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INTERNATIONAL ASSOCIATION OF REHABILITATION PROFESSIONALS

Uniting to Promote Interdisciplinary Services for Persons with Disabilities

DISABILITY MANAGEMENT NEWS



DM section kicks off with advanced seminar in San Jose, CA on August 21st

With a focus on advanced, real world applications of Disability Management, the first IARP Disability Management Section Seminar will feature presentations from its own members, and capitalize on our relationship building through our Association to Association membership.

Marcia Carruthers, President of Disability Management Employer Coalition (DMEC) will discuss Productivity and the Bottom-line of IDM. Section Members Janis Moebus of e-Benx, Bruce Flynn of Watson Wyatt Worldwide and Cindy Benner (Past Section Chair) will discuss Responding to RFP's, Issues of Transition from Counselor to Consultant, and Essential Function Job Analyses on a large Scale for ADA Consulting; IARP President Maria Henderson will discuss Training issues in for Attitudinal change

in Integrated Disability Management.

Slated for 5 CEU's, this seminar will be held at St. Teresa Kaiser Medical Center in sunny San Jose, CA. On August 21st, 2000. Look for additional information on the IARP-Disability Management Web Site (www.RehabPro.net) or contact Neil Bennett at (253) 874-0710 or nbenett@wmgld.com.

As part of IARP's Association to Association program we offer special thanks to DMEC for sponsoring Ms. Caruther's presentation and the CPDM credits and CMSA for assisting with site facilitation through Santa Teresa. In return their members enjoy the IARP discount and all participants gain invaluable networking opportunities!

**First thoughts on Disability Management
Neil Bennett, M.Ed. C.R.C., C.D.M.S. Section Chair**

Winging home from the NARPPS/IARP conference in Dallas on American Airlines, stuffed in coach behind a twitchy pre-teen, fending off the hips and elbows of the flight attendants, dodging the chips and sandwiches, I wonder if and how the principles of Disability Management could apply?

➤ If the airline had conducted a needs

analysis and integrated my preference for POS seat selection, would I have removed myself from the rolls of the crammed, into at least the emergency exit aisle?

➤ Although I was in the frequent flyer PPO, I had to request referral for my number to receive credit against my co-pay, irrespec-

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tive of my deductible.

- If I had the ability to self direct my transition between that of conference attendee and hard working slave, would I have opted to have incrementally increase my participation?
- If I was on vacation instead of a work/profession related jaunt, would I have spent my benefits differently?
- Will I know if my baggage will be coordinated to achieve resolution of it's diagnosis at the same time I conclude my period of disability?
- Will I be able to get off the plane, or will I just progress in the disinterested development of my flight?
- Will the airline implement a coordinated effort to satisfy my needs and interests, or just give me the choice of, 'coffee, water or juice?', then block the aisle and not let me get up to use the restroom?
- Does 'improved seating and legroom' really accomplish the desired outcome in a measurable, benchmarked format?
- If I am connecting to another flight/airline, will there be lapse in coverage, or will I experience a smooth, seamless transition?

OK, so maybe it's a stretch to draw corollaries between air travel and real Disability Management, but, if we set our goals to accept, understand, and improve the benefits of systems usage, by learning from the dis-benefits of other systems, then maybe using air travel as an outlier is not such a bad idea. Management of systems is all around us. DM, in its macro role, as defined by the 1998 White Paper, 'advises organizations on the design of the overall DM program, conduct needs analysis, make recommendations, design policies and procedures and manage implementation of company wide DM programs.' In other words, Big DM guys are supposed to have figured out ahead of time how to make my flight more enjoyable and not subject to the above worries. OOPS. 'Little dm' is apparently left to figure out how to reduce the discomfort and irritation of the squirming of the 'seat ahead' teen, by implementation of seat specific behavior management techniques.

With no disrespect to the distinguished authors of the White Paper, who have accurately analyzed the differences between Big and little DM, perhaps now the focus belongs on the practical integration of these paradigms into development of a set of skills that define and empower the 'working DM professional': As a profession, and professional association, perhaps it is time to ask, "So where does that leave us, in the sense of improving our collective professional knowledge and improved business opportunities?"

In reflecting on Steve Start's acceptance speech, I am struck by his comments that, 'in worker's comp, we have (almost) changed the world, in that we have taught employers what to do'. Bad news, on one hand, but good news on the other-as a profession, we have developed the skills to be overwhelmingly successful and able to demonstrate the worth/value of our ideas. Now, how did we do that? By declaring an industry of Big WC? I don't think so. Rather, I think we developed common sense ideas (early RTW programs), albeit in a vacuum, then implemented them. Once Risk Managers discovered how effective these programs were, they began to become more involved and influential in larger scale implementation, leading us to where we are today.

There is a middle ground, and role for the IARP DM section member. We are, I think, for the most part CDMS certified. We need to build on the body of knowledge that established that designation to improve our understanding of, on a day to day basis, how the various systems involved with dm really integrate. If we are to become effective proponents, disciples, or mavens of DM, both in the design *AND* in the implementation/direct service provision, we need to be able to do both. ***The most encouraging news I received at the conference was the results of the recent WBGH/Watson Wyatt survey that supported the efficacy of the coordinated use of two or more of the services we provide on a day to day basis as being the most critical factor in the decrease of disability costs.*** The emergence of DMEC gives us additional partners in this professional development effort. Our upcoming seminar exemplified how our two associations can provide interactive educational experiences that will benefit everyone.

I think about my own practice: starting (First Thoughts, continued) 15 years ago as an ERTW project, one relationship has evolved to meet the challenges that growth and employment patterns dictate as important regarding ADA and HR interface; another new customer has just figured out the value *(Continued on page 6)*

Integrated Disability Management: Considerations for Future Practice

Robert Hall, Ph.D., C.R.C., C.D.M.S.

This article will provide the reader an overview of the current integrated disability management arena and considerations for future practice.

The Integrated Disability Management Landscape

Disability management has evolved in several significant ways over the past fifteen years. When innovative approaches to improved management of disability in the workplace were first introduced in the early 1980's, the majority of programs were internally developed by large employers and staffed by internal personnel. These programs were usually initiated through the efforts of a few key personnel that advocated to upper management that a "better way" was needed to decrease the economic and human costs of disability. Clear differences in the roles and functions of internal and external DM staff have historically been present (Habeck, Kress, & Sculley, 1994).

Early DM programs were most often initially developed to respond to work-related injury and illness. As DM strategies were more widely utilized an increased understanding of workplace disability as a complex phenomena developed. With this understanding came a shift in focus from medically-driven to human resource-driven approaches to disability. This has resulted in the development of organizational efforts to focus on the identification of functional issues around injury & illness and the prevention of unnecessary work absence (Akabas, Gates & Galvin, 1992).

As DM programs demonstrated success in the workers' compensation area, it was logical to look at non-occupational disability programs as well. The heightened visibility given to all aspects of disability resulting from the passage of the ADA and FMLA legislation has served as a catalyst to focus on non-work related disabilities as well. While expanding horizontally across multiple healthcare and benefit systems, integrated DM (IDM) programs have also developed vertically to give more weight to disability prevention initiatives, including safety and wellness programs, supervisor and employee training efforts, as well as organizational interventions that focus on improved human resource systems. As information system capabilities greatly expanded in the 1980's, obvious ap-

plications were found in the IDM arena. Benchmarking and monitoring efforts have become a primary focus and challenge to the continuing evolution and justification of IDM initiatives.

Future Challenges for the IDM Provider

Program experience with integrated disability management has advanced significantly in recent years. Understanding this experience is vital for positioning and effectiveness in the IDM marketplace today and in the future. Several issues/trends have surfaced as a result of this experience that will guide employer-based IDM efforts in the years ahead. These issues/trends are summarized below:

- ❖ Disability in the workplace is a complex phenomena, having medical, psychosocial, environmental, organizational and economic dimensions.
- ❖ Disability has both MACRO (organizational-level) and MICRO (employee-level) components that must both be assessed and managed.
- ❖ MACRO responses to disability are proactive, seeking to prevent the injury or illness or improve organizational systems. MICRO responses to disability are reactive to the individual event, seeking to prevent or mitigate the amount of disability that arises out the employee's injury or illness
- ❖ To be effectively managed, disability must be linked to larger issues of employee productivity and satisfaction.
- ❖ Disability, on both the MACRO (organizational) and MICRO (employee) levels, is directly linked to economic incentives/disincentives that are separate from the medical issues involved.
- ❖ Disability is often preventable, both through improved safety and wellness efforts, as well as improved management of the physical and mental impairments that result from injury or illness.
- ❖ Disabilities occurring in the workplace have traditionally been treated differently and result in different medical and work outcomes than do non-work related disabilities.
- ❖ Decisions around disability and work capacity should not be strictly medical decisions.
- ❖ Management of disability in the

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workplace, just as any human resource issue, is related to organizational culture and structure.

- ❖ Success in integrated disability management is directly related to the level of organizational commitment.
- ❖ Shifting corporate priorities and reorganizing initiatives have resulted in an increasing number of IDM programs being designed, implemented, and administered by a variety of outsourced providers.
- ❖ Many employers, especially those with fewer internal resources, have become increasingly challenged by the complexity involved in management of IDM programs and have tended to look for “single-provider” solutions.
- ❖ Integrated disability management programs (employer-driven) are different than integrated disability management products (provider-driven). Products cannot succeed unless programs are effectively designed and managed.
- ❖ As IDM programs have become multi-dimensional and data intensive, the technical knowledge required to coordinate the programs has also increased.
- ❖ Providers who have established a significant IDM presence can largely be placed into three categories: insurers and claims administrators, benefit consultants, and specialized service providers for medical care and case management, utilization/bill review, return-to-work, safety/ergonomics, and worklife/wellness/employee assistance efforts.

The above issues reflect current general understanding of IDM best practices. They also act as a summary of some of the challenges that exist in the marketplace. A continuum exists among employers and providers, along which the utilization and effectiveness of their IDM programs and products can be placed. With the exception of a few, highly sophisticated employers, most employers are only now acknowledging their integrated disability management needs. Logically, they will expect to take advantage of the learning that has occurred with other employers and seek to “borrow” successful programs. Providers who have an established track record of successful program experience and can successfully tailor programs to individual employer needs and environments will establish themselves as market leaders.

Reactive responses to disability (MICRO), such as medical cost control programs, case management and

individual return-to-work services, etc., still comprise the majority of employer IDM efforts. Proactive responses (MACRO), including comprehensive organizational assessments, policy & procedure development, worklife and prevention initiatives, supervisor and employee training, and fully-developed return-to-work programs for both occupational and non-occupational injuries / illness are still quite rare. To effectively provide responses to disability and related performance issues, IDM providers must understand the continuum that exists between these two levels of service and the organizational underpinnings of each.

As healthcare and disability costs continue to rise, employers and their providers will need to develop alternate methods to control costs as well as retain valuable employees. Utilization of IDM services will continue so long as providers are able to measure the impact of the services and the return on investment that they provide. As discussed in the June, 1995 issue of *Risk Management*, successful IDM programs in the future will address the following issues:

1. Third Party Administrators / Insurers must be incented to move lost-time cases to successful closure.
2. Labor / management conflict as it relates to disability issues must be identified and resolved.
3. Reform of policy & procedures & benefit structures that promote time off work.
4. Elimination of “light duty” programs and the adoption of time-limited “transitional work” programs.
5. ADA complaints that rise out of disability and performance issues for existing employees.
6. Development of corporate healthcare systems that blend the best elements of managed care with injury/illness management.
7. Data systems that track all risk management events, including accident or injuries, ADA complaints, workers’ compensation losses, LTD leaves, and STD applications.
8. Lack of a proactive accident prevention & safety program.
9. The need for an active and utilized Employee Assistance Program.
10. Lack of top management support for loss control programs.

Integration of the above risk management efforts with the human resource issues of productivity and employee retention provides a blueprint for the future of IDM programs and products.

Integrated Disability Management and Integrated Benefits

It is important to highlight the development of integrated benefits as a unique and significant force impacting integrated disability management programs and products. As recently reported by Watson Wyatt Worldwide, over 40% of the one hundred employers surveyed (average size 13,000 employees) are working to integrate their health and disability programs. Integrated disability management was identified as one of four key strategies used by HR and Benefits in integrated benefit programs, along with vendor selection & management, plan design, and medical care. Core outcomes for these programs included:

- ❖ Percentage Cost Trend
- ❖ Number of Avoidable Claims
- ❖ Number of Work Days Lost
- ❖ Level of Employee Commitment / Satisfaction (as they related to overall measures of Employee Productivity defined as Employee Output divided by Employee Cost)

The perceived advantages of benefit integration, i.e. improved return to work, improved financial results, increased productivity, minimized administrative redundancy, and improved employee health are all impacted by integrated disability management programs. The historical disincentives that have existed in many organizations as a result of the differences in benefit structures and their related barriers and cultures are reduced through benefit integration. Achieving benefit integration then provides great stimulus for IDM programs to be implemented across all benefits, greatly expanding the utility and effectiveness of the IDM products. As use of integrated benefit programs expands, the market for IDM products will enjoy growth and expansion as well.

In closing, IDM practice is expected to evolve in ways never anticipated even a decade ago. The merging of IDM with overall human resource, benefits, and risk management practices has created an entirely new, dynamic environment. IDM professionals must become increasingly knowledgeable about and able to function in all areas of employee productivity and work disruption. The opportunity to fully integrate IDM practice into an employer's "way of doing business" has arrived and must be responded to in a sophisticated, coordinated manner to establish IDM for the years ahead.

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References

Akabas, S, Gates, L, Galvin, D. Integrated disability management: A complete system to reduce costs, increase productivity, meet employee needs, and ensure legal compliance. American Management Association (1992).

Habeck, R., Kress, M.& Sculley, S. Surveying the roles of practitioners in integrated disability management. Lansing, MI: Michigan State University (1994).

Schaefer, Rebecca (1995) Risk Management - v42, #2, p. 45.

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Sound Familiar?

What is, " ...a holistic approach...concerned with the total impact of injury, aging and limitations upon both the employer and employee. Aimed at cost containment it is a pro active response to people problems, rather than a reactive response. This coordinated program is designed for prevention, early intervention and restoration of function for the restricted employee, regardless of the cause of those limitations."?

According to Kay Hinds, Ph.D. in Workers Compensation Cost control – A Maverick Approach, (1988) it is nothing less than 'Employer -based ability management'.

Further, the author states that, "the difference between the new term, ability management and the old term 'disability management' is more than mere semantics. It is an attitude."

Food for thought.

DISABILITY MANAGEMENT NEWS



of outsourced services. Both are ready for more DM, when the time is right-my challenge is to be able to meet their needs when they are ready. And, I have a lot to learn in order to be prepared.

So, what I would offer as goals for the DM section for the next two years, is an exploration into an understanding of the research, concepts and tools of the working DM professional. Hopefully we can do this through discussion of ideas on the listserve, articles and comments in this newsletter, and involvement in section program development. After just one Board meeting, I can already tell that Board opportunities to reflect and ponder the vagaries of DM, small and big, will be limited at best. Sectional representation of the day to day business of a national organization will be a challenge that will serve best to raise the SVP level of Board member. Three section members have stepped forward: Janis Moebes, Ed Quick and Kathie McLean. Janis has volunteered to become facilitator of the listserve. She will act as a resource, researching, introducing and moderating relevant topics and monitoring usage patterns. Janis has a very interesting background and perspective in our field, and

I look forward to her contributions. Ed has offered his assistance in the management of the DM web page. He will be researching and developing resource links for us and helping us to stand out as leaders in our field. Kathie has offered her services as co-editor of this newsletter, which is slated to be published at least quarterly.

In closing, and in support of my proposal for the DM section, I am happy to introduce the first of these deliverables-the long awaited DM glossary. This is the result of the efforts of the prior DM Section Chair, Cindy Benner, who developed a partnership with the *Washington Business Group on Health* for the compilation of this interdisciplinary tool.

I hope to hear from you all in the weeks and months to come. Most importantly, *be sure to enjoy your summer.*
