

The Aging Workforce: The Role of Medical Professionals in Helping Older Workers and Workers with Disabilities to Stay at Work or Return to Work and Remain Employed

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Introduction

The low employment rates for older job seekers and workers with disabilities, combined with recent growth in Social Security Disability Insurance (SSDI) caseloads, have prompted new attention to the need to identify and craft new policies and provide supports that promote the employment and continued employment of aging workers with health issues and disabilities. Medical professionals play a significant role in keeping older workers working, or facilitating their return to work following an illness or the onset of age-related disabling conditions.

With support from the U.S. Department of Labor's Office of Disability Employment Policy, the John J. Heldrich Center for Workforce Development at Rutgers University convened a one-day, invitation-only roundtable entitled *The Aging Workforce: The Role of Medical Professionals in Helping Older Workers and Workers with Disabilities to Stay at Work or Return to Work and Remain Employed*. The event was held on September 19, 2012, in Washington, DC, and involved a select group of high-level international, federal, and state policymakers; medical professionals; researchers; and advocates with expertise in aging and disability, employment, vocational rehabilitation, and social security policy. Among the featured panelists were Jennifer Christian, MD, MPH, Webility Corporation; Andrew M. Pope and Tracy Lustig, both from the Institute of Medicine; Edward C. Alvino, MD, the Chief Medical Officer and Vice President for Unum; John Dreyzehner, MD, MPH, the Commissioner of the Tennessee Department of Health; Marianne Cloeren, MD, MPH, Chair of the American College of Occupational and Environmental Medicine's Council on Occupational and Environmental Medicine Practice; Ray Fillmore Garman, MD, MPH, Associate Professor and Clinic Director in the Department of Preventive Medicine and Environmental Health at the University of Kentucky, College of Public Health; Jennifer Hallden, President of the Arizona Work Disability Prevention Association; Dara Johnson, MPA, Program Development Officer for the Arizona Health Care Cost Containment System; Dr. Johannes Pieter Laurier, President of the Board of the Blik op Werk Foundation in the Netherlands; and Susan Webb, JD, MBA, Director of ABIL Employment Services. (The roundtable agenda and a list of participants are included in Appendices A and B.)

The purpose of the event was to explore the relationships among medical professionals, employers, and the public workforce and vocational rehabilitation systems in terms of their current and desired roles in preventing needless work disability, with "disability" in this context defined as the absence from work due to a medical condition. Participants were asked to reflect on the challenges in engaging the medical community in helping older individuals with disabilities, or who are experiencing reduced functionality, to stay at work and remain successfully employed until they choose to retire.

The day began by understanding the current situation from the clinician's point of view within the medical office and the larger health care delivery system. Through panel presentations, the participants shared information about efforts (both in the United States and abroad) to prepare medical professionals for taking a more active role in helping people with impairments, whether longstanding or due to increasing age, stay employed. The need to improve the nature and quality of the data that flows between health care professionals and benefits administrators was highlighted. Several promising strategies and actionable recommendations are presented in this brief.

Background

The Organisation for Economic Co-operation and Development or OECD (2010) noted that in virtually all OECD countries, the United States among them, too many workers are permanently exiting the labor market as a result of health problems or disabilities, and that too few people with "reduced work capacity" are managing to stay employed as well. This report described a paradox that has become "a social and economic tragedy": why are large numbers of working-age adults leaving the labor market to rely on long-term disability and sickness benefits, given that the average health status of the population is improving? This is so even while the nature of work is less physically demanding in the United States than ever before (Johnson, Mermin, & Resseger, 2007), and many U.S. employers are obligated to make reasonable accommodations under the Americans with Disabilities Act.

In the United States, applications for SSDI recently hit a "historic high" of more than 2.9 million in 2010 (Congressional Budget Office, 2012). The Congressional Budget Office attributes the steep rise in SSDI benefits to several factors, including changes in demographics, changes in federal policy, and changes in opportunities for employment and compensation. According to the report, the biggest jumps in SSDI claimants are tied to aging Baby Boomers. Another contributing factor has been the weak economy, with some job seekers who would prefer to work using disability insurance as an income safety net.

The Aging Workforce, Disabilities, and Long-Term Unemployment

The population of the United States is aging due to the aging of the disproportionately large Baby Boom generation, typically defined as those individuals born between 1946 and 1964. As the population ages, so does the workforce. According to the U.S. Bureau of Labor Statistics (BLS), in 2010, 30 million workers age 55 and older were in the labor force, representing 19.3 percent of the total, or just under one in five workers (Toossi, 2012). By 2020, BLS projects 41.4 million workers age 55 and older, representing 25.2 percent of the total, or more than one in four workers, will be in the labor force (Toossi, 2012). BLS (2011) also estimates that currently roughly seven million people age 65 or older are in the labor force, and that by the year 2050, that number will have almost tripled to 19.6 million. Over the next decade, the number of "prime-age" workers in the labor force (between the ages of 25 and 54) will grow by just 2 percent, compared to a projected 75 percent growth in the number of workers who are at least 65 years old (BLS, 2011).

Research has documented that as workers age, they are more likely to acquire a disability, which may affect their decisions regarding when to retire (Heidkamp, Mabe, & DeGraaf, 2012). Burkhauser, Daly, and Tennant (2010) analyzed data from the Current Population Survey and American Community Survey and found significant increases in the prevalence of a disability — and specifically a work-limiting disability — as people age. In

another study based on data from the Health and Retirement Survey of Americans, Hwang (2010) followed for two years individuals who were 50 years old or older, were working full time, and said that they did not have a disability in their baseline interview. After the two years, Hwang found that 10.1 percent of these workers indicated that they had acquired a disability that limited their ability to work.

As a group, older workers (age 55 and older) have a lower unemployment rate than younger workers (6.2 percent compared to 8.3 percent in July 2012). However, once they do lose a job, older workers appear to have a more difficult time reconnecting to the labor market than their younger counterparts. Older workers tend to stay unemployed longer than prime-age workers, with an average duration of unemployment at 51.4 weeks in July 2012, compared to 34.9 weeks for workers under 55 (Rix, 2012). In July 2012, roughly half (49.9 percent) of older job seekers were categorized as long-term unemployed — traditionally defined as unemployed over six months — compared to 37.2 percent for the labor force as a whole.

Workers with disabilities (of all ages) have also suffered in the labor market in the aftermath of the recent recession. From 2007 until 2009, Kaye (2010) reported a nine percent drop in the number of people with disabilities as a percentage of all employed workers. In addition, between June 2008 and September 2009, roughly one-third of people with disabilities were long-term unemployed, compared to a quarter of people without disabilities (Fogg, Harrington, & McMahon, 2010).

Rise in Applications for Federal Disability Insurance and Duration of Benefits

At the same time that long-term unemployment has soared in recent years in the United States, so, too, have applications for federal disability insurance (i.e., SSDI). In addition to the personal and financial toll that long-term unemployment can take on job seekers and their families, it can also result in individuals' physical and mental capacities declining, making them harder to reemploy and increasing the likelihood that these job seekers may become discouraged and possibly drop out of the labor force altogether (Orszag, 2010). Orszag attributed the spike in applications for disability benefits not to an increase in the number of workers with disabilities but rather to the weak labor market, with people qualifying for disability benefits they would not be seeking if they were able to find jobs. Orszag added that once someone qualifies for social security disability benefits, the odds of their returning to the workforce are "almost nonexistent."

In a June 2012 report, OECD (2012) urged reforms to disability programs in the United States to "stem the tide of new enrollments." OECD noted that in 1980, the share of the working-age population (ages 20 to 64) in the United States enrolled in SSDI was 3.6 percent; by 2010, this share had increased to 6.6 percent. One consequence of this rising proportion of the population receiving disability benefits is a reduction in labor force participation. OECD projects that the number of applications for SSDI will continue to rise in the aftermath of the recession. In addition, relaxation of eligibility requirements has made it easier to qualify as a result of back pain, arthritis, and mental impairments. These conditions have "early onset but low mortality" and have contributed to the lengthening expected duration of benefits, which rose from 6 years in 1983 to 14 years in 2004.

The Role of Medical Personnel in Stay at Work/Return to Work: Highlights from the Roundtable

Presentations made during the roundtable, which are available at <http://www.heldrich.rutgers.edu/projects/all-projects/ntar-leadership-center>, sought to answer the following questions:

1. How can physicians help aging workers and others with common everyday health issues, such as back problems, other musculoskeletal pains, and other consequences of normal aging, as well as depression, anxiety, and fatigue, to stay at work or return to work instead of ending up on SSDI or otherwise dropping out of the workforce? (It was noted that people with these types of medical problems are the fastest-growing segment of the SSDI population.)
2. How can physicians and other medical professionals work together more effectively with other stakeholders to help aging workers remain economically independent for as long as possible?
3. Are there policy or legislative changes that could help support this goal?

The roundtable conversation was led by Dr. Jennifer Christian, a national advocate and leading expert in occupational medicine and the role of medical professionals in preventing needless work disability. Dr. Christian distinguished between the concepts of “work disability” and “impairment disability,” with work disability referring to a period of absence from work as a result of a medical condition, as distinct from an impairment disability that is describing a physical or functional impairment that affects one or more life functions. Dr. Christian described a wide range of impairments, each of which might have different implications for working. Some impairments are temporary, such as a sprain or a wound following surgery or even the flu, which might result in temporary work disability (such as a few sick days), after which people typically return to their normal level of functioning. Other impairments may be permanent, but many people with permanent impairments such as blindness or paraplegia feel fine and work full time. Still others with a chronic illness may feel consistently unwell and find it difficult to work. Some impairments are due to lifestyle and/or aging-related loss of function due to heavy use and degeneration. With proper accommodations, however, Dr. Christian noted that many of these impairments need not result in work disability.

For purposes of the roundtable, Dr. Christian urged the participants to keep the focus on work disability, which describes a period of time during which an individual is not working or working at some reduced capacity attributable to a medical condition. This work disability can be due to a personal or a work-related medical condition and can be temporary, lasting days, weeks, months, or years, or permanent.

The focus of the roundtable was to explore the types of policies and practices that could be put in place to avoid or end needless work disability for those individuals who can start or resume productive work. Dr. Christian noted that the opportunities to prevent needless work disability among this group will not necessarily apply to people living with “classic” disabilities or those who have rapidly progressive degenerative conditions or a fatal illness. For a host of reasons, she stated that it is more difficult to help people with certain types of impairments to stay at, return to, or start to work than others. Some conditions are devastating and have poor prognoses. Some people have limited coping capability due to prior histories of trauma and deprivation, or are also burdened with additional co-morbid medical conditions. External and societal factors such as stigma and local job markets also have a significant influence. However, even if the discussion applies primarily to a subset of the

population, there are potentially enormous benefits for those individuals who can resume or start productive work

Dr. Christian presented the main points of the American College of Occupational and Environmental Medicine (ACOEM) guidelines on *Preventing Needless Work Disability by Helping People Stay Employed*. These guidelines focus on the large number of individuals who end up either permanently dropping out of the workforce or being out for prolonged periods following a medical condition that would normally result in only a brief absence. According to the guidelines, it is “not medical necessity, but nonmedical decision making involved in and the poor functioning of” the Stay at Work (SAW)/Return to Work (RTW) process that is to blame for much of the unnecessary absence. Fundamentally, the goal of an effective SAW/RTW process should focus on preventing work disability or prolonged absence from work (ACOEM, 2006).

According to ACOEM guidelines, the SAW/RTW process is triggered when an individual worker develops a medical condition or suffers an injury or accident that might interfere with his or her ability to do the job. The process (in brief) includes assessing the worker’s functional capacity, functional impairments, and the medically based restrictions that are necessary. This is followed by a comparison of the demands of the job, and/or a temporary alternative position, with the worker’s assessed functional capacity, impairments, and restrictions. The last step is to map out what needs to happen to enable the worker to return safely and comfortably to work, which might include the employer making reasonable accommodations.

The potential pitfalls in the SAW/RTW process are numerous, however, and the more complex a situation, the more participants become involved, and the more time-consuming the process becomes. The guidelines note that early intervention is the key to preventing prolonged absence, citing research that has found that people who develop a medical condition or have another precipitating event who never lose time from work have better outcomes than those who do, and that the longer they are away from work, the less likely they will ever return. The guidelines report that the odds of returning to work drop with every passing day that the individual does not go to work, with the odds for returning to full-time employment dropping to 50/50 by the time six months of absence has occurred (ACOEM, 2006).

The ACOEM guidelines point out, and physicians participating in the roundtable confirmed, that very few physicians outside of those in the specialties of occupational medicine and physical and rehabilitation medicine (physiatry) receive any training in work disability prevention and management. Further, most medical schools have not incorporated into their curricula the data on health risks of worklessness nor the methods to evaluate work ability. Yet without training in these areas, primary care physicians sign an average of five or more work-related notes per week to employers and payers, making them critical players in the SAW/RTW process (ACOEM, 2006).

The ACOEM guidelines also note that it is important to raise awareness about how seldom absence is medically required. Dr. Christian differentiated between medically required work disability and medically discretionary or unnecessary work disability.

Dr. Christian emphasized that few people today (both consumers and health care professionals) are aware how seldom work avoidance is actually medically required in order to avoid harming the health or safety of the individual. Likewise, few people are aware of the research showing the multiple kinds of harm that prolonged worklessness causes for individuals and their families. In fact, unemployment and worklessness have been shown to increase the risks of poverty, social isolation, addiction, crime, marital and family breakdown, multi-generational dysfunction, ill health, injuries, and early death. Worklessness is a poor health care outcome.

Dr. Christian also noted that an effective work disability prevention model has the potential to help create a shared sense of purpose among all stakeholders in the disability community; services and programs should maximize each individual's ability to lead the fullest possible life. Both health care and disability-related employment support programs should move beyond reducing mental or physical symptoms and supplying economic support toward helping the "whole person have a whole life." For working-age people, this usually means having responsibilities and doing something useful. Keeping all parts of the system attuned to that broader purpose is essential.

In practice, a more effective work disability prevention model shifts the focus by asking two simple questions:

1. Is this work disability medically required?
2. If not, how can we avert or end it?

According to Dr. Christian, no professionals are better prepared than physicians or similarly trained health care practitioners to distinguish between what is a truly medical issue and what is not. In addition, clinicians are often in a good position to identify ways to avoid work disability. But they are not usually asked to address either of the questions posed above.

To prevent needless work disability, it is essential to be clear about the actual nature of the obstacles to be overcome in each individual's situation. It is also important to map out exactly what needs to happen to enable that particular person to be safe, comfortable, and able to perform the functions required of a working person.

Physicians at the roundtable discussed their unique perspectives gained by differences among their own patient populations. They discussed the variability they observe every day in the practical impact of identical conditions on people's lives. That is, when two patients are faced with the same diagnosis, same severity of illness or impairment, or same level of underlying health, people differ in their responses to the intrusion of that diagnosis on their lives. Patients vary in their views of themselves, their futures, and what is possible. They differ in their intentions and ability to manage the challenges posed by their diagnosis, including their ability to create a mainstream everyday life for themselves and how much effort to make to remain productive contributors to their community's shared economic life (see Table 1).

Dr. Christian presented examples of the vastly different outcomes that individuals can have depending on who their doctors are and whether their employers are brought in as partners. If an injured worker is fortunate enough to have a "function-oriented doctor" who involves the individual's employer and supervisor in the recovery process, it can make a significant difference in the outcome. For example, working with the doctor and patient, the involved supervisor can encourage the quick return of the patient to work, making arrangements for transitional work and adaptive equipment as needed. On the other hand, a patient with the same set of medical conditions who does not have the support and encouragement of his or her doctor and work supervisor for a quick return to work may end up on prolonged or even permanent disability.

Table 1. Different Outcomes for Two Patients with Identical Medical Conditions

Patient One	Patient Two
Bad disc; surgery	Bad disc; surgery
Mediocre work history	Mediocre work history
Supervisor never called: "They will handle it"	Supervisor kept in touch: "We need you"
Weak supervisor	Good supervisor
Teasing by co-workers	Support from co-workers
Disabling doctor	Function-oriented doctor
"Stay home until you're able to do your job."	Transitional work; adaptive equipment
Permanent Disability	Back to Work in Six Weeks

Source: J. Christian, "Opportunities for change: The role of medical professionals in encouraging older workers and people with disabilities to stay at or return to work," roundtable presentation available at: <http://www.heldrich.rutgers.edu/projects/all-projects/ntar-leadership-center>.

Employees on their way back from illness or injury can fall through the cracks in the system if they do not have doctors who believe the SAW/RTW process is part of their responsibility. A work disability prevention vision must be shared by the treating provider, the employer, the patient, and other stakeholders. Teamwork and early intervention by an appropriate medical specialist or vocational rehabilitation counselor in contact with a worker is vital. This process includes ensuring that an appropriate return-to-work plan is in place for workers who are temporarily out of work because of an injury, illness, or disability, and ensuring that appropriate accommodations and assistive devices are in place for those who are able to remain at work safely.

Other examples were presented concerning workers in some economically depressed rural regions where individuals may be second or third generations on permanent federal disability insurance and have essentially developed a mindset and culture of disability entitlement. As illuminated by Dr. John Dreyzehner, Commissioner of the Tennessee Department of Health, individuals in these regions may have no frame of reference for seeing a return to work following an illness or injury as feasible or even desirable. Again it was noted that doctors are not trained in medical school to respond to this scenario. Medical training, in general, does not teach doctors that they should confront people when they see them using illness as an excuse not to work, and doctors do not see themselves as enforcers of programs and laws. One physician participant pointed out that the federal workers' compensation system has a mechanism for paying for behavioral therapy for people who have risk factors for disability as evidenced by the way that they are coping with an injury or illness, but added that few people know how to access these resources.

Physicians at the roundtable also noted that doctors have a unique perspective because they are called upon to play a key role at the center of every work disability program as well as every disability benefits program in the United States: employers' sick leave programs, Family Medical Leave Act, short-term disability programs, long-term disability benefits, state and federal workers' compensation, social security, Department of Veterans Affairs, Department of Defense programs, and others. All claims for every kind of health-related employment and income protection program have to be substantiated by a treating or evaluating physician who is required to fill out and sign some kind of form.

The distinction between “treating” and “evaluating” physicians is a meaningful one in terms of work disability. The vast majority of working-age people who apply for or are receiving benefits have been treated by a medical professional for the claimed condition. Treating clinicians have established a physician-patient relationship and owe a substantial emotional, ethical, and legal duty to their patients — and have an economic interest in pleasing them. Evaluating physicians may not have the same kind of relationship with patients as the treating physicians do. According to Dr. Christian, in the majority of cases, it is treating physicians who complete disability benefits forms.

Examples from Abroad

OECD (2010) points to a large and growing literature that has concluded that, generally speaking, working is good for health, and especially mental health. Furthermore, extended time out of work can turn into “a route to disability benefit schemes and permanent detachment from the labor market.” Given this fact, efforts to reduce sickness absence are urgently needed.

The Netherlands has been cited by OECD (2012) as an example of a country that has reduced its reliance on disability benefits. Johannes Pieter Laurier, President of the Board of the Blik op Werk Foundation, explained to the roundtable participants that in the early 2000s, the Dutch government took steps to rebuild many aspects of the national social security system, making changes to sick leave and permanent and temporary disability provisions, and increasing employer responsibility for helping sick workers return to work. Given demographic trends of an aging population, the government decided it was also important to find strategies to increase the longevity of people’s working lives. In 2007, the government bought the license for the Workability Index, developed in Finland and now operated by the Blik op Werk Foundation, a joint venture set up by employer and employee organizations, municipalities, service providers, benefits agencies, and client organizations. The Workability Index is a survey instrument designed to help predict risk factors that may affect the ability of workers to stay healthy and to continue working, and based on the data collected, appropriate interventions can be devised. The Foundation also maintains a database that enables it to examine health and employment trends based on industry, education level, and other demographic features.

Dr. Christian noted that significant progress had also been made in the United Kingdom, where the government recognized a need to review the health of the working-age population in light of increasing life expectancy and the high number of workdays lost to sickness. She described some highlights from the report *Working for a Healthier Tomorrow* (Black, 2008), which noted that the United Kingdom’s approach to treating working-age people and the sickness certification process assumes that being at work is not compatible with illness — an assumption that needs to be reviewed in light of the growing body of evidence that working can be good for health. Stigmas around ill health and disability, including mental health, need to be addressed to enable people with such conditions to return to or stay at work. Further, the report noted that the lack of professional training for health care professionals about the relationship between work and health has left them “naturally cautious” about treating patients, resulting in advice that may not be advantageous in the long run.

Working for a Healthier Tomorrow identified early intervention as a key strategy to help stop short-term sickness absences from turning into long-term absences and worklessness. It also called for equipping health care professionals with expertise in the importance of returning to or staying at work whenever possible, and for leadership from the occupational health and vocational rehabilitation communities, which must expand their purviews to work with new partners, including public health and general practice doctors to improve the health of working-age people. It recommended the creation of a multidisciplinary *Fit for Work* service that would offer treatment and advice to people in the early stage of sickness absence, including, depending on the case, financial and housing help as well as medical concerns (Black, 2008).

The Arizona Work Disability Prevention Association

In an example of a promising practice in the United States, representatives from the Arizona Work Disability Prevention Association (AWDPA) discussed their efforts to educate physicians and other stakeholders about strategies to prevent needless work disability. They noted the struggles they encountered trying to encourage Arizona physicians to participate but once the physicians did, they generally viewed the sessions favorably, and reported incorporating the tools into their everyday practices. It was noted that physicians were able to receive continuing medical education credits for attending AWDPA trainings. Arizona officials stated that the sessions focused on the ACOEM guidelines for preventing needless work disability as well as on the resources that exist to support SAW/RTW efforts. Between 2009 and 2010, AWDPA sponsored 40 sessions and trained more than 500 practitioners statewide.

Recommendations

Roundtable participants offered a range of recommendations for the education of medical professionals, changes to SSDI, engaging employers in promoting SAW/RTW, and support for research and demonstration projects.

Education and Guidelines for Physicians and Other Health Care Providers

The Office of Disability Employment Policy (ODEP) should work in partnership with the Institute of Medicine (IOM) and ACOEM to develop a national strategy and campaign that will educate the medical community, health care policymakers, and health care educators on the important role of medical professionals in helping older workers and workers with disabilities to stay at work or return to work and remain employed. This would include the following steps:

Educate physicians on why and how to play a role in preventing needless work disability and in participating in the SAW/RTW process.

ODEP, IOM, and ACOEM should encourage federal and state policymakers, state workers' compensation health care provider networks, and medical educators to train doctors in the prevention of work disability. The ACOEM guidelines on preventing needless work disability cite several promising examples that could serve as models for educating physicians about SAW/RTW, including educational efforts conducted by ACOEM and the American Academy of Orthopedic Surgeons. The ACOEM guidelines also highlight workers' compensation health care provider networks in Florida and California that urge physicians to take a course in disability prevention. For example, clinicians in the medical provider network of the California State Compensation Insurance Fund have been required to take training in work disability prevention. The efforts of AWDPA offer another model. Courses can be offered for continuing medical education credit.

Disseminate medical evidence and research to treating and evaluating physicians as well as government health care policymakers about how staying at work and being active contributes to the recovery process, producing improved clinical outcomes.

As part of IOM's Forum on Aging, Disability, and Independence, IOM, in partnership with ACOEM and ODEP, should disseminate existing medical evidence to policymakers and physicians encouraging the earliest possible safe return to work, as opposed to the passive medical rehabilitation and work avoidance that is often prescribed. OECD (2010) has cited guidelines developed in the Netherlands to educate general practitioners about the concept of work capacity and the benefits of returning to work, which could serve as a model.

Reform the education and training of medical professionals to ensure that they have the knowledge, training, and expertise to maintain and maximize the functional capacity of their patients.

ODEP and its Job Accommodation Network technical assistance center have extensive expertise in workplace accommodations and assistive technology. Together with IOM, they can reach out to medical professionals to help them develop an understanding of accommodations and assistive technology devices that enable patients with developing impairments or health-related conditions to remain functional at work and independent outside of work. Furthermore, it should be an expectation that appropriate practicing physicians and allied health professionals providing patient care have such training and maintain state-of-the-art expertise in this area.

Ensure health care providers develop an understanding of the range of policy options available for responding to a workplace medical interruption of a worker's career.

Roundtable participants recommended that health care providers must become knowledgeable about the resources of the Family and Medical Leave Act, the workers' compensation system, short-term disability, vocational rehabilitation, and care management. ODEP could work with federal agency partners, such as the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid, to develop a compendium of information geared to health care providers on these laws and programs as they pertain to SAW/RTW.

Provide medical guidelines, especially for general practitioners, about the ideal duration of work absence for the most common health problems, including mental and musculoskeletal health problems.

Sweden introduced medical guidelines in 2007 outlining appropriate periods of sickness absence for the 90 most frequent medical conditions, which account for three-quarters of all sick leave taken (OECD, 2010). ODEP should encourage IOM to consider the issuance of such medical guidelines in the United States.

Administrative procedures, coupled with compliance monitoring and incentives, for medical professionals could encourage sick workers to stay at or return to work.

The development of new administrative procedures that would require medical professionals to support SAW/RTW practices could encourage sick workers to stay at or return to work. OECD (2010) cites Norway as an example of a country with policies obligating general practitioners to guide sick workers in such a way as to "strengthen their work motivation." Sickness certificates are to be based on whether there is adequate medical rationale for absence from work. Beyond six weeks, an extended medical certificate must be prepared and

forwarded to the insurance authority. General practitioners risk losing their ability to issue medical certificates if they fail to follow these regulations, which can have financial implications for their incomes.

For procedures and guidelines to be effective, OECD (2010) notes that compliance must be monitored. Among the countries that have tightened systems for monitoring sickness certificates is Spain, where a dedicated directorate was established in 2004. Spain has an administrative database with detailed sickness-absence histories compiled for the entire workforce, allowing for monitoring of absences that are longer than the average duration for that particular sickness. This case may not be transferable to other countries, however, due to concerns about privacy and confidentiality.

Roundtable participants observed that few incentives are available for doctors to make good decisions about SAW/RTW. Doctors get reimbursed for making a diagnosis, providing treatment, and developing a follow-up plan, not for helping the individual have a plan that involves the other aspects of his or her life, such as work life. Participants urged changing the reimbursement system for doctors to include better incentives for them for participating in SAW/RTW.

Changes to Social Security Disability Insurance to Encourage SAW/RTW

ODEP could work with the Social Security Administration (SSA) and other relevant federal policymakers to reform SSDI to expand the use of partial return to work from sick leave.

Granting partial absence from work has been shown by recent research in Norway to result less frequently in people ending up on disability benefits (OECD, 2010). A policy could be developed in the United States to allow a patient to return to work in a reduced capacity, which limits the period of inactivity. Research by OECD (2010) has found that this policy is particularly useful for the growing number of patients with mental health issues, who may not be fully incapacitated.

ODEP could work with SSA and other federal policymakers to encourage the reorganization of the process for evaluating people applying for SSDI.

Roundtable participants recommended the reorganization of the process for evaluating people applying for SSDI to include the involvement of doctors with special training at designated centers to determine the potential for recovery with appropriate care (which may include addressing overmedication, functional restoration, and behavioral counseling) and the individual's current work potential, with effective vocational rehabilitation and support. The centers doing these evaluations could also serve as training grounds for medical residents of all specialties that engage in "signing the papers" related to work ability. Occupational Medicine specialists could provide clinical oversight of all the residents in disability evaluation issues. They could also provide clinical oversight of Occupational Medicine and Preventive Medicine residents in developing the vocational rehabilitation plans, along with state and local vocational rehabilitation professionals.

According to physicians present at the roundtable, the current emphasis of the process for evaluating people applying for SSDI is on determination of disability and not prevention of disability. It was noted that in conducting disability determinations, social security spends roughly the equivalent of two hours worth of professional time figuring out whether somebody gets onto social security, which typically equates to that person leaving the workforce permanently.

Engaging Employers in Promoting SAW/RTW

ODEP should encourage employers to adopt SAW/RTW policies.

ODEP should work with its alliance partners, the Society for Human Resource Management and the U.S. Business Leadership Network, and the Disability Management Employer Coalition, to raise awareness among employers of the SAW/RTW process. This would include promoting the provision of accommodations and transitional duty as strategies to enable workers to stay at work as opposed to their automatically taking a leave of absence when an injury or illness occurs.

Research and Demonstration Project

The National Institute on Disability and Rehabilitation Research could support a program to plan and conduct a project promoting state and local collaboration for initiatives to prevent needless work disability.

The National Institute on Disability and Rehabilitation Research could support a program to plan and conduct a research and demonstration project promoting collaboration at the state and/or local level for initiatives to prevent needless work disability. This effort could be based on the efforts under way in Arizona through AWDP.

Roundtable participants agreed that the key influencers of the broader “system” — including the full range of medical professionals, the patients themselves, employers, representatives from workforce development systems, mental health services, aging services, social services, vocational rehabilitation, and policymakers — all need to make a cultural shift from disability to work ability and to be educated about the necessity of work as critical to both an individual’s economic and personal wellbeing as well as to national prosperity. The National Institute on Disability and Rehabilitation Research’s support for research and pilot projects could be an important first step in encouraging this cultural shift.

It was noted that in preparing for new research, it would be worthwhile revisiting the lessons learned under the Centers for Medicare and Medicaid Services’ Demonstration to Maintain Independence and Employment. Under the demonstration, the Centers for Medicare and Medicaid Services funded four state studies (Minnesota, Kansas, Texas, and Hawaii) to identify ways to prevent or forestall people from entering federal disability programs.

At the end of the day, roundtable participants concluded that when someone is injured but in an environment where everyone (treating physician, employer, and patient alike) assumes that the individual is going back to work and to a fully productive life, it makes a huge difference in outcomes. Physicians cited the Hippocratic Oath’s mandate to “first do no harm,” noting that if doctors are treating patients and not returning them to work and not maximizing their functional capacity, then they are in fact doing those patients great, often irreparable, harm. Medical school and residency training programs, current physicians, employers, and other partners in the broader system all need to understand and promote the SAW/RTW process and the concept of work disability prevention, including accommodations that can maximize an individual’s functional capacity both at work and at home.

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Appendix A. Roundtable Agenda

September 19, 2012

Hall of the States
444 North Capitol Street, Room 333
Washington, DC

8:30 to 9:00 a.m.
Registration/Coffee

9:00 to 9:15 a.m.
Welcome and Introductions/Charge for the Day

Carl Van Horn, Ph.D., Director, John J. Heldrich Center for Workforce Development, Rutgers University

Andrew Pope, Ph.D., Director, Board on Health Sciences Policy, Institute of Medicine and National Research Council of the National Academies; Forum on Aging, Disability, and Independence

9:15 to 10:15 a.m.

The Role of Medical Professionals in Encouraging Older Workers and People with Disabilities to Stay at or Return to Work: Opportunities for Change

Jennifer Christian, MD, MPH, FACOEM, President, Chief Medical Officer, Webility Corporation and 60 Summits Project

10:15 to 10:30 a.m.
Break

10:30 to 11:45 a.m.

Preparing the Front Line of Medicine to Prevent Needless Work Disability: Private- and Public-Sector Initiatives

Jennifer Christian, MD, MPH, FACOEM (Facilitator)

Edward Alvino, MD, Vice President, Chief Medical Officer, Unum

Marianne Cloeren, MD, MPH, Medical Director, Managed Care Advisors

John Dreyzehner, MD, MPH, Commissioner, Tennessee Department of Health

Ray F. Garman, MD, MPH, FACOEM, Associate Professor, Department of Occupational Medicine and Environmental Health, College of Public Health, University of Kentucky

Dara Johnson, Program Development Officer, Community First Choice, Direct Care Worker Training and Testing Program, Project Director, Arizona Employment and Disability Partnership

11:45 a.m. to 1:00 p.m.

Working Lunch: Panel Discussion/Q&A and Presentation by Assistant Secretary Kathleen Martinez, U.S. Department of Labor, Office of Disability Employment Policy

1:00 to 2:00 p.m.

Multi-Stakeholder Strategies to Prevent, Shorten, or End Work Disability: Panel Discussion

Jennifer Christian, MD, MPH, FACOEM (Facilitator)

Jennifer Hallden, President, Arizona Work Disability Prevention Association

Jan Laurier, Chairman, Blik op Werk, Netherlands WorkAbility Index

Susan Webb, JD, MBA, Director, ABIL Employment Services and President, National Employment Network Association

2:00 to 2:30 p.m.

Panel Discussion/Q&A with Audience

2:30 to 3:30 p.m.

Call to Action: Clearing the Path to Specific Solutions — Strategies for Change

Jennifer Christian, MD, MPH, FACOEM (Facilitator)

3:30 p.m.

Wrap-Up and Adjourn

Carl Van Horn, Ph.D.

Appendix B. Roundtable Participant List

Edward Alvino

Vice President, Chief Medical Officer, Unum

Carol Boyer

Policy Advisor, Office of Disability Employment Policy, U.S. Department of Labor

Margaret Campbell

Senior Scientist for Planning and Policy Support, National Institute on Disability and Rehabilitation

Randee Chafkin

Senior Policy Advisor, U.S. Department of Labor

Jennifer Christian

President, Webility Corporation

Marianne Cloeren

Medical Director, Managed Care Advisors, Inc.

Speed Davis

Senior Policy Advisor, Office of Disability Employment Policy, U.S. Department of Labor

John Dreyzehner

Commissioner, Tennessee Department of Health

Rachel Feldman

Policy Associate, National Association of States United for Aging and Disabilities

Ray Garman

Associate Professor, College of Public Health, University of Kentucky

Ladimir Geake

HELP Disability Office Intern, U.S. Senate HELP Committee

Jennifer Hallden

President, Arizona Work Disability Prevention Association

Maria Heidkamp

Senior Project Manager, John J. Heldrich Center for Workforce Development, Rutgers University

Anne Hirsh

Co-Director, Job Accommodation Network

Christine Jenter

Communications Assistant, John Heldrich Center for Workforce Development, Rutgers University

Dara Johnson

Program Development Officer, Arizona Health Care Cost Containment System

Kathy Krepcio

Executive Director, John J. Heldrich Center for Workforce Development, Rutgers University

Johannes (Jan) Laurier

President, Board, Blik op Werk Foundation

Tracy Lustig

Senior Program Officer, Institute of Medicine

Rita Martin

Deputy Director, Council of State Administrators of Vocational Rehabilitation

Kathy Martinez

Assistant Secretary, Office of Disability Employment Policy, U.S. Department of Labor

Andrew Pope

Director, Board on Health Sciences Policy, The National Academies

Susan Reinhard

Senior Vice President, AARP

Nanette Relave

Director, Center for Workers with Disabilities, American Public Human Services Association

Jenn Rigger

Social Insurance Specialist, Office of Employment Support Programs/Social Security Administration

Lauren Stewart

Senior Policy Analyst, National Governors Association

Carl Van Horn

Director, John J. Heldrich Center for Workforce Development, Rutgers University

Michelle Washko

Policy Analyst, U.S. Administration for Community Living

Susan Webb

Director, ABIL Employment Services

Taryn Williams

Disability Policy Advisor, U.S. Senate HELP Committee

About the Authors

Maria Heidkamp is a Senior Research Project Manager at the Heldrich Center for Workforce Development at Rutgers University. Her research activities have focused on older workers, dislocated workers, and disability employment and its intersection with aging.

Jennifer Christian is a thought leader and innovator in the prevention of needless work disability and the improvement of medical outcomes in workers' compensation and disability benefits systems. Dr. Christian is also President of Weability Corporation, founder and Chair of the nonprofit 60 Summits Project, moderator of the multi-disciplinary Work Fitness and Disability Roundtable, and Chair of the Work Fitness and Disability Section of the American College of Occupational and Environmental Medicine.

About ODEP

The Office of Disability Employment Policy (ODEP) provides national leadership on disability employment policy by developing and influencing the use of evidence-based disability employment policies and practices, building collaborative partnerships, and delivering authoritative and credible data on employment of people with disabilities. Learn more at: <http://www.dol.gov/odep/>.

About the NTAR Leadership Center

Founded in 2007 under a grant/contract with the Office of Disability Employment Policy at the U.S. Department of Labor, the NTAR Leadership Center's mission is to build capacity and leadership at the federal, state, and local levels to enable change across workforce development and disability-specific systems that will increase employment and economic self-sufficiency for adults with disabilities. Learn more at: <http://www.ntarcenter.org>.

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