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## DISABILITY MANAGEMENT

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### OBJECTIVES

- Identify the linkage between nursing process and case management processes.
- Employ motivational interviewing techniques at a beginning level when working with clients with chronic disease.
- List materials needed to analyze a company's workers' compensation program.
- Choose advantages/disadvantages of telephonic case management from a list of options.
- Identify red flags that may indicate delayed recovery in a workers' compensation case necessitating a need for case management services.

**OUTLINE****Purpose and Role of Case Management****Individualized and Diverse Roles of Case Managers****Case Management Terminology****Nursing Process in Case Management**

Assessment in the Case Management Process

Planning in the Case Management Process

Implementation of the Case Management Plan

Evaluation of the Case Management Process

Integrating Nursing Process into Case Management

**Practice Settings for Case Management Services****Case Management Team Roles and Responsibilities****Client Advocacy****Development of Effective Case Management Programs****Fitness for Work**

Assessment of Fitness for Work

Planning for Fitness for Work

Conduct and Interpret Job Analyses

Implementation of Fitness for Work

**Management Programs for Chronic Diseases**

Administration or Management of Disability Programs

Family Medical Leave Act (FMLA) Programs

Evaluation of the Case Management Program

**Occupational Disability Case Management**

Assessment of Occupational Disability Case Management

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Planning for Occupational Disability Case Management

Implementation of Occupational Disability Case Management

Evaluation of the Occupational Disability Program

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Assessment of Non-Occupational Disability Case Management

Planning for Non-Occupational Disability Case Management

Implementation of Non-Occupational Disability Case Management

Evaluation of the Non-Occupational Disability Case Management Program

**Return to Work (RTW) Program**

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Planning for the RTW Program

Determine Need for Transitional Work and Identify Transitional Jobs

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### **Important Concepts in Case Management**

New Developments Related to Emerging Health Care Issues

Network of Resources for Case Management

Incorporating Technology into Case Management Practices

Ethical Issues in Case Management Practice

Referring Employees to Employee Assistance Programs (EAPs)

Integrating Disability Management Strategies

Monitoring Laws Affecting Case Management Practice

Demonstrating the Value of Case Management Services Provided

Best Practices in Case Management

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Overview of Managed Care

Quality Controls in Managed Care

Defining and Evaluating Quality Outcomes in Managed Care

HEDIS Healthcare Effectiveness Data and Information Set

Quality Improvement in Managed Care

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#### **KEY TERMS**

Alternative duty/job, p. 482

Clinical Practice Guidelines, p. 479

Exclusive remedy, p. 480

Functional capacity evaluation, p. 480

Job analysis, p. 481

Managed care, p. 481

Maximum medical improvement, p. 481

Modified duty, p. 482

Permanent partial disability (PPD), p. 479

Quality, p. 481

Reasonable accommodation, p. 481

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The American Association of Occupational Health Nurses (AAOHN) Position Statement on occupational and environmental health nurses (OHNs) as case managers identifies this group of professionals as ideal to assume this role “to coordinate client’s health care services from the onset of illness and injury to safe return to work or an optimal alternative” (2004, p. 1). It is a role that OHNs have been performing since the late 1800s to promote the achievement of the best possible outcomes for both individual and corporate clients (American Association of Occupational Health Nurses [AAOHN], 2004). More information on the evolution of the role of OHNs as case managers is provided in Chapter 1.

## PURPOSE AND ROLE OF CASE MANAGEMENT

OHNs should remain aware of the duality of their client base: workers and employers. The priority client is the worker. With this priority, the primary purpose of case management is to coordinate individual clients’ health care services after clients have sustained an injury or illness, including chronic disease, to assure that they receive the best necessary care possible in a timely manner. Cost effectiveness and cost containment are additional priorities (and are often perceived as priority one of employers). However, they do not eclipse the priority of the workers’ needs and, in the current economic environment, may require that OHN case managers advocate for clients to assure that they receive necessary services. Mullahy (2010) describes the role well: “[C]ase managers are coordinators, facilitators, impartial advocates, and educators” (p. 5). A major focus of case management is the empowerment of injured or ill workers through the dissemination of information. This knowledge facilitates greater understanding of their condition and allows for effective decision making as well as guidance through the complex health care delivery system (Mullahy, 2010). Gross and Tahan (2008) outline the role of the case manager as including educator, coordinator, communicator, collaborator, clinician, utilization manager, transition planner, leader, quality manager, negotiator, advocate, researcher, and risk manager.

AAOHN (2004) has outlined how an overall effective health and safety program can control costs and the ways in which case management fits into the program:

- Focus on all levels of prevention and the use of health promotion to reduce incidence of both injury and illness.
- Utilize experienced professionals in the field of occupational health to provide health care services.
- Employ case management approaches.
- Ensure communication between management and injured or ill workers.
- Educate workers to be informed health care consumers.

## INDIVIDUALIZED AND DIVERSE ROLES OF CASE MANAGERS

Case managers assume many different roles and often they are setting or site specific. The role of case managers needs to be determined by the organizations in which they function and by the type of workers for whom case management services will be provided. There is no “one size fits all” in the

world of case management, and the approach needs to be tailored to each individual situation (Mullahy, 2010).

The role of the nurse case manager must be clearly defined. Failure to do so and failure to communicate the case manager's role to the injured worker can result in loss of both efficiency and effectiveness of the services provided (Brines, Salazar, Graham, Pergola, & Connon, 1999). Injured workers participating in Brines et al.'s study regarding perception of case management services suggested the role of the case manager should be explained to the worker at the first contact. An explanation of the OHN role should be built into the process.

## CASE MANAGEMENT TERMINOLOGY

**Benefits:** Services owed an individual, as defined by law (i.e., employment benefits or workers' compensation benefits) or based on criteria established in a policy or summary plan description (i.e., rehabilitation, retraining, etc.) (Wassel, Randolph, & Rieth, 2005).

**Cash benefits:** Cash that is paid as either part of workers' compensation benefits or according to an employer's defined disability plan or negotiated in a union contract to replace a worker's loss of income or earning capacity due to disability resulting from an occupational or non-occupational injury or illness (Wassel, Randolph, & Rieth, 2005).

The following four classifications describe monetary workers' compensation disability benefits (Wassel, Randolph, & Rieth, 2005):

1. **Temporary total disability (TTD)**—tax-free reimbursement for partial wages when a worker is temporarily totally disabled.
2. **Temporary partial disability (TPD)**—tax-free reimbursement for partial wages when a worker is temporarily partially disabled.
3. **Permanent total disability (PTD)**—tax-free reimbursement for partial wages when a worker is permanently totally disabled.
4. **Permanent partial disability (PPD)**—tax-free reimbursement for partial wages when a worker is permanently partially disabled.

Workers' compensation benefits are determined and allocated according to state jurisdictional rules. Other disability benefits (short-term disability [STD] and long-term disability [LTD]) can be either tax-free when the worker pays for these plans or after-tax in employer-paid or employer self-funded programs. These disability benefits are determined and allocated according to language in the employer's disability plan descriptions or policy statement.

**Clinical practice guidelines:** "Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (Field & Lohr, 1992, p. 38).

**Deductible:** the amount that a member of the health care plan must pay for covered services per specified period (usually the policy year) before the insurer will pay benefits (e.g., health care, prescriptions, etc.).

- Earning capacity:** the potential wages a worker could achieve, given his or her education, training, skill level, previous experience, medical condition, proximity to available work, and other factors.
- Evidence-based practice:** “The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71).
- Exclusive remedy:** the legal concept that receipt of workers’ compensation benefits is the sole benefit (remedy) for the occupational condition incurred (injury or illness) and leaves the worker without any other courses of action against the employer.
- First report of injury:** a formal document required by the state jurisdiction to be completed by the employer to report a work-related injury or illness. It is sent to the workers’ compensation insurance carrier or the third-party administrator in the event of a self-insured program by the employer. Injured workers have the option of directly filing a report of work-related injury or illness with the applicable state or federal workers’ compensation board or industrial commission (DiBenedetto, 2008).
- Functional capacity evaluation (FCE):** a professional assessment to specifically determine a disabled person’s residual physical abilities.
- Gatekeeper:** term commonly used to refer to a primary care provider (PCP) who is responsible for coordinating all of a health plan member’s medical care. Also may refer to a type of managed care plan that requires that the member have a formal referral from a PCP for other care to be covered by the plan (e.g., precertification for hospitalization or preauthorization for procedures such as MRI, etc.).
- Impairment rating:** the basis upon which permanent disability is determined. Once an injured worker is determined to have reached maximal medical improvement (MMI), a licensed physician must determine the level of residual impairment. In many states, the use of the current American Medical Association’s *Guides to the Evaluation of Permanent Impairment* (Rondinelli et al., 2006) is required in making this determination because it is considered more objective than previous methods. This impairment rating is then used by the state or federal workers’ compensation board or industrial commission to determine the disability rating (DiBenedetto, 2008).
- Indemnity:** in workers’ compensation language, generally refers to payments made for lost wages.
- Indemnity plan:** a traditional health insurance program in which the insured person is reimbursed for covered expenses after a deductible is met; the amount of the deductible is determined by the plan.
- Independent medical examination (IME):** a second medical opinion related to a worker’s health condition in which the results can be legally binding in some jurisdictions and according to some plan designs.

- Job analysis:** a detailed description of a worker's job duties and physical and mental activities that identifies the essential functions of the job; often used to assist in determining return to work timing.
- Managed care:** a system of health care delivery that influences utilization of services, costs of services, channeling for services, and measures of performance.
- Maximal medical improvement:** used in worker's compensation to indicate the final level to which a person improves/recovers after sustaining a disabling medical condition (may or may not equate to pre-disability level).
- Quality:** "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Institute of Medicine [IOM], 2001, p. 232).
- Reasonable accommodation:** the term used in the Americans with Disabilities Act (ADA) of 1990 for medical accommodations necessary in the workplace for an otherwise qualified individual with a disability to perform the job. It is one aspect of compliance with Title I of the ADA that deals with employment (Commerce Clearing House Editorial Staff, 1990). Reasonable accommodation is any change to the work environment or in the way a job is performed that enables an individual with a disability to enjoy equal opportunity at any point in the employment relationship. These changes can be in the job application process itself, to the actual work environment, or to the usual and customary way the job is done. This also includes changes that make it possible for the applicant or employee with a disability to enjoy equal benefits and privileges associated with their particular stage of employment, including access to training (Commerce Clearing House Editorial Staff, 1990; DiBenedetto, 2008).
- Rehabilitation:** treatment or formal plan provided by multidisciplinary specialists intended to return the worker to optimal function. When specifically related to an occupational injury or illness, it is termed *vocational rehabilitation*. This benefit has been reduced or eliminated in some states or replaced with alternate benefits that may be more cost effective.
- Reserves:** money set aside by a self-insured organization or an insurance carrier to pay the ultimate monetary cost of claims/losses.
- Residual functional capacity (RFC):** the final determination of a person's physical capabilities or restrictions at the conclusion of recovery from an illness or injury, usually determined from a physical evaluation and review of an FCE test. The RFC determination is compared with the physical demands of the job activity to determine the appropriateness of vocational options or limitations in daily living.
- Return to work (RTW):** the desired goal for all workers after an injury or illness (occupational and non-occupational).
- Risk management:** the process of making and implementing decisions that minimize the adverse effects of accidental and business losses on an organization.

**Standards of care:** defined by the Healthcare Quality Certification Board as measures that define the type of care or service, with a resulting desired outcome expected from a health care encounter (Garrett, 2008).

**Third-party administrator (TPA):** a company that handles all administrative tasks involved in managing claims for self-insured employers who fund their own benefit plans (Mullahy, 2008).

**Transitional work:** a temporary job that accommodates the worker's restrictions for a limited period during recovery from an illness or injury. Options for transitional work assignments include

**Modified duty:** the worker's original job is adjusted to accommodate restrictions.

**Alternative duty:** the worker performs a different job because restrictions rule out continued performance of original job duties.

**Utilization review (UR):** a process that measures use and consumption of available resources (including professional staff, facilities, and services) to determine medical appropriateness, necessity, quality, cost effectiveness, and conformity to criteria for optimal use (Lowery, 2008; Shrey & Lacerte, 1995).

**Wage loss:** the amount of monetary losses sustained by a worker due to the inability to work.

## NURSING PROCESS IN CASE MANAGEMENT

The case management process mirrors the nursing process. Workers in need of case management services are identified; an initial assessment process is followed; care planning occurs; the plan is implemented; and the plan is evaluated. Assessment, planning, and adjustment to implementation continue throughout the case management relationship, and a final evaluation of outcomes is conducted when the final outcomes have been achieved.

### Assessment in the Case Management Process

In the initial contact with a worker, it is important for the OHN case manager to establish rapport, gather the necessary information to begin developing the initial plan, and develop treatment and recovery goals for that ill or injured worker. The information gathering process is greatly assisted by having a structured evaluation worksheet. Readers should refer to models available in the 4<sup>th</sup> edition of *The Case Manager's Handbook* (Mullahy, 2010).

In an initial evaluation, besides recording details about the case and demographics, an OHN case manager records pertinent medical history. An OHN case manager also records medical care that has been received, current treatment and status, current medications, list of care providers, the socio/environmental situation in which the worker is living, occupational details (including injury/illness impact, motivational and behavioral impact of injury/illness), financial situation (including benefits being received), and a summary statement of the case manager's impressions (Mullahy, 2010). Work with sources of social support such as families to facilitate their understanding and involvement in an injured worker's recovery process also begins at the time of initial assessment (Brines et al., 1999).

A medical release is obtained at the time of initial assessment. This allows the case manager to speak directly with the worker's health care providers to gather additional information as well as ensuring those team members are brought into the planning process (Mullahy, 2010).

When initially contacting a treating medical provider, it is important that the OHN case manager explain the case manager role and relate the desire to work with the provider for the best outcome for the injured/ill worker. The more the physician understands that the OHN case manager can help the worker achieve mutual goals toward treatment and recovery, the more likely a successful collaboration will result (Mullahy, 2010).

Issues for the case manager to discuss with the treating provider include current medical status, future treatment plans, the worker's long-range prognosis, and occupational issues of which the treating provider is aware. Also, the OHN case manager can ask if any residual disability is anticipated. Informing the provider that the case manager will remain in contact throughout the time the worker is being treated and offering assistance to help in any way with the worker promote the team approach to achievement of positive outcomes for the worker's recovery and RTW (Mullahy, 2010).

### **Planning in the Case Management Process**

Planning begins at the time of initial assessment. Initial recommendations are listed on the initial intake form after gathering the initial assessment information. Ultimately, case management is about identifying and solving problems that impede recovery and return to work (Mullahy, 2010).

Is treatment appropriate? Are the results being achieved desirable? Will the current treatment trajectory lead to the desired end results—recovery and RTW? Are there complications presenting barriers to the desired end results (Mullahy, 2010)? There are a myriad of other questions to ask about the appropriateness and quality of the care being provided and whether or not the worker's needs are being best served toward the desired end results.

An approach to each identified problem is identified. Alternatives to the current care plan are considered. Options for future care are explored. Costs of current and future options are considered. A case management plan is developed for each worker based on the information collected (Mullahy, 2010).

### **Implementation of the Case Management Plan**

Reporting takes into account the information that is most useful to the client. Employer clients are most interested in RTW issues. The workers' compensation carrier wants detailed medical information. Needs for different clients vary, and the case manager is advised to tailor reports to clients' needs with consciousness of what most effectively serves the worker's best interests (Mullahy, 2010). Reports should be prepared at least monthly, but verbal communication may occur more frequently, especially if the case manager attends medical appointments with the worker, which occurs in some case management situations (Mullahy, 2010).

Once the plan is developed, approval must be received to follow the plan. Approval is sought from the client paying the bill for case management services (as well as the cost for the worker's care).

Sometimes verbal consent is sought at the time of initial evaluation so that initial recommendations can be immediately put in place (Mullahy, 2010).

An RTW plan is developed within the planning process, and targets for the return to work date are discussed with the worker, employer, medical providers, and involved insurance carriers or TPA. Options for transitional work or modified duty are also explored with the goal of the worker returning to work as soon as medically feasible (DiBenedetto, 2008; Mannon, Conrad, Blue, & Muran, 1994).

Case managers must maintain a working relationship with appropriate resources within the geographic area of the workers they service and know the strengths and weaknesses of the various providers and services available. This enables more effective coordination of treatment and referrals to social, vocational, or financial aid services as needed (Mannon et al., 1994; Mullahy, 2010).

The plan is followed, with changes made as necessary along the way as the worker's condition changes. The case manager continues to coordinate the plan through recovery and successful return to full-duty work (Mullahy, 2010).

### Evaluation of the Case Management Process

Established standards of care and clinical practice guidelines are becoming an expected part of case management practice. Legal precedent has been established for holding case managers liable for their application in practice (Mullahy, 2010). Standards of case management practice have also been outlined by AAOHN in a position statement (AAOHN, 2004). The Case Management Society of America (CMSA) has also published standards of practice (Case Management Society of America [CMSA], 2010). Evaluating the OHN case manager's adherence to these standards in regard to practice is an essential practice component.

An audit framework has been developed specifically for OHNs to use for evaluating each worker's plan. The framework has been tested with a sample of 61 injured workers. The goal of the audit tool is to document case management activities in a way that provides measureable outcomes for reporting to employers. The *Case Management Tool for Occupational Health Nurses* is based on Donabedian's quality assessment framework of structure, process, and outcome. It is easy to use and can be helpful for an in-house case manager to begin data collection activities for evaluation of outcomes. Items are collected on case disposition, the assessment process, return to work planning, resource identification, collaborative communication, and the evaluation process (Donabedian, 1980; Mannon et al., 1994).

### Integrating Nursing Process into Case Management

As is evident from the preceding discussion, the case management process closely follows the steps of nursing process: assessment, planning, implementation, and evaluation. Following nursing process in case management, especially with the incorporation of specialized tools developed for the purpose, helps to assure meeting the needs of injured/ill workers in case management services.

**PRACTICE SETTINGS FOR CASE MANAGEMENT SERVICES**

Case management occurs in numerous practice settings by a number of different professional providers (Tahan, 2008; Wassel et al., 2005). Settings include workplaces or corporations, health care delivery systems (e.g., hospitals, clinics, and rehabilitation facilities); provider agencies and facilities (e.g., mental health and home health); managed care organizations, including health maintenance organizations (HMOs); public insurance providers (e.g., Medicaid, Medicare, and the Social Security Administration); private insurance providers (e.g., workers' compensation, health insurance carriers, long-term care, disability, liability, casualty, auto, and accident); and independent case management companies and providers (e.g., nurses and vocational counselors) (Tahan, 2008; Wassel et al., 2005).

Case management services may be provided in person or telephonically or through a combination of both. Telephonic case management encompasses the use of e-mail, faxes, or other forms of electronic communication, including text messaging (Tahan, 2008).

Telephonic case management is very cost effective and can be used in any or all phases of the case management process as an adjunct or follow-up to face-to-face contact or can be used exclusively, especially in less complex cases. According to Tahan (2008), telephonic case management uses two main strategies—demand management and triage. Demand management is focused on appropriate service and resource utilization. Phone contact allows case managers to educate workers about their disease or injury process, the treatment regimen, and outcome goals. Encouragement in self-care and empowerment in decision making are stressed with a goal toward reduction of unnecessary use of emergency services or other more expensive care alternatives (Tahan, 2008).

Triage in telephonic case management is the process of determining the urgency of service needs (Tahan, 2008). Needs are determined as (a) emergent, needing immediate attention which may require the use of an emergency department (ED); (b) urgent, requiring care within eight to 24 hours and recommendations given for the worker to follow until seen by a provider; and (c) non-urgent, in which a routine appointment can be made and appropriate self-care can be followed until the time of that appointment (Tahan, 2008).

Case management in person may involve meeting workers in their homes and in the case of workers' compensation cases, attending medical provider appointments with them. Meeting workers in their homes has the advantage of giving the case manager the opportunity to evaluate family support and other aspects of the socio-environment that may have direct bearing on the worker's ability to cope with injury/illness and successfully recover and return to work (Mullahy, 2010).

In recent years, the importance of case management at the points of transition, or handoffs, has been recognized. The value of this service in assuring client safety during transition from hospital to home or, in the case of work-related injury, when going from disability to return to work, is critical (Tahan, 2008).

Case management on an international basis is not yet a true reality. The laws and regulations vary significantly by country—local case management is still most appropriate. Case management is not ready for practice across international borders. In multinational companies, oversight of case management and analysis of trends may be done in the United States.

It is interesting to note that work-related stress claims occur more frequently in the United Kingdom and Europe and parts of Asia and are more acceptable in these other countries than currently in the United States. Case management as it is practiced in the United States has not yet translated into most other countries and is an evolving concept that has not currently taken hold (Kay Campbell, personal communication, December 10, 2012).

### CASE MANAGEMENT TEAM ROLES AND RESPONSIBILITIES

The case management team encompasses a number of individual team roles. These include the worker in need of case management services, the OHN (whether or not acting as the case manager), treating medical practitioners, the employer, insurers or third-party administrator's claims manager, rehabilitation personnel (when rehabilitation applies), and union bargaining representatives (Wassel et al., 2005). The responsibilities of each of these roles are described in this section.

The worker is the central player in the case management process and has certain main responsibilities, some of which are related to the employment relationship itself. These include (Wassel et al., 2005)

- Promptly reporting an occupational injury or illness to the employer.
- Reporting the need for time off, in a timely manner, for a non-occupational illness or injury causing disability.
- Cooperating and participating in incident investigation processes as needed.
- Keeping the OHN informed about medical care, treatment, prognosis, follow-up appointments, and progress toward return to work goals.
- Keeping all appointments with health care providers.
- Adhering to treatment and medical protocols recommended for recovery.

OHNs are involved at all points in the case management process. The OHN is the first contact with the injured or ill worker and conducts initial assessment and evaluation and provides treatment and referral to and coordination with subsequent health care providers. The OHN is responsible for educating the worker about benefits associated with workers' compensation and/or the disability program and answering or referring further questions to the appropriate claims manager or HR personnel. Ideally, this education begins long before injury or illness occurs. Workers are already familiar with their benefits and do not have to absorb as much new information at a time of stress associated with illness or injury. The OHN provides case management, with an emphasis on return to pre-injury function (AAOHN, 2004), and may be the only case manager involved, depending upon the complexity of the case. The OHN acts as a liaison among the many players involved in a case—the worker, other health care professionals, insurers, TPAs, the employer, and the state workers' compensation board, if applicable, on the worker's behalf (AAOHN, 2004).

The OHN establishes a target RTW date based on disability guidelines for an ill or injured worker (Provine & Vierling, 2008) and works with him or her to establish realistic recovery and/or rehabilitation goals and objectives. The OHN works with treating health care practitioners and the worker to jointly set a date for RTW and to coordinate RTW in a transitional job with plans for progression to regular duty or a permanent modified position as appropriate (DiBenedetto, 2008; Provine & Vierling, 2008).

The OHN also communicates with other health care professionals to negotiate for specialized services needed such as home care, durable medical equipment, rehabilitation, and hospice as well as to assess the adequacy of social support resources and any need for additional resources. The OHN is knowledgeable about the work environment and works closely with the employer to locate appropriate transitional work options when possible and to monitor the worker's progress in a transitional, modified, or regular duty position upon RTW (AAOHN, 2004; CMSA, 2010).

The OHN works diligently to accommodate any medically indicated restrictions and to comply with the ADA as well as the Americans with Disabilities Act Amendments Act (ADAAA) and researches sources for developing accommodations to meet specific job restrictions. One such resource freely available from the Office of Disability Employment in the U.S. Department of Labor (U.S. DOL) is the Job Accommodation Network (JAN), which can be accessed at <http://askjan.org>. Many helpful links to ADA information are available, and accommodation ideas are listed by diagnosis as well as by selected worksites and are searchable online. Free consulting services are available that can be accessed through the website (U.S. Department of Labor [U.S. DOL], Office of Disability Employment Policy, n.d.).

Throughout all workers' compensation and disability processes, the OHN maintains confidentiality of the worker's protected health information. This is in accordance with professional codes, laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Information Technology for Economic and Clinical Health Act (HITECH), understanding that workers' compensation-related medical information may be subject to different laws (AAOHN, 2012; CMSA, 2010; DiBenedetto, 2008; Mullahy, 2010; U.S. Department of Health and Human Services [U.S. DHHS], n.d.).

One or more physicians (usually one identified primary treating physician at a time) are most often the medical providers for workers requiring significant amounts of care for illness or injury, although nurse practitioners may provide initial treatment and may remain involved in the medical care of workers.

The physician's responsibilities include providing information about diagnosis, treatment, prognosis, and expected return to work date in a timely manner; determining and clarifying work limitations that are medically necessary; and approving transitional work (Wassel et al., 2005).

Physicians are better prepared to assist injured or ill workers when they are aware of workplace issues, including the types of work performed at the worksite as well as the options for transitional work. This goal is greatly furthered by conducting a workplace walk-through assessment in conjunction with the employer. The OHN's perspective in the walk-through is extremely valuable and can provide insights into the jobs that will help the physician understand the physical requirements

more fully. The walkthrough may be the first step in designing effective accommodations for worker limitations (Shaw & Feuerstein, 2004).

The treating physician must also communicate with members of the case management team, including the OHN or claims manager, before making referrals to other medical specialists when symptoms persist that have gone beyond that physician's purview of care (Wassel et al., 2005).

The employer is an important team member whose support is critical in an effective case management program, especially in expediting the RTW process. The employer is responsible for investigating the incident or issues impacting illness and injury that have occurred and reviewing workplace factors contributing to or causing the illness or injury (Wassel et al., 2005). Once the workplace factors have been identified, the employer has an affirmative responsibility to take corrective action, which may include engineering changes (such as new equipment, machine modifications, noise baffling, chemical elimination, or substitution); administrative or work practice modifications (such as schedule changes or modified procedures); or personal protective equipment [PPE] (respirators, gloves, etc.). These changes can be ergonomic improvements that may be in any of the forms mentioned.

The supervisor is a representative of the employer and is responsible for staying in touch with the worker on a regular basis during the disability period. This helps to maintain the link between the ill or injured worker and the workplace and to foster the good will upon which the employment relationship is based. Supervisors are often the first to know of an injury or illness, and their attitudes and responses to workers from day one may affect disability outcomes. Education for supervisors may improve their ability to respond appropriately to injured or ill employees and participate more fully as partners in the process from onset of injury or illness to RTW (Pransky, Shaw, & McLellan, 2001).

The employer, in the parties of the OHN, human resource (HR) professionals, and the supervisor, identify suitable transitional work, establish and support the company's RTW program for both occupational and non-occupational injuries and illnesses, and facilitate the worker's return to work as soon as is medically feasible (DiBenedetto, 2008; Mullahy, 2010; Provine & Vierling, 2008; Wassel et al., 2005). The importance of adherence to established policy and good communication between the involved parties to assure success in RTW is important.

The insurer (disability or workers' compensation) or TPA, which may be internal or external, is represented by a claims manager and acts as a consultant to all parties throughout all phases of the disability or workers' compensation claim. Responsibilities of the insurer include determining eligibility of the worker for benefits and/or compensability of the claim. The claims manager also authorizes medical care and payment of bills to providers. However, early in the claims process, the OHN may fulfill this role in some companies. The claims manager ensures the payment of wages specified in workers' compensation statutes and/or disability plans to the ill or injured worker and also files all statutorily required paperwork with jurisdictional authorities regarding the claim (Wassel et al., 2005).

The claims manager communicates on a regular basis with the employer and with the worker and responds promptly and accurately to the employer's and the worker's questions regarding the claim, including referrals, and benefits (e. g., TTD, PPD, settlements, and coordination of benefits). When needed, the claims manager requests periodic health and medical information from health care

providers, particularly if regular reports are not forthcoming (Wassel et al., 2005). The claims manager consults with attorneys, as needed, when questions arise regarding workers' rights under state workers' compensation law. An example of this is during denial or settlement of a claim (DiBenedetto, 2008; Wassel et al., 2005). In concert with the OHN and employer, the claims manager facilitates case closure by settlement, if appropriate.

Rehabilitation specialists (rehabilitation nurses, physical therapists, occupational specialists, and vocational counselors) work with the injured worker during the rehabilitation phases of recovery in those states in which rehabilitation remains a benefit available through the workers' compensation system (Schoenbeck, Tahan, & Powell, 2008). Major responsibilities of rehabilitation specialists include: (a) working with the injured worker to regain function and strength to meet the goal of RTW as soon as medically feasible; (b) communicating with the case management team about the worker's progress; (c) identifying barriers to RTW and "red flags" (Box 12.1 lists several indicators of delayed recovery); and (d) providing specialized programs to facilitate the worker's return to work that may include such techniques as functional capacity evaluations, ergonomic assessments, labor market surveys, and work hardening programs (Mullahy, 2010; Schoenbeck et al., 2008; Wassel et al., 2005). Vocational rehabilitation for workers' compensation injuries or illnesses has been significantly reduced or eliminated in many jurisdictions or has been replaced with less expensive alternatives. To date, there are limited data on the effectiveness of these alternatives.

Additional practitioners involved in the rehabilitation process may include specialized physicians, such as physiatrists (physical medicine and rehabilitation specialists) and pain management specialists (Schoenbeck et al., 2008).

All providers, along with the rehabilitation specialists listed in the previous paragraph, need to provide realistic expectations related to recovery to the injured worker and to provide meaningful assistance in helping the injured worker manage chronic pain (Wassel et al., 2005), while reducing the potential for substance dependence whenever possible (Dersh et al., 2008).

The union, represented by a bargaining representative, is important in its support of the case management process and injured or ill workers. Main responsibilities of the union include working with the employer and the OHN to understand and support the treatment and RTW objectives for ill or injured workers; helping ill or injured workers understand their responsibilities for return to transitional work; and helping ill or injured workers understand their benefits while disabled (Wassel et al., 2005).

The nurse case manager, whether it is the OHN internal to the company or an external case manager, is responsible for coordinating activities of other professionals providing services to the injured worker. Several goals of coordinating services are to assure a cohesive team approach (Brines et al., 1999), minimize duplication of services, and assure the appropriateness of treatment.

## CLIENT ADVOCACY

Client advocacy is an important role for both the OHN and the case manager. Being focused on the worker's concerns is an essential aspect of advocacy in the case management role (Brines et al., 1999). Even though assigning a case manager to a case is a cost savings measure in the eyes of an insurer or

employer, the OHN/case manager is aware that advocacy for meeting the worker's needs may result in the best outcomes, be cost effective, and result in greater productivity. Returning the worker to gainful employment is a "win" for all parties (Brines et al., 1999).

### Box 12.1: Indicators of Delayed Recovery (Red flags)

- Poor job satisfaction
- A modification in the story of injury occurrence
- Unresolved anger at employer concerning the injury
- Unwillingness to discuss or negotiate a RTW plan
- Multiple failures to successfully return to work
- Perceived lack of support from supervisor that is unsupportable
- History of job performance problems
- Time off without any change in symptoms
- Income on temporary disability equal to or greater than regular wage scale
- Double dipping between workers' compensation, STD, LTD or SSDI
- Other secondary gain issues: disabled partner at home, multiple demands, and entitlement issues
- Limited job offerings in the area
- "Doctor shopping" (multiple changes of treating physician)
- Involvement of an attorney
- Requests for narcotics renewals, especially with multiple pharmacy use
- Close to retirement age
- Undiagnosed or untreated depression (either preceding or concurrent with injury)
- Time off from the date of injury exceeds 6 months
- Continued subjective complaints without objective findings
- Unavailable when case manager calls
- Prolonged treatment with complications unrelated to the injury
- Concurrent disability or disease that may or may not be related to the work-related condition
- Non-English speaking and insufficient understanding and/or compliance with medical regimens
- Perceived lack of incentive to comply with medical treatment and RTW

Source: DiBenedetto, D. V. (2008). Workers' compensation case management. In S. K. Powell & H. A. Tahan (Eds.), *CMSA core curriculum for case management* (2nd ed., pp. 364-399). Philadelphia, PA: Wolters Kluwer Health; Wassel, M. L., Randolph, J., & Rieth, L. (2005). Disability case management. In M. K. Salazar (Ed.), *Core curriculum for occupational health nursing* (3rd ed.). Saunders.

**DEVELOPMENT OF EFFECTIVE CASE MANAGEMENT PROGRAMS**

Assessment of the need for a case management program begins with gathering data about the number of large dollar claims (both occupational and non-occupational) that have occurred in the company or companies for which the OHN is responsible. These data are available from the OSHA logs, workers' compensation loss runs, and the disability program records (Menzel, 2006). Partnership with benefits administrators or HR will be necessary to gather information on the non-occupational disability data.

Data analysis involves not only determining cost of claims, but also severity levels based on number of lost and restricted days of work. The severity rate is calculated by taking the number of lost time injuries and multiplying it by 200,000 and then dividing by the number of hours worked. This provides the severity rate per hundred workers, which is the usual comparison rate and can be done for any time period chosen—e.g., a month, a quarter, or a year (U.S. DOL, BLS, 2012).

One of the cutting-edge technologies used by approximately 15% of insurance carriers and TPAs that administer workers' compensation cases and often employ case managers is predictive modeling (Anderberg, Gavin, & Ungaretti, 2012). Predictive modeling is the analysis of existing data sources (claim files and histories) to build models that predict outcomes of individual claims. These models are used to enhance decision making about claims reserving, actions, and settlement, such as making early settlement offers if the model suggests that a claimant is likely to litigate. Some of the decisions made based on the modeling include the assignment of a case manager and identification of RTW issues. The predictive modeling software is not available commercially, but is built internally by individual companies and is, therefore, proprietary. Experts in the field anticipate that predictive modeling will be extended to non-work related disability in the near future (Anderberg et al., 2012).

Predictive modeling may be a useful tool to anticipate the trajectory of individual claims, but it does not replace the experience and judgment of experienced case managers and the claims personnel they interact with regarding cases (Anderberg et al., 2012). Currently, it is a useful adjunctive tool.

Once the need for a case management program has been determined, planning should commence. Curtis and Scott (2004) make a compelling case for integrating disability management into the strategic planning process for corporations. They argue that the promise employers make to their employees in the employment relationship necessitates caring for employees through illness and injury and keeping absent employees engaged in a way that contributes to a healthy organization that ultimately contributes to the bottom line. With disability management included in the strategic planning process, it becomes necessary to design the disability program with the essential elements to assure its success. This includes the development of enduring corporate policies and procedures that can continue to be used consistently and effectively. These policies and procedures embed the program firmly in the organization such that it becomes an organic part of the organization's culture and operations. With case management planned as part of an overall disability management plan within a corporation, implementation begins. Evaluation of the program and measurement of results then become essential to complete a best practice model of disability management (Curtis & Scott, 2004).

## FITNESS FOR WORK

### Assessment of Fitness for Work

Assessment of fitness for work is largely based on medical opinion, and it is usually determined by the treating physician. This health care provider establishes whether the ill or injured worker is ready to RTW, either to the worker's pre-injury job or to an alternative or modified job. A seemingly more objective way of accomplishing this is to have a professional actually measure the worker's abilities in a functional capacity evaluation (FCE). However, one study demonstrated that FCEs were worse than no testing to facilitate appropriate job placement. In the study, clients underwent FCEs. The subjects with physicians using data from the FCEs as the basis for return to work decisions had worse outcomes than those whose physicians ignored the FCE results and simply returned the workers to their usual jobs with reassurance (Gouttebauge, Wind, Kuijer, & Frings-Dresen, 2004). A single study does not discount the value of using FCEs. However, it does highlight that the current level of FCE technology should not be taken as absolutely superior to clinical judgment in RTW decision making. More research is needed to determine the effectiveness and best use of this technology.

### Planning for Fitness for Work

Conducting quality management/improvement programs for occupational health and safety (OH&S) issues in the company improves the environment such that fewer issues are present to preclude workers from performing their regular jobs. The safer the job, the less likely injury will occur. The section of this chapter on the RTW program discusses the job hazard analysis process. This is a technique for evaluating and recording each step of a job and systematically identifying and addressing job safety and health issues to reduce or eliminate identified hazards.

### Conduct and Interpret Job Analyses

Proactively performing job analyses with resulting ADA-compliant job descriptions also prepares the organization for evaluating fitness for work. ADA-compliant job descriptions outline the essential functions of the job. These essential functions can be determined by performing a job analysis. A job analysis includes identifying the job's purpose, the structure of the job setting, specifics about the work-site, the workstation, and activities performed within the job. Job activities are then identified as being either essential or secondary (Loy, 2010).

### Implementation of Fitness for Work

Fitness for work from a disability perspective is implemented within the context of the RTW program. (Refer to the RTW program section in this chapter.) If workers are not fit to return to either their pre-injury jobs or modified or alternative jobs, they may be eligible for rehabilitation, depending on the details of the benefits plan (in the event of non-occupational disability) or the availability of rehabilitation benefits in their state or jurisdiction (DiBenedetto, 2008).

Rehabilitation benefits have been significantly reduced or eliminated in some states or replaced by lower cost options. For example, in California, an educational voucher known as a Supplemental Job Displacement Benefit has been implemented.

If a worker is involved in a rehabilitation plan, the case manager maintains close contact with the rehabilitation professionals. This allows the OHN case manager to remain aware of the worker's progress so that RTW planning can proceed on schedule (DiBenedetto, 2008).

## MANAGEMENT PROGRAMS FOR CHRONIC DISEASES

With continually rising health care costs, the aging of the population with a concurrent rise in chronic disease, and the fragmentation of care that has occurred as a result of the heavy utilization of specialists, the need for chronic disease management programs has never been more apparent. Quality improvement projects have shown that care can be improved through the use of best practice clinical guidelines and process improvements, including the use of sophisticated software programs that accompany chronic disease management programs (Powell & Tahan, 2008).

Effective components of a disease management program include (Powell & Tahan, 2008)

- Clinical excellence and the use of evidence-based treatment guidelines.
- Appropriate use of both primary care practitioners and specialists.
- Client education to prevent disease exacerbation and complications.
- Successful disease prevention measures.
- Awareness of complementary and alternative health care.
- Referral to resources available from professional societies and associations.

The focus of a disease management program is on prevention and education. Goals should include improving worker adherence to the treatment regimen or understanding why non-adherence is occurring and working with employees to reduce barriers to adherence (Powell & Tahan, 2008).

Self-management strategies that promote change are employed in disease management. One effective technique is motivational interviewing in which the employee identifies personalized goals as a result of the interaction with the professional (The Care Continuum Alliance, 2008). Motivational interviewing is guided by four principles: (a) the expression of empathy, (b) the development of a discrepancy between the current situation and a desired change, (c) going with presented resistance and avoiding argumentation, and (d) supporting self-efficacy for the worker in the desired behavior. Five specific techniques to improve communication and understanding include (a) confirmation, (b) the use of open-ended questions, (c) reflective listening, (d) summarizing what is being said, and (e) initiating a discussion about changing the target behavior (Brobeck, Bergh, Odencrants, & Hildingh, 2011).

The use of behavior change models such as Prochaska's Transtheoretical Model of Change (TTM) is another effective strategy. The TTM identifies Preaction and Action stages of change which are identifiable and can be measured (Jones et al., 2003).

The Preaction phases consist of

- Precontemplation in which there is no intention of change in the near future.

- Contemplation in which change is intended within the next six months.
- Preparation in which change is being actively considered in the immediate future.

The Action phases consist of

- Action in which action is occurring but is not yet well established.
- Maintenance in which change has occurred and the individual is working to sustain it after the first six months after the change (Jones et al., 2003).

Some of the outcomes of a disease management program may include (Powell & Tahan, 2008)

- Reduced health care expenditures.
- Reduced hospitalizations and emergency room visits.
- Improved clinical outcomes for the diseases under management.
- Increased client satisfaction.
- Enhanced practitioner adherence to evidence-based clinical guidelines.
- Improved access to services.
- An overall more proactive approach to health care by the organization.

### Administration or Management of Disability Programs

The OHN rarely has full responsibility for administration or management of the disability program but should be the one making health care and medically-related decisions in the program or doing so in collaboration with other appropriate health care personnel (DiBenedetto, 2008). Ideally, the OHN is receiving any pertinent health care and medically-related documentation to enable appropriate assessment of fitness for work as workers RTW from any disability period. However, it is preferable that assignment of paperwork, such as benefits notifications, bill payment, etc., is given to qualified administrative personnel rather than the OHN.

### Family Medical Leave Act (FMLA) Programs

The Family Medical Leave Act (FMLA) is a federal law that provides certain employees with serious health problems or employees who need to care for a child or other family member with up to 12 weeks of unpaid, job-protected leave per year. It also requires that group health benefits be maintained during the leave. FMLA applies to all public agencies, including government employers, and private sector employers with 50 or more employees who work 20 or more workweeks in the current or preceding calendar year. For workers to be eligible, they must work for a covered employer, have worked for the employer for at least 12 months, and at least 1,250 work hours over the last 12 months. Employees must also work in the United States or a territory or possession of the United States where at least 50 other employees are employed within 75 miles. The act has recently been amended to allow up to 26 weeks of leave to care for a family member who is a member of the Armed Forces. Accrued paid leave for which a worker is eligible can be run concurrently with FMLA (U.S. DOL, Wage and Hour Division, 2010). The FMLA has a specific definition for “serious health condition”—an illness, injury, impairment, or mental condition that involves inpatient care (overnight in hospital, hospice, or residential care facility), including any period of incapacity or subsequent treatment associated with the inpatient care or continuous care by a health care provider that involves

a period of incapacity (U.S. DOL, Wage and Hour Division, 2010). The period of incapacity must last longer than three consecutive, full calendar days with subsequent treatment or incapacity relating to the same condition. Other definitions of “serious health condition” include (U.S. DOL, Wage and Hour Division, 2010)

- Any period of incapacity related to pregnancy or for prenatal care.
- Any period of incapacity or treatment for a chronic health condition that is serious and continues over extended time with periodic visits to a health care provider.
- Incapacity that is permanent or long-term due to a condition for which treatment may be ineffective—supervision by a physician only is required rather than active treatment.
- Any absence to receive multiple treatments for restorative surgery or for a condition that would likely result in incapacity of more than three days if not treated.

Employers must post a notice at their place of business that has been approved by the Secretary of Labor explaining the rights and responsibilities under FMLA. The notices must also be distributed to new employees at hire in some manner, such as in an employee handbook or other written guidance about benefits. When the employer receives a request for leave or becomes aware that a leave may be for an FMLA purpose, the employer must notify the employee of eligibility to take FMLA leave and inform the worker of rights and responsibilities under FMLA. Once enough information has been received to know that the leave is for an FMLA-qualifying reason, the employer must notify the worker that the leave is designated as and counted as FMLA leave. The U.S. DOL has developed forms to assist employers in meeting these notification requirements. Links to the forms can be found on *Fact Sheet #28: The Family and Medical Leave Act of 1993* (U.S. DOL, Wage and Hour Division, 2010).

Upon return to work from FMLA leave, workers are to be returned to their original job or an equivalent job with equivalent pay, benefits and other terms and conditions of employment—assuming they return within the job protected period allowed by FMLA. The leave time cannot be counted against the employee under “no fault” attendance policies. However, if bonuses or other payments are based on specific goals such as perfect attendance or products sold, the worker will not have achieved these goals (U.S. DOL, Wage and Hour Division, 2010). More discussion on FMLA can be found in Chapter 4.

### Evaluation of the Case Management Program

The OHN needs to evaluate health care delivered to employees by outside providers. Are workers receiving the expected standard of care? Are providers following evidence-based guidelines available in their areas of practice? Are employees returning to work in a timely manner?

Evaluating the quality of care provided by internal occupational health care services is another important component of the overall program. Are the in-house treatment protocols followed? Is the care provided by onsite OHNs keeping first aid cases from progressing to recordable status? Is motivational interviewing being used to promote changing behavior patterns and helping to prevent recurrence of incidents?

The OHN can conduct informal research to identify trends occurring in the program to target areas in need of corrective action. Evaluating and monitoring outcomes, quality, and the cost effectiveness of services are all important components of the program evaluation process. Additional tools for evaluating case management services are discussed later in this chapter.

## OCCUPATIONAL DISABILITY CASE MANAGEMENT

Approximately 10% of workers who leave work for any reason incur significant work absence and life disruption that may lead to prolonged disability and PPD. Occupational disability cost the United States over \$100 billion in 2006 and is fundamentally due to non-medical decision making (American College of Occupational and Environmental Medicine [ACOEM], 2006) and poor functioning of disability systems and RTW processes. The American College of Occupational and Environmental Medicine (ACOEM) calls this the stay-at-work/RTW (SAW/RTW) process (ACOEM, 2006).

ACOEM (2006) asserts that the current focus on evaluating and managing disability does little to prevent the problem. The focus should be on prevention. Its recommendations for improving performance in keeping people at work are to adopt a disability prevention model, address the behavioral and circumstantial realities that create and prolong disability, acknowledge the contribution of motivation and improve incentive alignment, and focus on system and infrastructure improvements.

OHNs are generally aware that work-related disability is a complex interplay of all of these forces in addition to the actual disabling condition. That is, “work disability is now conceptualized as a function of organizational, jurisdictional and social influences, rather than as primarily medically determined” (Franche, Baril, Shaw, Nicholas & Loisel, 2005, p. 525). This is one reason case management is so important in the OHN practice arena.

### Assessment of Occupational Disability Case Management

The goal of case management in the event of occupation-related disability is to return the employee to gainful employment as soon as possible. This includes intervening early after the disabling event to reduce disability as much as possible (Provine & Vierling, 2008).

The first step is to identify work-related cases appropriate for case management. Not all work-related injury cases are referred for case management services because the majority of injury cases resolve with little intervention. Identifying cases that may progress to be more prolonged or complex can sometimes be an art. However, skilled practitioners are often able to identify when case management services should be employed. Case management services can be secured and tailored to the injured worker’s needs at any point in a claim’s trajectory (Mullahy, 2010). The earlier in a complex claim process this occurs, the better, as development of a positive relationship between the injured worker and the case manager can assist in meeting the injured worker’s needs most effectively.

Catastrophic and very serious injury cases such as spinal cord injuries or major burns and amputations should be assigned case management services at claim initiation to assure early care planning and transitional care from hospital to home and eventual RTW (DiBenedetto, 2008).

Earlier referral of these cases may also prevent complications and costly hospital readmissions when effective case management services are provided (Mullahy, 2010).

### **Legal and Regulatory Implications of Occupational Disability Case Management**

Theoretically, workers' compensation provides an exclusive remedy for work-related injury and illnesses. As such, it would seem to be straight forward to determine which cases might be amenable to case management based on severity. However, the exclusive remedy of workers' compensation has eroded in some states, as injured workers are able to sue under ADA, state statutes relating to disability accommodation, and other discrimination claims, such as those related to unlawful discharge. The workers' compensation environment in some states responds to this "exclusive remedy" erosion by instituting legislative reforms every few years. These efforts are directed at attempting to swing the pendulum back into balance again for a few more years until the pendulum again swings out of balance through erosion of the reforms by new methods of litigation (Brown, 2012). This complex legal environment makes case management decisions all the more important and effective case management even more critical.

### **Planning for Occupational Disability Case Management**

Case managers who operate in the arena of workers' compensation must recognize the problems that result from work-related injury or illness and the consequences of those injuries and illnesses (DiBenedetto, 2008). They must have processes established for pre-authorization or pre-certification of procedures, services, or equipment in states in which that is a requirement. The case manager must also know if there are pre-established networks or panels of physicians from which workers must select their treating physician (Medical Provider Network [MPN], HMO, or preferred provider organizations [PPO]) (DiBenedetto, 2008; Medical Provider Networks, 2010).

UR and peer review are often used in the workers' compensation system as cost control measures (DiBenedetto, 2008). Case managers must plan to work within the constraints of this reality and can optimize the use of UR. They must avoid overuse by discouraging its use when the procedure or service for which UR is being considered is clearly medically indicated and for which UR will only delay the service authorization and increase the cost of the claim.

### **Implementation of Occupational Disability Case Management**

Case management in workers' compensation was one of the earliest practice settings for the discipline, and in many ways, it grew up in the workers' compensation environment. A 2002 Alexander and Alexander survey of more than 2,000 corporate executives determined that 86% of their corporations used case managers in workers' compensation to control increasing costs (as cited in Mullahy, 2010). Administration or management of a workers' compensation program is often within the purview of OHNs. This is, of course, an appropriate role for OHNs based on education, skill, and experience (AAOHN, 2012).

A primary program goal in occupational disability management is to provide timely and quality health care to workers. When injury or illness "arises out of employment" (the activity performed at the time of injury is either specifically required or is reasonably contemplated by the employment

relationship) and in the “course of employment” (the work-related nature of the employee’s activity) making it compensable under workers’ compensation laws, employers in most states can direct workers to a panel of pre-selected health care providers. In an effort to ensure the best health care outcomes, employers or their occupational health professional representatives should pre-select a panel of health care professionals who share their commitment to provide prompt, high-quality health care and treatment and returning injured workers to work as soon as medically safe. Developing and fostering trusting relationships with quality health care providers is essential to the success of both case management and an effective RTW program (DiBenedetto, 2008; Wassel et al., 2005).

Significant variation exists in how workers access medical and health care, depending on the state or jurisdiction involved. Some states require workers to choose within networks. Some require choice within posted panels of providers. Others allow employers to direct all referrals to their choice of health care providers. Some allow employers to direct referrals to health care providers under strict time frames. After the time frame has elapsed, the worker can change providers. Some states are designated as worker choice states, and employers are restricted from directing or referring workers to providers (Wassel et al., 2005).

Case managers must maintain a current level of knowledge in workers’ compensation laws in their jurisdictional areas and keep abreast of the changes occurring regularly in the field. The WorkersCompensation.com website is a useful resource organized by state at [http://workerscompensation.com/workers\\_comp\\_by\\_state.php](http://workerscompensation.com/workers_comp_by_state.php). The website has links to all state workers’ compensation statutes, forms and other useful information (WorkersCompensation.com, n.d.).

Almost every state with mandatory workers’ compensation insurance has “exclusive remedy” protection for employers. However a few states, notably Texas, do not require employers to carry workers’ compensation insurance. Case managers need to know the jurisdictions in which they work to be aware of those situations in which exclusive remedy does not apply and to determine whether an additional claim or suit may be active in conjunction with the workers’ compensation claim (Wassel et al., 2005). Also, the OHN case manager needs to be aware that the exclusive remedy of workers’ compensation has been eroded over time and suits are occurring under ADA and other statutes even when workers have received workers’ compensation benefits.

An additional goal of case management is to promote proactive transitional work programs. The most important principle of disability case management is early intervention (Mullahy, 2010). Early intervention is likely to result in cost-savings to employers, disabled workers, insurance carriers, and in important psychosocial benefits experienced by workers and their families (Shrey & Lacerte, 1995).

When injuries or illnesses result in actual or potential lost work days, a target RTW date should be established using recognized disability guidelines (e.g., ACOEM’s Occupational Medicine Practice Guidelines [2010]; The Work Loss Data Institute’s Guidelines [2012]; Presley Reed’s Medical Disability Advisor now known as MD Advisor [6<sup>th</sup> edition] and now an online resource [Talmage & Reed Group’s Medical Advisory Board, 2009]).

The preferred site for injured workers to rehabilitate in preparation for returning to their original jobs is their own workplace (Shaw & Feuerstein, 2004). This workplace rehabilitation/RTW model has the potential to reduce or eliminate most of the disincentives that result from the worker’s

potentially lengthy separation from the work site and yield more cost-savings than having workers away from work (Shaw & Feuerstein, 2004).

It is especially important in occupation-related disability cases that there are adequate job descriptions that have identified the essential and secondary functions of the job. This job description should be sent to the treating medical provider early in the treatment process so that a reasonable plan for early RTW can be made. If no job description exists or it is outdated, a job analysis should be performed. Job analysis is a process that involves a formal analysis of the tasks associated with a specific job or group of jobs. A job analysis specifically identifies the essential functions of the job. The job analysis should paint an accurate picture of the essential physical, cognitive, and environmental requirements of the job and be made available to treating health care professionals to help determine work return dates and job modification requirements (DiBenedetto, 2008; Wassel et al., 2005).

The treating health care provider is responsible for identifying any job restrictions, but the employer determines the job fit for those restrictions. A functional match of an injured or ill worker to the job is the fundamental principle for transitional work programs. Employers and case managers should use the job analysis to determine transitional duty options (modified or alternative work) for workers released to work with medical restrictions. Employers can expedite the RTW process by accurately completing a job analysis for each job category in advance of injury/illness occurring. This process helps with ADA compliance as well (DiBenedetto, 2008; Wassel et al., 2005).

Transitional work is intended to be temporary and progressive, not a permanent job accommodation. Time benchmarks must be established for limiting the duration of transitional work and re-evaluating the worker's progress toward full duty (Wassel et al., 2005).

Employers started becoming more active participants in rehabilitation and return to work efforts of their workers in the 1990s. This interest resulted from a reduced labor pool at the time, a desire to minimize the costs of workers' compensation and disability, and the implementation of the ADA, which mandated job modification and accommodation for persons with qualifying disabilities (Shrey & Lacerte, 1995).

After 60 to 90 days of temporary transitional work, the RTW team, including the case manager, should evaluate the injured worker's progress, the reality of potentially returning to the original job, and options for a permanent modified position or an alternate position for which the worker is qualified. Employers can expedite the RTW process by accurately completing a job analysis for each job category in their plant (DiBenedetto, 2008; Wassel et al., 2005).

Several important considerations need to be kept in mind when occupational illnesses and injuries occur. Workers who become ill or injured in circumstances that "arise out of and in the course of employment" are eligible for workers' compensation benefits. In addition, pre-existing conditions aggravated by employment are compensable in many jurisdictions. The percent of contribution by work varies by jurisdiction. Thus, the OHN case manager needs to become familiar with what applies in the appropriate state or jurisdiction (DiBenedetto, 2008; Wassel et al., 2005).

The majority of workers who become ill or injured in most workplaces receive first aid, medical, or health care treatment and RTW before absences result in payment for lost wages. In cases that

progress to lost time, most workers' compensation claims result in injured workers returning to full duty in their original position before completing 60 days of transitional work (Wassel et al., 2005).

Ongoing management of workers' compensation cases is an important role for the OHN case manager (AAOHN, 2012). Regular communication with injured/ill workers, insurers/TPAs claims managers, supervisors, health care providers, and any other providers of services to the worker is important to keep everyone on the same page.

A descriptive study conducted in 1995 (Brines et al., 1999) remains valuable. It surveyed injured workers about their perceptions of case managers and the services they provided. Through participation in written surveys ( $n=45$ ) and personal interviews ( $n=27$ ), workers reported they were satisfied with nurse case managers who understood their injury, who were able to see the "big picture," who anticipated their needs, and who helped them set appropriate goals. Workers who were not satisfied with their nurse case managers believed that the nurse was not interested in them and did not treat them with respect. They also believed the nurse was not knowledgeable about the injured worker's injury and, thus, did not add meaningfully to the process of their care.

Continuing to follow the case management process previously described, while also keeping an eye to the financial side of the claim, is appropriate in the management of workers' compensation cases. Having tracking mechanisms that assist the case manager to follow the status of each case and serve as a "tickler" for follow-up as well is very useful. A computerized case management information system (CMIS) would allow for more sophisticated tracking as well as measurement of outcomes, but would be an expensive option for many operations (McGonigle & Mastrian, 2008).

Educating management at all levels of the company about the OH&S programs offered, including the disability and workers' compensation case management, is essential. Management support and cooperation are necessary for the programs to succeed. Supervisors need to understand the importance of bringing their employees back to work and to avoid asserting that they only want them back if they are "100 percent." Supervisors also need to recognize the importance of keeping in contact with employees who are out on leave to maintain that all-important connection to the work group.

### Evaluation of the Occupational Disability Program

The OHN case manager needs to analyze the workers' compensation data from loss runs and the OSHA log on at least a quarterly basis. Questions could include (Menzel, 2006)

- Is the severity rate improving?
- Are there hot spots—departments with higher rates of injury?
- Are there specific jobs in which there are recurrent injuries?
- Is there success in bringing workers back to work?
- Are workers returning to work more quickly than the guidelines recommended or is it taking longer?
- What is the average cost of closed claims?
- Is that average cost increasing or decreasing?

- What are the trends showing?
- Are objectives for contact with workers for initial and for follow-up assessments being met?
- What other parameters are being measured and what are the performance outcomes?

Reporting performance outcomes to management is an important OHN function. Performance is likely to improve as the OHN case manager designs strategies to address barriers. Being able to demonstrate the ability, through case management services, to return a worker back to work earlier than the projected disability guidelines is a valuable way to demonstrate cost savings (Boseman, 2001).

## NON-OCCUPATIONAL DISABILITY CASE MANAGEMENT

The primary mission of disability management is to reduce costs associated with all disabilities in a non-adversarial environment. Experts in the field assert that this can best be accomplished by focusing on “ability” rather than “disability” (Provine & Vierling, 2008). This is consistent with the most recent definition of disability from the World Health Organization (WHO) and the National Institute for Disability Research:

Disability is a product of an interaction between characteristics (e.g., conditions or impairments, functional status, or personal and social qualities) of the individual and characteristics of the natural, built, cultural, and social environments. The construct of disability is located on a continuum from enablement to disablement. Personal characteristics, as well as environmental ones, may be enabling or disabling, and the relative degree fluctuates, depending on condition, time, and setting. Disability is a contextual variable, dynamic over time and circumstance. Environments may be physically accessible or inaccessible, culturally inclusive or exclusive, accommodating or unaccommodating, and supportive or unsupportive (Accessing Safety Initiative, 2010, para. 4).

### Assessment of Non-Occupational Disability Case Management

Identifying non work-related cases appropriate for case management is often more challenging for an in-house OHN, as all disability paperwork may not come through the occupational health office. If that is the case, a mechanism for case review may be appropriate. However, this can still be problematic. In some states, such as California, employers do not have a right to diagnosis in the event of non-occupational disability but only to the information that a disabling event has occurred and the expected duration of the disability. In such cases, external case managers are more likely to be used (Mullahy, 2010).

### Planning for Non-Occupational Disability Case Management

The planning phase in non-occupational disability management is similar to occupational disability with the goal of bringing the worker back to work as soon as medically feasible (Provine & Vierling, 2008). Recommending changes in the job/work to accommodate the workers’ health status based on

identified restrictions expedites the return by working with the employer to make it a reality (Provine & Vierling, 2008).

Assuring that the ill or injured worker has the resources needed to speed recovery and RTW is as important in non-occupational disability as it is with a work-related injury. Sometimes there is less urgency applied to these cases. However, in reality, there are significant cost savings as well as benefit to affected workers by applying the same practices and urgency to non-occupational cases as have traditionally been applied to occupational cases (Provine & Vierling, 2008).

### Implementation of Non-Occupational Disability Case Management

Providing direct care for non-work related illnesses and injuries for workers is the first step in managing non-occupational cases. This provides opportunities for educating workers about health issues, helping them manage their chronic diseases on-site effectively and encouraging them to continue appropriate treatment regimens with their primary care providers. It also provides the opportunity to establish client rapport so that workers seek out the OHN when they have a disabling event. Additionally, when workers use the in-house OHN for non-work related illnesses and injuries, a unique opportunity to use motivational interviewing or other methods for behavior change is created that may result in effective behavior change to reduce the likelihood of a disabling event. Also, providing direct care for non-work related illnesses and injuries meets the standards set by the profession (AAOHN, 2012).

Ideally, the OHN should manage the health care aspects of STD or LTD cases while administrative personnel manage the paperwork burden. Employer disability benefits for non-occupational illnesses and injuries often include salary continuance, the use of accumulated sick pay, STD, and LTD. Conditions and benefit amounts vary per plan description (Provine & Vierling, 2008; Wassel et al., 2005). Salary continuance is income replacement for a portion of regular earnings as defined by the employer's plan. The length of the benefit period can vary. It is generally 26 weeks and most often supplements STD (Provine & Vierling, 2008; Wassel et al., 2005).

STD is also income replacement and may be a voluntary plan provided by the employer, or it may be a state plan. This benefit is statutory in some states if workers meet eligibility requirements (e.g., New York, New Jersey, California, Rhode Island, Puerto Rico, and Hawaii) (J. W. Terrill Consulting Services, 2012; Sedgwick, 2014). Workers receiving benefits are usually required to provide appropriate documentation from treating medical providers as proof of continued need for benefits, as determined by plan. STD can bridge to LTD or Social Security Disability Insurance (SSDI) (Provine & Vierling, 2008; Wassel et al., 2005).

When a worker is on STD, benefits should be coordinated with FMLA, counting those days or weeks against that unpaid entitlement time of up to 12 weeks in a rolling calendar year that carries job protection (Haag, Kalina, & Tourigian, 2003). Union benefits may also be a source of income replacement when workers, who are union members, are off work due to disability (Provine & Vierling, 2008).

LTD is also an income replacement plan that does not cover medical payments. LTD is an employer sponsored or worker paid group benefit, not required by statute in most jurisdictions. Plans vary, but generally start after 26 weeks or after the STD ends. It is desirable for benefits to coordinate

with expiration of STD, but it is not always possible to avoid coverage gaps (Haag et al., 2003; Wassel et al., 2005). The emphasis of LTD is on RTW, retraining, or vocational rehabilitation; it is also directed at the advocacy of securing Social Security benefits if continued disability is appropriate. LTD may be coordinated with SSDI, pensions, workers' compensation, and other income replacement benefits as appropriate (Haag et al., 2003; Wassel et al., 2005).

In most LTD plans, after a defined period of time (e.g., two years), a plan may require the worker to meet an "any occupation" provision to continue to receive LTD benefits. The "any occupation" provision is a common requirement of LTD plans. If the worker is qualified to perform any other job or occupation comparable to his or her previous job or occupation, benefits cease (Wassel et al., 2005). This test is relatively rigorous, and benefits may be lost at this point.

Ideally, VR specialists are often asked to assess the worker's earning capacity to help determine if the worker meets the "any occupation" provision and other criteria and is or is not eligible for continuation of long-term disability benefits (Wassel et al., 2005). The use of VR specialists varies greatly by plan.

SSDI is administered by the Social Security Administration. The benefit depends on how long the worker has worked and how much money the worker has paid into Social Security (Haag et al., 2003; Provine & Vierling, 2008). To be screened for SSDI and other SSA benefits, workers should be directed to the website <http://www.benefits.gov/ssa>, which takes them through the process to determine eligibility. If at first they do not have success, it is important that they try again, as it often takes several tries before workers have provided all the necessary information for an affirmative decision regarding SSDI benefits. Workers should be counseled to include all requested information to help assure better success in the application process.

Case managers play a critical role in managing non-occupational cases. This role includes coordinating communications with health care providers, ill and injured workers, and employers; facilitating the worker's timely return to work; and assisting workers to reintegrate into their usual and customary job as medical restrictions are removed (Wassel et al., 2005).

### Evaluation of the Non-Occupational Disability Case Management Program

The evaluation of this program can include such questions as (Mullahy, 2010)

- Is there a sound basis for determining cases to receive case management services?
- Is it based on diagnosis, cost, or clinical outcome risk, if the OHN does not manage the case?
- Is each worker getting a full assessment?
- Are worker needs identified?
- Are workers falling through the cracks or being lost to follow-up?
- Are outcomes improved?
- Is the OHN mutually developing goals with workers?
- Are those goals being reached?

One important strategy for a corporation to consider as an adjunct to disability management is the implementation of an absenteeism control program to address all unscheduled absences due to illness, disability, personal reasons, or other issues (Provine & Vierling, 2008). This includes addressing

presenteeism. Presenteeism is when employees are present at work but unable to be fully engaged in their work environment (Lack, 2011).

## RETURN TO WORK (RTW) PROGRAM

### Assessment of the Need for a RTW Program

The need for a RTW program will be evident to the OHN case manager. Gathering information from the last three to five years of insurance loss runs for lost time cases and presenting it to management demonstrate the need in most cases. Using commercially available standardized disability guidelines for length of expected duration of disability and comparing this to the actual time workers were away from work documents whether improvements can be made by implementing a RTW program. The OHN can inform management that implementing a RTW program provides the company with an improved ability to comply with laws such as the ADA. More information about potential for employee accommodations can be found later in this section on the RTW program.

This latter rationale is a strong one. The legal exposure for litigation under ADA (and ADAAA) or comparable state legislation is potentially much greater monetarily than it is under workers' compensation in most states. Being able to provide reasonable accommodation to meet the obligation under that statute is an important consideration. The structure and processes of the RTW program make meeting the obligations under ADA feasible.

Another argument for designing a RTW program is that, when a worker is off work, there is urgency in getting the person back to the job as soon as medically feasible. Prolonged time away from work is harmful to well-being. Workers lose the social relationships they have with co-workers, they lose the self-respect that comes from gainful employment, and they also lose a major component of adult identity: their occupation. These impacts on injured and ill workers are rarely recognized by most players in the field of RTW. Many think stress is reduced when away from work, but new stresses are created as normal life is disrupted and income may be lower despite wage replacement benefits (ACOEM, 2006).

The ADA of 1990 went into effect in 1992 and provides widespread civil rights protection to individuals with disabilities in employment, public arenas, and telecommunications. It was amended in 2008 with the ADAAA, which broadened the definition of disability, making it easier to be covered by the protection of this law (U.S. Equal Employment Opportunity Commission [U.S. EEOC], 2009; U.S. EEOC, 2011).

Title I of the ADA applies to employment and states that a covered entity shall not discriminate against a "qualified" individual with a disability. A prospective or current employee must be qualified for the job—or be able to perform the essential functions of the job with or without accommodation. This applies to the application process, hiring, advancement, discharge, provision of benefits including workers' compensation, job training, and any other terms, conditions, or privileges of the employment relationship. Discrimination may take the form of not providing reasonable accommodation for known physical or mental disability, not promoting employees with disabilities, or denying employment opportunities to qualified individuals with disabilities. Under the ADAAA, the original

language of the law stating that a disability must substantially limit a major life activity is to be broadly construed (U.S. EEOC, 2009; U.S. EEOC, 2011).

### **Planning for the RTW Program**

Once it is decided that a RTW program is needed, the OHN determines the necessary steps to design and implement the program. These include getting manager and insurance carrier/TPA buy-in, developing transitional jobs, developing ADA-compliant job descriptions, and educating supervisors and managers about the program. Once the program is implemented, employees also need to be educated about the program and its benefits.

### **Determine Need for Transitional Work and Identify Transitional Jobs**

The need for transitional work depends upon the type of work performed in the company. If there are jobs that are physically demanding, repetitive in nature, have certain exposures, or require significant amounts of cognitive functioning, transitional work may be needed. This needs to be determined on a site-by-site basis. Once determined, transitional jobs need to be identified that meet workers' temporary restrictions.

The goal in determining transitional jobs is to identify jobs that allow the company to bring workers back to work as soon after injury as medically possible (Mullahy, 2010). Regardless of the injury, normalizing life and reducing disability time as much as possible have been shown to result in the best outcomes for workers (ACOE, 2006; Harris, Mulford, Solomon, van Gelder, & Young, 2005).

### **Implementation of the RTW Program**

The specific steps needed to implement the RTW program are program specific and follow the plan created, but all programs require the development of a written RTW policy statement (Provine & Vierling, 2008). Employers now recognize the importance of their policies in the effectiveness of return to work outcomes. Greater consensus is forming, with supporting evidence, that more of the variability in the outcomes associated with RTW are connected with what happens within, rather than outside, the workplace (Franché et al., 2005).

Specific steps must be taken to formalize the RTW program. Companies must have an established RTW Program with a written RTW policy statement. Written RTW policy statements should have the approval of upper management to assure its commitment to the program. Such policies clarify management expectations and reinforce a corporate culture in which all workers are valued, receive prompt and quality health care, and are returned to either full-duty or temporary/transitional duty as soon as is medically safe following a period of disability from either non-occupational or occupational causes (Kalina & Haag, 2005; Wassel et al., 2005).

Companies have written policies for sick leave, STD, and LTD that refer to the return to work and transitional work expectations. The corporate RTW policy and procedures should be included in the worker policy and procedure manual. Both workers and supervisors should be educated about the policy (Kalina & Haag, 2005; Wassel et al., 2005). The RTW policy needs to be applied equally to all employees, regardless of their job classification or performance level (Kalina & Haag, 2005).

Labor representatives should be included when developing the company's RTW policy and program and consulted when modification is contemplated. Since they share the RTW goals of employees, labor representatives are often the OHN's or OHN case manager's advocate in bringing the worker back to work (Wassel et al., 2005).

Any return to work assignments that are not the worker's usual and customary job (full duty) need to be periodically reviewed for appropriateness by the case manager and the employer (Provine & Vierling, 2008). This is particularly critical in some states in which extended periods of time in modified jobs under workers' compensation (more than one year) may mean, from a de facto perspective, that the worker has been granted a permanent position in the modified job.

One of the most important processes involved in RTW is the engagement in the informal interactive process required under ADA to determine the need for accommodation. If a worker requests an accommodation, either verbally or in writing, the employer must begin this process to determine what accommodation is needed. The notice of need for accommodation may also come from a source other than the employee. The employer, at this point, interacts with the worker to determine the specifics of the needed accommodation (Provine & Vierling, 2008). Reasonable accommodations may include job restructuring, leaves of absence, modified jobs or part-time work, or reassignment to a vacant position. Reassignment to another position is the last resort, and the employer is neither required to displace another worker nor to create a new position for this purpose. Examples of accommodations that are not reasonable and do not have to be considered include (a) reducing performance or production standards for this single worker, (b) changing the worker's supervisor, (c) providing supervision of medication, (d) promoting the employee without merit, or (e) eliminating essential functions of the job. Transferring to another work shift may or may not be a reasonable accommodation, depending on the condition involved (Provine & Vierling, 2008).

At times, the employer needs additional information about the specific disability to determine the need for accommodation. Determining need may entail requesting information from the workers' physician or, rarely, a medical exam performed at the expense of the employer to determine the functional status of the worker. Once the accommodation is determined, if the worker refuses the offer of the accommodation, the worker may no longer be qualified to remain in the job (Provine & Vierling, 2008).

The ADA does protect individuals with drug addiction if they have been rehabilitated—i.e., they would be eligible for rehire if, for example, they had been fired previously due to drug use and have now successfully gone through a treatment program. However, current drug users have no protection under ADA. The above protection does not apply if the company has a universal no-rehire policy that applies to any employee who violated any company policy (Provine & Vierling, 2008).

The ADA may or may not protect alcoholism, depending on the circumstances involved and existing company policies. Because of the nebulousness of the law, many companies offer medical leave of absence to these employees for the purpose of an alcohol treatment program to avoid potential litigation. However, the company is not precluded from firing them for violating company policy if they were impaired on the job once the treatment program is complete.

The RTW processes do not occur in isolation. Other processes that may occur simultaneously and may impact RTW include

- The personal adjustment that results from being sick or injured, including the impact on family.
- The disability benefits administration process, which is often confusing to workers.
- The ADA reasonable accommodation process that may be triggered by the nature and extent of the injury (ACCOEM, 2006).

Preventing disability should be the major focus of a corporate health and safety program. The number one goal of the OH&S programs and services should be the prevention of lost-time injuries and illnesses. Even in workplaces with proactive health and safety programs and services, incidents and injuries may occur. Ideally, the frequency and severity are greatly reduced.

Incident procedures should require immediate notification of supervisors, appropriate transportation of the worker to health care treatment or on-site treatment when available, a requirement for thorough incident investigation, and prompt reporting of the incident to the insurance carrier or TPA to assure timely reporting to any jurisdictional entity (Wassel et al., 2005).

To ensure a safe and healthy workplace, loss prevention and safety programs should address the exposures for the class of business and types of jobs in the company. These programs should also focus on loss sources revealed in a thorough analysis of recent historical loss data obtained from OSHA logs and insurance loss/claims information obtained from the insurance carrier or TPA (Wassel et al., 2005). One effective method of doing this is through the process of job hazard analysis (JHA). During the JHA, each job, starting with those showing the greatest losses, is analyzed in detail for real and potential hazards. Plans are then made for corrective action to reduce or eliminate the hazards.

Prompt, thorough incident investigation must be used as the primary strategy for learning from incidents and “near misses,” directing corrective actions for faulty processes, and preventing future incidents (Wassel et al., 2005). The OHN has a valuable role to play in this process using insight from interaction with the worker to help guide the investigation. At times, the OHN is the most skilled practitioner onsite to conduct certain investigations or to partner in the investigation, for example, if the injury is ergonomic in nature.

Holding supervisors and department managers accountable for safety as a performance measure is one recommended method of ensuring compliance (Wassel et al., 2005). However, it is essential that the process does not discourage injury reporting.

### Evaluation of the RTW Program

Questions that could be included in the evaluation process are

- How successful is the program in returning both occupational and non-occupationally ill or injured workers to work?
- Are the transitional jobs successful?
- What is the feedback from the involved workers?
- What is the feedback from the workers’ supervisors?

- What are the cost savings from bringing workers back to transitional work, versus staying out on disability for the full length of their disability?

To assist in this data gathering, it is best to develop a questionnaire for workers and supervisors with questions based on a Likert scale with an even number of choices (this avoids neutral answers). If desired, the OHN may choose to have one or two open-ended questions to gather some qualitative data as well.

RTW is an area in need of further research to increase the evidence base for practice. Enhancing evidence-based practice is needed to assist professionals in successfully returning employees to productive employment following either non-work related or work-related disability. Wasiak and colleagues (2007) have identified the importance of research in the areas of setting goals for return to work, motivation, employee and employer expectations, the process of job seeking, maintaining the job once secured or returned to, and job advancement. Consistent conceptualization and measurement of RTW aspects in research improve the understanding of this important process and enable professionals to more consistently return employees to work (Wasiak et al., 2007).

Social support in the workplace is an important factor in injured workers' successfully managing the stress of RTW. It should be considered in the overall RTW plan (Lysaught, Fabrigar, Larmour, Stewart, & Friesen, 2012). Researchers have proposed multiple dimensions to social support, including emotional, instrumental, and appraisal or validation. Social support also comes from multiple sources, including supervisors and fellow workers, the corporation or employer, spouse and significant others, friends, and professionals working with the employee, including the case manager (Lysaught et al., 2012).

## IMPORTANT CONCEPTS IN CASE MANAGEMENT

### New Developments Related to Emerging Health Care Issues

Ostrowsky (2012) spoke to the importance of case management at the points of transition and underscored the issue of case management being about "the right care at the right place at the right time" (p. 6). Transition specialists are case managers with specialized skills in insurance, managed care services, and discharge planning. They fill a special niche to assist in hospitalization cases with particularly complex discharge plans.

Another new development in case management is the case management patient care advocacy programs that assist clients without specific coverage to get the care they need. An example of one currently available program is at Memorial Sloan-Kettering (Ostrowsky, 2012).

### Network of Resources for Case Management

A number of resources are available for case managers. These include the annually updated *Case Management Resource Guide* (Mullahy, 2010), now available online. This resource includes mail-order pharmacies, hand rehabilitation centers, hotlines for physical and mental disorders, auto remodelers for wheelchair ramp refitting, and other resources (Mullahy, 2010).

Another previously printed source that is now web-based is the Castle Connolly Medical *How to Find the Best Doctors/Hospitals* (Castle Connolly Medical Ltd., 2012). This resource includes hospitals, medical centers, and specialists, with ratings for physicians (Mullahy, 2010).

### **Incorporating Technology into Case Management Practices**

One of the easiest and most effective uses of technology in case management is the use of video job analysis that can show a true-to-life picture of the job for a treating physician to evaluate before returning an injured worker to work. This can be invaluable in assuring a realistic plan, both in treatment goal setting and for RTW timing (Mullahy, 2010). Treating practitioners should be provided with a video job analysis relatively early in the treatment course. This information allows the practitioner to be familiar with the specifics of the employee's job and able to make a realistic assessment of the potential for returning the worker to that job in either a full or modified capacity.

Technology is changing OHN practice, and case management is no exception. The Internet makes possible face-to-face interaction without being physically face to face! A wealth of information is available online for workers, but they need direction to discern information credibility. Case managers need to build a resource bank of sites for the various populations they serve and share the most useful of these. In addition, more professionally focused resources can be shared with other professionals, especially those working on the same cases. It is up to professionals to harness technology to the best service for their clients (McGonigle & Mastrian, 2008). Chapter 8 provides more discussion on this topic.

### **Ethical Issues in Case Management Practice**

Case managers are expected to act according to the principles of their parent discipline's ethical code and professional standards (AAOHN, 2012). Case management is a process of coordinating an individual client's total health care services to achieve optimum quality care meeting the standards and ethical principles of the profession. Based on the complexities of health care and business environments, case management services must be delivered in an ethical manner by qualified health care professionals who possess sufficient knowledge and expertise to perform this important function (American Board for Occupational Health Nurses [ABOHN], 2012). Case management specific ethical principles can also be found in the *Code of Professional Conduct for Case Managers* (Commission for Case Managers [CCM], 2004). This code is applicable to case managers with CCM certification and CMSA's statement on case management ethics, which is contained within its standards of practice (CMSA, 2010).

When ethical issues arise, these guiding documents are the first place the case manager looks for guidance as to appropriate action in the specific situation. Consultation with peers who practice case management while maintaining worker confidentiality is also useful to help clarify the ethical issues present in any given situation. At all times, the ethical case manager recognizes ethical dimensions of case management practice, acts in the best interests of the ill or injured worker, is professional and accountable to practice, acts as an advocate for the ill/injured worker, mediates ethical conflicts, and prevents their occurrence, whenever possible (Banja, 2008). More discussion related to ethics can be found in Chapter 4.

### Referring Employees to Employee Assistance Programs (EAPs)

When employees are having significant psychological difficulty as a result of an injury or illness, consideration should be given to referral to the employee assistance program (EAP). Many OHNs are reluctant to do this as they fear that, if the case is occupational, the company will end up buying an added psychological add-on to the current injury or illness claim. However, if the employee is sufficiently stressed, progress to recovery may be delayed, resulting in increased claim costs. Early intervention to the EAP may improve employee progress. The EAP is an excellent resource for the employee to get assistance to cope with the financial pressures that injury or illness has created or with the emotional burden it is creating in the worker's primary relationship (Provine & Vierling, 2008).

### Integrating Disability Management Strategies

When corporations integrate disability management and combine administration of STD, LTD, workers' compensation, and group health benefit programs, handling claims becomes more efficient, along with the potential for cost savings, reduced disability, and reduced absenteeism. Additionally, with this model, RTW activities can be combined and the best practices can be shared across programs. When the focus is on the employees' abilities rather than their disability, additional potential for success is gained (Provine & Vierling, 2008).

A coordinated disability management approach includes FMLA employee notifications and monitoring as well as the ADA, including the ADAAA provisions of 2008. (See the Return to Work section of this chapter for a discussion of the informal interactive process required under ADA.) The interactive process is an ideal time to focus on an employee's abilities rather than disability and presents a unique opportunity to increase the employee's sense of feeling valued by the organization.

### Monitoring Laws Affecting Case Management Practice

Case managers who are RNs must be licensed in the state in which the client is located. The licensure can either be through individual state license in non-compact licensure states or through compact licensure if the OHN has a license in a compact license state. It is considered good practice to notify, in advance of beginning the practice work, the state board in the additional compact license state(s) in which the OHN will be performing services (National Council of State Boards of Nursing [NCSBN], 2012). The OHN also needs to obtain a copy of the Nurse Practice Act for each of the states in which she or he is performing case management. For many case managers, this may necessitate holding multiple state nursing licenses. A resource on the nurse licensure compact can be found at <https://www.ncsbn.org/nlc.htm> (NCSBN, 2012).

Workers' compensation laws, which are state and territory specific, affect case management practice in work-related cases. Case managers need to stay apprised of the changes that occur in the states and territories in which they practice. The U. S. Congress makes the laws for the workers' compensation program for federal workers and the District of Columbia. Additional programs overseen by the federal government include: Merchant Marine Act, Longshore and Harbor Workers' Compensation Act (LHWCA), Federal Employment Liability Act (FELA), and the Black Lung Benefits Act (DiBenedetto, 2008).

Since laws frequently change, it is important to remain current through continuing education and through self-study of resources such as annual editions of *Analysis of Workers' Compensation Laws* published by the U.S. Chamber of Commerce and through websites such as the U.S. DOL's [www.dol.gov/dol/topic/workcomp](http://www.dol.gov/dol/topic/workcomp) (DiBenedetto, 2008) and <http://www.ic.nc.gov/ncic/pages/all50.htm> (McDowell, 2011), a website that includes links to all 50 states and the District of Columbia's workers' compensation laws. It is periodically updated as changes warrant the need.

The laws dictating the selection of the treating health care providers in workers' compensation can be the most challenging. States determine this selection process, and it varies widely from state to state (DiBenedetto, 2008; U.S. Chamber of Commerce, 2012). Some of the possible initial choices of medical provider include (a) no restriction of choice on the part of the injured worker, (b) choice restricted to employer or insurance company selecting the provider, (c) posting a panel of providers from which the injured worker makes a choice, and (d) the use of a predetermined medical provider network from which the provider may be chosen by the injured worker (DiBenedetto, 2008). State laws also dictate when changes in providers can be made, with this also varying from state to state.

The use of special medical examiners for independent medical examinations (IME) and other specialty exams that may exist in certain states is also determined by state statute. These evaluations are used to confirm, supplement, or refute findings of the treating or applicant's medical provider, in the event of litigation. The type and number of these examinations allowed are also limited by state statute, and the statute may also require that all parties be bound by the findings of such examinations in certain situations (DiBenedetto, 2008).

### **Demonstrating the Value of Case Management Services Provided**

Demonstrating value is not only being able to show dollars saved, but also documenting improved outcomes. Both approaches have been discussed in several areas of this chapter and should be used together to demonstrate the value of case management services.

### **Best Practices in Case Management**

The use of evidence-based guidelines can be considered one of the recent best practices in medicine, nursing, and case management practice. They have become statutorily required in the State of California workers' compensation program in the form of ACOEM's *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers* (2010), which are presumptively considered correct for treatment in that state. Other evidence-based guidelines can be used, but they must be shown to be peer reviewed and equally effective and acceptable to the workers' compensation system.

Other states have recently passed legislation that requires their workers' compensation systems to either adopt or develop evidence-based guidelines. Montana has passed legislation requiring rules to be established for use of evidence-based guidelines. Arizona passed legislation requiring development of state-specific evidence-based treatment guidelines by the end of 2014 (Brown, 2012).

Oregon currently has a project underway that is not workers' compensation specific, but diagnosis specific. That state is developing evidence-based treatment guidelines for 10 major diagnoses, including spinal injections and congestive heart failure (Oregon.gov, 2012).

### Research Applicable to Case Management

In 2010, the U. S. Department of Health and Human Services (U.S. DHHS) awarded more than \$6 million in American Recovery and Reinvestment Act of 2009 (ARRA) funds to establish a Center of Excellence in Research on Disability Services, Care Coordination and Integration. A key component of this effort is the collaboration with the Centers for Medicare and Medicaid Services' Chronic Conditions Warehouse (CCW) to link data sources relevant to disability so that the analytic ability regarding disabilities is increased (U.S. DHHS, 2010). A conference sponsored by the Center of Excellence in Research on Disability was held in Crystal City, Virginia (near Washington, D.C.), in March 2013 to present important new research findings on care coordination and integration for people with disabilities.

### Overview of Managed Care

Managed care is a system of health care delivery that provides a generalized structure to manage the use, access, cost, quality, and effectiveness of health care services to which it is applied. It is a cost containment strategy that emerged first in the group health insurance arena and later in the workers' compensation arena. Managed care incorporates use of preferred provider networks, HMOs, direct contracting, bill audits, utilization review, preadmission authorization, concurrent and retrospective review, second surgical opinions, independent medical exams, and targeted case management (e.g., disease management, catastrophic cases, etc.). Government-based insurers, including Medicare and Medicaid, influence the processes used in managed care plans (Cunningham, 2008).

In 2008, 247 million Americans were covered by some type of managed care plan. PPOs enrolled more than 165 million of that number. These numbers reflect a decline in HMO use over a 15-year period in which PPO use significantly increased (Mullahy, 2010).

The reimbursement methodologies vary widely in health care services, but capitation is a common mechanism. In capitation, a set amount is paid to the provider per year or per month regardless of the amount of services used. The amount is predetermined based on the age and gender of the plan members and is stipulated in the plan contract. In other plans, a co-pay is required from the covered worker and the PPO insurance pays the remainder of the medical bill, provided the service is authorized and the covered worker is seeing an authorized provider. If the covered worker is seeing a medical provider other than his or her own primary care provider or having a service other than routine lab work or x-rays, a pre-authorization may be required for payment for services to occur. However, the services are then often covered at 100% (Cunningham, 2008).

The managed care environment is continuing to evolve and is becoming more complex. Case managers are challenged in this arena with more "players" and frequently changing rules. Organizations merge with large health systems acquiring small community hospitals and branding them as their own. This raises both quality-of-care and negotiation issues for the case manager.

The balance of power has shifted away from physicians to large health care organizations (Mullahy, 2010).

Many managed care programs include brokered fee arrangements with networks of health care professionals and treatment facilities. These fee arrangements are among the cost control strategies for managing benefit costs and insurance premiums/fees. In addition to providing prompt access to cost effective care for workers, it is imperative that there also be a process for monitoring and ensuring quality treatment outcomes for workers treated by network or panel health care providers (Wassel et al., 2005).

Although managed care programs strive to reach all potential users of health care service, case management is a personalized process that focuses on certain high-risk or high-cost individuals. Some of the greatest cost savings are achieved when case management efforts are focused on the 3% to 5% of the worker population responsible for 60% to 70% of the expenditures in any health plan (Mullahy, 2004). Decision factors or triggers for case management services are often developed based on the goals of the individual program (Wassel et al., 2005).

### *Quality Controls in Managed Care*

Maintaining quality of health care is important in today's competitive health care environment. To meet customer expectations, a focus on evaluating the standard of care and continuously improving the quality of that care is important.

The use of evidence-based clinical guidelines has already been discussed in this chapter. Their use is one method of assuring quality in managed care, just as it is in other settings. Managed care is one environment in which the use of clinical guidelines by medical providers can be an expectation of the organization, and pay can be based on their use. An example of this is tracking whether or not certain clinical tests were conducted on high-risk clients at selected intervals (i.e., colonoscopy or sigmoidoscopy on all plan members over the age of 50; and annual LDL cholesterol on all plan members with type 2 diabetes). This concept is known as pay-for-performance, and it is increasingly used to encourage desired behaviors on the part of health care providers (Cunningham, 2008).

Unfortunately, a major arena for judging standard of care is the legal system. Court cases have impacted the definition of adequate care. Clinical guidelines are becoming more frequently referenced in court cases, although they are not yet relied upon exclusively as an expected standard of care (Moffett & Moore, 2011). In the law of negligence, standard of care is judged as the degree of care that a reasonable professional at the same level of preparation in a similar situation would exercise (Muller, 2008).

### *Defining and Evaluating Quality Outcomes in Managed Care*

UR is one mechanism used extensively in workers' compensation in some jurisdictions to determine the medical necessity of services that have been ordered by medical providers. It is also used in other managed care environments as a cost control mechanism to reduce the use of expensive services by managing the intensity of health care use (Ceniceros, 2009; Telles, 1993).

*HEDIS Healthcare Effectiveness Data and Information Set*

The Healthcare Effectiveness and Data Information Set (HEDIS) sets measurement goals annually for Medicare, Medicaid, and commercial health service systems that allow for assessment of quality performance. The 2012 HEDIS goals included general guidelines for data collection and reporting, guidelines for calculation and sampling and specific items to measure in the areas of effectiveness of care, access to and availability of care, experience of care, utilization and relative resource use, and health plan descriptive information (National Committee for Quality Assurance, 2011). Some of the detailed areas of measurement for 2012-2013 included (a) adult BMI assessment, (b) colorectal cancer screening, (c) use of spirometry in assessment and diagnosis of COPD, (d) controlling high blood pressure, (e) comprehensive diabetes care, (f) medical assistance with smoking and tobacco use cessation, (g) follow-up after hospitalization for mental illness, (h) annual dental visit, and (i) physical activity in older adults, among many others (National Committee for Quality Assurance, 2011; 2012).

Health care services are a finite resource, and increasing the quality of their delivery is beneficial to health care consumers, health care providers, and the executives behind the scenes. Health care executives are aware that focusing on quality is the best way to assure a healthy bottom line (Garrett, 2008).

Some of the benefits that may be realized in providing an enhanced quality of health care include: efficient use of an increasingly scarce health care resource; more effectively meeting the needs of customers; improved customer and staff satisfaction; increased client safety; and the provision of more compassionate, culturally competent, and ethical care (Garrett, 2008). The benefits of evaluating quality of health care are worth the effort.

Measuring outcomes allows OHNs to base improvement on actual performance and to subsequently measure outcome improvement over time. For outcomes management to be successful, tracking and measurement of several critical parameters must occur. These parameters include the worker's clinical condition, the level of functional ability, and measures of quality of life or overall well-being. Additionally, health care practitioners must follow standards of care and evidence-based guidelines for the conditions measured in the outcomes management program. The worker parameters being measured need to be performed on a systematic basis at predetermined time intervals, and the outcome measurements need to be pooled in a large enough sample to be statistically meaningful. Once analyzed, results need to be disseminated to appropriate decision makers, as well as to clinicians, in a way that will enable them to improve their practice, i.e., reduce variation in results to improve outcomes (Garrett, 2008).

**Quality Improvement in Managed Care and Case Management**

According to Brines et al. (1999), "Whereas structure establishes the context of medical case management, process encompasses the timing, frequency, and quality of interactions between the worker and service providers in the course of recovery" (p. 359). When the resulting outcomes from the case management process are added, there are the three basic components of Donabedian's (Donabedian, 1980) structure-process-outcomes quality model, a basic start for quality improvement.

Donabedian would be the first to say that the structure-process-outcomes triad is just the beginning (Donabedian, 1988). There are essential principles pertinent to design, operation, and effectiveness: interdependency, organizational dependency, consensuality (coalescence of views and interests), congruence, relevance, ownership, mutuality of interests, facilitation, coerciveness (requires “teeth” to be successful), and virtue, both personal and public (Donabedian, 1991; Schiff & Rucker, 2001). In addition, seven pillars of quality include

1. Efficacy—the ability of care to improve health, effectiveness—the degree to which attainable health improvements are reached.
2. Efficiency—obtaining the most health improvements at lowest cost.
3. Optimality—the best balance of cost and benefits.
4. Acceptability—conforming to client preferences in terms of accessibility.
5. Client-provider relationships, and effects and cost of care.
6. Legitimacy—conformity to social preferences concerning the above.
7. Equity—fairness in distribution of care and its effects on health (Donabedian, 1990; Schiff & Rucker, 2001).

In today’s health care environment, quality improvement uses sophisticated technologies that, once variation in outcomes is detected, can significantly reduce variation in outcomes. These quality improvement technologies include Six Sigma, Lean, and Human Factors (Garrett, 2008).

Six Sigma is a business strategy that uses a disciplined structured approach to eliminate defects. Users of this technology need specific training to become skilled. Lean methodology focuses on reducing lead times by eliminating waste and non-value added processes. Human Factors is a scientific discipline that focuses on the interaction between humans and other systems at the point of interface to optimize human well-being and system performance (Garrett, 2008). Whatever technology is used, the potential to improve outcomes makes the effort behind quality improvement projects well worth the investment in time and resources. Six Sigma, Lean, and other strategies are discussed in more detail in Chapter 9.

## SUMMARY

This chapter has examined the use of nursing process to assess, plan, implement, and evaluate case management for workers with both occupational and non-occupational health issues. It has explored some of the common practice settings in which case management is practiced for OHN case managers and explored the various team roles and responsibilities. The importance of the case manager as a worker advocate—even when employed by the employer, insurer or TPA—was stressed. Discussion of developing effective case management programs followed. Fitness for work was addressed. Major components of managing occupational disability and non-occupational disability were explored. RTW programs, disability benefits, FMLA, and ADA compliance were discussed within the context of disability management. Quality controls and outcomes in managed care were then explored, including technologies used to reduce variation and improve outcomes that can be applied to any health care setting.

Disability case management, whether for occupational or non-occupational disability, is a rewarding role. In this role, the OHN has the potential to make a difference in the life of ill or injured

workers by focusing on returning them to gainful employment and a more productive life. It is ultimately rewarding for the OHN case manager who is successful in helping ill or injured workers navigate through a confusing and possibly frightening system to achieve the goal of successful RTW.

## CASE STUDY

C. M. is a 42-year-old production manager in a high technology firm in the Silicon Valley. The production environment that she supervises requires the donning of a full-body “bunny suit” to enter. She has been employed by the same company since high school graduation, through college, and has worked her way up through the ranks into management. She is very skilled at her job, knows the processes that she is supervising well, and is highly regarded by the employees she supervises and the management group to whom she reports. After a meeting, she is walking downstairs with several other managers and falls down half a flight of stairs, severely twisting her left ankle and landing with her back against the stairs. Her co-workers run to her aid. She is conscious and complaining of left ankle and back pain, although she says she hurts all over. She is sure she did not hit her head. One co-worker quickly finds a security guard in the lobby to call the OHN to respond to the scene of the incident.

The OHN responds and immediately assesses the client. The client is first assessed neurologically and is neurologically intact; she is able to move all of her limbs and has normal sensation. Her vital signs are within normal limits. The client has distinct point tenderness at the posterior edge of the left lateral malleolus with swelling. She is unable to bear any weight on the left side. Based on application of the Ottawa Ankle Rules in the box (Jenkin, Sitler, & Kelly, 2010) and the velocity of the fall, sending the employee for x-rays and physician evaluation at the local ED is appropriate in this situation.

Because the employee is rapidly improving, is neurologically intact and does not appear to have a herniated disc based on the OHN’s assessment, the decision is made to send her to the ED in a cab. Another management employee accompanies her. Her husband is notified, but reassured that she is doing well, and he makes a plan to meet her at the ED.

The OHN already has an established relationship with the ED. Based on previous orientation from the OHN, the ED understands the nature of workers’ compensation cases and information that can be provided to

### Ottawa Ankle Rule

In the event of an ankle injury, X-rays are only indicated when pain is present in the malleolar zone and one of the following is also present:

- Bone tenderness along the distal 6 cm of the posterior edge of the tibia or tip of the medial malleolus.
- Bone tenderness along the distal 6 cm of the posterior edge of the fibula or tip of the lateral malleolus.
- An inability to bear weight immediately and for four steps in the ED.

Source: Jenkin, M., Sitler, M. R., & Kelly, J. D. (2010). Clinical usefulness of the Ottawa Ankle Rules for detecting fractures of the ankle and midfoot. *Journal of Athletic Training*, 45(5), 480-482.

the employer and the specific paperwork required. The OHN receives a call from the ED nurse after evaluation of C. M. The x-ray of her left ankle is negative for fracture, but she does have a severe sprain requiring the use of crutches for a week to 10 days and an air cast for four-to-six weeks. She also has multiple contusions. She has been placed on non-steroidal anti-inflammatories (NSAIDS) and given non-opioid pain medication. She may return to work tomorrow with restrictions of activity to tolerance (due to the crutches) and need to elevate her left foot as much as possible. Within an hour of the appointment, the OHN receives the work status report from the ED via encrypted e-mail.

At this point, it needs to be determined whether the restrictions can be accommodated. The OHN calls the second level manager to which C. M. reports. He states that, due to the employee's job as a manager, he is able to accommodate her working with crutches. He will have one of the other managers perform all the supervisory duties within the production environment where crutches are not allowed and C. M. will perform the more administrative functions of her job until she no longer needs crutches. In the meantime, the OHN will work with C. M.'s supervisor to determine whether the air cast will fit in the bunny suit required for working inside the production environment. A plan will be made to further accommodate her restrictions if she is unable to go into the production environment. Elevating her foot is not a problem. The OHN keeps several footstools and cushions as loaners for that purpose. They fit well under desks or next to the desk to elevate the leg to above hip height. This is as high as can be comfortably accommodated for most people at work. Each work station is already fitted with an adjustable keyboard arm so the employee is able to arrange her computer monitor and keyboard to accommodate the footstool.

The OHN opens a workers' compensation case as a medical only claim because there is no lost time anticipated beyond the date of injury. This involves filing an Employers' First Report of Injury with the employer's insurer or TPA. She also records the injury on the OSHA 300 log as a recordable case due to medical treatment without lost time.

The OHN calls C. M. at home to check in with her and to notify her that arrangements have been made for her return to work the next day. She states she is feeling much better and is icing the affected area every two hours per the ED physician's recommendations. She is also taking the medication as prescribed. C. M. will check in with the OHN upon return to work in the morning.

The next day, C. M. returns to work. As part of the RTW evaluation, C. M. shares that this is actually the fourth fall that she has experienced in the last two months. The other three have occurred on her personal time, two at home and one in a shopping center parking lot. She was not significantly injured in any of the falls, sustaining only minor scrapes and bruises. She was not aware of any precipitant, such as uneven pavement, that caused her to trip, and she is becoming concerned something else is causing her to fall. The OHN advises C. M. that it is appropriate for her to seek a full evaluation by her primary care provider because there may be an underlying cause for the falls, given the frequency and suddenness of onset.

Over the next few weeks, C. M. undergoes testing to determine the underlying causation for the falls. She is diagnosed with multiple sclerosis (MS) and is in a rapidly progressive phase. She quickly deteriorates over the next few weeks and is unable to return to full work following her ankle injury. Instead, she is placed on medical leave due to the rapidly progressive MS symptoms.

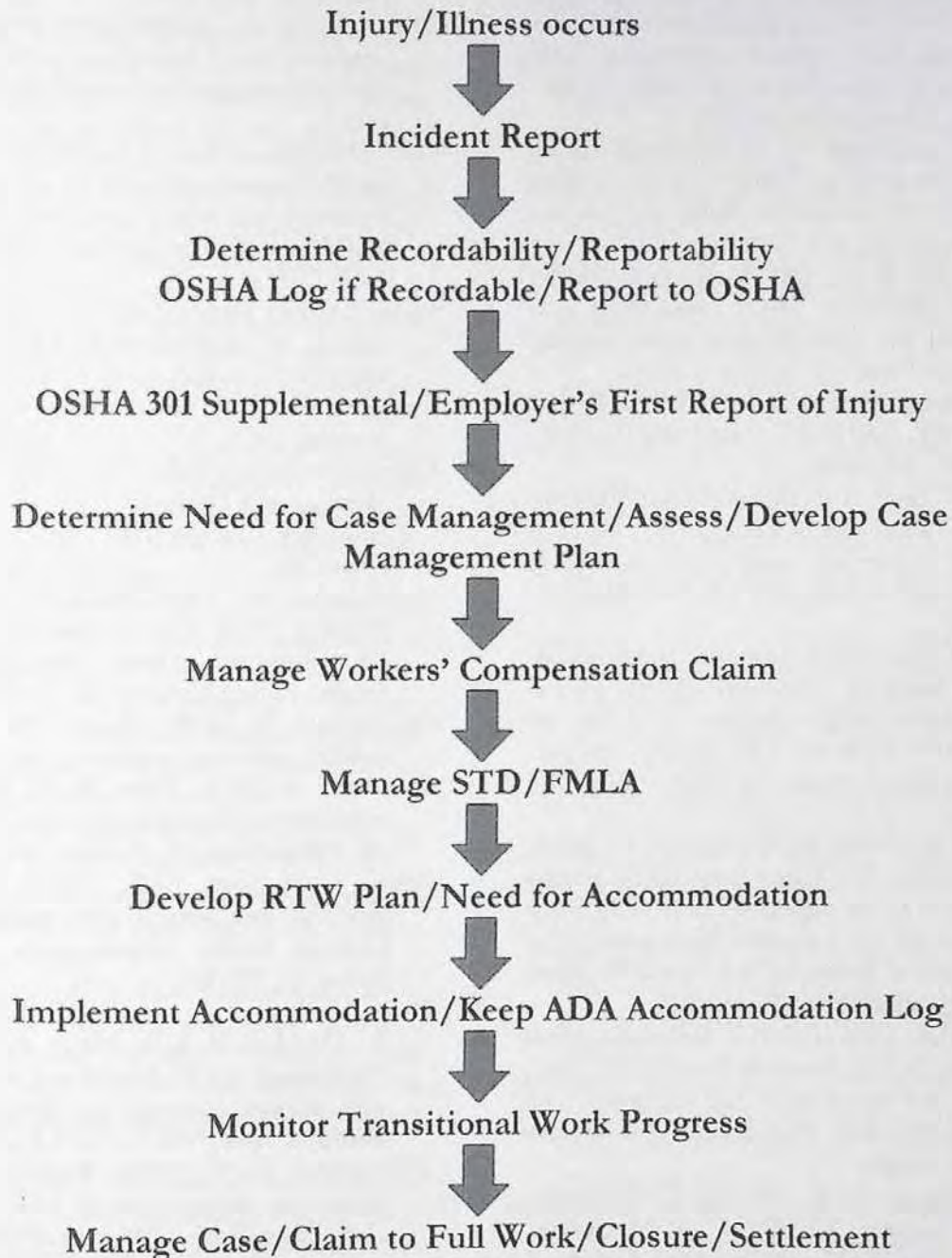
She files for STD benefits and is placed on FMLA. The OHN and the benefits department coordinate the notification and tracking processes for benefits administration purposes. When C. M. is ready to return to work, she contacts the OHN and informs her that her doctor has indicated, and C. M. agrees, that she is no longer capable of handling the stress of a managerial position, given her medical condition. Additionally, with the progression of the MS, she is returning to work in a wheelchair.

The OHN informs upper management that the employee is ready to RTW, but that she is unable to return to her regular job. She is returning within the job-protected FMLA period. Thus, the OHN notifies management of the necessity to return her to a comparable job for which she is qualified. A hunt is begun for a comparable job, but there are none available, and the company is under no obligation to create a job for the employee. It is determined that a less stressful lower-level job that could accommodate a wheelchair was appropriate. The employee will be paid at her regular rate for one year, and then her salary will be lowered if another position closer in pay scale to her previous position does not become available during that time. The new work environment is set up to accommodate C. M. working in a wheelchair, and she returns to work. The OHN records the accommodation in an ADA Accommodation Log. The new job is a success and C. M. is able to work for two more years before the MS progresses to the point where she was no longer able to work. At that point, she returned to medical leave, which led to LTD, and then transitioned to SSDI. The OHN and disability administrators served as advocates to ease the transition to SSDI.

C. M. felt very grateful to her employer and to the OHN for making it possible for her to maintain employment for as long as possible, given her medical condition. She was still able to make a valuable contribution to the company in her alternate job. The extra two years of employment helped her add significantly to her 401K plan and employer-sponsored retirement benefits. At the point of starting SSDI, her retirement income was significantly better than it would have been two years earlier when she was first diagnosed with MS. During the two-year time period, she was able to increase contributions since her husband's income was sufficient for her family to live on with careful planning and money management.

The OHN in this scenario fulfilled numerous roles related to disability management. She was the initial evaluator of an injured worker. She arranged for follow-up evaluation and care. She initiated and managed the workers' compensation claim and managed OSHA recordkeeping. She initiated determination of ability to accommodate restrictions and maintained a log of accommodations to demonstrate compliance with Title I of the ADA. The OHN counseled the employee to receive initial evaluation on a non-occupational basis, based on significant symptoms consistent with major undiagnosed illness. She worked with benefits administrators in the management of STD and FMLA. She initiated the discussion with management for long-term reasonable accommodation of a non-occupational disability. The OHN facilitated RTW for the employee and monitored her success in the alternative job. When the disability progressed, she advocated at the appropriate time for the employee to facilitate transition to LTD and SSDI. The OHN fulfilled many of the roles of a disability case manager in this situation and was able to make a difference for the employee with a disabling condition and the employer by maintaining employment of a valued long-term employee for two additional years.

APPLICATION TO PRACTICE:  
WORKERS' COMPENSATION CASE MANAGEMENT



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# Fundamentals of Occupational & Environmental Health Nursing

## AAOHN Core Curriculum

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FOURTH EDITION

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