

Physical therapy services can be purchased from the organizations that employ PTs or directly from PTs in private practice. Therapy services are usually billable to third party payers.

Current and Future State of the Profession

The *Occupational Outlook Handbook* [1] predicts that demand for PTs will be very high over the next ten years.

Detailed Career Description

"Physical therapists provide services that help restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities of patients suffering from injuries or disease. They restore, maintain, and promote overall fitness and health. Their patients include accident victims and individuals with disabling conditions such as low-back pain, arthritis, heart disease, fractures, head injuries, and cerebral palsy.

Therapists examine patients' medical histories and then test and measure the patients' strength, range of motion, balance and coordination, posture, muscle performance, respiration, and motor function. They also determine patients' ability to be independent and reintegrate into the community or workplace after injury or illness. Next, physical therapists develop plans describing a treatment strategy, its purpose, and its anticipated outcome. Physical therapist assistants, under the direction and supervision of a physical therapist, may be involved in implementing treatment plans with patients. Physical therapist aides perform routine support tasks, as directed by the therapist. (Physical therapist assistants and aides are discussed elsewhere in the Handbook.)

Treatment often includes exercise for patients who have been immobilized and lack flexibility, strength, or endurance. Physical therapists encourage patients to use their own muscles to increase their flexibility and range of motion before finally advancing to other exercises that improve strength, balance, coordination, and endurance. The goal is to improve how an individual functions at work and at home.

Physical therapists also use electrical stimulation, hot packs or cold compresses, and ultrasound to relieve pain and reduce swelling. They may use traction or deep-tissue massage to relieve pain. Therapists also teach patients to use assistive and adaptive devices, such as crutches, prostheses, and wheelchairs. They also may show patients exercises to do at home to expedite their recovery.

As treatment continues, physical therapists document the patient's progress, conduct periodic examinations, and modify treatments when necessary. Besides tracking the patient's progress, such documentation identifies areas requiring more or less attention.

Physical therapists often consult and practice with a variety of other professionals, such as physicians, dentists, nurses, educators, social workers, occupational therapists, speech-language pathologists, and audiologists.

Some physical therapists treat a wide range of ailments; others specialize in areas such as pediatrics, geriatrics, orthopedics, sports medicine, neurology, and cardiopulmonary physical therapy." [1]

Sources and References

[1] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2006-07 Edition, Physical Therapists, on the Internet at http://www.bls.gov/oco/ocos080.htm(visited June 11, 2006).

[2] American Physical Therapy Association (APTA) http://www.apta.org/

[3] Bureau of Labor Statistics, U.S. Department of Labor, National Occupational Employment and Wage Estimates, May 2005
http://www.bls.gov/oes/current/oes_nat.htm#b29-0000 (as of October 17, 2006)

Physicians / Surgeons (MD, DO)

NOTE: This section is intended to provide information of relevance to the current project, and **not** to provide a comprehensive description of all aspects of physicians' careers.

Overall Description

Physicians focus on the diagnosis and treatment of disease and injury. They are among the most highly-trained healthcare professions, are expected to be most responsible for the outcome of a medical episode, and are most likely to be held accountable for error or harm Their first precept is to “do no harm.” They have been strongly socialized to put the patient’s needs above their own, and to protect patient information from disclosure. Physicians have been trained in and tend to use standardized methods and procedures of evaluation and documentation. They enjoy high income and social status.

Essence of the Profession

In general, physicians are among the most well-prepared to diagnose medical conditions and to formulate treatment plans and strategies, and have a good sense of the natural history of disease with and without treatment. They are not well prepared to determine medical restrictions, functional limitations and work capacity.

Relative Emphasis on Functional / Vocational Expertise

Most physicians in most specialties have historically not paid much attention to their patients’ lives outside the exam room, and have not specifically focused on minimizing the impact of injury and illness on everyday life and work. Disability prevention, management, and evaluation are generally not regarded by physicians as within the purview of their profession, but rather as a non-medical administrative issue or “paperwork.” Research has shown that the average primary care practitioner is asked for advice or an opinion about return to work approximately 5 times per week.

The specialties that have traditionally paid more attention than most to the implications of illness and injury on everyday function and work are: occupational medicine, PM&R, and rheumatology although many of the individuals in the latter two specialties do not focus on the working age population.

Isolated individual physicians within any specialty may have had work experience (a contract with a local employer or agency) or personal experience (personal experience with injury/illness) that has alerted them to the issue of functional evaluation and the need to provide quality information to support patients in staying at or returning to work. Often they will express this interest by becoming a member of a committee within their professional society, for example the Occupational Psychiatry Committee, or Occupational Allergy Committee or Occupational Orthopedics Committee.

In general, the only practitioners who have developed significant expertise in assessing the impact of a medical condition on ability to work are those who have been confronted constantly with return-to-work issues:

1. Physicians in occupational medicine or industrial medicine practice.

2. Physicians in orthopedic surgery, orthopedic medicine, neurology and neurosurgery who regularly provide care for workers' compensation injuries.

3. Physicians who have contracts with local employers to provide pre-placement physicals and other occupationally-related services.

4. Physicians who frequently perform fitness for duty or disability evaluations, or independent medical examinations.

Since professional societies are where physicians with like interests congregate, it is likely that physicians with occupational medical/functional expertise are concentrated in the membership of the American College of Occupational & Environmental Medicine (ACOEM) and the American Academy of Physical Medicine and Rehabilitation (AAPMR).

ACOEM: "The American College of Occupational and Environmental Medicine (ACOEM) represents more than 6,000 physicians and other health care professionals specializing in the field of occupational and environmental medicine (OEM). …..ACOEM is the pre-eminent organization of physicians who champion the health and safety of workers, workplaces, and environments. . . . Occupational and environmental medicine is the medicine specialty devoted to prevention and management of occupational and environmental injury, illness and disability, and promotion of health and productivity of workers, their families, and communities." [3] (http://www.acoem.org)

AAPMR: "The American Academy of Physical Medicine and Rehabilitation is the national medical society representing more than 7,000 physicians who are specialists in the field of physical medicine and rehabilitation. They are called physiatrists (fizz ee at' trists). Physiatrists focus on restoring function. They care for patients with acute and chronic pain, and musculoskeletal problems like back and neck pain, tendonitis, pinched nerves and fibromyalgia. They also treat people who have experienced catastrophic events resulting in paraplegia, quadriplegia, or traumatic brain injury; and individuals who have had strokes, orthopedic injuries, or neurologic disorders such as multiple sclerosis, polio, or ALS." [4] (http://www.aapmr.org)

Other more highly-specialized professional societies or interest groups within larger professional societies also attract physicians with occupational/functional orientation and interest. Examples include the American Academy of Disability Evaluating Physicians (http://www.aadep.org), the Academy of Organizational and Occupational Psychiatry (http://www.aoop.org/), and the Occupational Orthopedics Committee of the American Academy of Orthopedic Surgeons (http://www.aaos.org).

Alignments / Motivations / Allegiances / Potential Conflicts

All physicians are members of a helping profession, and many took a sacred oath to put the patient's interest before their own and to keep the patient's confidences. They have been exhorted to be "patient advocates" but often have not had instruction on what that really means. However, a core value in medicine is maintaining appropriate professional distance and independent decision-making. Physicians do not feel they owe a professional duty to administer financial or insurance programs appropriately. Many are uncomfortable in neutral or forensic roles, although some enjoy the intellectual challenge.

Physicians also are in a service business, and must please their customers in order to keep the revenue coming in the door.

Similar to other helping professions, physicians commonly make an assessment regarding the need for services and then provide and bill for them. It is often in their economic self-interest to declare that services are warranted.

Although taking commissions for referrals to colleagues has been seen as unethical for decades, self-referral has been common, with physicians prescribing treatments such as on-site physical therapy or MRI scans provided by radiology centers they own part of. These practices are not inappropriate on their face, but the financial incentives have led to financial abuses and inappropriate care.

Comments Relating to Use by SSA

Physicians are relied on by SSA today as their major source of medical and functional expertise.

Distinctions Among Groups of Practitioners Within the Profession

The difference between MD and DO physicians has become blurred over time and is essentially meaningless for SSA's purposes. State licensing agencies and most hospitals and residency programs recognize the degrees as equivalent. In other words, osteopathic doctors are legally and professionally equivalent to medical doctors. Although the MD and DO medical schools and accrediting bodies remain separate, the residency training programs are now often combined.

Within the profession of medicine there is huge variability in skill and practice, driven by choice of specialization as well as by work experience and personal preference.

Licensed physicians are free to describe themselves as any kind of specialist regardless of education or certification. Areas of practice are divided into primary care and more technical specialties and sub-specialties.

Differences From Other Professions in this Paper

Only licensed physicians have unlimited privileges under law to diagnose and treat disease, to prescribe medications, and to do surgery.

Professional Preparation / Education / Core Curriculum

Pre-requisites for medical school include completion of an undergraduate college degree.

There are 20 schools of Osteopathic medicine in the U.S., 126 accredited U.S. M.D.-granting medical schools. The curricula of both schools are nearly identical. Medical school is typically four years in length, consisting of two years of primarily classroom instruction and two years "on the wards" in a mixture of clinical and classroom work.

Post-graduate medical education is the norm, and at least one year of training beyond medical school is required for state licensure in almost all states.

In the past, specialty board certification (see Certification below) was rare and a mark of scholarship and high distinction. It is now extremely common and a prerequisite for inclusion in provider networks in many areas.

Licensing

State licensure is required for the practice of medicine in all 50 states. The licensure process is extensive and rigorous including primary verification of all education and background checks.

Proof of completion of continuing medical education (for example 50 hours) is typically required for re-licensure, which usually occurs every two years.

Proof of malpractice insurance is also a common requirement.

Certifications / Certifying Agencies / Associations

Medical schools are accredited by the Liaison Committee on Medical Education or the American Osteopathic Association. Physicians who complete medical school and one year of post-graduate training take an examination to be certified by the National Board of Medical Examiners. This is the minimum credential required for licensure in most states.

Post-MD training programs (residency) are accredited by the Accreditation Council for Graduate Medical Education (ACGME). To become board certified, a physician must have completed an approved post-MD training program usually consisting of three to five additional years of study and clinical practice, and successfully pass an examination administered by the applicable specialty's board of examiners.

Only twenty-four specialties have been approved for membership in the American Board of Medical Specialties (ABMS). It is the leading entity overseeing physician certification in the United States. (Non-approved accrediting boards, specialty boards, and residency training programs along with non-standard professional societies also exist.)

Professional societies also play a large role in most physician's lives. Specialty-specific professional societies in particular provide continuing medical education and opportunities for networking, collegial exchange, and professional recognition.

Typical Practice Settings / Employers / Clients

More than half of physicians are now employed, as opposed to being in private solo practice. Less than a fifth of physicians now starting out choose solo practice, which is more prevalent in some states and cities than others.

The most common practice setting is now the group practice, either a single specialty group or a multi-specialty one. Group practices vary in size from 2 to more than 500 physicians. Individual autonomy decreases as group size increases. Other less-common but standard settings include: staff-model HMOs, local, state, and governmental institutions such as the Veterans Administration.

The newest practice settings are the integrated delivery systems (centered around a hospital) and hospital-based practice in which physicians are employees of the integrated system or hospital (a non-traditional relationship). The lack of physician autonomy in these arrangements often leads to instability of leadership and turnover of physicians.

According to the *Occupational Outlook Handbook,* "Physicians and surgeons held about 567,000 jobs in 2004; approximately 1 out of 7 was self-employed and not incorporated . About 60 percent of salaried physicians and surgeons were in office of physicians, and 16 percent were employed by private hospitals. Others practiced in Federal, State, and local governments, including hospitals, colleges, universities, and professional schools; private colleges, universities, and professional schools; and outpatient care centers.

Population and Employment

Data describing the number of physicians in the US vary. Estimates are available from numerous sources, but there is only rough agreement between those sources due to differing ways in which physicians are counted, and real-world complexities that confound attempts at simple counting methodologies. For example, some reports show the number of licensed physicians, other reports include only those in active practice, or in specialties that involve direct patient contact (as opposed to radiology or pathology). Some reports exclude state and federal government physicians, and so on.

According to one source, at present there are an estimated 800,000 doctors of medicine (MDs) in practice in the US, or about 2.6 for every 1000 residents. While America's 47,000 D.O.s account for only 5 percent of the country's physicians, they handle approximately 10 percent of all primary care visits. " [5]

The physician workforce is neither evenly distributed among the states, nor within states, tending to concentrate in urban areas, especially in the Northeastern U.S. The number of doctors per thousand residents averages 2.6, ranging from a high of 4.3 in Massachusetts to a low of 1.6 in Idaho.

Pay Rates

Compensation rates for physicians vary with the practice setting as well as with the specialty and region of the country. Wide ranges are often observed. Individuals in private solo practice live on the fees they collect. Employed individuals usually receive a mixture of salary plus productivity bonus or incentive.

"Earnings of physicians and surgeons are among the highest of any occupation. According to the Medical Group Management Association's Physician Compensation and Production Survey, median total compensation for physicians in 2004 varied by specialty, as shown in table 2. Total compensation for physicians reflects the amount reported as direct compensation for tax purposes, plus all voluntary salary reductions.

Table 2. Median total compensation of physicians by specialty, 2004

Specialty	Less than two years in specialty	Over one year in specialty
Anesthesiology	$259,948	$321,686
Surgery: General	228,839	282,504
Obstetrics/gynecology: General	203,270	247,348
Psychiatry: General	173,922	180,000
Internal medicine: General	141,912	166,420

Pediatrics: General	132,953	161,331
Family practice (without obstetrics)	137,119	156,010

SOURCE: Medical Group Management Association, Physician Compensation and Production Report, 2005.

Self-employed physicians—those who own or are part owners of their medical practice—generally have higher median incomes than salaried physicians. Earnings vary according to number of years in practice, geographic region, hours worked, and skill, personality, and professional reputation. Self-employed physicians and surgeons must provide for their own health insurance and retirement."

Compensation of occupational medicine is generally similar to that of family practice and internal medicine physicians and that for PM&R is between psychiatry and the surgical specialties. [1]

Buying Arrangements / Economics

There are many different economic arrangements in America for obtaining healthcare services from physicians, and most physicians deliver services under multiple of these arrangements at any point in time. This is a very complex area.

Some payment arrangements involve fee-for-service rates based upon coded representations of the services delivered (typically CPT codes). In general, actual fees paid under large volume contracts are discounted off the "usual and customary" prevailing fees in a market region or discounted off a fixed fee schedule. Other arrangements involve capitation: pre-paid monthly flat rates per person covered, though this has become less frequent. Many, many complex variations on these themes exist.

Both buyers and sellers of healthcare services have used the strategy of building size in order to have economic strength in their buying and selling activities, as well as cost efficiencies in their operations. Numerous middleman entities have also sprung up to connect large buyers (health insurers and employers) with large (but relatively smaller) sellers (physician groups) around the country. This is especially important to national employers and insurers who do not wish to set up their own nationwide management systems for obtaining healthcare services.

Most physicians or physician group practices simultaneously provide services via multiple middlemen ("networks") and via multiple local health services delivery organizations, such as healthplans and HMOs. In today's world, managing multiple contracts has become a necessary skill for healthcare provider offices.

Current and Future State of the Profession

Demand for physicians is expected to continue growing, and shortages are already being experienced in certain specialties, especially orthopedics and ophthalmology, as the baby boomers age. [1] New physicians are expected to primarily be employed by large groups, a change from an earlier generation that often worked for themselves in solo private practice.

Expectations for autonomy have dropped. Physicians tolerate much more intrusive oversight and management controls than a generation ago. Newer physicians are less likely to be as fiercely independent as a result.

Detailed Career Description

(This information was deemed to be common knowledge and not that germane to the current project, and therefore omitted.)

Standard Protocols and Practice Methodologies Employed

Physicians across the country are taught similar methods of assessing patients and documenting the results in a "history and physical" report. The section headings and scope of material covered in a report from a good general internist in Washington state will look very similar to those of a good orthopedist in Florida. Not all physicians are careful in their documentation, however. Likewise, sterile technique is universally taught, and surgical techniques vary only modestly.

Impairment evaluations are increasingly being standardized using the methodology prescribed in the AMA Guides to the Evaluation of Permanent Impairment. Forty-four states now use the AMA Guides to determine the extent of permanent impairment resulting from workers' compensation injuries at the end of the treatment episode. However, despite the uniformity with which the use of the Guides is prescribed, the actual reports prepared by physicians still display remarkable variability due to the lack of widespread and accessible basic training in their use, and the failure of purchasers to set specifications and employ quality auditing procedures.

Sources and References

[1] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2006-07 Edition, Physicians, on the Internet at http://www.bls.gov/oco/ocos074.htm (visited June 12, 2006).

[2] American Medical Association http://www.ama-assn.org

[3] American College of Occupational and Environmental Medicine http://www.acoem.org

[4] American Academy of Physical Medicine & Rehabilitation http://www.aapmr.org

[5] American Association of Colleges of Osteopathic Medicine http://www.aacom.org

Psychologists

Overall Description

Psychology is a helping profession, with deep roots in both science and in the art of dealing with people. "Psychologists are interested in how people act, react and interact as individuals and in groups." [2]

Essence of the Profession

. . . . Think of any question about how and why humans do the things they do, and the chances are that a psychologist somewhere will be researching it to find the scientific answer and further our understanding. . . .The knowledge gained is used by applied psychologists and other professionals in almost every setting.

Relative Emphasis on Functional / Vocational Expertise

Most psychologists have historically paid more attention to their patients' personal relationships and much less to their work lives. Psychologists tend not to focus on minimizing the impact of injury and illness on the ability to function at work. Preventing and minimizing work disability and assessing ability to perform particular tasks at work are generally not regarded by psychologists as within the purview of their profession, but rather as a non-medical administrative issue or "paperwork." Nor have they had any professional instruction on how or why to do it.

However, insurers and employers rely on psychologists regularly for information about medical restrictions, limitations and statements about ability to work.

Alignments / Motivations / Allegiances / Potential Conflicts

Psychologists may be associated with psychiatrists, sharing both referral patterns and business relationships.

All psychologists are members of a helping profession, and many took a sacred oath to put the patient's interest before his/her own and to keep the patient's confidences. They have been exhorted to be "patient advocates" but often have not had instruction on what that really means. However, a core value in psychology is maintaining appropriate professional distance and independent decision-making. Psychologists do not feel they owe a professional duty to administer financial or insurance programs appropriately. Many are uncomfortable in neutral or forensic roles, although some enjoy the intellectual challenge. However, in comparison to other helping professions, psychology's respect for objective data and adherence to standardized methods of assessment is notable.

Similar to other helping professions, psychologists commonly make an assessment regarding the need for services and then provide and bill for them. It is often in their economic self-interest to declare that services are warranted.

Psychologists also are in a service business, and are used to pleasing their customers in order to keep the revenue coming in the door.

Comments Relating to Use by SSA

SSA is already very familiar with psychologists both as treating sources of information and as internal consultants.

Similar to the other helping professions, they will need professional reinforcement from peers and regular scrutiny of the quality of their work and the independence of their assessments.

Distinctions Among Groups of Practitioners Within the Profession

"Clinical psychologists, neuropsychologists, counselling and health psychologists work in health and social care. Their aim is to prevent illness and improve health. Educational psychologists work within schools and with families and communities to ensure that children and young people make the most of their potential. Occupational psychologists aim to improve organisational effectiveness and well-being in the workplace. Forensic psychologists work in various 'legal' settings - prisons, courts and with the police - striving for a fair and effective legal system. . . . .

Clinical Psychologists aim to reduce psychological distress and to enhance and promote psychological well-being. They work with people with mental or physical health problems – which might include anxiety and depression, serious and enduring mental illness, adjustment to physical illness, neurological disorders, addictive behaviours, childhood behaviour disorders, personal and family relationships. They work with people throughout the life-span and with those with learning disabilities.

They work largely in health and social care settings including hospitals, health centres, community mental health teams, child and adolescent mental health services and social services. Some work as trainers, teachers and researchers in universities, and some work in the private sector.

Counseling Psychologists apply psychology to working collaboratively with people across a diverse range of human problems. These include helping people manage difficult life events such as bereavement, past and present relationships and working with mental health issues and disorders. Counselling Psychologists accept subjective experience as valid for each person, explore underlying issues and use an active collaborative relationship to empower people to consider change. Counselling Psychologists utilise a holistic stance, which involves examining the issues brought to them within the wider context of what has given rise to those issues.

Educational Psychologists apply psychology to helping children and young people. They use a wide range of psychological techniques in assessing abilities and assisting those who have difficulties in learning or social adjustment. They have a central role in assessing children with special needs. Services offered might include counseling, planning programmes to overcome behavioural problems, supporting teaching and learning techniques, as well as working with teachers and policy development at single school level or across the whole of the local education authority. Most Educational Psychologists work within the local education system, but others work with adults, or in staff training, teaching and research in universities or private practice.

Forensic Psychologists are concerned with many aspects of psychology across the forensic field. They are interested in offending behaviour and its detection, re-offending and its reduction, the administration of justice, aspects of evidence and work of the courts. Sometimes they are called as expert witnesses in these areas.

Health Psychology is the practice and application of psychological research into:

- the promotion and maintenance of health
- the prevention and treatment of illness
- the identification of etiological and diagnostic correlates of health and illness
- the analysis and improvement of the {health care system and health policy formation.

Health Psychologists work primarily in universities and the health service in research, consultancy and teaching roles. Health Psychologists with a clinical qualification will also provide a therapeutic input in general health care services.

Neuropsychologists apply their psychological training and skills specifically to help brain damaged and brain injured people. Their main aim is to improve the quality of life of those people. They will have major roles in assessment, treatment and rehabilitation of the brain injured, in research and in the training of other professionals involved in this area." [3]

Differences From Other Professions in this Paper

Psychologists differ from psychiatrists in their interest in what drives human behavior, the “normal” as well as the “abnormal” -- not just psychopathology and frank mental illness.

Psychologists differ from social workers and counselors in the depth and duration of their training, and the amount of mentoring and supervision they have had by the time they become independent.

Among the varieties of psychologists, clinical, educational, forensic and neuropsychologists are all distinguished by their reliance on and heavy use of standardized and validated testing for assessment and diagnosis. These psychologists are very data and research-oriented, and have a strong identity with evidence-based practice. They psychologists tend to weave study results into most of their work. Counseling psychologists, as is obvious from their name, employ less formalized techniques that are more similar to those employed by other kinds of counselors.

Clinical psychologists generally are not permitted to prescribe medication to treat patients; only psychiatrists and other medical doctors may prescribe certain medications. However, two States—Louisiana and New Mexico—currently allow clinical psychologists to prescribe medication with some limitations, and similar proposals have been made in other States.

Professional Preparation / Education / Core Curriculum

"A doctoral degree usually is required for employment as an independent licensed clinical or counseling psychologist. Psychologists with a Ph.D. qualify for a wide range of teaching, research, clinical, and counseling positions in universities, health care services, elementary and secondary schools, private industry, and government. Psychologists with a Doctor of Psychology (Psy.D.) degree usually work in clinical positions or in private

practices, but they also sometime teach, conduct research, or carry out administrative responsibilities.

A doctoral degree generally requires 5 to 7 years of graduate study. The Ph.D. degree culminates in a dissertation based on original research. Courses in quantitative research methods, which include the use of computer-based analysis, are an integral part of graduate study and are necessary to complete the dissertation. The Psy.D. may be based on practical work and examinations rather than a dissertation. In clinical or counseling psychology, the requirements for the doctoral degree include at least a 1-year internship.

Persons with a master's degree in psychology may work as industrial-organizational psychologists. They also may work as psychological assistants under the supervision of doctoral-level psychologists and may conduct research or psychological evaluations. A master's degree in psychology requires at least 2 years of full-time graduate study. Requirements usually include practical experience in an applied setting and a master's thesis based on an original research project." [1]

Licensing

"Psychologists in independent practice or those who offer any type of patient care—including clinical, counseling, and school psychologists—must meet certification or licensing requirements in all States and the District of Columbia. Licensing laws vary by State and by type of position and require licensed or certified psychologists to limit their practice to areas in which they have developed professional competence through training and experience. Clinical and counseling psychologists usually require a doctorate in psychology, the completion of an approved internship, and 1 to 2 years of professional experience. In addition, all States require that applicants pass an examination. Most State licensing boards administer a standardized test, and many supplement that with additional oral or essay questions. Some States require continuing education for renewal of the license." [1]

Certifications / Certifying Agencies / Associations

The American Board of Professional Psychology (ABPP) recognizes professional achievement by awarding specialty certification, primarily in clinical psychology, clinical neuropsychology, and counseling, forensic, industrial-organizational, and school psychology. Candidates for ABPP certification need a doctorate in psychology, postdoctoral training in their specialty, five years of experience, professional endorsements, and a passing grade on an examination." [1]

Typical Practice Settings / Employers / Clients

Psychologists most commonly deliver clinical patient care in private solo practice, in association with other mental health professionals in a group practice or in outpatient mental health clinics or other healthcare institutions. Many psychologists are not in clinical practice, but do administrative, research or organizational work.

Population and Employment

"Psychologists held about 179,000 jobs in 2004. Educational institutions employed about 1 out of 4 psychologists in positions other than teaching, such as counseling, testing,

research, and administration. Almost 2 out of 10 were employed in health care, primarily in offices of mental health practitioners, physicians' offices, outpatient mental health and substance abuse centers, and private hospitals. Government agencies at the State and local levels employed psychologists in public hospitals, clinics, correctional facilities, and other settings.

After several years of experience, some psychologists—usually those with doctoral degrees—enter private practice or set up private research or consulting firms. About 4 out of 10 psychologists were self-employed in 2004, compared with less than 1 out of 10 among all professional workers." [1]

The American Psychological Association has 150,000 members of whom 93, 524 are active doctoral-level psychologists, some of whom are school or counseling (rather than clinical) psychologists.

Pay Rates

According to the American Psychological Association in 2001, median income for doctoral level clinical psychologists was $72,000, and for master's level providers of clinical psychology services, the median income was $46,000.

Only grouped data is available from governmental databases. "Median annual earnings of wage and salary clinical, counseling, and school psychologists in May 2004 were $54,950. The middle 50 percent earned between $41,850 and $71,880. The lowest 10 percent earned less than $32,280, and the highest 10 percent earned more than $92,250. Median annual earnings in the industries employing the largest numbers of clinical, counseling, and school psychologists in May 2004 were:

Offices of other health practitioners	$64,460
Elementary and secondary schools	58,360
Outpatient care centers	46,850
Individual and family services	42,640

" [1]

Buying Arrangements / Economics

Psychologists in private clinical practice operate like other clinicians and bill on a fee for service basis to third party payers when available. They can bill Medicare. If they are employed by a group or institution, their services are billed by the employing entity.

Current and Future State of the Profession

The Occupational Outlook Handbook [1] anticipates growth in the number of positions for psychologists in the coming years.

Detailed Career Description

". . . Psychologists in health service provider fields provide mental health care in hospitals, clinics, schools, or private settings. . . ..

Psychologists apply their knowledge to a wide range of endeavors, including health and human services, management, education, law, and sports. In addition to working in a variety of settings, psychologists usually specialize in one of a number of different areas.

Clinical psychologists—who constitute the largest specialty—work most often in counseling centers, independent or group practices, hospitals, or clinics. . . . Clinical psychologists often interview patients and give diagnostic tests. They may provide individual, family, or group psychotherapy and may design and implement behavior modification programs. Some clinical psychologists collaborate with physicians and other specialists to develop and implement treatment and intervention programs that patients can understand and comply with. . . . Some administer community mental health programs.

Standard Protocols and Practice Methodologies Employed

Psychology as a discipline is rooted in the scientific method and extensively employs standardized testing in assessment and diagnosis.

Sources and References

[1] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2006-07 Edition, Psychologists, on the Internet at http://www.bls.gov/oco/ocos056.htm (visited June 13, 2006).

[2] The British Psychological Society http://www.bps.org.uk/the-society/about-psychology/types-of-psychologist.cfm (visited June 13, 2006).

Social Workers

Overall Description

Social workers provide a very broad range of assistance to their clients, helping them address their entire life situation. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. They also often help orchestrate the provision of other services as required.

“The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living." [2]

Essence of the Profession

Social work is the professional activity of helping individuals, groups, or communities enhance or restore their capacity for social functioning, and creating societal conditions favorable to this goal (Barker, 2003, The Social Work Dictionary, 5th edition, Washington, DC: NASW Press).

Relative Emphasis on Functional / Vocational Expertise

Social workers are trained in observing how people function in their environments, including assessing their abilities to care for themselves and interact in their community and families in a global way. The professional ethos of social work begins with a multi-dimensional assessment of the person – “person in environment.”

Depending on their field of practice and level of training, social workers are trained in the psychosocial aspects of disability and illness. Many have specialized training in areas including health/medical issues, aging, behavioral health, and employee assistance. There are 40,000 Medicare providers who are licensed clinical social workers who have specialized skills to perform mental health services. Licensed social workers are the largest providers of mental health services in the U.S. (Center for Mental Health Services, Mental Health United States, 2002. Manderscheid, R.W., and Henderson, M.J., eds. DHHS Pub No. (SMA) 3938. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004).

Alignments / Motivations / Allegiances / Potential Conflicts

Social workers are members of a helping profession, and are bound by an ethical obligation to promote the well-being of clients. A core value in social work is maintaining appropriate professional distance and independent decision-making. In comparison to other helping professions, social workers are usually more comfortable in neutral or forensic roles, because their training prepares them to make decisions that require the evaluation of competing interests.

The interdisciplinary nature of social work practice may provide potential conflicts for individual social workers. Clinical social workers may be associated with psychiatrists,

sharing both referral patterns and business relationships. They may also work in settings where they must deliver services in accordance with organizational politics. In some instances, the organizational criteria for eligibility of services may be in conflict with their independent evaluations.

Comments Relating to Use by SSA

Licensed clinical social workers provide mental health services such as individual, group, and family counseling. They are often the "treating source" for many Social Security claimants, especially among the SSI population.

Section 1861(hh)(2) of the Social Security Act considers clinical social workers as treating providers when they supply "services related to diagnosis and treatment of mental illnesses that the clinical social worker is legally authorized to perform under state law, and those that would otherwise be covered if furnished by a physician or as an incident to a physician's professional service."

Clinical social workers in some practice settings are well equipped to handle the multi-dimensional assessment proposed in the Recommendations section, particularly for the SSI population, and to help applicants or beneficiaries who are capable of returning to work to do so. Clinical social workers with the most pertinent and desirable skill set (familiarity with the needs of chronically disadvantaged populations) may be working for governments, social service agencies, or for institutions, rather than in private practice. Thus, it is their employing agencies with whom Social Security might have to contract for service.

Social workers are trained to perform structured and standardized evaluations and reports, but depending on state statute, may not do psychological testing. A social work education requires training in research and data analysis techniques, including the skills to perform assessments / evaluations, and written reports. Licensed social workers are required by most state licensing boards to participate in continuing education programs to develop, maintain, and retain their skills. Having continuing education refresher courses and continued feedback/performance improvement programs would be advisable to ensure retention of these specific skills. .

Though clinical social workers have experience with making difficult assessments and decisions in the course of doing their work (e.g. deciding whether someone needs involuntary hospitalization or to be reported to authorities for possible child abuse), the bulk of their efforts are devoted to helping their clients.

Distinctions Among Groups of Practitioners Within the Profession

One way of differentiating different levels of social work practice is between clinical and non-clinical practitioners. The bulk of social workers are clinical. Clinical implies direct practice, individualized, one-on-one work with clients. Non-clinical practitioners include those in administrative, management, teaching, and research roles.

Another important distinction is between those holding bachelors, masters, and doctoral degrees. The educational programs are usually guided by the requirements of the Council on Social Work Education (CSWE). Most licensing authorities require a degree from a CSWE accredited program.

Finally, some schools divide their programs by area of practice, whether clinical or non-clinical. Each degree may have a concentration in areas such as mental health, health, child welfare, administration, etc. Depending on state statutes, there may be several licensing levels that require a different skill set.

Differences From Other Professions in this Paper

Social workers have perhaps the broadest mandate, scope of relevant issues, and range of potential intervention types of all the professions in this paper. They are trained to broadly assess the client's situation and structure a complete plan for better coping, often involving the services of others.

Professional Preparation / Education / Core Curriculum

Practitioners have either a bachelors (BSW), masters degree (MSW) or doctoral degree (PhD or DSW) in social work, with the largest majority holding a masters as their highest degree. While a bachelor's degree is the minimum requirement, a master's degree in social work or a related field has become the standard for many positions.

"The Council on Social Work Education (CSWE) lists 168 accredited MSW programs. Master's degree programs prepare graduates for work in their chosen field of concentration and continue to develop the skills required to perform clinical assessments, manage large caseloads, take on supervisory roles, and explore new ways of drawing upon social services or resources to meet the needs of clients. The MSW is the standard for most positions in the field. It builds upon the BSW core program (see below). A minimum of 900 hours of supervised field instruction or internship is required.

At present, 442 accredited BSW programs exist. Courses include values and ethics, dealing with a culturally diverse clientele, at-risk populations, promotion of social and economic justice, human behavior and the social environment, psycho-social development, social welfare policy and services, social work practice, social research methods, and field education. BSW programs require a minimum of 400 hours of supervised field experience." [1]

Licensing

"All states and the District of Columbia have licensing, certification, or registration requirements regarding social work practice and the use of professional titles. Although standards for licensing vary by state, a growing number of states are placing greater emphasis on communications skills, professional ethics, and sensitivity to cultural diversity issues. Most states require two years (3,000 hours) of supervised clinical experience for licensure of clinical social workers, the passage of a state-recognized exam, adherence to ethical codes and standards, and the completion of annual continuing education requirements.

A licensed clinical social worker has either a BSW, MSW, or doctoral degree in social work. A licensed clinical social worker has a MSW or doctoral degree in social work and post degree clinical supervision, which allows them to independently provide individual, marital, couple, family and group counseling and psychotherapy from a biopsychosocial orientation. Also known as: Clinical Social Worker, Therapist, Counselor,., L.C.S.W, L.I.S.W., L.I.C.S.W." [1The ASWB defines four levels of licensure based on education and

work experience: Bachelors, Masters (without post-degree experience), Advanced Generalist (MSW with 2-years post-degree supervised experience) and Clinical (MSW with two years post-master's direct clinical social work experience). States vary in which of the four levels they offer.

Licensed clinical social workers are qualified to assess, diagnose and treat mental and emotional conditions and addictions in all states, but cannot prescribe drugs.

Certifications / Certifying Agencies / Associations

"The National Association of Social Workers (NASW) offers voluntary credentials. Social workers with an MSW may be eligible for the Academy of Certified Social Workers (ACSW), the Qualified Clinical Social Worker (QCSW), the Diplomate in Clinical Social Work (DCSW), or other credentials within a practice specialization, depending on their professional experience. Credentials are particularly important for those in private practice; some health insurance providers and the military require social workers to have them in order to be reimbursed for services." [1]

Partly because of their large numbers and diverse practice settings and areas of specialty, there are many voluntary associations to which social workers can belong. The National Association of Social Workers (NASW) is the largest and most diverse, and provides various certifications as described above. (www.naswdc.org/credentials). Some associations are devoted to a particular practice focus, such as the Clinical Social Work Association (CSWA) (http://www.cswf.org/).

State licensing boards that regulate social work in their state have their own organization, the Association of Social Work Boards (ASWB) (http://www.aswb.org/)

Typical Practice Settings / Employers / Clients

According to the NASW survey of 10,000 licensed social workers, social work employment is divided roughly two-thirds in the private sector and one-third in the public sector. They work in a variety of settings, most commonly private practice or social service agencies. See charts below from the National Study of Licensed Social Workers [3].

Figure 6. Percentage of Licensed Social Workers with Primary Employment in Selected Employment Sectors

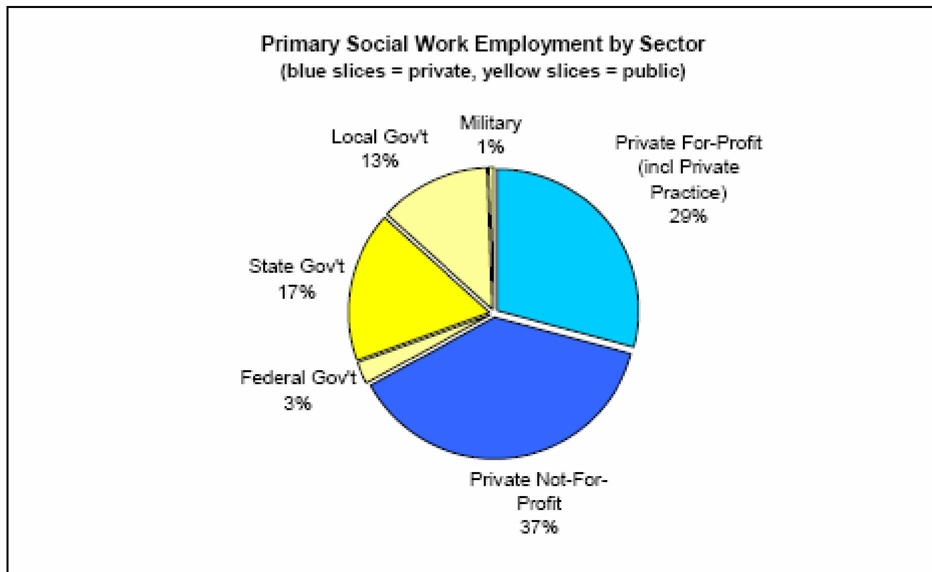


Table 4. Percentages of Active Licensed Social Workers Employed in Selected Settings

Employment Setting	Percent
Private Practice	17.5%
Social Service Agency	14.5%
Hospital	12.2%
Behavioral Health Clinic	9.4%
School	9.0%
Health Clinic/Outpatient Facility	5.6%
Psychiatric Hospital	3.7%
Nursing Home	2.9%
Hospice	2.5%
Higher Education	2.1%
Other	20.6%
N	3,178

Medical and public health social workers may work for public and private hospitals, nursing and personal care facilities, individual and family services agencies, or local governments. They provide persons, families, or vulnerable populations with the psychosocial support needed to cope with chronic, acute, or terminal illnesses, such as Alzheimer's disease, cancer, or AIDS. They also advise family caregivers, counsel patients, and help plan for patients' needs after discharge by arranging for at-home services, from meals-on-wheels to oxygen equipment. Some work on interdisciplinary teams that evaluate certain kinds of patients – geriatric or organ transplant patients, for example.

Mental health and substance abuse social workers assess and treat individuals with mental illness or substance abuse problems, including abuse of alcohol, tobacco, or other

drugs. Such services include individual and group therapy, outreach, crisis intervention, social rehabilitation, and training in skills of everyday living. They also may help plan for supportive services to ease patients' return to the community. Mental health and substance abuse social workers are likely to work in hospitals, substance abuse treatment centers, individual and family services agencies, or local governments. These social workers may be known as **clinical social workers**." [1]

Commonly, social workers may earn their income in several ways. They may be salaried employees, contractors, as well as fee for service providers. Those who are working on housing, employment, etc. are more likely to be salaried governmental or non-profit organizations. A large percentage of clinical social workers in mental health are in fee for service private practice. Private insurance, Medicaid, and Medicare are the most common payers.

Population and Employment

"Social workers held about 562,000 jobs in 2004. About 9 out of 10 jobs were in health care and social assistance industries, as well as State and local government agencies, primarily in departments of health and human services. Although most social workers are employed in cities or suburbs, some work in rural areas. The following tabulation shows 2004 employment by type of social worker:

Type of Social Worker	Total Employment
Medical/public health	112,220
Mental health and substance abuse	120,140
Child & family	256,430

Nationally, there are roughly 101 social workers per 100,000 population, with the highest ratios in Maine, Maryland, New York, North Dakota, and Wisconsin. Social workers are concentrated in urban areas: 81% of them work in metropolitan areas, 10% in micropolitan areas, 6% are in small towns and 3% are in rural areas. One reason for concentration in metropolitan areas is the frequency of social problems there. [5]

Pay Rates

The table below displays percentile wage estimates for different types of social workers [5]:

Type of Social Worker	Hourly Wages				
	10th %ile	25th %ile	50th %ile	75th %ile	90th %ile
Medical/public health	$12.56/hr $26,130/yr	$15.68/hr $32,610/yr	$17.00/hr $35,350/yr	$24.69/hr $51,360/yr	$29.27/hr $60,880/yr
Mental health and substance abuse	$10.57/hr $21,980/yr	$13.00/hr $27,040/yr	$16.54/hr $34,410/yr	$21.43/hr $44,560/yr	$26.63/hr $55,400/yr

Child & family	$11.35/hr $23,610/yr	$13.79/hr $28,690/yr	$17.00/hr $35,350/yr	$22.25/hr $46,290/yr	$28.46/hr $59,200/yr

"Median annual earnings in the industries [1] employing the largest numbers of medical and public health social workers in May 2004 were:

General medical and surgical hospitals	$44,920
Home health care services	42,710
Local government	39,390
Nursing care facilities	35,680
Individual and family services	32,100

Median annual earnings in the industries employing the largest numbers of mental health and substance abuse social workers in May 2004 were:

Psychiatric and substance abuse hospitals	$36,170
Local government	35,720
Outpatient care centers	33,220
Individual and family services	32,810
Residential mental retardation, mental health and substance abuse facilities	29,110

Buying Arrangements / Economics

There are many ways in which social workers may be reimbursed. The primary ways include salary, direct fee for service reimbursement, as an incidence to work with a physician, or through an agency/group provider. Social workers who are providing mental health care treatment use CPT codes for reimbursement.

Current and Future State of the Profession

After considering numerous factors influencing the demand for social workers in America, both increasing and decreasing, the Occupational Outlook Handbook [1] predicts growth in

the number of positions over the next ten years, with more competition for positions in urban areas than rural.

Detailed Career Description

"Social work is a profession for those with a strong desire to help improve people's lives. Social workers help people function the best way they can in their environment, deal with their relationships, and solve personal and family problems. Social workers often see clients who face a life-threatening disease or a social problem, such as inadequate housing, unemployment, a serious illness, a disability, or substance abuse. Social workers also assist families that have serious domestic conflicts, sometimes involving child or spousal abuse.

Social workers often provide social services in health-related settings that now are governed by managed care organizations. To contain costs, these organizations emphasize short-term intervention, ambulatory and community-based care, and greater decentralization of services.

Most social workers specialize in a certain area of practice or with a certain population. Although some conduct research or are involved in planning or policy development, most social workers prefer an area of practice in which they interact with clients, for example, geriatrics, substance misuse, families, etc.

Child, family, and school social workers provide social services and assistance to improve the social and psychological functioning of children and their families and to maximize the family well-being and academic functioning of children. Child, family, and school social workers typically work for individual and family services agencies, schools, or State or local governments. These social workers may be known as child welfare social workers, family services social workers, child protective services social workers, or occupational social workers.

Medical, public health and gerontological social workers provide persons, families, or vulnerable populations with the psychosocial support needed to cope with chronic, acute, or terminal illnesses, such as Alzheimer's disease, cancer, or AIDS. They also advise family caregivers, counsel patients, and help plan for patients' needs after discharge by arranging for at-home services, from meals-on-wheels to oxygen equipment. Some work on interdisciplinary teams that evaluate certain kinds of patients—geriatric or organ transplant patients, for example. Medical and public health social workers may work for hospitals, nursing and personal care facilities, individual and family services agencies, or local governments.

Mental health and substance abuse social workers assess and treat individuals with mental illness or substance use problems, including misuse of alcohol, tobacco, or other drugs. Such services include individual and group therapy, outreach, crisis intervention, social rehabilitation, and training in skills of everyday living. They also may help plan for supportive services to ease patients' return to the community. Mental health and substance misuse social workers are likely to work in hospitals, substance abuse treatment centers, individual and family services agencies, or local governments. These social workers may be known *as clinical social workers*." [1]

Standard Protocols and Practice Methodologies Employed

Therapeutic interventions are rarely solitary – the approach and the solutions tend to be multi-dimensional. Therapeutic interventions includes any effort to connect a person with needs to a solution, any kind of help, including referrals and reducing barriers to access, factual information, psycho-education (helping a person to understand their own psychosocial needs), advice, and frank psychotherapy. Most services billable on a fee-for-service basis are delivered in mental health private practice or agency settings.

The "PIE" evaluation perspective – Person In Environment -- is a good metaphor for how social workers are trained to look at a situation. Social workers are taught to consider all aspects of a person's life in considering what they need to improve their lives and to improve themselves.

Clinical social workers are trained to use the DSM IV and the ICD-9 codes. All master's programs also require two courses in research/data analysis, providing experience collecting data in a formalized manner. Social workers may be limited in the types of psychological testing they are able to perform, depending on state statutes. However, there will be similarity from report to report because social workers are held to the same diagnosis, treatment, and documentation standards as are psychiatrists and psychologists.

Sources and References

[1] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2006-07 Edition, Social Workers, on the Internet at http://www.bls.gov/oco/ocos060.htm (visited June 12, 2006).

[2] Bureau of Labor Statistics, US Department of Labor, Occupational Employment Statistics, May 2005 on the Internet at http://www.bls.gov/oes/current/oes211022.htm (visited August 5, 2006).

[3] Supplement to the National Study of Licensed Social Workers social workers by Center for Health Workforce Studies, School of Public Health, University of Albany and National Association of Social Workers. 2004 http://workforce.socialworkers.org/studies/supplemental/supplement_ch3.pdf (visited August 5, 2006).

[4] National Association of Social Workers http://www.naswdc.org

[5] National Association of Social Workers Foundation, Assuring the Sufficiency of a Frontline Workforce: A National Study of Licensed Social Workers Executive Summary, 2006.

Vocational Rehabilitation Counselors

Overall Description

Counseling as a helping profession covers a very broad range of client issues and circumstances, and has correspondingly varied skill requirements. According to NBCC, professional counseling involves "The application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology." [2]

To make sense of the profession for purposes of the SSA FVE project, this summary focuses on the particular branch of counseling most relevant to the topic at hand: vocational rehabilitation counselors. Since much of that national level data on counselors is generic, and varieties of counselors are grouped, the information below sometimes refers to counselors of all kinds and sometimes to educational, vocational and school counselors, and occasionally to vocational rehabilitation counselors specifically.

Essence of the Profession

Counselors assist people with personal, family, educational, mental health, and career decisions and problems. Through listening and interactive discussion, they provide advice and support to help people deal with the circumstances in their lives. Their duties depend on the individuals they serve and on the settings in which they work. Their scope of practice does not include either making diagnoses or prescribing medications.

Relative Emphasis on Functional / Vocational Expertise

The counseling professions vary in their interest and experience in assessing functional and vocational issues.

Of particular interest to SSA are vocational rehabilitation counselors who are among the most expert of all professions in the vocational area. However, even vocational rehabilitation counselors have no formal training or expertise in assessing medical impairments and only modest expertise obtained on-the-job in anticipating the functional implications of medical impairments. In general, vocational rehabilitation professionals (VRs) rely on others to supply them with functional abilities or limitations, upon which the VRs rely to do their vocational assessments.

Alignments / Motivations / Allegiances / Potential Conflicts

The vast majority of counselors chose their line of work out of a desire to help people. Only a minority would be attracted to or enjoy working in a solely neutral or forensic position.

Similar to other helping professions, counselors commonly make an assessment regarding the need for services and then provide and bill for them. It is often in their economic self-interest to declare that services are warranted.

Similar to licensed clinical social workers, some counselors will work in conjunction with other mental health professionals with whom they may have referral and/or business relationships.

Comments Relating to Use by SSA

Some counselors likely serve already as "treating sources" for SSA, since for many claimants, counselors may be their own source of care.

In addition, vocational rehabilitation are well-prepared to play important roles in helping SSA work with applicants to find ways to prevent permanent withdrawal from work and to help willing applicants and beneficiaries to return to work. Their primary area of expertise is assessing obstacles to returning to work, and planning some aspects of the return-to-work effort for those willing to attempt it. In particular geographic locations, they are also likely to be aware of available services and be able to make appropriate referrals.

Relatively few counselors will be enthusiastic about the neutral or forensic role involved in making a disability determination decision *per se*, instead of focusing on improving their clients' living situations. Without some outlet for the desire to be helpful, counselors may not be attracted to or enjoy the work. If counselors end up as members of the Medical/Vocational Network, some form of regular peer-to-peer interaction will provide reinforcement and reminders. This is likely to be required to reinforce professional integrity, intellectual rigor, and performance standards, all of which will maintain morale and assure quality performance.

It is unlikely that vendors exist with large numbers of contracted counselors already available nationally for use by a large purchaser like SSA. However, quite a few counselors practice either independently or have multiple contractual relationships, which would probably make it feasible for a large number of them to be engaged on a part-time contract basis.

Distinctions Among Groups of Practitioners Within the Profession

Practicing counselors are divided into numerous very different groups based on the clients they serve. Practice areas listed by the National Board for Certified Counselors are listed below, in order to provide a context for employment figures presented later on. The type of counselor most likely to have a substantial subset of members able to contribute functional and vocational expertise in a disability program setting are the rehabilitation counselors.

1. Addictions and Dependency
2. Aging/Gerontological
3. Career Development
4. Childhood & Adolescence
5. Clinical Mental Health
6. Corrections/Offenders
7. Couples & Family
8. Counselor Education

9. Depression/Grief/Chronically or Terminally Ill
10. Disaster Counseling
11. Eating Disorders
12. Mental Health/Agency Counseling
13. **Rehabilitation or Vocational Rehabilitation**
14. School
15. Sexual Abuse Recovery
16. Sports Counseling

The definition and scope of these practice areas can overlap somewhat, and the titles used by practitioners can vary somewhat (Career Counselor, Vocational Counselor, etc.).

Duties of a **vocational counselor** are generally to help people find suitable careers either at the beginning of their work life, or later on if a change is desired. Usually this does not involve any impairments of the client. But in the setting of workers compensation, Washington Department of Labor & Industries (worker's compensation) describes a vocational counselor as follows: "First, they work with you, your doctor and your employer to see if your old job can be temporarily or permanently changed to meet your needs. If not, they investigate other job options with your employer. If that's not possible, the vocational counselor will assess your skills for a new job." [4]

Rehabilitation counseling is described by the CRCC as follows. "Rehabilitation counseling is a systematic process which assists persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process. The counseling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and behavioral interventions." [3]

Rehabilitation Counselors are also referred to as Vocational Rehabilitation Counselors. Some Vocational Counselors are referred to as Career Counselors. The key distinction appears to be that Rehabilitation Counselors **always** deal with some type of functional limitations, while Vocational Counselors **may** have clients without any impairments or limitations who just need help with career decisions. Not all clients of rehabilitation counselors will have been or intend to be part of the workforce.

Differences From Other Professions in this Paper

Among the professions under consideration, counselors are most similar to social workers in their level of professional preparation. Counselors typically have less broad-ranging scope of initiative than social workers (see descriptions above), and a smaller range of activities they undertake on behalf of clients. Counseling is provided through discussion, rather than action in the field.

Typical Practice Settings / Employers / Clients

"State and local governments employ about 4 in 10 counselors, and the health services industry employs most of the others. ...

Educational, vocational, and school counselors work primarily in elementary and secondary schools and colleges and universities. Other types of counselors work in a wide variety of public and private establishments, including healthcare facilities; job training, career development, and vocational rehabilitation centers; social agencies; correctional institutions; and residential care facilities, such as halfway houses for criminal offenders and group homes for children, the elderly, and the disabled. Some substance abuse and behavioral disorder counselors work in therapeutic communities where addicts live while undergoing treatment. Counselors also work in organizations engaged in community improvement and social change, drug and alcohol rehabilitation programs, and State and local government agencies. A growing number of counselors are self-employed and work in group practices or private practice, due in part to new laws allowing counselors to be paid for their services by insurance companies and to the growing recognition that counselors are well-trained, effective professionals." [1]

Work arrangements vary widely from full time employee to part time employee to individual practice. Individual counselors often make their living from a combination of part-time employment, contract work, and fee-for-service work.

Standard Protocols and Practice Methodologies Employed

Face to face and telephonic interaction is the way the work of counseling is done, with face-to-face predominating. Specific methodologies vary from practice area to practice area as well as within practice areas. There is not a particularly standardized or rigorous of working.

Education / Core Curriculum

Practitioners may possess a bachelors or masters degree, with the latter preferred and most common. A large number of educational institutions offer accredited programs leading to bachelors and masters degrees in the various practice areas of counseling.

Counseling education is based on learning a foundation of general professional counseling skills to which is added training in the specific counseling practice areas chosen.

"A master's degree is typically required to be licensed as a counselor. A bachelor's degree often qualifies a person to work as a counseling aide, rehabilitation aide, or social service worker. Some states require counselors in public employment to have a master's degree; others accept a bachelor's degree if the practitioner took appropriate counseling courses. Counselor education programs in colleges and universities usually are found in departments of education or psychology. There are areas of focus to select from when earning a counseling degree. These include college student affairs, elementary or secondary school counseling, education, gerontological counseling, marriage and family counseling, substance abuse counseling, rehabilitation counseling, agency or community counseling, clinical mental health counseling, counseling psychology, career counseling, and related fields. Courses are grouped into eight core areas: Human growth and development, social and cultural diversity, relationships, group work, career development, assessment, research and program evaluation, and professional identity. In an accredited master's degree program, 48 to 60 semester hours of graduate study, including a period of supervised clinical experience in counseling, are required.

... Accredited master's degree programs include a minimum of 2 years of full-time study, including 600 hours of supervised clinical internship experience." [1]

Licensing

"For counselors based outside of schools, 48 states and the District of Columbia have some form of counselor licensure that governs their practice of counseling. Requirements typically include the completion of a master's degree in counseling, the accumulation of 2 years or 3,000 hours of supervised clinical experience beyond the master's degree level, the passage of a state-recognized exam, adherence to ethical codes and standards, and the completion of annual continuing education requirements." [1]

Certifications / Certifying Agencies

"Counselors may elect to be nationally certified by the National Board for Certified Counselors, Inc. (NBCC www.nbcc.org/), which grants the general practice credential "National Certified Counselor." To be certified, a counselor must hold a master's degree with a concentration in counseling from a regionally accredited college or university; must have at least 2 years of supervised field experience in a counseling setting (graduates from counselor education programs accredited by CACREP are exempted); must provide two professional endorsements, one of which must be from a recent supervisor; and must have a passing score on the NBCC's National Counselor Examination for Licensure and Certification (NCE). This national certification is voluntary and is distinct from state licensing. However, in some states, those who pass the national exam are exempted from taking a state certification exam. NBCC also offers specialty certifications in school, clinical mental health, and addiction counseling, which supplement the national certified counselor designation. These specialty certifications require passage of a supplemental exam. To maintain their certification, counselors retake and pass the NCE or complete 100 credit hours of acceptable continuing education every 5 years.

Another organization, the Commission on Rehabilitation Counselor Certification (CRCC www.crccertification.com), offers voluntary national certification for rehabilitation counselors. Some employers may require rehabilitation counselors to be nationally certified. To become certified, rehabilitation counselors usually must graduate from an accredited educational program, complete an internship, and pass a written examination. (Certification requirements vary according to an applicant's educational history. Employment experience, for example, is required for those with a counseling degree in a specialty other than rehabilitation.) After meeting these requirements, candidates are designated "Certified Rehabilitation Counselors" [or CRCs]." To maintain their certification, counselors must successfully retake the certification exam or complete 100 credit hours of acceptable continuing education every 5 years." [1]

Population and Employment

Educational, vocational and school counselors combined held about 248,000 jobs in 2004 [1]

The number of vocational counselors outside of school settings, which would be of most interest to Social Security, is not immediately clear.

NBCC reports the following number of certificate holders for the certifications they authorize. [2] Comparing to the above table, it is clear that not all counselors hold certifications.

NCC - National Certified Counselor	39,176
NCCC - National Certified Career Counselor	617

Pay Rates

"Median annual earnings **of educational, vocational, and school counselors** in May 2004 were $45,570. The middle 50 percent earned between $34,530 and $58,400. The lowest 10 percent earned less than $26,260, and the highest 10 percent earned more than $72,390. School counselors can earn additional income working summers in the school system or in other jobs. Median annual earnings in the industries employing the largest numbers of educational, vocational, and school counselors in 2004 were as follows:

Vocational rehabilitation services	$27,800

Median annual earnings of **rehabilitation counselors** in May 2004 were $27,870. The middle 50 percent earned between $22,110 and $36,120. The lowest 10 percent earned less than $18,560, and the highest 10 percent earned more than $48,130.

For substance abuse, mental health, and rehabilitation counselors, government employers generally pay the highest wages, followed by hospitals and social service agencies. Residential care facilities often pay the lowest wages.

... Self-employed counselors who have well-established practices, as well as counselors employed in group practices, usually have the highest earnings." [1]

Buying Arrangements / Economics

Counselors are employed by many different organizations and types of organizations. Some services are provided on a fee-for-service basis, but many are provided without direct charge to clients through the organization employing the counselor (schools, community service organizations, etc.).

Current and Future State of the Profession

The Occupational Outlook Handbook [1] predicts growth in demand for all types of counseling in the coming years.

Detailed Career Description

Vocational counselors who provide mainly career counseling outside the school setting are also referred to as ***employment counselors*** or ***career counselors***. Their chief focus is helping individuals with career decisions. Vocational counselors explore and evaluate

the client's education, training, work history, interests, skills, and personality traits, and arrange for aptitude and achievement tests to assist the client in making career decisions. They also work with individuals to develop their job-search skills, and they assist clients in locating and applying for jobs. In addition, career counselors provide support to persons experiencing job loss, job stress, or other career transition issues. [Counselors in these positions may be described as ***outplacement counselors***.]

Rehabilitation counselors help people deal with the personal, social, and vocational effects of disabilities. They counsel people with disabilities resulting from birth defects, illness or disease, accidents, or the stress of daily life. They evaluate the strengths and limitations of individuals, provide personal and vocational counseling, and arrange for medical care, vocational training, and job placement. Rehabilitation counselors interview both individuals with disabilities and their families, evaluate school and medical reports, and confer and plan with physicians, psychologists, occupational therapists, and employers to determine the capabilities and skills of the individual. Conferring with the client, they develop a rehabilitation program that often includes training to help the person develop job skills. Rehabilitation counselors also work toward increasing the client's capacity to live independently.

Sources and References

[1] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2006-07 Edition*, Counselors, on the Internet at http://www.bls.gov/oco/ocos067.htm (as of June 11, 2006

[2] National Board for Certified Counselors, Inc. (NBCC) www.nbcc.org/

[3] Commission on Rehabilitation Counselor Certification (CRCC) www.crccertification.com

[4] Washington Department of Labor & Industries http://www.lni.wa.gov/ClaimsIns/Claims/RTW/Voc/default.asp

[5] Bureau of Labor Statistics, U.S. Department of Labor, National Occupational Employment and Wage Estimates, May 2005 http://www.bls.gov/oes/current/oes_nat.htm#b29-0000 (as of October 17, 2006)

III. Use of Functional and Vocational Expertise in Other Systems

INTRODUCTION

This section of the report presents information about how other disability programs obtain and use mFV expertise, with the intent of learning lessons from them about how SSA can best do the same.

Numerous studies have been published describing and analyzing the differences between SSA's disability programs and other disability programs, both public and private sector, American and international. The intent of this section is not to provide a complete analysis of program differences – for that please consult these already-published sources – but to provide a basis for understanding how other programs use mFV expertise, with what results, and to thereby learn what SSA can usefully emulate, given the nature of SSA's programs.

Although we began this study early in the project, the detailed results from the panelist conference calls and from writing the Shared Understanding, Potential Recommendation, and Uses of Expertise papers (working papers delivered as part of the Interim Report) shed important light on this section's topic. Inquiries we made to people in a position to know revealed no examples of systems or organizations that have a highly effective approach and that operate under similar-enough circumstances that the approach could be adopted wholesale by SSA. Furthermore, it was clear that the panel collectively had very broad and deep knowledge of best practices in this area, and would bring that to the panel meeting. Consequently, the project team decided it would not be productive to survey a large number of organizations for this section of the report, but instead to assemble an informative picture of the key related disability programs, describing them in general terms allowing best practices in the use of functional and vocational expertise that can apply to SSA to be identified.

We had in-depth conversations with knowledgeable individuals in the workers compensation and private long-term disability systems. Their situations are very relevant to SSA's, though they each have many key differences from SSA that influence their use of mFV expertise. There are some good lessons for SSA from their approaches.

A quick review of the Veterans Administration and active military disability programs made it clear that their benefit programs are defined so differently from SSA's that there are no significant lessons to learn from them in this realm.

Most conversations on this topic – how best to use mFV expertise given SSA's objectives stated elsewhere in this report – quickly expanded to include other program facets such as benefit eligibility definitions and particular program features that differ from Social Security's. This revealed that the nature of the governing laws and the definitions of specific benefit program features strongly shapes the use of mFV expertise in each system.

FINDINGS AND OBSERVATIONS

Workers compensation, private disability, and veterans and active military disability programs provide benefits to a population similar to that of SSDI. TANF programs provide benefits to a population similar to SSI.

Workers compensation and LTD share a number of important attributes, as do Veterans Administration and active military disability programs. However, these two groups are very different from each other.

Since they can be discussed so quickly, we start with Veterans and military disability.

A. Veterans Disability

VA disability benefits are payable to veterans with service-related medical conditions that result in some impairment. The VA's disability program centers around the assessment of a percent impairment rating, stated as a multiple of 10%. The nature and dollar amount of disability benefits are tied to this rating coupled with certain aspects of the applicant's life situation. Medical expertise is applied in the process of determining the degree of impairment, and the definition of impairment is primarily a medical issue rather than one of vocational disadvantage. Little functional expertise is called for in assessing the degree of anatomical or physiological impairment. Ability to work, availability of compatible jobs, and ability to sustain gainful employment are essentially irrelevant in this determination, making the program very unlike Social Security's disability programs.

The Veteran's Administration disability program offers no obvious models for SSA to use regarding best practices for applying mFV expertise.

B. Active Military Disability

The military services each have disability retirement programs for active duty service personnel who are eligible and who become physically unfit to perform duties required of their grade, office, rank, or rating. The administrative process of making a disability decision when an individual acquires a potentially-disabling medical condition is grounded in a fitness for duty determination. If the person is found unfit, a similar benefit program to the VA program applies. There are also administrative factors that can significantly influence the nature and amount of any award, such as length of service and whether the condition arose in the line of duty.

The fitness for duty examination requires both functional and vocational expertise, and in that way is similar to SSA programs. However, the universe of "jobs" for which the individual's ability to perform is in question is very limited and specific, somewhat like Step 4 in the SSA determination. Unlike SSA programs, however, (a) the person is currently employed (by the military), (b) the employer, who presumably has very good knowledge of the requirements for their "jobs," is involved in making the determination of the individual's ability to work, and therefore (c) a fairly precise and well-informed analysis of fit between the individual with their impairments and the requirements of available "jobs" is possible.

While the exact administrative process for making the disability decision varies between the services, they all have one or more physicians assessing fitness for duty and making the disability determination.

The fact that the military system has the employer involved gives them a substantial advantage compared to SSA because the employer's input provides more reliable information for an accurate disability determination and keeps open the possibility for return-to-work in cases where that is feasible. Although many SSA disability applicants have never been or are no longer employed, some still are, and SSA could benefit by involving employers when that is possible.

C. Workers Compensation (WC)

Workers compensation (WC) provides benefits for medical care and wage replacement if workers need medical treatment for an injury or illness that occurs in the course of employment, and if as a result they are unable to return to work for some period of time, or are left with permanent residual from the injury. Because WC pays workers wage replacement while they are unable to work, the WC system is relevant enough to SSA to warrant a fairly in-depth analysis.

At a high level, SSA disability programs seem similar to WC because claimants in both systems can receive payments to cover living expenses (i.e. replacement for lost wages) as well as medical benefits, but the two systems are extremely different in critical details. Some best practices in WC can be carried over to SSA, but many of the ways that mFV expertise is used in WC are not relevant to SSA because of key differences between the programs.

WC and SSA Compared

The table below contrasts key aspects of WC and SSA disability programs that are of relevance to this discussion.

	Workers Comp	SSA
GENERAL		
Start date	Eligibility for medical care coverage begins on the date of injury, or date that the injury/illness is reported; eligibility for wage replacement begins after a short waiting period (typically 3-14 days).	Waiting period of five months after disability began.
Covered individuals	Nearly all US workers, for incidents occurring while employed	SSDI: Workers meeting minimum work requirements in past years (up to fifteen) SSI: Individuals with limited means
Fraction of beneficiaries that return to work	Very high – > 85%	Very low – < 1%
Benefit award basis	Medical condition caused by or arising out of employment.	Inability to perform substantial gainful activity (work) … by reason of impairment resulting from a serious medical condition..

Medical conditions covered	Any and all that are work-related, no matter how small	Only serious conditions expected to result in death or last more than twelve months.
Makes payments for	Medical care and wage replacement while unable to work during recovery, plus financial awards for permanent residual	Wage replacement and eligibility for other medical benefit programs (Medicare or Medicaid),
Posture	An array of postures from pro-active to passive management. Pro-active companies attempt to influence outcome of episode by directing/influencing choice of medical provider, establishing expectations and protocols for medical care, refusing to authorize inappropriate care, using case managers to expedite medical care and return to work. Passive companies adjudicate, observe the medical care and return to work processes, and pay benefits.	Passive: Adjudicate, observe medical care and return-to-work process, pay benefits.
Fault / no-fault	Most jurisdictions have no-fault program. Tort claims allowed in special circumstances (third party liability, willful negligence, etc.). Some systems are still tort-based (e.g. railroad and merchant marine workers).	Fault not an issue.
Number of coverage providers / claim administrators	Many hundreds of WC insurance carriers, third-party administrators, and self-insured employers	Just SSA
LOST WAGES		
Lost wages benefit duration	Pays replacement wages up to lifetime.	Pays until full retirement age, then Social Security retirement benefits take over.
Provisions for ongoing review after benefit award	Alleged inability to work can be challenged essentially at any time by claim adjuster	SSDI & SSI: Periodic reviews conducted to determine change in medical condition, continued inability to work. SSI: Subject to periodic means testing.
Offsets to benefit	In a few states, payers can	In most states, SSA can subtract

amounts owed to claimant	subtract SSDI awards from amounts payable. Third-party liability may cover some costs (subrogation).	WC awards due from amount owed to beneficiary.
MEDICAL		
Medical expenses paid / coverage included	Pays for all reasonable medical care services from date of injury without deductible, co-pay, waiting period, or time limit Claim administrator can influence care delivered to varying degrees.	SSDI: Medicare pays for covered services after two year wait SSI: Medicaid pays for covered services immediately
DISABILITY DETERMINATION		
Award types	Temporary Total, Temporary Partial, Permanent Partial, Permanent Total. (Temporary awards made while medical condition is still evolving)	Only total disability
Decision process	State law requires rapid decisions unless contested. Typically very fast to begin paying benefits – two weeks or less is common.	Often very slow to decide whether to award benefits – can be over two years.
Causation analysis	Causation – whether condition was caused by employment -- is required by law and often a key issue. Causation assessment is sophisticated, often requires explicit apportionment between multiple causes.	Causation – whether inability to work is caused by impairment related to medical condition – is required by law. However, not often seen as a key issue; law is silent as to apportionment between causes.
Investigation and active management process	After award, frequent or regular ongoing management until claim is closed or stable condition reached.	No or occasional involvement once award is made, even in claims expected to improve.
Employer involvement	Employer is almost always still involved when claim opened. Employer engagement often declines over time.	Often no employer involved or available at time of application. Many applicants have already been out of work several months.
Standard that must be met to demonstrate ability to work	At claim initiation, worker's usual job. Subsequently, varies by jurisdiction, with some requiring substantial work capacity, others requiring jobs available in a labor market survey, and others requiring a *bona fide* offer at a wage roughly equivalent to prior	Roughly, any occupation for which the person is qualified based on age, education, and skills, and which will result in sustained gainful employment, that exists in reasonable numbers in the regional or national economy -- regardless of whether

	wage	openings exist.
LEGAL / REGULATORY		
Laws and regulations	Different for each of 54 jurisdictions, which include state and federal programs and certain industries.	One set of laws and regulations for entire country
Dispute resolution	Adversarial proceedings (both sides represented before the judge)	Non-adversarial proceedings (only claimant is represented before the judge.)
Legal representation	Plaintiff attorneys typically receive 1/3 of settlement amounts plus expenses	Representatives receive modest fee out of retroactive award - roughly $3,000 per case

Dynamics of WC Claim Administration

This section explains in simplified form the key dynamics of workers compensation claims from the viewpoint of understanding the use of mFV expertise. We found it helpful to group claims into categories within which the nature of the use of mFV expertise is similar.

Important note: The legal and regulatory aspects of the WC system are extremely complex and arcane, and vary by jurisdiction as well. This description intentionally simplifies and generalizes many points in order to paint a clear overall picture.

Today, most claim operations actively investigate only those claims with enough lost workdays to qualify for wage replacement benefits. (They either use computers to auto-adjudicate claims for minor injuries or assign them to junior level claims handlers.) They start their claim investigation with a "three-point contact" that involves a brief discussion with the injured worker, the employer, and the treating clinician. This helps to establish the facts and to guide the course for further investigation and decision-making. Generally, some sort of triage happens as a result of these initial calls or of subsequent unfolding of events, with catastrophic, complex, questionable and litigated claims being assigned to more senior claims handlers.

Claim Category 1: "Medical Only" Claims

Most workers compensation claims (typically about 75%) are for minor injuries that resolve fairly quickly and easily such as simple lacerations (cuts), skin rashes, foreign bodies in the eye, a sprained ankle, and so on. These are called "medical only" because the injury is self-limited, medical treatment quickly resolves the problem, and there is no or so little time from work that the waiting period for wage replacement is not met. In these cases, the rudimentary mFV "expertise" of the worker and their supervisor is sufficient, possibly assisted by the treating clinician. They assume that the worker will shortly be able to resume their regular job and decide how long the worker needs to be absent from work. Soon, the worker recovers fully, returns to work, the medical bills are paid, and the claim is closed.

Claim Category 2: Non-Compensable Claims

Some claims are initially rejected because they are determined not to be compensable, either because of administrative reasons or because the medical condition is deemed not to be work-related. The claim administrator (which might be an insurer, a third party administrator, or a self-insured employer) investigates these issues at the outset. The claimant may choose to fight this determination, and if so the case will move into the dispute resolution process, often including litigation and possibly the use of expert witnesses in an adversarial proceeding regarding the issue of compensability. (Note that in some circumstances the initial compensability decision can be delayed for several months, e.g. if there are points that cannot be clarified immediately, but in general the compensability decision must be made within several weeks of receiving a claim.)

Medical expertise alone is usually adequate to address the initial question of causation: deciding if it is likely the claimed work-related incident would result in the claimed medical condition. Opinions on this matter will be sought to help the claim adjuster make their decision. The most frequently used experts for this task will be physicians, who may either be the treating physician or an Independent Medical Examiner. If the administrator decides the claim is not compensable and the worker contests that decision, formal dispute resolution will ensue under the legal processes defined for the jurisdiction. Appropriate medical experts will be called on by both sides to present their opinions on this matter.

Initial compensability disputes in WC are not concerned with the causal relationship between lost work time and the medical condition. The only issue is the causal relationship between employment and the medical condition.

"Indemnity" Claims

Claims that are not "medical only" – roughly a quarter of all claims – are called "indemnity" claims and are more complicated. Either wage replacement or financial awards, or both, end up being paid. These claims involve additional process steps and time, sometimes taking several or more years. The situations involve a wide spectrum of complexity levels, issue types, and expertise needed, and cluster into several different categories with respect to how mFV expertise is used. Nationally, the average number of lost work days for all indemnity claims is approximately one month, with the vast majority having less than a week of lost time, and a small fraction remaining off work for multiple years or permanently.

Claim Benefit / Status Categories

Indemnity claims will work their way through one or more of the following five different benefit / status categories. It is useful to understand the categories before continuing with the discussion of how mFV expertise is used.

- **Temporary Total Disability** (TTD) is when the worker is considered totally unable to work for the present, but is presumed to be still recovering. Most commonly, during a period of TTD, the doctor has not yet released the worker to return to work, the medical condition has not yet stabilized, and further improvement may still occur – in industry parlance the point of "maximum medical improvement" (MMI) has not yet been reached. TTD payments are made during this period. TTD will also be paid if the worker is not working because the employer cannot or does not provide suitable work within the limits and restrictions of the worker's current capacity. While on TTD, the worker receives

replacement wage payments from WC. TTD disability benefits generally are capped at a finite number of weeks, usually two or more years. If the worker has not returned to work by the end of that time (or the claim closed for other reasons), a major transition point occurs, and they will move to one of the four states described below. The majority of WC claimants that receive TTD payments return to work fully cured and do not proceed to another status.

Workers who have had an injury are sometimes not able to return immediately to their full regular duties, but need time off work or on "light duty" to recover fully. While unable to work, WC pays the worker an "indemnity benefit" either TTD (temporary total disability) or TPD **(Temporary Partial Disability)** to replace lost wages if the worker is temporarily working less than full time or at less than full wages.

- **Permanent Partial** disability (PPD) occurs if the point of maximum medical improvement (MMI) has been reached, but some residual of the injury remains (some permanent loss). The residual may be minor (amputation of a single joint of a finger, for example) and the worker may have returned to their previous job without difficulty. Generally for these cases a "permanent impairment rating" (PI rating) is calculated by a physician using a very structured process. The rating process is established by regulation in each jurisdiction, and most commonly results in a numerical rating for the worker's impairment expressed as a percentage of loss of the involved body part or of the whole person. (44 states use the AMA Guides to Evaluation of Permanent Impairment, a structurally-driven methodology that does not concern itself with the functional or vocational impact of the anatomical or physiological loss. This is the same or similar process to that used by the VA and the military services as described earlier.) A financial award is then calculated based on that rating using a formula and possibly considering age and other demographic factors. The award may be a lump-sum, but other financial arrangements are possible. PPD settlements end the obligation to pay TTD wage replacement benefits. The worker may have already returned to work or then finds employment within their new and diminished capabilities, or not. The medical portion of a claim may be left open to provide for future care, and the whole claim can often be re-opened at a later date if the medical condition worsens. In some jurisdictions, regulatory conditions cause more claims to end in PPD than in other jurisdictions. In a couple of states, the number of PPD awards exceeds the number of claims that receive TTD. Nationally, though, only about a third of claims that are initially paid TTD end up with PPD awards. but they account for a significant fraction of total WC claim costs – 30% by one recent report. Lawyers are often involved in claims that are closed with PPD awards, and they may receive substantial portions of the total awarded amount.

- **Permanent Total** disability (PTD) occurs when the impact of the work-related injury or illness is so severe that there is little chance the worker can ever engage in meaningful work again. These individuals receive a financial award intended to compensate them for their future medical costs and their lifetime loss of work capacity. Again, the financial arrangements can vary widely. Although there is variability from state to state, less than half a percent of all indemnity claims become Permanent Total, but the individual cost of these claims is very high - often $500,000 or more.

- **Settlements** are the product of a negotiation between the worker and the WC payer, and result in a monetary award to the worker. These resolutions are made outside the rules and regulations that govern claim disposition via PPD or PTD, though in many jurisdictions there are rules that must be followed for a settlement to be valid, primarily

rules to protect the worker's interests. Settlements are designed to bring rapid closure to a claim that is dragging on without resolution. Claimants often retain lawyers to assist with settlements, who stand to receive a substantial share of the money. A settlement often leaves unresolved key issues which have been in dispute, such as compensability, appropriate treatment, or ability to work. In many states, the settlement stipulates that the claim cannot be re-opened in the future. The parties negotiate a settlement that they each feel is better than facing the uncertainty and delay of resolution via the administrative hearing or judicial process, or of leaving the matter unsettled.

- **Terminated** is the status when a claimants' WC benefits have been stopped, and if any appeals were mounted, they have been unsuccessful. Terminations usually occur while a claimant is in TTD status and the WC payer has proven the worker can return to work, or in the process of resolving the situation after the maximum TTD award period has expired, a determination is made that there is no residual permanent impairment.

With this understanding of WC benefit situation types, let us turn again to the discussion of the rest of the claims: those that have been accepted as compensable and that involve significant lost time from work – indemnity or so-called lost-time claims.

Claim Category 3: Indemnity Claim That Resolves Without Major Dispute

In this group of claims, the situation resolves over time without significant dispute or complication (or with minimal disagreements or complications that are resolved without having to resort to formal dispute resolution processes).

Note that the worker, employer (via the supervisor, risk management staff, human resources, etc.), claim administrator, plaintiff attorney (if one is involved), and possibly the treating clinician all influence the course and outcome of the claim by the decisions they make and the actions they take. It is difficult for any one to force a particular outcome if others object. The claim outcome depends greatly on how well the parties work together, as well as on the medical, functional, and vocational specifics.

If the worker, employer, clinician, and insurer are in harmony about the implications of the medical condition and what should be done, the worker will return to work when agreed, possibly to a transitional assignment before going back to full duty on their regular job. If the injury has changed the workers' functional capacity permanently, and all parties agree to it, the employer may modify the previous job or arrange a new one. If there is permanent residual from the injury at the time MMI is reached, and there is no argument over that, the worker will receive a Permanent Impairment rating and a PPD award will be made based on that rating. Finally, in the very rare cases where the worker has been catastrophically injured and all parties agree he or she will be unable to work again at any job that satisfies the regulatory requirements in the jurisdiction, the person will be given permanent total disability (PTD).

In many cases included in this category, mFV expertise is called for to assist with problem solving, coordination, communication, planning, and delivery of functional restoration and rehabilitative services. The parties themselves are not disputing the nature of the impairment, the assessment of work capacity, job requirements, whether the worker can perform the available job(s), and the plan of action. Nurse case managers are commonly relied on to provide most of this mFV expertise, but occupational and physical therapists (and occupational physicians) often get involved as well, first by recognizing the need for and then providing functional restoration and rehabilitation services. A key function of nurse case management is

to build and maintain good relationships among the parties whenever possible in order to avoid the development of adversarial relationships.

Under some circumstances, involvement of mFV experts is required in order to assist in establishment of facts because of differences of opinions or minor disputes. The professionals providing the mFV expertise will be asked to do many of the tasks in the task clusters described in an earlier portion of this Supplemental Report.

1. If there are important questions about the probable course of recovery, about what steps need to be taken to bring back as much function as possible, about the worker's remaining functional capability, about the worker's suitability for employment, etc., mFV experts will be brought in as needed to evaluate the worker and the situation, make assessments, formulate plans, and provide opinions and advice. These experts might be physical therapists, occupational therapists, physicians (occ med, PM&R), vocational rehabilitation counselors, or other experts.

2. In addition to making assessments and providing advice, the same professionals listed above will often provide active services to the worker to rebuild their functional abilities and capacity to return to work, either at the worker's original job or a new one. The mFV experts will work to enable the best possible return to gainful employment for the worker.

3. In the more unusual cases where the outcome is not a relatively full recovery (PPD or PTD), formal mFV expertise will usually be required in evaluating and documenting that situation, since these cases are so costly, and payers (and the regulatory bodies involved) want to be sure they are handled correctly.

Note that there may well be disagreements at times in claims in this category, but they are worked through via discussion, investigation, and compromise rather than going to formal arbitration or court. For example, the worker may feel they can't do some specific tasks, but is reassured when functional testing shows they can. The adjuster may feel sure the employer can find transitional duty to allow the worker to return to work before full recovery, but may back down when the employer declines to do so. The employer may feel the worker should return now, but respects the doctor's preference for a longer period for recovery. The treating physician may want to prescribe a twenty-session course of physical therapy, but does not appeal when a peer-review physician referencing an established practice guideline decides that no more than ten sessions are appropriate. The treating physician may want to do spine surgery, but chooses a different treatment plan after an Independent Medical Examination indicates the procedure is inappropriate given the worker's condition. The important point for this category of claims is that the parties eventually reach a compromise position that is accepted without initiating a formal dispute.

The resolution of these cases can take months, and sometimes years, with fairly constant, regular, ongoing participation by the claim adjuster, amounting to dozens of hours or much more. The interventions persist over time. mFV experts and expertise may be used on multiple occasions over an extended period of time to assess the situation, make recommendations, and deliver services to actively help the worker recover and return to work when that is possible.

Claim Category 4: Major Disputes – Formal Dispute Resolution in the Court System

The final category is those cases where the parties are unable to reach an amicable agreement on the issues, and resort to going to court. Though relatively few cases start out immediately in

such a posture of dispute, a significant number wind up here. (The percentage varies very widely by jurisdiction due to regulatory conditions, as does the nature of the issues that lead to litigation.)

Many claims start out in a prior category but migrate here when agreement cannot be reached at key decision points, and one party or another resorts to the legal system to press their position. (When that occurs, the use of mFV expertise often shifts to a more confrontational model.) As an example, sometimes in the course of working with the claimant to restore their functional capacity, vocational rehabilitation services will be engaged to retrain the worker. (Ongoing payment of indemnity benefits may require the worker to be in such a program, providing an incentive for them to do so.) Upon completion of that service, the claim adjuster will naturally want to declare the worker able to return to work and to close the claim, but some workers will assert they are still unable, and dispute that decision.

The three most common issues that precipitate a resort to the courts system in compensable claims are:

- disagreement over the particular medical treatment
- the extent of permanent impairment
- whether the worker can return to work or not.

Note that in the WC system, disputes that go into litigation are handled in adversarial proceedings, unlike SSA's disability programs. Both the employer and the claimant can retain lawyers. Lawyers representing injured workers can receive very large fractions – one third is typical – of any amount awarded to the worker, which can be hundreds of thousands of dollars. This turns many disputes into high-stakes actions for both sides, and many strategies of the involved parties – claim administrators, defense lawyers, claimants, and plaintiff lawyers – revolve around this fact.

The regulations governing exactly how these disputes are handled vary significantly from jurisdiction to jurisdiction, but the general case is the same: the payer (the defense) will attempt to prove the worker can return to work and earn an acceptable living, possibly with the assistance of vocational rehabilitation services, assistive devices, reasonable job accommodations, etc., while the worker (plaintiff) will attempt to prove they cannot.

When the issue is ability to return to work, the defense will engage mFV experts to describe the impairments resulting from the medical condition, the functional limitations that result, the functional abilities that remain, the vocational options available for the worker (occupations and available jobs), and the path that can be taken to achieve gainful employment again. For the plaintiffs, the same types of experts may be engaged to address the same points, but drawing the opposite conclusion.

Uses and Sources of mFV Experts and mFV Expertise in WC Systems

WC administrators use mFV expertise in three very different ways. First, to assess the situation, form opinions, and figure out what type of resolution is possible. Second, based on that assessment, and when possible, to help a claimant (impaired worker) actually return to work – to regain or restore their functional abilities, obtain new job skills if necessary, find

acceptable job openings, etc. And third, in resolving disputes, to help establish whether a claimant is able to return to work under the rules of the jurisdiction involved.

The WC system utilizes mFV experts and mFV expertise to handle all of the tasks in the task clusters identified earlier in the Supplemental Report, including services to help the worker regain their function and find, in fact, new employment when needed. (SSA does not get involved with this latter task.) The appropriate services and sources of expertise are selected and employed for each claim based on all relevant claim characteristics, and services are obtained and delivered over time as the claim develops and progresses, sometimes over many years.

As noted earlier, the WC system often is able to rely on informal mFV expertise possessed by employers, injured workers, treating clinicians, and claim administrator staff. In less complex or contentious cases, these informal sources can accomplish many of the mFV tasks identified earlier in the Supplemental Report: address questions about the effects of medical conditions, identify restrictions and limitations, plan for functional restoration, articulate job requirements, find job availability, and undertake return to work efforts.

More formal mFV expertise is utilized when needed – in complex or unclear cases, in contentious situations or formal dispute processes – by a broad array of professionals, but primarily by physicians, physical therapists. occupational therapists, vocational rehabilitation counselors, and nurse case managers. Social workers are seldom involved, and psychologists are involved less often than for SSA cases.

Most WC claim administrators regularly use nurse case managers, either directly employed or contracted, to help manage their more complex cases. A typical staffing ratio is one nurse case manager for every five to fifteen adjusters handling indemnity claims. The case managers communicate with the claimant, employer, and treating sources (including mFV experts such as physicians, nurse practitioners, physical therapists, occupational therapists, and vocational rehabilitation counselors) in order to help ensure the best and most appropriate treatment is obtained, and that a safe return to work is achieved.

WC claim administrators must be able to find mFV experts all over the country, since many of the tasks they carry out require face-to-face contact with claimants. It would be daunting for all but the largest individual administrators (or administrators who cover a very small geographic area) to find and credential a roster of these experts one at a time, so most administrators contract with organizations that assemble and manage nationwide "networks" of mFV providers. Networks may not have enough or the most desirable providers in all geographic areas required, so administrators typically also find at least some of their mFV experts individually. (Note that networks less often include vocational rehabilitation providers.)

Observations

The above information leads to the following observations about WC and the use of mFV experts and mFV expertise in that system:

1. In the private sector workers' compensation companies, roughly one third of total dollars are spent on claims adjustment activities (with another third spent on medical care, and the last third on indemnity benefits). They tend to allocate their lower-level staff to simple claims, and their internal experts to the most complex claims. Thus, WC adjusters can spend much more time than SSA DEs do in developing and managing

their claims that involve non-trivial medical conditions with long-term disabling potential. However, WC has a very different case mix than does SSA, and most WC indemnity claims would not make it past Step 2 in the SSA sequential determination process. As a result, the need for highly-qualified mFV experts to work on very serious medical conditions is much rarer than for SSA cases, and in those cases more time and attention is paid to managing the claim than SSA typically can afford.

2. Given the clear financial benefits of minimizing total claim loss cost in the private sector, there is somewhat less pressure on the fees / rates of mFV experts brought in on serious cases because the claims organization is acutely aware of the large potential cost to the payer of an incorrect decision.

3. Since WC incidents almost always begin while the worker is employed, WC has the advantage of the worker's employer's participating during the claim handling process (at least for several months or more), with a real job the worker might return to, the potential for transitional duty jobs, and an interest in the worker returning to work if that is possible, both in order to maintain workforce productivity and to minimize financial impact. The employer has a theoretical, and often actual, motivation to help the worker return to work. The employer also possesses important informal mFV expertise: knowledge of the requirements of their jobs. A key strategy, therefore, for preventing needless disability in WC is to work with the employer to help the worker return to work when that is feasible, either to their regular job or some kind of transitional job during the period of regaining full function. SSA seldom has an employer to work with in resolving issues about ability to work or in helping an applicant return to work.

4. WC almost always has the advantage of being engaged with the claimant from the time they first are unable to work. Studies have shown that the earlier an injured worker is engaged in planning for return to work, the more likely that will happen, regardless of the medical circumstances involved. Non-medical issues grow in magnitude and difficulty to address as time off work increases. SSA applicants often have been out of work for six to twelve months (or much longer for SSI applicants) before applying for benefits, so the issue for SSA of whether the applicant can do any job rather than just their own job is much more common than in WC.

5. WC provides a low barrier to eligibility for benefits, but typically devotes extensive energy for the remaining life of the claim to minimizing total claim cost by resolving the claim and returning the worker to work if that is feasible. When WC needs to involve formal mFV expertise, it is often as part of a lengthy and concerted attempt to help a worker return to work, or to prove that they are able to do so in order to force a settlement or terminate benefits. This is not like SSA's programs, where there is an initial push for a decision on benefit award after which the beneficiary is largely left alone regarding recovery and return to work (notwithstanding that SSA uses CDRs to evaluate beneficiaries from time to time after having awarded benefits, and has programs such as Ticket to Work which are intended to help beneficiaries return to work).

6. In the large majority of WC cases (albeit often not the complex or expensive ones), the claim is amicably resolved by collaboration among the worker, employer, claim adjuster, treating clinician, with frequent assistance of mFV professionals. They address the issue of the worker's medical condition, impairments, and functional abilities, the demands of the regular job involved, the availability and demands of transitional jobs available, and the employer's ability to help bring the worker back, and get to work

removing the obstacles to resolution. In contrast, a high proportion of SSA cases now end up disputed and in judicial proceedings where formal testimony by a Vocational Expert is required.

7. If the claim administrator feels a claimant is able to work but the claimant disputes that, formalized application of mFV occurs in order to attempt to develop more detailed and objective data regarding the issues of whether the claimant can work. While this step can occur near claim onset, it is much more common for it to occur later on when statutory temporary total benefits near expiration or the worker reaches maximum medical improvement (MMI). In these situations, the claim administrator has accumulated extensive information about the claimant and the situation, having been interacting with the claimant from the first week of disability onset forward, with a claim file containing a historical record of all events recorded contemporaneously.

8. Though the general features of the WC systems in the fifty-four US jurisdictions are very similar, the detailed provisions set up in the statutes and regulations often differ very significantly between them. Many of the steps, processes, and strategies employed in resolving WC claims are driven by these legal factors. Formal WC disputes are resolved in adversarial proceedings where plaintiff attorneys are paid substantial portions of any awards made. Since the stakes can be very high (hundreds of thousands of dollars in some cases), complex legally-oriented strategies are devised, by both sides, and these often employ mFV experts and their expertise as tactical weapons in a legal battle.

9. Some years ago, many state WC laws provided for mandatory referrals to vocational rehabilitation out of a belief that this would foster more returns to work. Those laws have now all been rolled back. For various reasons, mandatory voc rehab programs did not accomplish the obviously desirable objective of helping people return to work in a new vocation. Commonly, participation in a vocational rehabilitation plan was used (a) as a way a worker could prolong wage replacement benefits and avoid returning to work or (b) a way for claim administrators to cut off benefits.

10. Since WC covers only conditions that can arise as a result of work, some medical conditions common in the general population are rare or nonexistent in WC claims, and the mix of WC medical conditions differs from SSA's (though both have a substantial number of claims based on soft tissue injuries). SSA has many more psychiatric and degenerative / chronic disease cases, which call for different types of expertise and may call for different investigation processes.

Points of Value to SSA Regarding Disability Determination

Given the nature of the differences between WC and SSA disability programs, many aspects of the way mFV expertise is used by WC do not apply to SSA. However, some points can be of value to SSA, given the objectives of making the correct decision as early as possible, helping people return to work when that is possible, and being a responsible steward of public funds. (The recommendations in the Core Report have already drawn on these points.)

1. Triage incoming claims based on their specific circumstances, and re-classify them over time as circumstances change.

2. Use the telephone to get information early in the claim processing cycle – from claimants, employers, and treating clinicians. (Employers may not be available for SSA.)

Actively maintain contact with participants via telephone throughout management of the claim.

3. Based on the specifics of each claim, select the appropriate mFV tasks to be done, the appropriate types of mFV experts, and the appropriate level of mFV expertise.

4. Use a broad range of types of mFV experts, so that appropriate expertise can be matched to each claim.

5. Engage provider network organizations to assemble and manage the nationwide roster of mFV experts. (But be sure to set up management oversight processes that ensure they do a quality job.)

6. Gather as much information as possible before decisions have to be made. Use face-to-face encounters to ensure accurate information is received. Use objective testing to establish functional abilities.

7. Whenever the applicant still has a recent employer, attempt to engage them in the process to encourage return to work if that is possible.

8. Give claimants concrete, useful help in returning to work so that those who are interested in doing so can overcome any attendant difficulties.

D. Private Disability Benefit Programs

A number of different types of programs pay benefits to workers to provide income security during short-term or long-term inability to work due to medical conditions. Short-term programs include formal and informal employer-administered wage-replacement programs such as sick leave and salary continuation, as well as third-party administered programs such as Short-Term Disability insurance. Long-term income security programs are virtually always administered (and mostly underwritten) by private insurance carriers. The discussion below refers to all of these programs as either STD or LTD programs and focuses primarily on programs that are administered on behalf of employers by commercial carriers or third party administrators.

Unlike WC programs, which by law cover the vast majority of workers in America, short term disability programs are voluntary for employers (except as provided below) and often for workers. It is estimated that less than 40% of the workforce is covered by STD and LTD programs combined.

Private disability insurance divides into two very different program types – short term and long term. Short term disability (STD) provides temporary benefits, with maximum duration typically ranging from three months to a year, with very short waiting periods. Waiting periods for long term disability (LTD) typically range from three months to a year. LTD pays benefits for as long as the disability persists, up until retirement age. Neither STD nor LTD includes coverage for medical costs. Neither is as heavily regulated as worker's compensation. Although there are 54 workers' compensation systems, nearly all STD and LTD programs are designed by private companies to meet the needs and preferences of their customers. Therefore, detailed policy provisions vary widely, and are very flexible and customized to individual purchasers. As a result, there is much more variability in all aspects of STD and LTD than there is for WC. Litigation rates in STD and LTD are significantly lower than they are in both WC and SSA programs.

Because of their major differences, STD and LTD are discussed separately. The STD discussion is brief because it is so different from SSDI and SSI.

Short-Term Disability and Similar Programs

A number of different types of programs provide benefits that protect workers from loss of income during a short-term inability to work due to medical conditions. These include formal and informal employer-administered wage-replacement programs such as sick leave and salary continuation, as well as third-party administered programs such as Short-Term Disability insurance (STD). Due to the high volumes of claims and limited financial risk due to the short duration, it is relatively easy and common for employers to self-insure for STD. For purposes of discussion, all of the benefit program variants described above are referred to as STD programs in this report.

These programs generally pay for a period of disability not longer than a year. Disability that extends longer than that will be covered by a Long Term Disability program for some, or not be covered at all for others unless eligibility for SSDI or SSI is established.

These programs are similar to SSDI in that they pay benefits when a worker is unable to work because of a medical condition, but in most other respects are very different. Most STD claims are for relatively minor or temporary medical conditions, and a typical employer has many such claims per year – typically of an order of magnitude similar to worker's compensation claims rather than Long Term Disability claims (see below). In a given time period, an employer will generally have many more STD claims than LTD, the average cost per STD claim will be much lower than per LTD claim, and the cost of the largest STD claim will also be much lower than the cost of the largest LTD claim.

Salary continuation and sick leave programs are often, though not always, informally administered. Typically a doctor's note is all that is required to establish eligibility. If the duration extends unusually long, more attention may be paid, and opinions of mFV experts may be called for or required to verify inability to work and continued receipt of benefits. Since the time period involved is relatively short, the issue is generally whether the worker can do their own job or a transitional job leading back to their own job, rather than a broader question of ability to work at any job.

STD programs provided by insurers are <u>formally</u> administered. The worker is usually required to submit adequate medical evidence to establish that they have a medical condition and that it is preventing them from working, absent which benefits will not be payable. The worker also must usually sign a release allowing the claim administrator to obtain medical records from their treating sources. Policy provisions frequently require the worker to be under the care of a licensed physician or other appropriate healthcare provider as a condition for receiving benefits.

Compared to WC and LTD, STD claims have a much smaller maximum possible cost, and this often results in a decision by claim administrators to limit the amount of resources applied to achieving early return to work and minimizing avoidable disability days.

Unlike WC, STD programs do not cover medical expenses. The worker's healthcare coverage, if any, will pay for them. In this way, STD operates like SSDI in the months before Medicare eligibility is received: if medical treatment that would reduce the effect of the medical condition is unobtainable, the period of disability will continue even though it could be averted with

treatment. (The STD payer can elect to pay for such expenses on their own, but this is relatively uncommon.)

Unlike WC, STD programs are not heavily regulated by state or federal entities, and litigation plays a much smaller role in claim administration. Also unlike WC, there are no lump sum awards for permanent impairment.

Mandated public STD programs exist in five states: California, Hawaii, New Jersey, New York and Rhode Island. Provisions vary widely. Private disability programs may supplement mandated benefits in these states. These programs are primarily administrative in nature and there is little or no mFV expertise brought to bear on the claimants' situations.

Like the public programs, many private STD programs are managed primarily as administrative programs and there is little or no mFV expertise brought to bear on the claimant's situation. However, that is not universally the case. In pro-active programs (generally driven by employer-customers who demand an aggressive claim management approach in order to avoid unnecessary disability days and lost productivity), mFV experts are primarily used to make assessments of the claimant's ability to do their regular job, to provide advice on how to minimize the impact of the medical condition, and to help negotiate transitional jobs within the worker's restrictions and limitations if they have recovered enough for a partial return to work. A best practice for STD claim administrators is to actively help arrange return-to-work for the large majority of claimants whose medical condition will improve.

Since STD does not pay for medical expenses, mFV experts such as physical therapists and occupational therapists are not engaged for their rehabilitative services as they are in WC (though they may be paid for by other programs). Actively managed STD programs will usually employ nurse case managers to facilitate the process of care and return to work, but this is not an industry norm. Case management services are often provided by non-clinical staff. Duplication of terms creates confusion between STD/LTD and WC programs. The term "case manager" is often used in STD and LTD to denote the person administratively managing the benefits claim, in contrast to WC where the term indicates a nurse or vocational rehabilitation counselor who is actively trying to influence the medical care and/or return-to-work process.

Although disabilities caused by very serious medical conditions will begin their administrative life as STD claims before migrating to LTD, the vast majority of STD claims are for medical conditions that are not serious and not expected to last a long time. The mix of medical conditions in STD claims is thus very different from those in SSA's programs. (For example, for many employer groups, uncomplicated pregnancies make up the largest portion of their STD claims.)

LTD carriers prefer it when the STD carrier identifies and begins management of serious conditions early, as appropriate management can often result in an STD claimant returning to work rather than extending their disability benefit period into an LTD claim. LTD reinsurers also prefer this for the same reason. The marketplace is now seeing a significant number of programs to integrate STD/LTD to some degree in order to manage the risk better. A best practice for employers and insurers alike is to identify STD claims that either will or could extend into a long duration of disability, and to place extra claim management / case management attention on those situations to help prevent avoidable longer durations.

In spite of the very major differences between STD programs and SSA disability programs, there are some useful lessons for SSA about how to employ mFV expertise:

1. The STD industry explains its relatively passive and largely administrative approach to claim management on the grounds that the vast bulk of claimants will return to work on their own and the economic stakes are low (the total payout is limited by the short duration of benefits). This rationale is not as defensible in the SSA setting, where virtually every claimant has already experienced prolonged disability and future benefit payouts are likely to be last for many years.

2. The customer's (the employer's) preferences and expectations for outcomes determines the required posture of the claims management process (passive vs. pro-active), and in turn the nature of the use of mFV expertise. A desire for return-to-work when possible and for minimal avoidable disability days requires a pro-active stance, and use of mFV expertise in the process of removing barriers to return to work.

3. Use of Disability Duration Guidelines helps set claimant and clinician expectations and provides a basis for conversations with clinicians about how to address clinical circumstances that may be prolonging work absence.

4. Employer involvement is key to optimal outcomes, but they often need assistance to help engineer return to work at both transitional and full duty.

Long-Term Disability (LTD)

Long term disability programs pay benefits if a worker is unable to work because of a medical condition for an extended period of time. Waiting periods before benefits begin are typically three, six, or twelve months, and benefits are payable up to the Social Security retirement age (at which point it is assumed the worker would have stopped earning a living if their disabling medical condition had not arisen.)

LTD programs are similar to SSA disability programs in many ways, though there also are important differences that lead to differing uses of mFV experts.

General Program Characteristics

LTD programs are always formally administered. Most LTD programs are provided through insurance companies; there is very little self-insurance by employers except for extremely large companies. LTD coverage is common for white collar / managerial / professional employees and collective bargaining unit employees, but much less common for others, and certainly less common for lower-wage service positions. LTD premiums may be paid in whole or in part by the employee rather than the employer, and some LTD policies are directly purchased from insurance companies rather than through an employer-sponsored program.

Unlike WC, LTD programs are not heavily regulated by state or federal entities, and litigation plays a much smaller role in claim administration. Also unlike WC, there are no lump sum payments or settlements. LTD plans are often subject to ERISA regulations which govern a claimant's rights to appeal benefit denials, however.

Like STD, LTD policies are crafted to meet the varying needs of employers and insurers, so there are many different policy provisions in place. Claim administration processes must be designed to appropriately administer these varying provisions.

LTD programs are similar to SSDI in that they pay benefits when a worker is unable to work because of a medical condition. They are intended to cover more serious, long-lasting conditions than STD. However, not all accepted LTD claims are for medical conditions that are serious enough to meet SSA's requirements for Step 2 of the sequential determination process. A number of cases that result in LTD benefits eventually resolve medically and the worker is able to return to work - such as complicated pregnancies. A typical employer has many fewer LTD claims in a year than STD claims or WC claims, and the typical cost of an LTD claim is much higher than an STD claim.

Like STD, LTD programs do not cover medical expenses. The worker's healthcare coverage, if any, will pay for medical care. In this way, LTD operates like SSDI in the months before Medicare eligibility is received: if medical treatment that would reduce the effect of the medical condition is unobtainable, the period of disability will continue even though it could be averted with treatment. As mentioned for STD, the LTD claim administrator can elect to pay for such expenses on their own, but this is uncommon, and only done when the result would clearly result in return to work.

Important Policy Provisions

Though as mentioned earlier, LTD policy provisions vary widely, some provisions are fairly common and have an impact on the use of mFV expertise.

Waiting periods are commonly three, six, or twelve months. For employer-sponsored plans where STD is also provided, the LTD policy generally begins coverage at the point STD expires. Plans with shorter waiting periods will tend to have more claims with less serious medical conditions, lower projected costs, and higher expected rates of return to work.

Most plans include a provision that in order to receive benefits, the beneficiary must be under the care of an appropriate medical provider. (If the medical condition has reached stability and further treatment will be of no benefit, treatment is not required.) As stated earlier, the LTD carrier may elect to pay for medical care if the beneficiary does not have health coverage, though this would only be done if a return to work would be expected to result.

As for STD, the claimant must provide adequate medical evidence of their medical condition and inability to work, and typically as a condition for receiving benefits must sign a release authorizing the claim administrator to receive information about their condition from treating sources. Typically such evidence must be submitted every twelve months throughout the period benefits are paid, even for situations where there is little chance of change.

Many plans exclude pre-existing conditions, so part of the investigation process involves establishing whether the current condition stems from a pre-existing condition.

Many recent plans impose a limit on the number of months that benefits can be paid for certain conditions, most commonly mental/nervous conditions. Typically the limit imposed is twenty-four months.

Some plans include provisions for mandatory vocational rehabilitation, under which benefits can be terminated if the beneficiary does not participate in an appropriate vocational rehabilitation program designed to qualify them for a new occupation. Otherwise such participation is voluntary.

Perhaps the most important provision deals with what occupations a claimant must be unable to sustain in order for benefits to be paid. This is commonly called the "own occ / any occ" provision. Most recent policies provide that for the first two years, the claimant will receive LTD benefits if they are unable to perform their own occupation, but after that they will receive benefits only if they cannot do any occupation for which they are reasonably qualified and which pays something close to what they earned before the disabling condition arose. (Exact provisions vary from policy to policy.) These two conditions correspond loosely to Steps 4 and 5 of SSA's sequential disability determination process.

Most plans incorporate an offset for SSDI benefits. This offset reduces the amount payable by the LTD payer by the amount paid by SSDI – essentially making SSA a re-insurer for LTD carriers. These policy provisions typically require the claimant to apply for SSDI, regardless of the assessed chance of being awarded benefits, and subtract the presumed SSDI award if an application is not made. (If the claimant applies and is denied, no subtraction occurs.) Most LTD administrators contract with applicant representative firms to help beneficiaries apply for SSDI benefits, and many of those report high degrees of success in obtaining SSDI awards.

Dynamics of LTD Claim Administration

The next few paragraphs describe the typical dynamics of LTD claim administration in a well-managed organization, from a point of view intended to shed light on when, why, how, and by whom mFV expertise is employed.

A best practice is to learn about the expected arrival of LTD claims by being in communication with STD administrators or health plans, and to provide advice or support in the management of the claimant's situation before an LTD claim is filed, with an eye to achieving return to work before an LTD claim materializes. This is easier if the STD and LTD programs are administered by the same organization, or if a large employer has established processes to integrate / coordinate the administration of their benefit plans. In practice this appears to occur far less than is possible however due to organizational barriers and poor alignment of financial incentives between the STD and LTD claim administrators.

Claims are initially investigated in some detail to be sure that claimants qualify administratively, that they have a bona fide medical condition, that the medical evidence is in order, and that their functional limitations indeed prevent them from carrying out their usual occupation. A heavy emphasis is placed on receiving adequate information from treating sources. LTD administrators typically employ or contract with clinical staff, including physicians, nurses, and social workers, as well as with vocational rehabilitation processionals, to help evaluate the medical evidence, assess the vocational situation, and help claim adjusters decide whether the criteria for benefit award have been met. At times functional testing will be employed to help establish functional abilities, but this is apparently not done as often as under WC programs.

Relatively intense telephone contact will be made with the claimant and treating sources during the investigation and early claim management period to ensure complete and accurate information is obtained, and to explore the possibilities for return to work. Treating sources can be difficult to reach, however. Disability carriers report that it commonly takes upwards of ten attempts to obtain adequate information from the treating physician. The employer will also be contacted to learn about job duties and possible avenues for return to work, though unlike STD and WC, it often occurs that the claimant has been terminated by the time the waiting period expires, and thus is no longer actually an employee. (Unlike the SSDI program, people covered by LTD programs must have been working at the time their period of disability began.)

Often in the initial period of working on a claim, a vocational rehabilitation assessment will be made to determine the likelihood of a return to work being possible with that support. Except for the cases where return to work is very unlikely, initial contacts with claimants will emphasize the benefit of return to work, and set the stage for efforts to make that happen over time.

After the initial investigation , a triage generally occurs to separate claims into handling categories.

- Some conditions are expected to resolve medically without much intervention and probably allow the claimant to return to work – such as a complicated pregnancy or recovery from major trauma. These will receive relatively minimal management other than ensuring that appropriate medical treatment is provided, that changes in condition are noted, and that return-to-work efforts commence when ready.

- Some conditions are very serious and have little hope of medical improvement, such as quadriplegia. These receive minimal management other than ensuring that SSDI benefits are applied for and received, and that annual updates on the medical condition indicate continuing disability. (Some cases that start out in other categories wind up here if the medical condition deteriorates.) These are often designated "stable and mature," implying that no change is expected.

- In a similar category are conditions that are probably, but not definitely, going to preclude the claimant from working at their own occupation or any other occupation.. These will be managed relatively modestly, periodically looking for changes in the medical condition and return to work opportunities. At some point, those which appear never to resolve will be placed in the stable and mature category.

- Other conditions fairly clearly prevent the claimant from doing their own occupation, but in the assessment of the claim administrator should not prevent them from engaging in another occupation that meets the administrative criteria for an acceptable other occupation for the any occ determination. These will be managed at a moderate level of activity in the interim until the any occ determination. The claimant will generally be advised of the likelihood that they will need to transition to a new occupation when the "any occ" date is reached, allowing them to prepare themselves for what that entails (though some will decide to dispute their ability to qualify for another occupation). Some beneficiaries will voluntarily proceed to qualify themselves for a new occupation and return to work, but many do not. As the any occ determination date approaches, the claim adjuster will mount an intense effort to develop and document the information necessary to prove that the claimant is able to perform another occupation. This will include labor market surveys, transferable skills analysis, functional and medical opinions, etc. The administrator will also be in touch with the claimant again to learn of any changes in situation. When the any occ determination date is reached, assuming the preparation has indeed borne out that the claimant is able to undertake another acceptable occupation, benefits will be terminated. This decision can be appealed, and become the subject of a lawsuit, but as remarked earlier such outcomes are far less common than for WC and SSDI.

- The remaining cases are not so clear cut, and have the possibility of medical improvement and / or return to work, possibly with the help of better medical care, vocational rehabilitation services or other services that can remove barriers to returning to work. These claims will generally receive greater claim management attention in an

attempt to minimize avoidable disability days and achieve return to work, until the outcome is clarified. Soft tissue musculoskeletal claims, mental/nervous claims, self-reported illness, and similar hard-to-measure conditions generally fall into this category slated for more intensive investigation and management.

For some of these, the LTD carrier will disagree with the claimant's / treating clinician's assertions that the claimant cannot work, and obtain Independent Medical Exams, peer reviews, surveillance, or other evidence to establish a case that the claimant can work. A smaller fraction of claims wind up in this category than for WC claims, and as mentioned earlier, litigation is far less prevalent in LTD claims than in WC.

Similar to WC and SSA, the specific processes and staff used to handle claims with mental diagnoses tend to differ from those used for physical diagnoses, and appropriate staff is retained to work on claims of both types. For complex cases, it is an increasingly common practice for LTD carriers to either create condition-specific units (for example, to handle mental/nervous or self-reported illnesses).

Similar to WC, a best practice with LTD administrators is to hold regularly scheduled claims roundtables to obtain the insights of multiple staff members, often of different disciplines, on how best to manage individual claims.

Successful LTD claim handling depends greatly on knowledgeable and skilled staff. LTD carriers train their staff in functional and vocational analysis, and employ specially-trained physicians, nurses, and vocational rehabilitation consultants to provide expert support to the claims management units.

Uses and Sources of mFV Experts and mFV Expertise in LTD Systems

Much like WC administrators, LTD administrators use mFV expertise in three very different ways. First is to assess the situation, form opinions, and figure out what type of resolution is possible. Second, based on that assessment, and when possible, is to help a claimant actually return to work – to regain or restore their functional abilities, obtain new job skills if necessary, find acceptable job openings, etc. Unlike WC, LTD does not regularly pay for many of these services, but can suggest them and occasionally try to arrange for them via case management interventions. And third, in forcing the issue of ability to work (i.e. in preparation of terminating benefits or resolving formal disputes), is to help establish whether a claimant is able to return to work under the rules that apply to the plan.

Since so many of their claims have a need for mFV expertise, LTD carriers typically employ or contract with a number of physicians, nurses, vocational rehabilitation professionals, and psychologists to do the medical, functional, and vocational assessments and planning.

Most LTD carriers utilize automated tools for transferable skills analysis.

Points of Value to SSA from LTD's Usage of mFV Expertise

1. Multiple personal telephonic contacts with claimants, employers, and treating clinicians is critical to establishing expectations in the client's mind and to developing a full understanding of the claimant's situation, both for deciding on benefit award and for facilitating return to work.

2. There is a big advantage to having time enough to learn about the situation in depth and gather and analyze appropriate information before having to make the "any occ" decision. When appropriate, think of the initial period of benefit award as temporary, and focus effort on making a more permanent decision after more information has been gathered.

3. Both LTD and WC present a relatively low barrier to initial awards, but then work diligently to achieve RTW where that is feasible, or to terminate awards that prove not to be warranted.

4. LTD, STD and WC divide claims into categories that determine the type, nature, and degree of management they will receive.

5. Have qualified, experienced mFV experts participate in the process. Have a full range of mFV professionals available, especially physicians, psychologists, nurse case managers, and vocational rehabilitation counselors.

6. Train staff in functional and vocational issues.

7. Use multidisciplinary roundtable discussions to ensure the best possible thinking is applied to each claim.

8. Start planning for return to work from the outset where that is feasible, and from the beginning set claimant expectations that you will be doing that.

9. Envision and arrange for necessary supports to help claimants overcome their barriers to returning to work.

10. Stay in touch more frequently with claimants whose conditions are not stable, and set the expectation that benefits will continue only until they get better and regain work capacity. Also stay in touch with claimants whose conditions are stable on at least an annual basis.

11. Utilize commercially-available tools for steps such as transferable skills analysis

IV. Project History

This section of the report provides a brief history of the project. The Core Report contains a list of all project participants.

Pre-Award and Contracting

SSA issued the RFP for this project on July 7, 2005. SSDC and Webility Corporation decided to make a bid. Prior to preparing the response, Jennifer Christian, MD, contacted a number of potential experts to sit on the panel, describing the project overall, its potential to make a significant contribution to SSA and to the nation, and generating enthusiasm and commitments for participation.

After bid submission, SSA notified the SSDC / Webility team in November 2005 of their interest in contracting, but first wanted to make several changes to the scope of work. The most important change eliminated the first paper referred to in the RFP (describing SSA's current status with respect to use of functional and vocational expertise).

The contract was awarded to SSDC/Webility on January 11, 2006.

Startup

Project work began in earnest immediately thereafter. The project team notified all expert panel members that had been recruited earlier of contract award, and the project team began its background research and the development of briefing materials that the panelists would receive.

A project kick-off meeting was held on February 3 in Baltimore between the project team and involved SSA staff. The group discussed project objectives, current status of disability programs in SSA, working arrangements, and potential panelists in addition to those previously approached by Dr. Christian. Present at this kick-off meeting from SSA were Deputy Commissioner Martin Gerry and Assistant Commissioner Pam Mazerski, chief project sponsors, and approximately 10 other SSA personnel including Suzanne Payne, project officer. Present from the SSDC/Webility Team were project director Jennifer Christian, MD; project administrator Craig Horton; project manager Gloria Gillette; and project author, David Siktberg.

Panel Selection

Following the kickoff meeting, the project team collected the remaining biographical materials required of potential panelists and recruited several additional individuals beyond those contacted before proposal submission. The deliverable listing potential panelists was sent to SSA on March 1, 2006.

On March 24, 2006, the project team again met with SSA in Baltimore. Further discussions were held about the use of functional and vocational expertise by SSA, about appropriate activities for developing the briefing papers, and about the optimal way to conduct the expert

panel meeting. At this meeting SSA's provided the team their decision on which external potential panelists to include in the project. (The decision on internal SSA panelists to include followed shortly thereafter.) Also on this trip, the project team was given in-depth training on the disability determination process.

Interim Report (Briefing Papers), Preparation for Panel Meeting

The project team planned to develop five papers for the panelists' use, to be included in the briefing packets to be sent to them in advance of the panel meeting:

1. Background paper on the basic facts about, and current issues in, SSA's disability evaluation programs and processes.
2. Use of Functional and Vocational Expertise (specified in the contract).
3. Shared Understandings (not in the RFP, suggested by the project team).
4. Potential Recommendations (not in the RFP, suggested by the project team).
5. Comparative paper (specified in the contract)

In developing the Background paper, the project team studied numerous documents from SSA and other organizations, reviewed a number of SSA disability claim files, held informal discussions with past SSA employees, and received intensive training on the disability determination process by experts from SSA.

In order to develop the Uses of Expertise paper, the project team did extensive research on the various professions involved, created and fleshed out a conceptual structure for describing functional and vocational expertise, and held discussions with panelists involved in the professions under study.

As these papers were being developed, the project director held another series of individual telephone interviews (1-3 hours in length) with all 20 of the panel members. The purpose of these calls was to orient each panelist to the purpose of the project, to establish a sense of "team", to identify what it was that each panelist was prepared to uniquely contribute, and to obtain information and suggestions from each panelist that would direct the project team's continuing research and analysis. In addition, each panelist was asked to contribute ideas and suggestions for inclusion in the Shared Understandings and Potential Recommendations papers.

In addition, in order to maximize the value of the brief time of the panel meeting itself, the project team set up during the last two weeks of May a series of conference calls which all panelists were invited to attend. These were held as the project team began to catalog, synthesize and formulate understandings and recommendations. An initial series of eight conference calls were held with variable numbers of panel members on each call. Each of the calls focused on a particular thorny issue or problematic design question that had been raised during the individual calls.

Recognizing that panelists should arrive at the panel meeting with a solid shared baseline understanding of SSA disability programs and operating metrics, a second series of calls were held the first week of July to present and discuss the Background paper material.

Out of these individual and group conversations came much valuable material that ended up in the Shared Understandings and Potential Recommendations papers as well as the Background paper and Uses of Expertise paper. In addition, these telephone calls were instrumental in

developing the strong cohesion and sense of mutual respect that characterized the panel when it finally met face to face.

All key points made by each of the panelists in the telephone interviews and conference calls were included in the Shared Understandings paper. Also, all potential recommendations made by each of the panelists were included in the Potential Recommendations paper. Overall, the source material for these papers was the observations and suggestions made by the expert panelists during their individual interviews and conference calls as well as the project team's research, professional judgment and personal familiarity with the matters at hand. Thus, these papers were an unsorted and unedited list of possibilities contributed from everyone – a universe of raw material from which the expert panelists could begin their group deliberations.

A significant result of these calls was shared interest in using multi-dimensional assessments to more fully understand claimant situations in complex, unclear,

As the other papers were being developed, research on the Comparative paper was being done, and related information from the contacts with panelists was being digested. It became apparent that the Comparative paper was going to be of minimal value in the panel meeting compared to the other papers and materials, so its completion was postponed.

While the papers were being prepared, the project team made logistical arrangements to hold the panel meeting at the Mt. Washington Conference Center in northern Baltimore, owned by Johns Hopkins University.

Two weeks before the Panel Meeting, the briefing packets were delivered to the panelists for study before the panel meeting. The packets included:

1. The Background, Uses of Expertise, Shared Understandings, and Potential Recommendations papers. As mentioned above, the Comparative Paper was intentionally deferred, and was not included in the briefing packets. Several of the experts on the panel came from other systems, and were able to contribute their knowledge of other systems.
2. A list of all panelists with contact information and biographical data, as well as the statements made by the panelists as to their fitness for serving on the panel and their goals in participating in the project.
3. A detailed agenda.
4. Pertinent excerpts from the project contract establishing the scope for the meeting.

Panel Meeting

The two-day panel meeting was held July 11-13, 2006 at the Mount Washington Conference Center. Additional materials were distributed to the panelists at the beginning of the conference.

Shortly before the panel meeting convened, all of the panelists had voted on the extent of their agreement or disagreement with each of the Shared Understandings and Potential Recommendations, using a web-based voting tool developed by Webility. Among the materials handed out at the conference were the aggregate results of the voting along with an anonymous list of each panelist's comments, if any, about each of the specific items. These documents revealed strong to very strong agreement on most items. The voting results allowed the panelists to focus on areas where there were differences of opinion or concerns that needed to be addressed.

When the panelists arrived in Baltimore the evening of July 11, a welcome reception and buffet dinner was provided that enabled everyone to meet and discuss the project in an informal setting. Those who had not yet voted were allowed to complete their voting on computers provided by the project team.

In addition to the panelists and project team, several SSA staff were present in the room, including Pam Mazerski and Suzanne Payne. Interaction between the panelists and SSA staff occurred several times as Pam Mazerski and others clarified various issues and provided guidance to keep the panel focused on meeting SSA's needs.

Time was very tight during the panel meeting due to the scope and breadth of the potential recommendations. Most topics could be discussed for no more than a half hour. The value of the pre-work that had been done was revealed because the panelists were united in their commitment to delivering useful recommendations to SSA that would make a positive contribution to the system. They were able to move quickly through the material and pithily discuss those few areas that needed clarification or dialogue. By the end of the second day, a spirit of team unity and harmony was palpable among these people – many who had previously been unacquainted or had never met face to face.

The first day of the meeting focused on the briefing papers, and establishing the universe of possibilities from which the recommendations would be drawn. Additional recommendations were elicited beyond those laid out in the Potential Recommendations paper. The list of potential recommendations was sorted for the first time according to their importance, desirability, and practicality. In the afternoon, panelists broke into small groups to sort the list of recommendations according to their importance, desirability, practicality, and need for revision. They also clarified obstacles and issues that needed more work. The group as a whole reconvened and the small groups reported their findings. Detailed notes were kept of the fast-moving group reports.

That evening, the project panelists enjoyed an informal evening with dinner and discussion with SSA staff including Deputy Commissioner Martin Gerry. Mr. Gerry made some brief remarks to the whole group about the context of the project, his goals for it, and his visions for improving SSA's services to applicants and beneficiaries as well as making it more efficient. This presentation was both inspiring and informative for the panelists, and helped them focus the work the next day.

The second day, some core issues were discussed by the group as a whole, and Dr. Christian presented the draft design for the program to provide face-to-face multi-dimensional assessments. The panelists expressed enthusiastic general agreement for the design. then the panelists were again divided into small groups to come up with recommendations for the use of functional expertise in the existing disability evaluation system, for the use of vocational expertise in the existing disability determination system, and for both kinds of expertise if the constraints imposed by current system design (laws and regulations) were lifted. The group as a whole reconvened and the three groups presented their findings and recommendations. Detailed notes were kept of the fast-moving group reports.

By the end of the second day, the panel had reached overall agreement and the project team felt they had a clear and adequate picture of what changes the expert panelists wanted made to the draft recommendations. The meeting was adjourned.

Post Panel Meeting – Final Report

Subsequent to the panel meeting, all notes were transcribed and the project team held a series of conference calls to plan the preparation of the final report.

SSA requested that the final report contain a terse, pithy summary report of the key recommendations suitable for distribution to decision makers and busy senior executives, accompanied by a longer document with conceptual foundations, background materials, and other details that could be referenced by anyone wanting more information. The report writing process began with work on the terse summary.

Using the results of the panel meeting, the team developed several initial versions of a very brief Executive Summary internally, and when satisfied sent a first draft to the panel and SSA for review. Responses indicated there was not enough supporting material for the points to be clearly communicated. In addition, some language led to unintended inferences and needed clarification.

A major revision was made to expand the contextual and background material included and to improve the document structure. This version contained all of the panel's recommendations, along with enough background information to make them understandable. This second draft was then sent to the panel, now titled the Summary Report. Responses were very positive and helpful. Again, some language led to unintended inferences regarding the definition of disability. This issue was worked out in collaborative discussions, and the language made unambiguous on the points involved.

In parallel with this process, the detailed tables defining the qualification criteria for mFV experts were being fine tuned and reviewed / approved by panelists with appropriate knowledge of the professions.

Comments received on the second draft were digested and incorporated into the third draft, for which no structural change was required, but much refinement of language and honing of key points occurred. In this process, a few unresolved minor issues became evident and were resolved as well. This third draft was distributed to and accepted by all panelists.

The project team in concert with SSA decided to retitle the Summary Report as the Core Report, and to place the other final report materials into a Supplemental Report. An executive summary was created to open the Core Report. The components of the Supplemental Report were finalized by the project team, including the Comparative Paper, and all components integrated into the draft final report submitted to SSA for their final review.