



Implementing a Community-Focused Health & Work Service (HWS)

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Abstract

Our original proposal for a Community-Focused Health & Work Service (HWS) was one of 12 included in the McCrery-Pomeroy SSDI Solutions Initiative. We recommended that the Federal government build the capability to deliver services nationwide that will reduce demand for SSDI by helping working people who lose time from work due to the most common musculoskeletal and mental health conditions to stay employed. Nearly 30 percent of people newly awarded SSDI cite back pain, joint pain, anxiety, or depression as their major problem. Research has shown that the best way to improve both health and work outcomes is to act quickly, discern which individuals need extra attention, and then actively intervene to help them get what they need and get back on their feet. The HWS concept is modeled on Washington State's successful Centers for Occupational Health & Education (COHE) program, which reduced demand for long-term disability pensions and SSDI by 30 percent. It is also grounded in more than 20 years of disability prevention research, policy, and program innovations in both the UK and the US. As designed, the HWS is an addition to a community's social fabric and serves a target population whose unmet needs create demand for disability programs but have been largely overlooked until now. This concept is new and quite different from other disability-related programs, so implementing it will be a challenge. Part 1 of this paper is aimed at policymakers. It asks and answers fundamental questions in order to garner support for implementing a HWS. Part 2 alerts those who will guide or run the program at the national or state level to some critical issues that will lead to success or failure of the operationalization effort – and influence the outcomes produced. It also addresses some little details that could derail the program unless noticed and well managed by those responsible for delivering services in individual cases. For one example, this includes allocating substantial resources to marketing and community relationship building in order to assure a sufficient and on-going volume of referrals. Part 3 considers the interaction of program design and development challenges with the imperative to objectively evaluate program effectiveness. The Technical Appendix provides even more practical advice on key topics for local operators, such as suggested hiring criteria, training requirements, details concerning the referral process, eligibility screening, behavioral incentives, information management during start-up, and so on.

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This paper has been published as part of the McCrery-Pomeroy SSDI Solutions Initiative, a project dedicated to identifying practical policy changes to improve the Social Security Disability Insurance (SSDI) program and other policies for people with disabilities. More information about the SSDI Solutions Initiative is available at <http://www.SSDISolutions.org/>.

The SSDI Solution Initiative is a project of the Fiscal Institute at the Committee for a Responsible Federal Budget. The views expressed in this paper represent those of its authors and not organizations or individuals affiliated with the authors, the McCrery-Pomeroy SSDI Solutions Initiative, or the Committee for a Responsible Federal Budget.

Permanent Link: <http://www.crfb.org/project/ssdi/implementing-community-focused-health-work-service-hws>

Introduction

This paper is a follow-up to our original proposal for the development and refinement of a Community-Focused Health & Work Service (HWS). It focuses on implementation issues at two levels. This is Part I, in which we provide the rationale for our proposal, describe some relevant intervening events since it was proposed, and then briefly summarize the specific features we envision for the HWS. The rest of Part 1 asks and answers five questions that policymakers might reasonably pose before deciding whether and how to implement (create) something like an HWS via legislation and/or other processes available to them.

In Part 2, we discuss some issues that a state agency or similar entity charged with actually implementing (operationalizing) an HWS as a program would need to address, while Part 3 covers design and evaluation issues. In doing so, we make suggestions for how to optimize the likelihood the program will fulfill its purpose and produce the expected outcomes. Lastly, the online [Technical Appendix](#) contains more practical information at a level of detail we hope will be useful for those actually carrying out those tasks.

Overview of Proposed Health & Work Service (HWS)

Our society today offers little help to workers who are struggling with work disruption, especially those experiencing common health problems (CHP) that are the most frequent causes of short- and long-term work absence: musculoskeletal disorders (MSK) like back, shoulder, and knee pain, and common mental disorders (CMD) like stress, anxiety, and depression. As a result, too many of these workers end up with unexpectedly poor recovery and job loss – both of which can often be avoided.

Recent reviews of the evidence show that work promotes positive physical, mental, family, and social wellbeing for working-age adults, including those with chronic health conditions (Waddell and Burton 2006) – and how worklessness does the opposite (Rueda et al. 2012, Waddell and Burton 2006, Strully 2009). Thus, in addition to supporting people with longstanding disabilities enter into employment, a major effort should be made to help working adults preserve their work ability when health problems start disrupting their ability to work so they can stay in the workforce. Avoidable impairment and loss of livelihood are not yet recognized as very poor outcomes of medical care and employer-based disability benefits programs, but we believe they should be.

Policy and program changes can be made to increase the likelihood that workers with new health-related work disability get timely help and keep their jobs or promptly find new ones – similar to the way that policy changes have been made to support more people with longstanding disabilities enter into competitive employment. A program in Washington State has confirmed under real-world conditions what research studies have already shown: rapid response to new episodes of health-related work disruption and delivery of evidence-based simple, short-term interventions can improve both health and work outcomes and even reduce eventual job loss and entry onto Social Security Disability Insurance (SSDI) by as much as 30 percent (Wickizer et al. 2018). The designers of that program realized that change needs to occur in systems at the community level because that is where workers live and work, and it is also where their health care is delivered face-to-face.

The HWS we propose will offer something that is presently missing in most communities: access to simple and short-term services by experts in the stay-at-work and return-to-work process (SAW/RTW) soon after those individuals begin struggling with the simultaneous challenges of:

- Dealing with a common health problem that has started interfering with their work,
- Navigating today's complex health care and benefits systems, and
- Wondering what the future holds and whether this means their livelihood is in peril.

In order to operate cost-effectively, the HWS must be able to:

- quickly recognize and release with a just bit of guidance the large group of workers likely to get back to work as expected and the resources already available to them;
- focus its energies and effectively assist the subset of individuals who need help because they are vulnerable or in difficult situations that may derail recovery and SAW/RTW; and
- refer elsewhere those workers with medical, bio-mechanical, legal, or other risk factors for prolonged work disability that require more expertise and resources than the HWS has to offer.

By responding with alacrity and providing limited assistance during the critical early period of situations that fit its eligibility criteria, the HWS can reduce the number of workers going on to prolonged work disability. This means the HWS will exert greater leverage with much less effort and expense per case than existing programs that are geared for people who have been living with disabilities for a significant period of time: months, years, or a lifetime.

In addition to providing assistance in individual situations, the HWS we propose will also drive ongoing positive change: bridging gaps and enriching existing local systems of care while strengthening each community's ability to keep people functional, productive, and employed despite the occurrence of CHP. In doing so, the HWS will also build capacity and interconnections within and across the health care, employment, and insurance sectors, strengthening the community's ability to support its working people when they need help managing the impact of CHPs on their lives and livelihoods.

The design of the HWS is a synthesis of desirable features of two innovative initiatives: one the Centers for Occupational Health & Education (COHE) in Washington State, and the other the Fit for Work Service in the United Kingdom. Although the core issues that the HWS addresses and the interventions it delivers will be similar across the entire program, some specific features will differ due to variability in laws among jurisdictions, in geographic realities, and local cultures. Our original proposal and its three appendices offered rationales and suggestions for the program's design, orderly development, testing, evaluation, and implementation, and is available at www.SSDISolutions.org.

Below is a summary description of how the HWS will look when it is in operation:

- HWS will be a secondary prevention program: averting adverse secondary consequences and avoidable work disability. HWS will get involved very early in individual episodes of health-related employment disruption – ideally after one week of work disability, and never later than the sixth week. In general, the program will end by the three-month mark, though it may occasionally extend to six months for a specific medical reason. The purpose of HWS involvement is to ensure episodes unfold in a way that puts the worker on track, given their circumstances, for optimal restoration of functional ability and participation in society, including retention in the workforce.

- HWS will be a multi-disciplinary **membership organization** that augments and enhances the existing system of care for working people in a specific geographic area or region. It will be a magnet for workers, physicians, employers, labor groups, and claims payers because of its independence, impartiality, and expertise as well as its explicit commitment to “best practices” and a philosophy that minimizing life and work disruption due to illness and injury has substantial benefits for workers, their employers, and the community – and that job loss should be avoided.
- The target population served by the HWS is not “people with disabilities.” Instead, it is working people who at the moment see themselves as too sick or injured to go to work and do their usual tasks – and might develop prolonged work disability. HWS will solicit referrals of individuals with new health-related employment disruption (no matter the cause of the health problem, whether work-related or not) from any party involved in the episode. The HWS will not provide any hands-on medical care. HWS will offer special expertise in multi-party communication, coordination, and problem solving to facilitate functional recovery and the stay-at-work and return-to-work process (SAW/RTW).
- The HWS will conduct most of its interactions in individual cases telephonically and online, since this has been shown to be as effective and lower cost than services delivered in person at a particular location.
- As referrals are received, HWS staff will identify the subset of workers in situations that pose a risk for unusually poor outcomes. For that group, HWS staff then serve as guides and interlocutors with a purpose, which is to identify the reasons for reduced work ability, develop a plan of action to overcome those obstacles, and assist in carrying it out. The interactions will take a human-centered (biopsychosocioeconomic) approach and include demonstrating empathy, concern, and care; providing empowering information and practical tips; facilitating communications among the worker and any professionals who are involved; and coordinating the SAW/RTW process between the medical office and the workplace.
- Physician members of the HWS will agree to adopt the HWS’s set of recommended occupational health best practices that have been shown to improve work ability – and will be paid every time they perform one. As members, physicians also gain access to HWS staff to help them deliver appropriate SAW/RTW outcomes for their patients.
- Employer members of the HWS will also gain access to HWS staff for assistance with implementing SAW/RTW plans and will receive financial incentives when they refer eligible workers and agree to provide temporary work adjustments and/or reasonable accommodations that enable SAW/RTW.
- The staff within the HWS consist of: (a) Recovery Coordinators who focus on resolving obstacles to SAW/RTW in individual worker’s situations, (b) Community Relations staff who build and nurture collaborative working relationships between the HWS and community physicians, employers, benefits payers, labor groups, and community and government agencies; and (c) Administrative staffers who manage and deliver financial and/or other types of incentives to physicians and employer members and support the general operations. HWS will also contract with consulting physician specialist advisors as well as various professionals offering specific services and solutions that may be required to effect a successful SAW/RTW.
- Based on findings from actual programs as well as research studies, we estimate the level of effort required will vary from 30 minutes for processing new referrals to eight hours of HWS professional effort for the predicted 5 percent of complex cases, with a median level of effort per referred case of 1.5 hours (Wickizer et al. 2011, Wynne-Jones et al. 2018). The very few cases requiring different kinds of services or more intensive or longer-term services will be referred out to other existing programs.

Relevant Developments Since Our Original Proposal

In the interval since we made our original proposal, three relevant developments have occurred. First, a new analysis of eight years of follow-up data from Washington’s COHE program confirmed that it substantially reduced withdrawal from the workforce and reduced award of total disability pensions or SSDI benefits by roughly 30 percent (Wickizer et al. 2018). Second, the UK’s checkered experience with the launch of its Fit for Work Service offers important lessons. That program was canceled due to critical failings in details of its implementation and operations, even though the conceptual design had a solid evidence base and strong political support. Funding constraints resulted in some critical deviations in actual operations from the evidence-based model. The main problems included low referral rate, inadequate funding for staff training, and worker perceptions that the service as delivered was unhelpful (U.K. Department for Work & Pensions 2018). Third, the U.S. government decided to invest more than \$100 million in a five-year demonstration project in eight states called RETAIN – a project that appears to have significant similarities to our HWS proposal (U.S. DOL 2018). However, RETAIN allows states to propose their own programs and has an extremely accelerated (and in our view unrealistic) timeline for design, development, rollout, and evaluation. See the [Technical Appendix](#) for key details about these developments, especially quantitative data from an eight-year follow-up of the Washington COHE program showing the beneficial impact on long-term outcomes.

PART 1: QUESTIONS AND ANSWERS: WHY AND HOW SHOULD THIS PROPOSAL BE IMPLEMENTED?

This section anticipates and answers questions that policymakers might reasonably ask when considering whether and how to incorporate our ideas for a HWS into a policy or program or legislative agenda.

Q-1. Why should HWS focus on MSK and CMD?

Although most people agree that work disability is an unfortunate outcome, few people realize how often worklessness can – and thus should – be prevented. This is particularly true for health conditions for which severe impairment and permanent withdrawal from the workforce are unusual and result in unexpectedly poor outcomes; for example, MSK and CMD.

Yet today too many people experience those poor outcomes, their lives going downhill after onset of MSK and CMD with profound life disruption, prolonged work disability, job loss, loss of livelihood, and subsequent dependency on social safety net programs. There are usually other adverse secondary consequences of the original problem, such as intractable chronic pain, anxiety or depression; addiction to opioid medications; over-impairment due to ill-considered medical advice or ineffective or inappropriate medical and mental health care; or frank bodily harm due to bungled surgical procedures that were not necessary in the first place (IOM 2001, Dartmouth 2008, Franklin and Mueller 2015). One of the saddest outcomes is the creation of people who now consider themselves as invalid: too sick or damaged to continue working and enjoying the many benefits of full participation in society. And it all could have been avoided.

Recent reviews of the evidence show how work promotes positive physical, mental, family, and social wellbeing for working-age adults, including those with chronic health conditions (Waddell and Burton 2006) – and how worklessness does the opposite (Waddell and Burton 2006, Strully 2009). Thus, in addition to supporting people with longstanding disabilities into employment, a major focus of public policy should be to help working people preserve their ability to function and work when they experience a health problem so they can stay in the workforce.

Most working people experience a variety of CHP at intervals over their working lifetime that may interfere with their ability to carry out all of their usual responsibilities for a short while. Many do not even seek medical care. People often continue working despite aches, pains, and levels of anxiety and depression that would benefit from treatment but have not been diagnosed. The vast majority of people with CHP either lose no time from work or are able to return to work within a matter of days. MSK and CMD are among the leading causes of short-term work absence.

Most people understandably presume that the reason why people with new medical conditions start losing time from work is because work avoidance is medically required. However, complete cessation of usual daily activity is rarely medically required beyond a very short period of time (Stay-at-Work and Return-to-Work Process Improvement Committee 2006). In fact, research has shown that for MSK and CMD restoring a normal daily rhythm of life as soon as possible during recuperation is generally beneficial and speeds healing (Caruso et al. 2010, Darlow et al. 2012, Franklin et al. 2013, Franklin and Mueller 2015, Loisel and Anema 2013, Rueda et al. 2012). Thus, it is usually appropriate and often beneficial to stay at or return to work performing tasks that are safe and medically suitable while awaiting maximum recovery.

But some – a small minority – of workers with new or changing health problems are headed for a poor outcome unless something happens to turn it around. Some of those on the wrong path are particularly vulnerable due to a history of adverse childhood experiences (ACEs) that altered their nervous systems and increased the likelihood of both health problems and disability in adulthood. The relationship between ACEs and disability remains strong even after adjustment for physical and mental health conditions (CDC 2010, Hughes 2017, Liu 2013, Schussler-Fiorenza Rose et al. 2014). Other workers have been caught unprepared or ill-equipped to deal with their predicament. Those with low health literacy are uncertain about how to interpret their symptoms, afraid of what their pain means, and thus afraid to move. They do not know how to interact with their caregivers or how to participate in their own recovery. Workers whose confidence in themselves and their work capacity has been shaken are often unsure whether they can make it if they return to work or when and how to do so. Some are concerned about the effects of work on their injury or illness and are unaware of the safety or benefits of working during recovery and the negative consequences of prolonged work absence.

Workers may get inadequate, inaccurate, contradictory, or frightening information and advice from various parties, including their physicians and employers (Barsky 2017, Bowling 2000, Colloca and Finniss 2012, Darlow et al. 2011). Workers may request or receive inadequate, excessive, inappropriate, or harmful medical care (Franklin et al. 2008, Franklin et al. 2014, Nguyen et al. 2011). Workers often assume a passive position, feeling dependent, powerless, and sometimes resentful and stuck in a big system (Aurbach 2014). Any or all of these things may keep them stuck in limbo for months at a time or for the rest of their lives. Many of those in these difficult situations could have had good outcomes and continued to earn a living but instead end up dispossessed: they have suboptimal functional recoveries, leave the workforce, and end up dependent for the rest of their lives on disability pensions or benefits.

Among the millions of cases of CHP that occur each year, a small fraction have unusually difficult or stalled recoveries, treatment failure, and even job loss. For example, roughly 10 to 20 percent of workers who receive work disability benefits end up with prolonged time away from work – weeks or months instead of the more typical few days (Neuhauser et al. 2018, Wickizer et al. 2011). A small number out of every 100 new workers’ compensation cases ends up withdrawing from the workforce permanently (Wickizer et al. 2011). CHPs are also the leading causes of long-term disability claims, but by the time individuals are eligible for benefits, most have already lost their jobs (Kuhnen 2016).

While the proportion may be small, the numbers are huge and costly for society. The population of workers dealing with newly-disrupted lives and livelihoods – and their reasonable need for help navigating the challenges they are facing – has been in our society’s blind spot.

SSDI is the final option for many working people who have ended up with unusually poor outcomes as a result of CHPs as well as those who suffered catastrophic injuries or who are now living with irreversible losses of function due to an illness with an inevitably poor prognosis. Today, more than a third of all new SSDI awards are being made to individuals with MSK or CMD diagnoses (SSA 2018), which apparently gradually transformed their lives into “creeping catastrophes.” Over time those conditions, rather than improving as expected, worsened and evolved into long-lasting impairments with indefinitely prolonged work disability that need not have occurred.

Q-2. Why should the taxpayers (government) subsidize efforts to prevent needless work disability and preserve livelihoods?

When one looks at the large number of SSDI awards now being made to people whose CHPs evolved into creeping catastrophes as evidence of system failure, openings for action appear. Today’s fragmented and siloed processes for health care and benefits administration during health-related work disruptions are failing to protect vulnerable workers with CHPs or those in difficult situations from prolonged work disability and needless loss of livelihood.

We recommend that the U.S. Government take a major role in an effort to protect American workers and itself (and the taxpayers, general public, and other levels of government) from avoidable costs and other consequences of work disability that could and should have been avoided. Research indicates that instituting a secondary prevention approach (see more below) can mitigate the long-term impact of new CHPs on working peoples’ lives and livelihoods, thereby reducing demand for SSDI benefits and reducing pressure on other government programs that serve people who are not working for health reasons.

Most insurance companies have risk management programs designed to identify potential events that may adversely affect the financial health or other aspects of their company and take proactive steps to prevent those events from occurring and/or defensive steps to minimize their impact. SSDI, which is the largest disability insurance program in the world, currently has no risk management program. What is needed is a comprehensive Federal risk management strategy to enhance the wellbeing and productivity of the working-age population while protecting the solvency of SSDI as well as other work disability-related programs funded by public money or administered by the government.

A logical as well as humane strategy to protect SSDI would be for the U.S. government to make policy and program changes so that more workers who develop CHPs preserve or regain their ability to function and continue earning a living. Reducing the number of new SSDI applications and reducing the strain on the SSDI Trust Fund is a way to free up resources to provide better service and more support to persons who have devastating conditions, have suffered irrevocable losses, or have disabilities that make it impossible for them to work.

To our knowledge, there is currently no organization in this country – neither a governmental agency nor a non-government organization – that has any explicit accountabilities for systematically avoiding needless work disability. No organization has been assigned ongoing responsibility for tracking and reporting job loss due to illnesses and injuries in working people, much less preventing it from happening by providing policy leadership, research funding, or direct services of any kind.

A Federal disability risk management program should not focus primarily on issues related to the medical condition itself because the factors that predict unexpectedly poor outcomes (serious impairment and prolonged work disability) as a consequence of MSK, especially low back pain, are not tightly related to either the specific diagnosis or the extent of the pathology (Caruso 2013, Franklin et al. 2014, Franklin and Mueller 2015, Habeck et al. 1998, Harris et al. 2009, Johnson and Fry 2002, Mahmud et al. 2000, Nicholas et al. 2011).

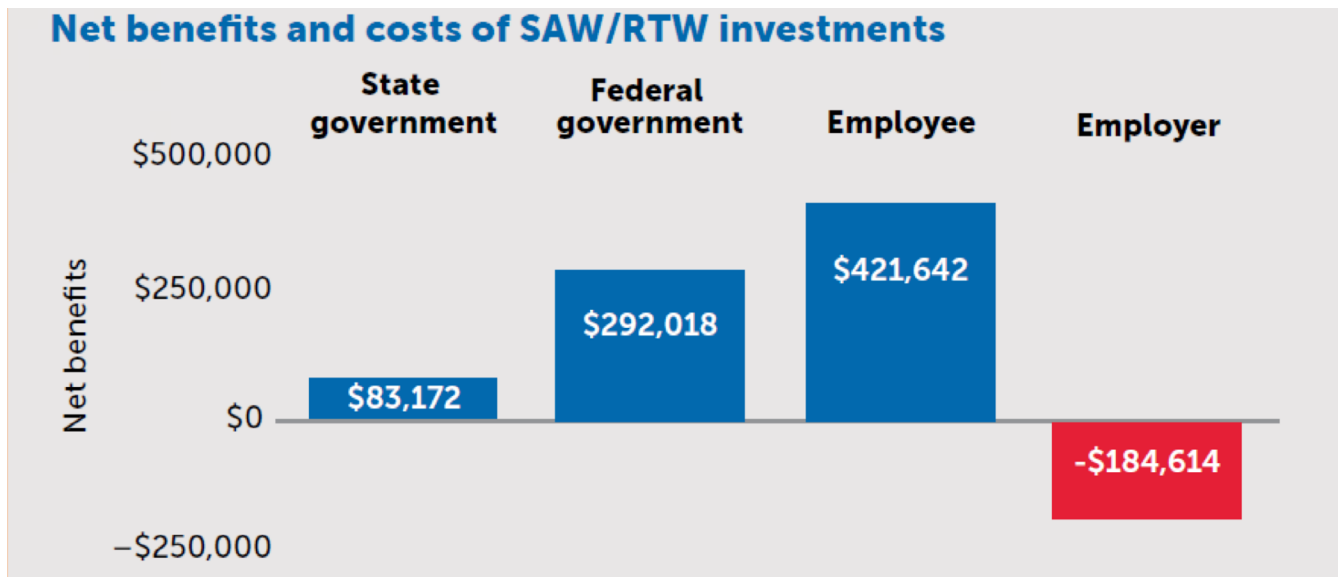
Instead, a Federal disability risk management program should focus on risk factors that affect outcomes and can be influenced. Some risk factors are immutable (such as age, previous events, past medical history, and work history), but others are potentially remediable. These include elapsed time out of work (Caruso et al. 2010, McLaren et al. 2010, Loisel and Anema 2013, Wickizer et al. 2011); delays, uncertainty, and distrust due to lack of communication or information (Bowling 2000, Besen et al. 2016, Loisel and Anema 2013); uncoordinated or inappropriate medical care and advice (Abásolo et al. 2000, Barsky 2017, Berwick and Gaines 2018, Colloca and Finniss 2012, Darlow et al. 2012, Franklin et al. 2014); low expectations of recovery (Cornelius et al. 2011, Sullivan et al. 2005); excessive vigilance, catastrophic thinking, false beliefs, fear of pain, fear of re-injury, or perceived injustice (Sullivan et al. 2005); and lack of employer support (Cornelius et al. 2011). Less research has been done on factors that predict poor outcomes in CMD, and diagnosis does play a more significant role, but there are important non-medical influences on the outcomes of these conditions as well (Arends et al. 2014, Cornelius et al. 2011, Loisel and Anema 2013).

Thus, the trajectory of health-related work disruption over time is being influenced by biological, psychological, social, and economic factors. To acknowledge this reality, a new conceptual model of sickness and disability has crystallized referred to as the biopsychosocial model of sickness and disability (Waddell et al. 2008, Waddell et al. 2009, Loisel and Anema 2013, Schultz and Gatchel 2016), or more recently the biopsychosocioeconomic (BPSE) model (Christian 2015). To date, however, effort is rarely made to identify specific non-medical obstacles in work disability situations and then apply a problem-solving approach. By doing so, interventions such as the HWS can resolve obstacles to work quicker, more effectively, and at a much lower cost than improved access to medical care (Waddell et al. 2008).

Both workers and government have a lot at stake that would justify systematic efforts to avoid needless work disability and job loss. The private sector’s current standard processes for medical care and benefits administration offer insufficient help. None of the three professionals who typically respond to health-related work disruptions (doctors, employers, and benefits administrators) see their job as driving the situation towards an optimal outcome, nor is there any accountability for them or the organization that employs them when jobs are lost (Christian 2015). Today’s fragmented health care, employment, and insurance sectors have not been and are unlikely to ever be appropriately configured or incentivized to meet the reasonable needs of workers with tenuous attachment to the workforce: aging workers, those who work for smaller companies, those in low wage jobs with high physical demands, those with lower educational attainment, or those who have no employer (do contract or temporary work, do casual labor, or are self-employed). The cost-benefit ratio for efforts to prevent job loss look very different in the private sector. In fact, most current attempts to intervene in work disability situations are not made until months or years later – long after the best opportunities have passed by (Stay-at-Work and Return-to-Work Process Improvement Committee 2006).

The economic value to government and taxpayers of retaining workers in the workforce has recently become much clearer. Figure 1 displays the substantial difference that keeping a middle-aged worker in the workforce can make (Ben-Shalom and Burak 2016). In this case, a hypothetical worker earning the median wage who is able to stay employed for another 20 years after reasonable accommodation will benefit from more than \$400,000 in additional earned income over that period. The benefit to the Federal government will be almost \$300,000. The benefit to state government will be roughly \$80,000 due to continued tax revenue and avoided disability-related program costs. But surprisingly, the model predicts in this case that the employer will lose money because of specific facts in the hypothetical case including a 16 percent loss in overall productivity due to the period of work absence and the reasonable accommodation.

Figure 1



Overall, it seems inequitable as well as fiscally irresponsible for the Federal government to continue to ignore the needs of workers while they are slowly becoming disabled for preventable reasons.

Q-3. Why is a secondary prevention approach the best way to do this?

The secondary prevention approach can be summarized as “take action to keep little things little and stop them from becoming serious future problems.” A seemingly minor issue can be a signal that a process has begun which (only in some cases) will gradually transform into a very big challenge later. The aim of secondary prevention is to detect those small signals early and take action that short-circuits the transition. Secondary prevention requires touching many people to protect the few who would otherwise be destined for serious problems later. These programs are only put in place if they can be delivered timely, safely, and cost-effectively. The effort, hazards, and expense of delivering a program must be less than the consequences of letting things go along their predictable course.

The public is more familiar with primary prevention in which the aim is to stop bad things from happening at all. Smoking cessation and seat belt use are primary prevention techniques. Tertiary prevention techniques are used after a big problem has already occurred, so they tend to be more extensive and expensive; their aim is to avoid additional damage and reduce future costs. In the disability arena, some examples are spinal cord rehabilitation and vocational rehabilitation.

A secondary prevention approach is perfect for workers whose health has started affecting their work ability. The best opportunity to avoid the drift to work disability is early in the course of the episode while it is still possible for a small intervention to powerfully influence the future course of events. During this unsettled period, workers are typically left to fend for themselves and must decide how to deal with this life predicament. Most are resilient or in a supportive setting. Some are better prepared to respond appropriately and make wise decisions in those circumstances than others. Some have already reacted poorly to the stress or unfortunate experiences. They are formulating their view of their predicament, developing their expectations for how things are likely to unfold, and deciding what to do about it, either explicitly or by default. Some are eager for expert guidance and practical assistance.

Thus, a small intervention can have a major impact if delivered near the beginning of the episode – while things are still fluid before the worker, the doctor, and the employer have settled on suboptimal strategies for how to deal with it. Research on persuasion says influencing someone’s thinking before they have made a choice is much easier than getting people to change their minds after they have made a decision (Cialdini 2007).

Research has also confirmed that the likelihood of a good outcome is influenced, for good or ill, by what happens during the first few days or weeks after onset (Bowling 2000; Cornelius et al. 2011; Franklin et al. 2013; Loisel and Anema 2013; Nicholas et al. 2011; Shaw et al. 2013; Waddell and Burton 2004; Waddell, Burton, and Main 2001). See the diagram in Figure 2, which shows some specific issues and events that can drive situations in a favorable or unfavorable direction. Many unexpectedly poor outcomes are due to obstacles to recovery that were neither identified nor addressed in the early stages, when they are readily amenable to change (Darlow et al. 2012; Franklin et al. 2008; Franklin et al. 2014; Franklin and Mueller 2015; Habeck, Hunt, and VanTol 1998; Nguyen et al. 2011). Thus, there is sometimes only a fleeting opportunity to address and resolve pivotal issues.

A timely analysis of situations can often identify potentially fixable problems. Someone who understands the SAW/RTW process can often resolve them by simply facilitating problem-solving communication and coordination among all of the parties directly involved. The Washington State COHE program is the largest program to date to demonstrate that these simple things work: ensuring everyone has the same facts, clarifying the nature of any issues, providing education and reassurance, soliciting solution ideas from an expert, getting everyone on the same page, agreeing on a plan and a timeline, and so on. These small things are low-cost and high-leverage; they can change the future course of events.

Thus, the best way to prevent later adverse secondary consequences of these conditions is to implement a secondary prevention program. It starts from the presumption that on day one of work disability, some vulnerable workers and difficult situations already exist, and (importantly) as early events unfold, the level of risk may rise or fall. However, the basic descriptive information about the participants in a new work disability situation are usually limited to proper names, company names, places, dates, diagnoses, body parts, and accident descriptions. That data does not identify the situations in which the HWS is needed and can make a difference. Based on the available information, it is impossible to know which ones they are.

Although it may seem most cost-effective to wait until it becomes clear who is in trouble before intervening, time is passing and the dynamics that will drive some cases toward poor outcomes are irrevocably altering the course of the episode. This is the window of opportunity (Waddell and Burton 2004) to optimize the overall outcome of these situations by simultaneously attending to the worker's initial needs and concerns (Shaw et al. 2013) as well as by coordinating and streamlining the medical, functional restoration, and occupational aspects of the situation (Wickizer et al. 2011).

The first step is to establish referral criteria by which doctors, employers, and insurance companies can select cases to refer. They may have access to databases that allow them to refine the process of identifying potential candidates (Bourbonniere and Mann 2018, Contreary et al. 2018, Neuhauser et al. 2018). Until computer-based predictive analytics are capable of accurately identifying the workers and situations most at risk, the HWS will need to respond to a new referral with a manual but efficient triage process, sorting the cases into groups by apparent level of risk. A referral form plus a very brief structured interview by phone will be effective as a first step in separating low from potential risk cases (Young 2015, Young 2017). Those deemed low risk as well as those not meeting referral criteria will receive some practical and plainly written information and then be released.

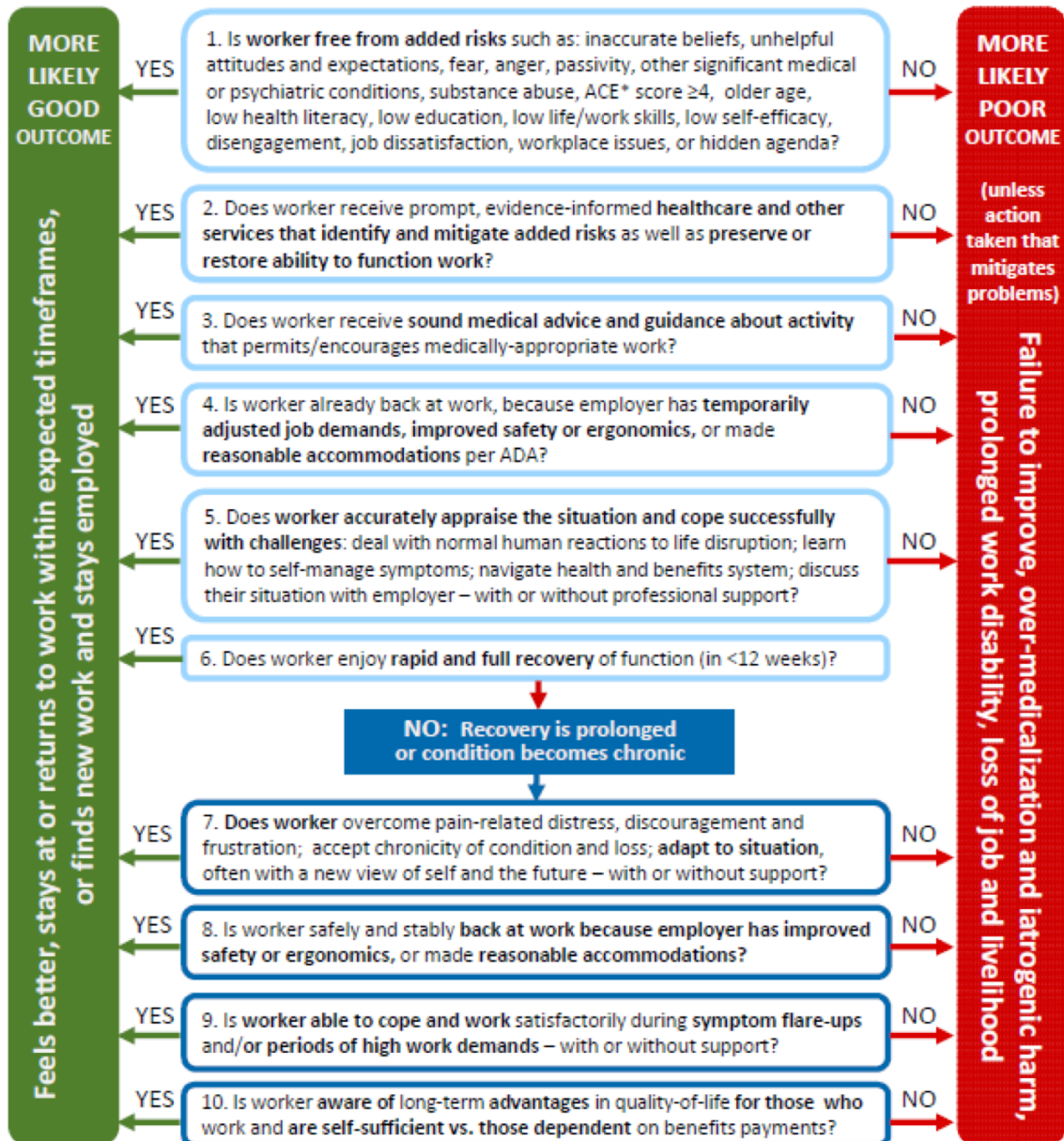
Figure 2

How to Mitigate Risk Factors for Long-Term Musculoskeletal Work Disability

As a worker's health episode unfolds, situational factors and events increase the likelihood of a **good** vs. a **poor** outcome

START: Worker seeks care for a common musculoskeletal (MSK) condition

Typical symptoms: pain, weakness, swelling, spasm, decreased function.
80-90% of episodes resolve rapidly and rarely cause job loss.



* ACE = Adverse Childhood Experiences. See www.cdc.gov/violenceprevention/acestudy

Chart by Jennifer Christian MD, member of SAW/RTW Policy Collaborative, ODEP, US Dept. of Labor v.2017-08-26

For those in the potential risk group, the next step is a more thorough screening that both verifies the risk classification and identifies specific and potentially remediable issues needing attention. Multiple screening methods and tools have been developed and deemed both predictive and useful (Kendall et al. 2009, Caruso et al. 2010, Laisne et al. 2012, Loisel and Anema 2013, Lotters and Burdorf 2006, Melloh et al. 2009, Nicholas et al. 2011, Schultz and Gatchel 2016, Shaw et al. 2013, Turner et al. 2008). At screening, some cases will be re-classified as low risk. Some high risk cases will have needs that the HWS is not equipped to meet and will be referred elsewhere for services as appropriate. Cases that meet HWS eligibility criteria will receive brief HWS services. Many studies have tested and support the benefit of simple and practical interventions delivered with a human touch for CHPs (Aurbach 2014, Bowling 2000, Burton et al. 2013, Caruso et al. 2010, Cullen et al. 2018, Loisel and Anema 2013, McLaren et al. 2010, Russell and Kosny 2018, Schultz and Gatchel 2016, Sullivan et al. 2005, van Vilsteren et al. 2015), including MSK (Iles et al. 2012, Mahmud et al. 2011, Nicholas et al. 2011, Waddell and Burton 2004, Waddell et al. 2008, Wickizer et al. 2004, Wickizer et al. 2011, Wynne-Jones et al. 2018) as well as for CMD (Brenninkmeijer et al. 2019, Lagerveld et al. 2012, Lerner et al. 2015, Mikkelsen and Rosholm 2018, Novack 1987, Parloff 1986, Reme et al. 2015, Stone et al. 1966). The last step is follow-up monitoring to ascertain the impact of the intervention.

Predictably, the triaging process will misclassify some truly high-risk cases as low risk, or the passage of time will increase the level of risk in some cases because of an unfortunate event. Therefore, every worker referred should receive helpful information – such as lists of community resources and/or empowering written advice on how to cope with the life and work disruption while they recover from their illness or injury. Getting this written guidance will be an important benefit the HWS delivers to all referred workers, be they high or low risk, as well as the employer or physician who referred them. Indeed, the referring party should receive a copy of the brochures given to the worker, along with one tailored for them with suggestions for what they can do to drive their end of the situation in a good direction. Consistent messages and basic guidance are crucial to get all stakeholders onside, neither of which are routinely provided anywhere now. Information delivered on a “just in time” basis can equip and empower the three key stakeholders to play their parts well.

Q-4. Why is a government-subsidized Community-Focused Health & Work Service the best way to deliver this secondary prevention approach?

A generally-agreed role of government is to intervene in the private marketplace when that marketplace fails to provide goods or services for which consumer demand exists. In some cases, the failure to provide services when demand exists arises because of externalities, and a service can have qualities of a “public good.” In the case at hand, secondary prevention activities are services having public good qualities, combined with externalities that arise because injured or ill persons who suffer avoidable work disability ultimately end up on SSDI at a significant cost to taxpayers. The private sector will not offer prevention services to reduce avoidable long-term work disability at all or in sufficient quantity to meet consumer demand. Most employers tolerate a certain amount of employee absence and turnover as a usual cost of doing business. Insurers adjust their claim operations to meet the cost and service expectations of their employer customers and can adjust premiums as necessary to maintain profitability. Hence the rationale for some sort of public intervention as described here.

We believe that, by themselves, modest policy changes or financial incentives are unlikely to produce shifts in behavior that will noticeably reduce avoidable work disability and job loss due to CHPs – enough to meaningfully preserve the SSDI trust fund. The economic incentives to preserve the status quo are too strong.

From an organizational perspective, we recommend that the HWS be a discrete national program overseen by an organization that is both committed to its secondary prevention approach and that will be held accountable to the public for minimizing job loss and preventing needless work disability.

At the community level, the HWS will solve problems that many organizations (businesses, medical practices, insurers) view as minor – problems that are tangential to their core business, infrequent, and/or so technical that it doesn't make sense for them to invest the time and money required to develop the internal capability to solve themselves. Those same problems, however, loom large in the lives of individual workers. From the perspective of the social fabric, the HWS solves a practical problem by supplying actual assistance with the SAW/RTW process that is now sparse or missing entirely in specific locales while actively working to build more capacity in the community to handle more of the easier problems themselves. Lastly, due to its voluntary (yet aspirational) membership structure, the HWS will not increase the burden of government regulations or requirements on any of the stakeholders.

Over time, the HWS will attract more doctors and employers as members, and they will increasingly adopt the best practices. The number and nature of individual cases in which the HWS staff needs to actively intervene will be reduced as simple cases are handled well within the community, although the more complex ones will still need the added expertise of HWS staff. Two features of the HWS program will drive these evolutionary changes:

- (a) The attractiveness of the HWS' positioning within the health care sector as a trustworthy and caring source of expert, timely, and practical help – representing a higher quality and transparent alternative to the inexpert, slow-moving, and often disorganized or adversarial status quo. The Washington COHE program has shown that this appeals to workers, and along with them come their doctors and employers.
- (b) Its membership structure, which offers crucial education and ongoing support and feedback to physician and employer members as well as economic and other positive incentives for adherence to best practices.

Q-5. Can this be done cost-effectively? What kind of return on public investment will we get?

Because the high volumes and low unit costs of secondary prevention programs may be unfamiliar to those in the disability policy arena, here is actual data on physician fees from Washington state and some estimated hours of effort and associated fees for HWS staff extrapolated from 2009 COHE actual program data for health care service coordinator (HSC) services.

The fee schedule rate (rounded to nearest dollar) for the specific physician services that have been deemed the COHE Best Practices are as follows:

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|---|------------------|
| 1. Fee for report notifying the state and COHE of new injury > 9 days after 1 st visit | \$21 |
| a. Additional fee for prompt delivery of that report (< 2 days) | \$40 |
| 2. Fee for completing Activity Prescription
(at 1 st visit and any visit where work capacity changes) | \$53 |
| 3. Fee for communicating with employer or HSC at COHE by phone: | \$25 / 5-10 min |
| | \$47 / 11-20 min |
| | \$71 / 21-30 min |
| 4. Fee for an electronic communication exchange with employer or HSC at COHE: | \$45 |
| 5. Fee for comprehensive analysis of impediments to RTW | \$169 |

In every eligible case, the HWS will encourage the physician to (a) promptly report /refer a new episode of work disability and bill the increment for fast delivery (\$61) and (b) complete the detailed Activity Prescription, discuss with the worker, and submit the form (\$53). Nothing more will often be required other than perhaps a brief phone call with HWS staff to answer a quick question (\$25). In cases of prolonged work disability with multiple medical visits or when there is uncertainty about the appropriateness of a specific modified duty assignment, additional Activity Prescriptions or telephone calls/emails may be required.

In actual practice, all physicians will not remember to do all of these things all of the time. Because a COHE analysis showed that aggregate length of disability and cost per claim went down as the number of best practices billed for all claims increased, COHE staff routinely presents reports to member physician offices showing them the number of cases on which they missed billing opportunities and encourages them to remind the doctor to do the best practices and bill for them. Mean billings from physicians are thus unlikely to exceed \$150-\$200 per referred case.

The second source of costs is billings from the HWS staff. We have estimated this based on numbers in an operational model built for COHE based on 2009 actual data. It has been adjusted in two places: (a) we increased the expected time spent on intake of each new referral because the HWS is unlikely to have access to the payer’s or physician’s electronic records, and (b) we changed the predicted ratio of simple to complex cases. We increased the fraction of complex cases for two reasons: first, the cases referred to HWS will have had ongoing work disability for more than a week but the COHE referrals arrive on the first visit for treatment of a new injury, and second it is possible that the level of effort to get the stakeholders aligned in cases due to non-work-related conditions may be a bit higher.

The health care service coordinators in the COHE (akin to HWS Recovery Coordinators) bill the following three items:

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|--|-----------|
| • Administrative fee for receiving/processing a referral (to cover overhead) | \$50 |
| • Initial Evaluation and Coordination (optional; not necessary in all cases) | \$133 |
| • HSC services (billed in 6 minute increments) | \$88 / hr |

We estimate that the average level of effort by HWS staff in individual situations will be as follows:

- Intake + basic service process for 100% of referrals = 30 minutes
 - (frequency increased from 60% in COHE; duration increased from 18 in COHE)
- Service-only intervention in 15% of cases = 15 minutes
 - (frequency identical to COHE, duration increased from 12 in COHE)
- Simple intervention in 40% of cases = 50 minutes
 - (frequency decreased from 80% in COHE; duration identical to COHE)
- Standard intervention in 30% of cases will take = 2 hours
 - (frequency increased from 20% in COHE, duration identical to COHE)
- Complex intervention in 10% of cases = 4 hours
 - (this level of effort not in COHE model although effort capped at 8 hours)
- Comprehensive intervention in 5% of cases = 6 - 8 hours
 - (this level of effort not in COHE model although effort capped at 8 hours)

Preliminary data comparing the cost of COHE to its benefits from Washington State's COHE program showed the average case (reflecting a mixture of cases, many untouched, some standard and a small number of complex ones) had a return on investment (ROI) of 3:1. However, the Washington State cost and benefit data is only partially applicable because in Washington workers' compensation the same state agency pays for all costs related to the COHE program and enjoys all the benefits in terms of the resulting reduction in total claims costs. Its employer customers then benefit from lower premiums.

From location to location, the HWS is likely to operate in very different environments with many potential payers (self-insured employers, insurance companies, state agencies, etc.) that are also potential beneficiaries of the improved outcomes. Although it is reasonable to expect a ratio of costs to benefits for the HWS similar to that of COHE, it is beyond our capability to apportion the anticipated economic benefits among the various sectors of society that will benefit if the Federal government supports the HWS through direct funding or financial incentives of some sort.

However, we expect that the HWS's funding model will evolve to have declining reliance on government funding over time. Federal funding will be required while the HWS is developed and becomes established in each specific geographic area. Then, as each unit of HWS proves its value to stakeholders and the community at large and begins generating a predictable and sustainable volume of referrals, the funding model can evolve. Then, similar to other government-funded programs such as Health Centers funded by the Health Resources and Services Administration (HRSA), the source of HWS operating funds could become a combination of federal, state, and charitable grants; Medicaid; Medicare; private insurance; patient fees; and other resources. In many areas, it is very likely a substantial portion of cases referred will have a potential private-sector payer involved (an employer, a workers' compensation company, or a commercial disability benefits company). A sliding scale would keep the HWS affordable for small employers and allow them to contribute to the sustainability of the service.

In rural areas dominated by a single health care delivery organization, hosting an HWS may help that organization fulfill its larger mission or duty to the surrounding community. It could incorporate the HWS into its larger organizational structure; co-location would thus encourage cross-fertilization between the two entities and foster inter-professional communication. As one example, Health Centers that receive Federal funding from HRSA might be ideal hosts for HWS.

Conclusion

We remain excited by the potential of the HWS and the secondary prevention approach to reducing avoidable work disability that it represents. We are confident that, if well implemented, the HWS will improve outcomes for many workers who today have nowhere to turn for assistance in minimizing the impact of injury, illness, or changing chronic conditions on their lives and livelihoods. It has the potential to improve work ability for many, to substantially reduce the number of workers becoming disabled due to unresolved issues around common health problems, and to create a concomitant reduction in the number of people relying on SSDI benefits.

We appreciate being offered this opportunity to think through in detail some of the predictable issues involved in getting something this new and different off the ground. Transformational social change takes time – and begins when people become so committed to a better future that they declare they are willing to get started and do their best under imperfect conditions. We hope our observations and recommendations are useful.

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Appendix: Parts 2 and 3

Part 2 covers a few major issues that a state agency or similar entity charged with actually implementing (operationalizing) the Health & Work Service as a program would need to address. In doing so, we make suggestions for how to optimize the likelihood the program will fulfill its purpose and produce the expected outcomes. Part 3 discusses the need to demonstrate effectiveness and its impact on program design and the evaluation process. Lastly, the online [Technical Appendix](http://www.crfb.org/sites/default/files/Community-Focused_HWS_Technical_Appendix.pdf) can be found at http://www.crfb.org/sites/default/files/Community-Focused_HWS_Technical_Appendix.pdf. It contains more detailed and practical information on several additional issues at a level of detail we hope will be useful for those actually carrying out those tasks.

PART 2: OPERATIONAL PROGRAM IMPLEMENTATION ISSUES

This next section of the paper provides a very brief overview of some major considerations that those responsible for overseeing the implementation and operations of an HWS or actually designing, planning, operationalizing, and running it will need to address.

The separate [Technical Appendix](#) includes more information on all the items discussed in this overview as well as several others. The [Technical Appendix](#) is intended for those who will be responsible for actually doing the work of the detailed design, overseeing the implementation of the service, or setting up and actually operating an HWS-type program.

The HWS's target population and secondary prevention approach is distinct from traditional disability programs

The HWS' success at producing beneficial outcomes will depend on keeping it separate and distinct with high fidelity to the conceptual basis of its biopsychosocioeconomic model and secondary prevention approach. The HWS actually has a dual purpose: (a) to help workers with CHPs avoid over-impairment and disability – because their medical conditions, by nature, need not result in long-term major functional limitations, as well as (b) to prevent needless work disability and loss of livelihood.

The HWS approach is intentionally distinct from other programs that serve people already living with disabilities. It must be made clear to all that the HWS' services are aimed at a tightly targeted population – those who are at the start of their potential work disability journey and are at a stage where progression is avoidable. Extending the population would leave the HWS vulnerable to mission creep, to capture by existing programs with very different parameters, or dilution with less rigorous and outcome-focused approaches.

When the HWS has had its intended impact on a particular community's social fabric, the change will be subtle. Like most other preventive programs, it will generate little drama and few heart-warming stories. Many professionals in different sectors of society will have simply made small but crucial changes in how they do their usual work – and will occasionally be fleetingly collaborating with one another to solve SAW/RTW problems. They will view the HWS as a pragmatic resource that helps get workers in

difficult situations onto a good track. However, as a result of the HWS' existence, fewer workers with still-evolving or newly chronic health problems will be living in limbo because they will be working at their usual job or at a new one. And SSDI will be financially sound and better able to support individuals on the rolls for whom work disability is medically necessary because of overwhelming medical conditions or is impossible to return to work due to irrevocable losses of functional ability, as well as individuals who are on SSDI for other reasons.

Operationalizing the HWS will require patience due to its novelty and simultaneous attention to critical issues in multiple domains.

Those responsible for setting up an HWS will need to anticipate and manage the added difficulty of starting something that is new and different in several ways.

At a practical level, as the HWS goes into operation, it will be offering a solution for a problem the community has not had on their radar and for which they are unaware solutions might exist – so few may initially sense the need for it. The urgent predicaments faced by newly-injured or ill workers for the first three to six months after onset of a work-disabling condition have been in a blind spot pretty much everywhere in our society, not just at the Federal and state policy level. Thus, the community will first need to first be alerted to the dilemma faced by ill and injured workers who aren't able to work. They need to buy into the idea that having a resource to help workers through their SAW/RTW would also help employers and the payers – and then the HWS can be presented as a solution.

Also, those who are setting up and staffing the HWS need to be introduced to and become supportive of three major concepts or paradigms that underlie the HWS' philosophy, approach, engagement strategies, and interventions. They are (a) the biopsychosocioeconomic (BPSE) model of sickness and disability, (b) the idea that work disability is hard on people and should be minimized, and (c) the concept of secondary prevention. Together, these three represent a real paradigm shift. We have found that it takes several repetitions before people really grasp how these things differ from previous approaches with which they are more familiar. All HWS staff will need to be introduced to these new ways of thinking several times, in different language, sources, and settings before they really buy-in and get comfortable with the subtle way these models change our thinking, speaking, what we focus on and how we approach problems.

There are several mission critical issues in different domains that will have major influences in the success or failure of the HWS to deliver the intended outcomes. See the [Technical Appendix](#) for more information about each of these topics.

- (1) **Focus on building the referral pipeline and maximizing the perceived helpfulness of HWS services.** The HWS cannot survive much less succeed without a steady stream of requests for help from workers themselves as well as a steady stream of referrals from treating physicians, employers, labor organizations, benefits payers, and other potential sources in the community. A sobering fact: the cancellation of the UK's Fit for Work Service was mostly due to lack of referrals. The HWS in the US can build and sustain a substantial number of referrals in three main ways: (1) by gaining the buy-in and collaboration of multiple referral sources in the community; (2) by creating a visible and positive brand image; and (iii) by earning a reputation for respect, caring, and practical problem-solving expertise that produces valued results.

- (2) **Pay most attention to delivering effective services very early in individual situations.** The HWS must devote most of its creative energy, effort and resources on rapid response to workers with new and ongoing health-related work absence. The relative allocation of effort and resources in the program should heavily favor services and interventions during that period. The HWS must make sure that workers are being referred to the HWS early enough – preferably within 1-2 weeks of absence onset, and not longer than 6 weeks. The tempo of the underlying secondary prevention philosophy requires that a strong sense of urgency must be instilled among all the participants who collaborate in this program. Because each day spent “in limbo” worsens the odds of each worker’s continued participation in the workforce, elapsed time should be viewed as the enemy. Thus, from an operational perspective, that means taking a “just in time” and often improvisational approach, providing just what is needed at the moment it is needed.
- (3) **Assure fidelity to the evidence-based core conceptual model for intervention while adapting the design and everyday operations of each HWS unit to the demography and geography of the area it serves.** Discourage experimentation in the intervention domain because there is insufficient evidence to support other strategies. Most of the opportunity to mitigate non-medical risk factors in health-related employment disruptions is under the control of physicians, workers, employers, and benefits personnel. Their beliefs, knowledge, choices, decisions, and actions strongly influence the outcome. The international scientific evidence says all the players must be brought on board, aligned in support of an optimal outcome, and then start acting in concert. Thus, the success of the HWS will depend on its power to engage and positively influence those parties. We strongly recommend that fidelity audits be regularly conducted within the HWS in order to confirm adherence to the main precepts of this conceptual model, as outlined in our original proposal (Christian et al. 2015).
- (4) **Carefully recruit, select, and thoroughly train HWS staff, especially Recovery Coordinators who are the backbone of the HWS.** Their successes in individual cases add up to the HWS program’s performance. They must employ the core conceptual intervention model in their work. They must have a strong personal agreement with the purpose of their work: to help workers find a solution that helps them get back on their feet, be productive, and keep earning their own living. HWS Operations should place the greatest weight on hiring individuals with interpersonal empathy and skills in persuasive communications, facilitation, problem-solving, and negotiation. Second priority in hiring should be familiarity with the ways that health conditions affect people’s ability to function and work as well as familiarity with both ends of the SAW/RTW process – medical offices and workplaces. Every individual served by the HWS will have an actively evolving medical problem and their doctors will have a major influence on SAW/RTW, so the Recovery Coordinators must have capable clinical backup.
- (5) **Provide incentives that reward specific desired behaviors (best practices) by the three professional stakeholders and ensure the financial sustainability of the HWS itself.** The purpose of incentives for the stakeholders is to increase the frequency of best practices because they will fuel outcome improvement. For example, the COHE design for physician incentives is brilliant (yet rare). The promise to pay flat fees for tasks that are clearly defined, simple, time-defined, and tangible has clearly increased the frequency with which they are performed. As long as the behavior is appropriately documented and billed, the payments become unconditional and immediate. There is no waiting period and no arguing about whether payment is due. Physicians

and their business office get a simple message: do these specific things during a clinic visit, email, or phone call and you'll get paid. The list of best practices for the HWS needs to be carefully constructed so physician behaviors being rewarded are those that advance the HWS program in specific ways. Examples might be (a) getting HWS involved early by making timely referrals to HWS or (b) enabling three-way flow of information by asking their patients to sign appropriate HIPAA privacy releases, then forwarding them to the HWS.

Little Details that Could Derail the HWS

Some critical little details of the design or plan for implementing and operating the HWS have the potential to derail the whole thing. A single example should suffice: how will HWS work around the barriers that HIPAA and other privacy laws pose, because the success of the HWS depends on rapid and easy exchange of essential information among the key participants in a work disruption situation?

On a policy level, Congress is unlikely to be so committed to the success of the HWS that it will take steps to ameliorate the problems that HIPAA is creating for worthwhile information exchange today with third parties outside the health care sector. The Federal government has to date not effectively acted to relieve much bigger problems that HIPAA – or more accurately, widespread fears about HIPAA based on myths and misconceptions within the health care sector – is causing with the medical care process itself by preventing easy exchange of information among health care professionals treating the same patient (Berwick 2018). Unless creatively addressed, the small but very thorny issue of HIPAA and privacy laws certainly has the potential to derail the success of HWS. See items 4 and 5 below for some potential solutions.

Our recommendations for how to handle other small but potentially pivotal elements of design and operationalization are summarized in the list below. The [Technical Appendix](#) describes each issue and the basis for our suggestions in more detail. We can only offer preliminary thoughts about how to handle these critical details because, as we hope is now obvious, the actual way to work around these challenges will depend on the specific nature of the program design under a particular set of geographic and programmatic constraints.

1. The HWS must integrate itself into an existing community cadre of organizations and programs.
2. Start preparing the ground in advance because building community awareness, demand for, and readiness of other organizations to interact with the HWS will take time.
3. Recognize the challenge of simultaneously operationalizing at least three important but new and unfamiliar outcome-changing things in different sectors / silos / parts of the social fabric: (a) activities inside the HWS, (b) activities at doctors' offices, and (c) activities at workplaces.
4. House the HWS' Recovery Coordinators and their medical back-up within the health care delivery system in order to create trust and buy-in by all parties and also to reduce HIPAA-related barriers to communication.
5. Consider paying physicians for the time it will take them to select and make referrals of eligible patients – and explain the referral to patients. If possible, pay the doctor's office to obtain and send in two HIPAA releases for the duration of an episode signed by their patient – one a full release to the HWS and a more limited release to the employer.

6. Establish simple and easy to implement referral criteria for community sources to use; make the HWS referral process similar to current referral processes with which they are familiar, which will make it as easier for the referrers.
7. Make eligibility screening processes part of the HWS rather than asking referral sources to do it.
8. Screen for eligibility for continuing services after referral but ensure everyone who is referred gets something they perceive as valuable (to serve as positive reinforcement for the effort they made to participate).
9. Identify community providers of specialized services and equipment that can save jobs; make arrangements in advance so they are delivered promptly when needed.
10. Beware premature attempts at high-tech data interchange solutions that severely limit ease of revisions; in the early phases, it may be better to use paper, Excel, and fax.

PART 3: DESIGN AND EVALUATION CONSIDERATIONS

In conclusion, we would like to comment on a few overall program design and evaluation issues. First, given how easy it will be for the people staffing an HWS to stray from the original purpose, secondary prevention approach, conceptual intervention model, and intended outcome, we recommend that major criteria for contract or grant renewal should require credible evidence that:

- (1) The entire HWS organization remains aligned around the goal of maximizing early referrals and taking prescribed steps to achieve the intended optimal short-term outcomes for as many eligible workers as possible in a geographic area so they receive coordinated care in a collaborative manner that focuses on functional recovery, stay productive, and keep their jobs;
- (2) The services delivered exhibit high fidelity to the conceptual model;
- (3) The organization employs a vigorous continuous improvement approach to keep perfecting its delivery model; and
- (4) The program is achieving success in its core mission, measured in three ways:
 - An ever-increasing percentage of all workers in the geographic area in need of SAW/RTW services are being referred to and accepting HWS services;
 - An ever-increasing percentage of workers who receive services are achieving good functional and employment outcomes; and
 - Community stakeholders (workers that have received services, all workers, employers, labor organizations, payers, and state agencies) perceive the HWS as a trustworthy and valuable community asset.

Defining Success

The HWS must plan spend a considerable amount of effort to capture or otherwise obtain data to evaluate its performance. The most concrete way to define success will be to document an improvement in outcomes, but it will be very hard to get some of the information that would provide the most persuasive evidence of effectiveness: a reduction in lost work days, fewer lost jobs, fewer entries onto public disability programs, and so on. The problem is that the HWS does not own any historical data and will not own any of the data about outcomes that occur beyond its walls. Moreover, since the HWS program is just 12 weeks long, it will be several months to years before “graduates” of the HWS would apply to or get on SSDI.

Only employers and insurers have historical data. Getting them to share it may be an unsurmountable challenge (they often are protective, viewing internal process and outcome data as competitive, confidential business information). Only employers will have objective information about actual RTW dates and work status (e.g. not working, at work full duty, at work with temporary adjustments, or at work with reasonable accommodations.) This will also be a challenge unless the HWS establishes an expectation with the employer community that they will provide that information on request. Only state and Federal agencies will have information about entry on various programs – requests for job-finding assistance, vocational rehabilitation, applications for disability-related benefits, and so on.

The only hope for historical and outcome data seems to be congenial business relationships within the community or possibly state agencies. The HWS in a particular geographic area may eventually develop relationships of sufficient size and trust with major referral sources that they become willing to share their data with the HWS. Although rare, it has happened.

The easiest source of information will be workers, employers, and insurers who may be willing to provide it while they are receiving services or immediately afterwards. Long-term follow-up phone calls, surveys, or questionnaires are likely to have comparatively low response rates without persistent repeated efforts. Setting an expectation at the beginning that the HWS service includes monitoring and follow-up over time may improve participation.

As the program proceeds, progress and outcomes of treatment should be gauged in a variety of ways – by repeated administration of risk screening instruments, functional status questionnaires, re-review of initial assessments and SAW/RTW plans compared to actual interventions and accomplishments, as well as semi-structured worker interviews and satisfaction surveys.

Based on the literature, which shows how an individual’s own expectations for recovery and return to work (along with other beliefs and perceptions) influences ultimate outcomes (and our view that the HWS must engage with participants at this profound level in order to make a difference), we also recommend that the definition of success for the HWS include changes in the high risk subgroup of workers’ expectations, view of themselves and their role in their situation, and any specific events that influenced their perceptions.

It is critical to monitor adherence to processes and the occurrence of interim and sentinel events as well as the expected outcomes of those processes.

Business and clinical processes and procedures are put in place with the expectation that they will create some sort of final outcome. If the final outcome is not achieved, but neither the adequacy of or adherence to processes nor the frequency of expected interim and sentinel events has been assessed, one does not know whether the logic chain was flawed or the execution of the plan was inadequate. Both are possible explanations, and corrective action requires the ability to distinguish between the two.

Because the HWS will have many moving parts, some of which are mission-critical as discussed above, it will be essential to monitor numerous processes. Key topics to examine will be physician and employer membership growth and satisfaction, referral volumes and sources, worker satisfaction, timing of referrals, number of best practices being performed and by whom, number of incentive payments made and to whom, operational challenges, achievements, worker acceptance of the program, anecdotal accounts, and the hard numbers being produced by the awardees' programs and pilots.

Other criteria should include whether the operating model and data systems are functional and scalable; whether necessary information is being captured and flowing smoothly among the participants to support both operations and evaluation of effectiveness; and whether workers, doctors, and employers are cooperating and support the program.

Need for Flexibility While Learning What Works and What Does Not

As a society, it is imperative that we find a way to bridge the upstream gaps that produce unnecessary work disability. But the essential capability to collaborate and communicate efficiently across organizational boundaries, benefit systems, and sectors of society is very weak today. That is precisely why the gaps exist.

The authors of this paper have been part of innovative development projects involving multiple stakeholders that are similar to this in many ways – although less broad – and we have good knowledge of what works according to the scientific evidence. However, we do not want to see the taxpayers' money wasted on overly-rigid projects driven by premature and unrealistic demands for a simple “yes or no” answer regarding improvement of employment outcomes. In particular, the private sector knows that flexibility is a mandatory feature of early stages of development and testing. Planning is never perfect, and unexpected problems always come up – sometimes profound ones. Solving them through rapid identification, revision, and refinement cycles is an essential part of successful development.

Because this is everyone's initial foray into this arena, the HWS Operations should be given the freedom to innovate in delivery both at the beginning and during the project. They must be encouraged to keep thinking deeply, logically, and rigorously, and to keep sharing what they are learning “real time” during initial implementation and on-going operations with others (including other implementation grantees as well as the technical support and evaluation contractors).

As they develop and roll out their program, some or all of the local HWS Operations organizations are going to encounter unanticipated roadblocks and obstacles or will realize they have made unrealistic assumptions or have under-resourced an area that turns out to be vitally important. Substantial difficulties should be viewed as the hard-won and very valuable discoveries of pioneers: the practical knowledge of what doesn't work due to front-line realities that become clear only during implementation. Their contributions should be learned from – not wasted – because they each will be pointing the way forward to more efficient and effective models in the future.

Thus we recommend against holding HWS Sponsors or Operations strictly accountable for adhering to their original operational delivery designs, plans, and timelines as envisioned in contracts or grants during the early years. Lack of fidelity to the original delivery design and timeline can be due to weak organization or poor execution, but it may also reveal flexibility, adaptability, and creative problem-solving. Therefore, we recommend holding HWS Sponsors or Operations strictly accountable for fidelity to the program's intended purposes and conceptual framework and for the willingness/ability to keep making changes in the operational delivery until the program actually works.

As the first HWS programs go live and then again as they ramp up to scale, they must have the freedom (and access to supplementary funding) to revise their models, causal chains, volume expectations, and operational procedures. Without that flexibility, any program that encounters serious flaws will be doomed to fail – and waste the taxpayers' investment. If the requirements of a rigorous evaluation prohibit modification of the design, it is better to stop immediately as soon as unrecoverable issues appear rather than keep spending money on a lost cause.

In fact, the demonstrated interest of the HWS Operator organization in honestly assessing what has actually happened compared to policies and procedures, and their willingness and ability to keep making changes to increase their effectiveness, should be seen as evidence of their commitment to the success of the HWS concept as a whole.

Contractors/grantees should get credit for an organizational ethos that rewards staff who keep a lookout for overlooked issues, unanticipated obstacles, critical design flaw and simple mistakes –especially if it is apparent that the contractor/grantee rapidly takes effective action to address them by acknowledging the problem, diagnosing the cause(s), and modifying their designs and/or operational methods.

About the McCrery-Pomeroy SSDI Solutions Initiative

The McCrery-Pomeroy SSDI Solutions Initiative is a project dedicated to identifying practical policy changes to improve the Social Security Disability Insurance (SSDI) program and other policies for people with disabilities. Launched in 2014, the initiative originally commissioned a number of accomplished policy experts from a variety of backgrounds to put forward 12 different policy proposals, each addressing a unique issue with current disability policy. These papers were peer-reviewed, presented at the Initiative's 2015 SSDI Solutions Conference, and ultimately published in the 2016 book [SSDI Solutions: Ideas to Strengthen the Social Security Disability Insurance Program](#). The Initiative's work helped to elevate SSDI to the attention of policymakers and has led to the proposal, enactment, and implementation of numerous legislative and regulatory improvements.

Beginning in 2018, the SSDI Solutions Initiative commissioned seven additional papers designed to build upon the work of the 2016 book. These papers will present additional research, offer implementation guidance, or offer new ideas to further improve disability policy in the United States.

The SSDI Solutions Initiative is co-chaired by former Congressmen Earl Pomeroy (D-ND) and Jim McCrery (R-LA), both former Chairmen of the House Ways & Means Social Security Subcommittee. The SSDI Solutions Initiative is a project of the Fiscal Institute at the Committee for a Responsible Federal Budget.

More information about the SSDI Solutions Initiative is available at <http://www.SSDISolutions.org/>.

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