# SAW/RTW During Recovery: The Basics of Arranging Temporary or Transitional Work Assignments

December 10, 2020

RETAIN | Retaining Employment and Talent After Injury/Illness Network

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ODEP Office of Disability Employment Policy

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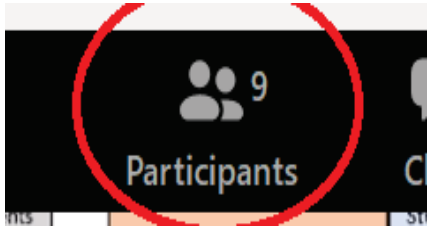
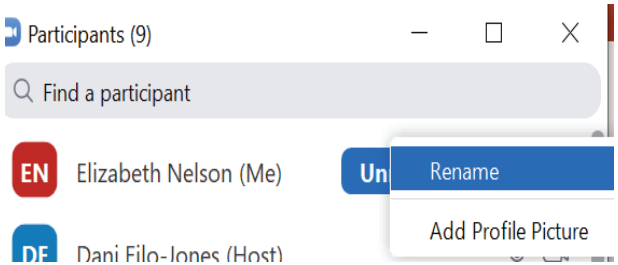
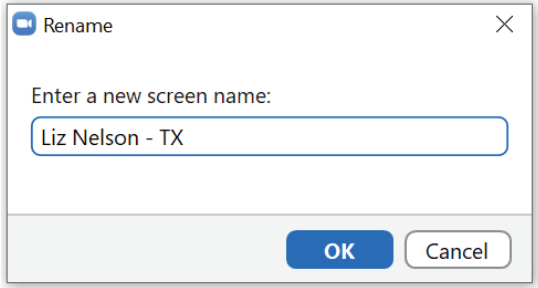
- Chat throughout the session in the chat box
  - Chat in your tech problems or email RETAINTA@air.org
- Raise your hand and we'll call on you; remember to lower your hand after you've been called on
- Other helpful features of Zoom
- Add your state abbreviation to your name
  - Find your name under "participants," click "more" next to your name, and select "rename"



# Welcome

RETAIN | Retaining Employment and Talent After Injury/Illness Network

# About RETAIN

- Retaining Employment and Talent After Injury/Illness Network (RETAIN)
- Joint initiative led by the U.S. Department of Labor (DOL) and the Office of Disability Employment Policy (ODEP), and funded by ODEP, DOL's Employment and Training Administration, and the Social Security Administration
- RETAIN technical assistance (TA) funded by ODEP and housed at the American Institutes for Research (AIR)
- Focused on building state capacity in stay-at-work/return-to-work strategies across eight states
- Explores ways to help people who become ill or injured during their working years remain in the labor force

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# Disclaimer

These materials were prepared for the U.S. Department of Labor (DOL), Office of Disability Employment Policy (ODEP), and Retaining Employment and Talent After Injury/Illness Network (RETAIN) state grantees, by Dr. Jennifer Christian, Senior Advisor to ODEP.

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The information contained in this presentation is intended as general guidance. It does not constitute legal advice and is not binding.

Given the variety of individual workers' situations, checking specific guidance from EEOC and labor attorneys concerning the relationship of FMLA and ADAAA to TWA is encouraged.

# Objectives

As a result of this webinar, attendees will be prepared to:

1. Describe the purpose and benefits of TWA from both the worker's and employer's perspective
2. Anticipate and address the reasonable concerns of the worker, doctor, and employer while arranging a TWA
3. List the major questions that must be answered in the stepwise process of arranging a successful TWA

# Introductions

Jennifer Christian, MD

Senior Advisor, ODEP

Presenter

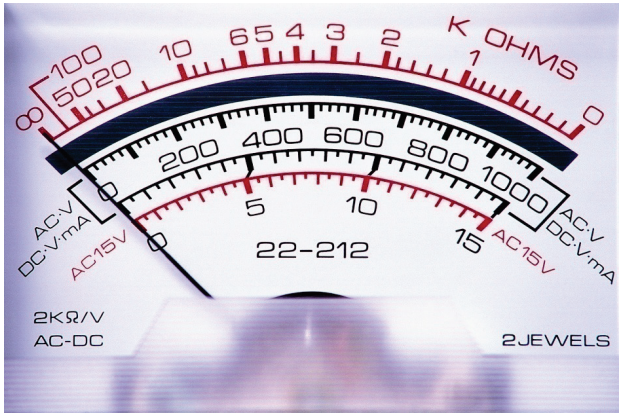
Wehmah Jones, PhD

Senior Researcher, AIR

Moderator

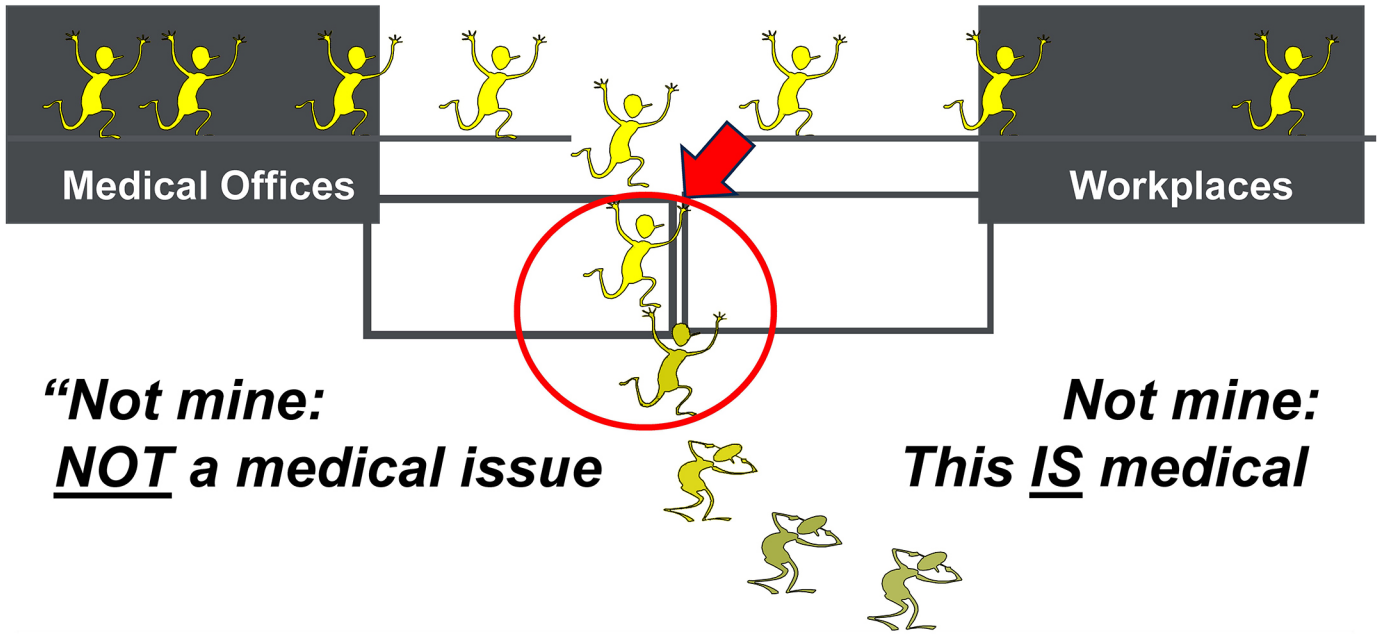
# Poll Question

# How Confident Are You Now?




On a scale of 1 to 10, how confident are you now that you are equipped with the necessary understanding, processes, tools, and techniques to facilitate **temporary adjustments to work** so RETAIN participants can stay busy and feel productive **during recovery**? (10 = very confident, 1 = very unsure)

# RETAIN's Intervention Interval




***Result: Preventable Impairment, Work Disability, Job Loss, Worklessness***

# RETAIN Can Preserve Workforce Participation and Reduce Demand for SSDI in Two Key Groups

1. For workers who have new but irrevocable functional losses / impairments:
   - Amputations
   - Strokes
   - Progressive diseases
2. For workers with common health problems:
   - Low back, knee, shoulder, foot and hand problems, and other chronic musculoskeletal (MSK) conditions, including age-related changes
   - Common mood disorders (CMD), esp. depression and anxiety

# MSK & CMD Conditions

- Among the most prevalent health problems around the world.
- Leading causes of casual absence and short-term disability among workers in the USA.
- Workers often do not seek or get medical care for these problems.
- The vast majority of people with these conditions remain in the workforce.
- Poor outcomes are most often the result of pre-existing risk factors or adverse events during the unfolding of the illness/ injury episode—not the original anatomical/biological facts.

# Key Differences

## Classic Disabling Conditions

- Work disruption is precipitated by obvious and irreversible anatomical/physiological loss and change
- Adapt to/accommodate long-term, lifelong impairments
- Early intervention: Reasonable accommodation by same or different employer, new job, VR, SSDI
- **SAW:** Stable and successful in new regular job

## MSK / CMD

- Work disruption is precipitated by subjective symptoms (pain, fatigue, fear)
- Recovery of function is ongoing; outcome is still uncertain
- Avoid transition from acute to chronic disabling symptoms; optimize ultimate functional recovery
- **SAW:** Restore usual rhythm of life ASAP via temporary adjustments
- Fallback plan: Reasonable accommodation, new job, VR, SSDI

## “Classic” Disabilities

- Usually look serious from the start
- Major illness or injury is causing irreversible losses
- Obvious immediate or imminent anatomical / physiological damage or multi-system insult
- May or may not meet SSA “listings” and end up on SSDI

## “Creeping Disabilities”

- Start out looking like common health problems
- Recovery stalls
- Nothing works
- Illness > disease
- Desperation drives search for expensive / destructive measures
- Go downhill over time
- Ruined lives lead to SSDI

# Poor Outcomes Can Sometimes Be Averted

- Loss of capacity and functional impairment are typically due to subjective symptoms and beliefs (especially distressing pain, fatigue, fear, and self-perception of incapacity / inability to perform).
- Keeping people active and focused on getting life back on track during recovery can prevent acutely disabling subjective symptoms and beliefs from becoming persistent / chronic disabling ones.
- The transition from acute to chronic occurs 3–6 months after onset. Acute symptoms are innate and protective; chronic ones can be dysfunctional.

## MSK:

| Sad Sam | Lucky Lou |
| --- | --- |
| • Bad disc in back; surgery<br>• Mediocre work history<br>• Supervisor never called: “They will handle it”<br>• Weak supervisor; teasing by co-workers<br>• Disabling doctor<br>• MD & ER: “Stay home until you’re able to do your job.”<br>• PERMANENT DISABILITY | • Bad disc in back; surgery<br>• Mediocre work history<br>• Supervisor kept in touch: “We need you”<br>• Good supervisor; support from co-workers<br>• Function-oriented MD<br>• MD & ER: Transitional work; adaptive equipment<br>• BACK TO WORK IN 6 WEEKS |

## CMD: Droopy Don

- Depression/anxiety
- Mediocre work history
- Supervisor never called: “I don’t matter”
- Weak supervisor; teasing by co-workers
- Treated by naïve doctor
  - “Don’t go back until you are sure you can cope and are symptom-free.”
- ER: No light duty.
- PERMANENT DISABILITY

## Active Abe

- Depression/anxiety
- Mediocre work history
- Supervisor kept in touch: “They need me”
- Good supervisor; respect from co-workers
- Treated by function-oriented doctor
  - “Keep active; be useful.”
- ER: Transitional work OK
- BACK TO WORK IN 4 WEEKS

# PAUSE FOR REFLECTION

# WRITE YOUR QUESTIONS IN CHAT

# Colledge's SPICE Model: Prevent Poor Outcomes

*(adapted from US military)*

- Simplicity – *Don't medicalize normal things; avoid fancy diagnostic / anatomic terms*
- Proximity – *Preserve daily routine*
- Immediacy – *Manage with urgency*
- Centrality – *Focused on workers' current and long-term quality of life / well-being (not laws, benefit rules, $$, etc.)*
- Expectancy – *Reassurance*

# See Handout: Work Disability Prevention Charter

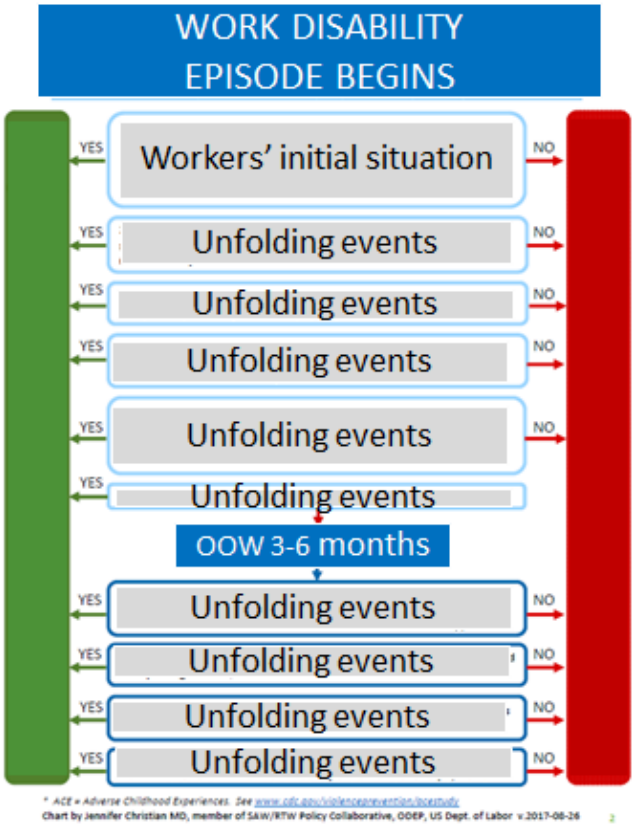
**KEY EXCERPTS (adapted slightly for RETAIN):**

- Medical conditions by themselves rarely require prolonged work absence, but it can look that way.
- The harms of overtreatment and needlessly long periods of life in limbo are not usually recognized.
- Unexpectedly poor outcomes are frequently due to a mix of medical and non-medical factors.
- Health care providers do not feel responsible for avoiding job loss, but do not want to harm their patients.
- Health-related work disruption should be viewed as a life emergency.
- Productive activity should be a part of treatment regimens.
- When work disruption begins, a Coordinator can help focus all stakeholders' attention on maximizing recovery, restoring function, accommodating irreversible losses, and making plans for how the worker can keep working, return to work, or quickly find a more appropriate job.

# See Handout: How to Mitigate Risk Factors for Long-Term MSK Work Disability

Page 1


Page 2 – Layout




Green = increases likelihood of good ultimate outcome

Red = increases likelihood of poor ultimate outcome

The Coordinators who can "make the right things happen" in items 1 through 5 on the handout who will achieve RETAIN's intended outcomes.

It will not be possible to succeed every time! It's the "batting average" that counts.

Doing this will require:

- Moving rapidly; keeping an eye on elapsed time
- Orchestrating events
- Active support from RETAIN medical directors & others.
- Buy-in and collaboration with other stakeholders/ partners

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

1. **Is worker free from added risks** such as:

2. **Does worker receive prompt, evidence-informed health care and other services that identify and mitigate added risks as well as preserve or restore ability to function & work**?

3. **Does worker receive sound medical advice & guidance about activity that permits / encourages medically appropriate work?**

4. **Is worker already back at work, because employer has temporarily adjusted job demands, improved safety or ergonomics, or made reasonable accommodations per ADA?**

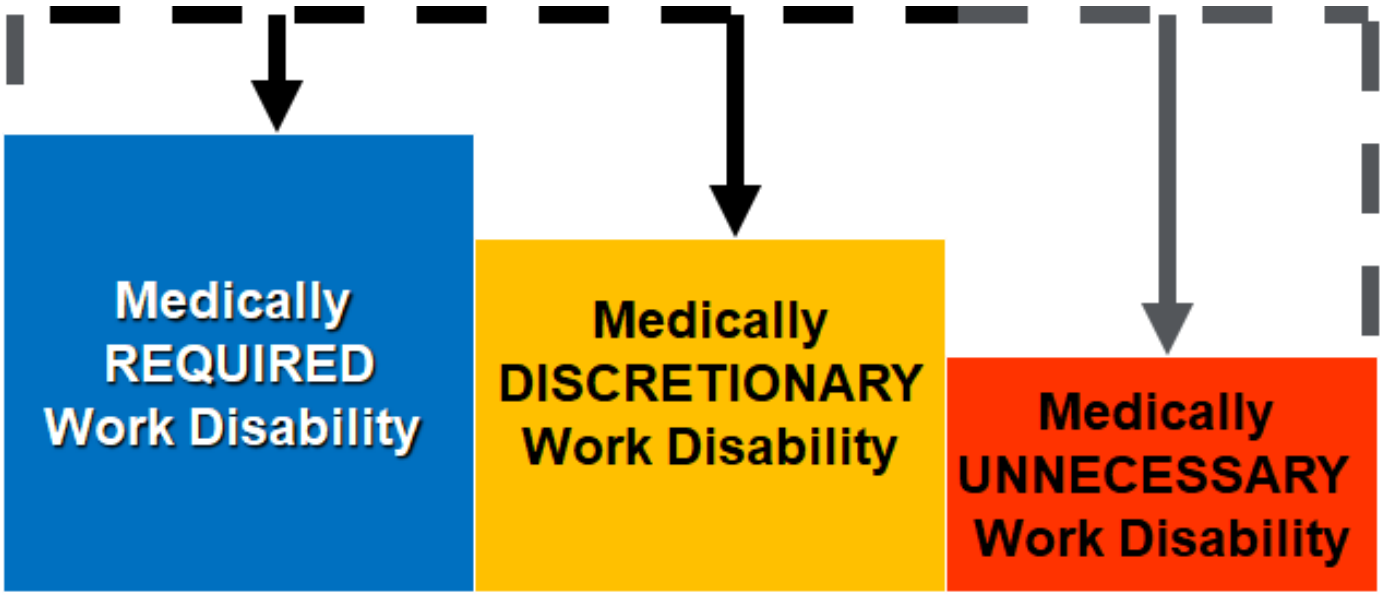
5. Does **worker accurately appraise the situation and cope successfully with challenges**:

6. Does worker enjoy **rapid and full recovery** of function (in <12 weeks)?

**NO: Recovery is prolonged or condition becomes chronic**

# Work Disability Prevention = Reduce Needless Absence

The biology of injury/illness determines duration of medically required work disability. Thus, reducing medically discretionary and unnecessary work disability is the biggest opportunity and deserves most attention.



# Temporary Work Adjustments (TWAs)

- TWAs reduce demands on affected body parts or systems while they heal.
- Commonly, TWAs are the workers' own job with a specific change or two. Good TWAs are also constructed from task banks on a case-by-case basis. Some non-unionized companies create special light jobs for workers during recovery.
- TWAs should be modified at intervals, because function usually returns in phases.
  - Progressive relaxation of restrictions allows increased job demands and a step-by-step transition back to full duty.
  - Prolonged, unchanging TWA's create risks for the employer: they can be deemed a de facto "permanent job."

# TWAs, FMLA, & ADA

- Employees on FMLA leave must voluntarily agree to a TWA. Job will be protected if worker does not agree but may mean losing cash benefits. While on TWA, employee is not using FMLA leave.
- Employers voluntarily provide time-limited TWAs in order to aid recovery—and get some rather than no productivity from the worker.
- TWAs typically eliminate some essential functions of the usual job and reduce productivity requirements.
    - A painter who cannot reach overhead can do just the low work.
    - A welder who cannot kneel or squat now can repair welding leads at a bench, order supplies, or brush up on training courses.
- Some TWAs are temporary assignments to other departments, or even other organizations, such as non-profits or charities.
- TWAs can be part of a reasonable accommodation plan.

# PAUSE FOR REFLECTION

# WRITE YOUR QUESTIONS IN CHAT

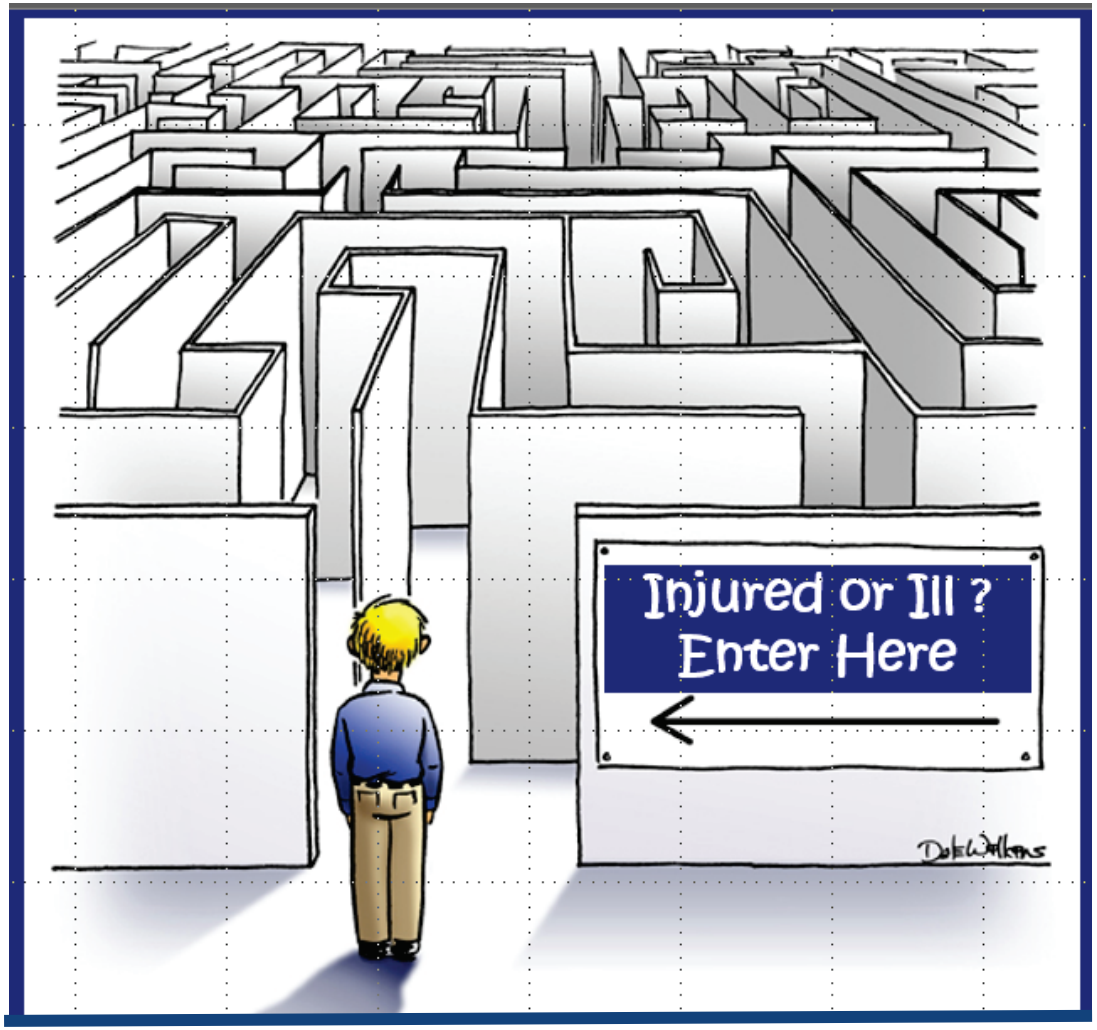
# SAW / RTW Process

- A **sequence** of questions, actions, and decisions
- made separately by **several** parties
- that, taken together **as a whole**,
- determines the practical **outcome** of a health-related employment situation

# Arranging a TWA: Questions to Ask / Answer

- Is now the right time to arrange a TWA? Is complete work avoidance medically required? If so, for how long? If not, proceed.
- Would it be good for this worker to get out of the house, keep busy, be more physically active, and feel useful / productive now?
- Is there any specific thing that would be potentially dangerous/unsafe or medically harmful for this worker to do now?
- What part of the body / system needs protection now?
- What specific parts / tasks of this worker's usual job are now too difficult, energy-draining, or uncomfortable to do all day / all week?
- If we discount productivity for the moment, how can we get around each of those obstacles temporarily? (Is there more than one way?)
- Who can make that happen and by when?
- Who needs to buy in to this plan? What would persuade them?

Newly injured or ill workers often feel they are now in unfamiliar territory facing an unknown future. They are dealing with MORE than just the mazes of the healthcare and disability benefits or workers' compensation systems.




Cartoon shows person entering a maze. Sign says "Injured or Ill? Enter Here."

# **Four Parallel Processes** (*running simultaneously*)

1. Medical care
2. **Personal adjustment**
3. Benefits administration (e.g., healthcare, PTO, disability, workers' compensation)
4. **SAW / RTW (with FMLA & ADAAA)**

The **worker** has the most power to determine the eventual outcome of a health-related work disruption . . .

. . . because he or she decides how much discretionary effort to make to get better and get life back on track.

# Want to build a great relationship with workers? Help them get good answers to these questions.

- What is the matter with me? Has my doctor made the right diagnosis?
- Why am I not getting better? Am I getting the right treatment?
- Why do I have to wait so long to get a test, see a specialist, have surgery?
- How long do I have to take it easy?
- What is it safe for me to do? What shouldn't I do? How can I speed up or maximize my recovery?
- How long am I going to be out of work?
- When will life be back to normal? …if ever?
- What does this mean about me as a person? About my future?
- Who's in charge here? My doctor? My employer? Insurance company?
- What am I supposed to do with all this paperwork?
- How am I going to pay my bills next week / next month?
- What's my role in this situation?
- Who will really help me with this? Whom can I trust?

The **employer** (often the **supervisor**) plays the second most powerful role in determining the outcome . . .

. . . by deciding whether to manage the worker's situation actively, passively, supportively, or hostilely, and whether to allow on-the-job recovery.

# Small Employers & Most Supervisors Are Naïve and Uncertain About Injury/Illness/Impairment

- Unfamiliar with medical world
- Unfamiliar with SAW/RTW/disability jargon
- Don’t want to hurt anyone
- Afraid of causing re-injury / new injury
- Can’t think of ways to adjust job
- Responsible for getting the company’s work done
- Afraid of breaking multiple laws
- No time to spend fooling with this
- Driven by comfort, convenience, not “big picture”

# Messages Employers Want / Will Like to Hear

- NO JARGON. They probably don't know what "modified" or "transitional" work means.
- A clear distinction between "temporary" adjustments and "permanent" changes to a worker's job.
- Mutually agreed on "**temporary**" adjustments are:
  - During recuperation only; limitations will decrease over time.
  - Part of therapy; increases likelihood of full recovery.
  - Can count as part of a reasonable accommodation.
- A **long-term** reasonable accommodation should make the impairment irrelevant—the impact on work "disappears."

**Doctors / other treating clinicians** can profoundly influence the outcome. . . .

. . . by providing factual information, making remarks, or giving advice that will either encourage / support OR discourage / obstruct efforts at SAW / RTW

# These terms mean very different things but are often used interchangeably.

## RESTRICTIONS

- A **MEDICAL** issue
- **RISK** – What the person SHOULD NOT do
- What the employer SHOULD do
- May be modified only by the clinician
- If not followed, medical harm may occur

## LIMITATIONS

- An **ABILITY** issue
- **CAPACITY** – What the person CAN do now
- Clinician is serving as an objective assessor
- May be modified by agreement (but employers may be wary)
- Little / no medical harm if not followed

# TOLERANCE = Ability / willingness to cope

This distinction should accompany questions about restrictions and limitations, but is rarely used.

Functional impairment due to chronic symptoms like pain, fatigue, weakness, and apathy is sometimes truly a medical issue—***and sometimes is a choice, whether acknowledged or not***.

Is the problem due to ongoing anatomical or physiological damage or still-healing tissue, or is it due to unhelpful beliefs, inability to cope, or unwillingness to tolerate any discomfort?

One measure of someone's commitment to something is the amount of discomfort or risk they are willing to take for it.

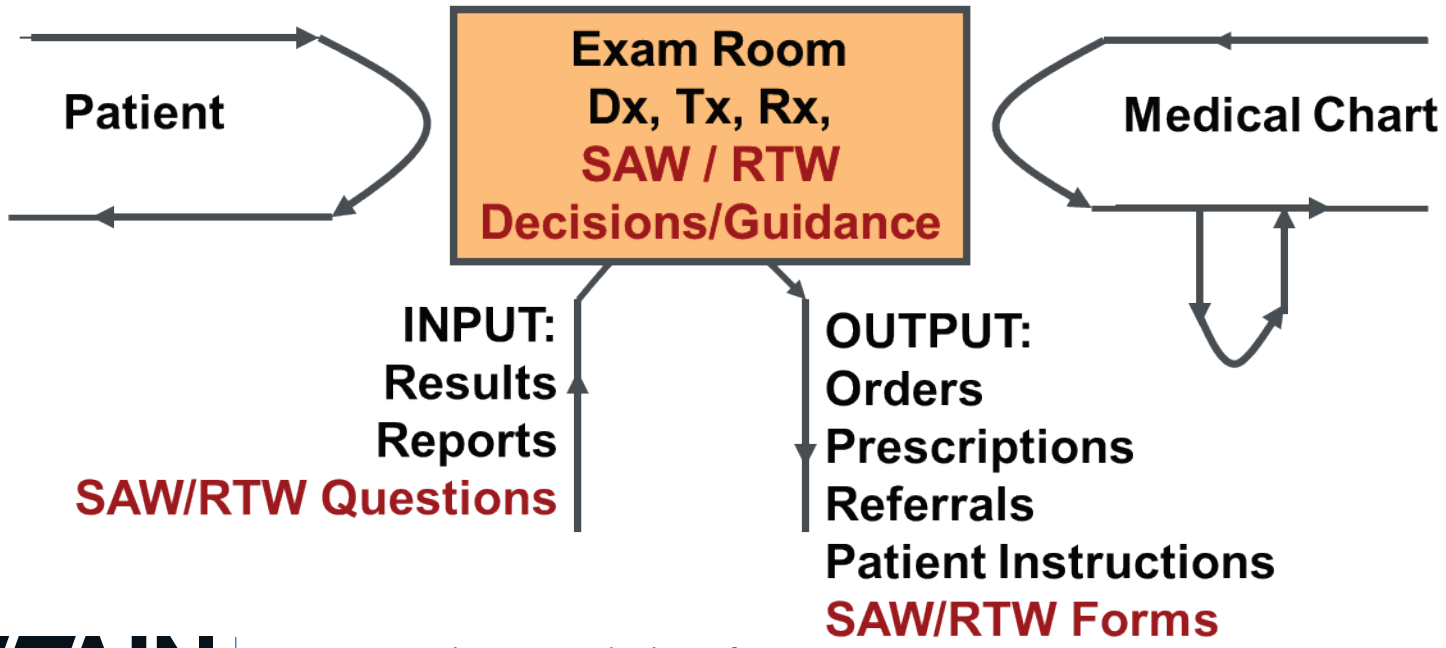
# My Recommendations re: Interactions With Doctors

- Treat information about work capacity / restrictions from doctors as current estimates, not final “true facts.”
- For risks: Defer to treating doctors for input re: medical or safety risks of specific tasks, or conditions in the workplace—but make sure they have the same facts you do, and offer access to clinical experts.
- For limitations / tolerance: Presume they want the best for their patient. Allow them to save face. “I found some more information to help you…” “In case you were unaware…”
- Help the clinician feel comfortable / make a solid decision: Provide a timely and very brief summary of the usual job, possible alternatives, the employer’s willingness to make adjustments and honor restrictions—all of which will make it easier for the clinician to support SAW/RTW.

# Timing Is Everything

Try to time the arrival of your questions or supplementary information to coincide with a medical appointment visit. The exam room is the physician's workstation in the "assembly line" of healthcare delivery.

This diagram illustrates the idea. Conveyor belts are bringing in and taking out the patient, information, and the clinician's work products.



# QUESTIONS?

Contact Dr. Christian
christian.jennifer.h@dol.gov

# Thank you!

Please take a moment to complete this evaluation:
*https://www.surveymonkey.com/r/12-10_RecoveryTWA*