Approved March 19, 1985
Date

MINUTES OF THE SENATE COMMITTEE ON LABOR, INDUSTRY AND SMALL BUSINESS.

The meeting was called to order by Senator Dan Thiessen at
Chairperson

1:30 ~~a~~p.m. on Tuesday, March 5, 1985 in room 529-S of the Capitol.

All members were present except:

Senator David Kerr (excused)
Senator Norma Daniels (excused)
Senator Jack Steineger (excused)
Senator Merrill Werts (excused)

Committee staff present:
Jerry Ann Donaldson, Legislative Research Department
Gordon Self, Office of the Revisor of Statutes
Nedra Springler, Substitute Secretary

Conferees appearing before the committee:
Frankie Gibson, Director, Projects with Industry, Wichita
Morris Taylor, Workers' Compensation Division
Gabe Faimon, Menninger Foundation, Topeka
Dick Thomas, Rehabilitation Services, SRS
Rod Caldwell, Kansas Elks Training Center Projects with Industry

The Chairman called the meeting to order at 1:45 p.m.

The Chairman stated the purpose of the meeting was to hear a report on "Projects with Industry" by persons involved with these projects which are cooperative efforts with industry and rehabilitative jobs for disabled workers.

Frankie Gibson, Director of Projects with Industry, said the group was a division of the Elks Training Center in Wichita, and the program concept is replicated across the country. It is a good example of the private and business sectors and the state agency cooperating in an effort to place individuals in jobs. She added that the Elks Training Center became involved in the program because of a successful similar program instigated at the Boeing Company in Seattle. The projects are funded with state and federal dollars. An executive advisory committee to Projects with Industry meets quarterly. Ms. Gibson said this group has been seeking better ways to assist injured workers in a rehabilitation process. She introduced other conferees who serve on the advisory committee: Dick Thomas, Rehabilitation Services, SRS, Morris Taylor, Workers' Compensation Division, Gabe Faimon, Menninger Foundation, and Rod Caldwell, Kansas Elks Training Center Projects with Industry who is the statewide coordinator.

Mr. Taylor said there is a rehabilitation program within Workers' Compensation but problems arise because of the "system" which does not provide an incentive for people on welfare or for the disabled to return to work. He noted the average Workers' Compensation claim for an injury is $15,000. After medical bills, attorney fees, and other expenses are deducted, not much is left which means that individuals turn to welfare. Mr. Taylor said provisions in SB 324, presently in committee, would help put these people back to work.

Mr. Thomas said Rehabilitation Services believes there is a need to contact injured workers early before they turn to welfare and become used to being dependent. He believed SB 324 gives both the employee and the employer an incentive to get the individual back on the same or a similar job. It addresses vocational rather than medical rehabilitation.

Mr. Faimon gave a background of federal and other states' rehabilitation and workers' compensation programs which have not addressed the problem because some are short-term programs or only address a specific injury. Lack of incentive in programs nationwide has resulted in a system that is not a system because the worker has to prove he is separated from the labor market when the purpose of the system should be to return the worker to work. He noted the Vocational Rehabilitation Research and Training Center at Menninger's is studying the dilemma which is costing this country $2 hundred billion a year and 400,000 people a year nationwide will leave the labor market because of disabilities and because of the way the program is structured. Mr. Famon said individuals now have to go through an adversary process, and after two or three years without work, lose their currency skills and

become obsolete. There is no place they can go unless they have access to good rehabilitation programs. He suggested there was a need for an open flow of information and cooperation among workers, employers, insurance companies, and family members; early intervention is important, preferably within 10 days; laws are needed to determine medical and vocational limitation so the person can be returned to the job he was doing with or without modification; costs should be separated that are attributable to permanent impairment and outright recovery; payment of claims should be stretched out, not given in a lump sum; and contested settlements should be avoided. Mr. Faimon said workers' compensation laws should provide rehabilitation without raising the issue of employer credit,there should be an economic incentive for rehabilitation, a job and rehabilitation plan should be provided, and actions should be based on definite measures of work that the individual is reasonably able to perform. Mr. Faimon furnished the committee with copies of two Menninger publications, "Return to Work", and "New Directions in Disability Management". (Attachments A and B)

In response to questions, Mr. Faimon said Menninger's is attempting to determine what is happening to the people who annually leave the labor market and how many could be kept in the labor force. This group is hoping to bring attention to the problem of keeping disabled persons at the same or a comparable job rather than training them for a different job with lower pay. He believed SB 324 addresses this and other workers' compensation problems but noted it would be an educational challenge to get it through the legislature. A concern has been and will be the court's interpretation of worker's compensation laws.

There was discussion regarding the 1984 interim committee's study concerning workers' compensation laws that resulted in SB 9 which is aimed toward rehabilitation of workers. The need for a task force or advisory committee regarding workers' compensation laws was noted. A member objected to what he believed was the hard-nosed approach that SB 324 takes by mandating that these workers go through rehabilitation and no lump sum payment being allowed. In his opinion, a task force should have made recommendations before SB 324 was introduced. If the goodwill of industry is lacking, a restriction would be placed on workers' compensation funds without results. Another member pointed out the lump sum payment was not allowed only during the rehabilitation period in order to make sure benefits continued during rehabilitation.

Ms. Gibson thanked the committee for making time available for her group. She believed dialogues such as this would bring about a better solution regarding the entire gamut of rehabilitation.

The Chairman adjourned the meeting at 2:30 p.m.

3-5-85
Att. A.
Senate Labor, Industry & Small Business

The Menninger Foundation

Preventing Disability Dependence

Vocational Rehabilitation
Research and Training Center

RETURN-TO-WORK

A
Literature
Review

Topeka, Kansas
913 233 5501

THE MENNINGER REHABILITATION RESEARCH AND TRAINING CENTER

PREVENTING DISABILITY DEPENDENCE

RETURN-TO-WORK: A LITERATURE REVIEW

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Dr. Jack Steward, dean of the Office of Economic Development, City Colleges of Chicago, and Dr. Marvin Kuehn of Emporia State University, both members of our National Advisory Council, provided technical assistance in this literature review.

This document was reviewed by Mr. Al Green, MSW, who directs the Employee Assistance Program offered by The Menninger Foundation and who is a member of our Internal Advisory Council. In addition, several rehabilitation professionals who work directly with the problems of return-to-work for injured and ill workers provided constructive comments. They include: Ms. Candy Girard of Burlington Northern Railroad; Mr. Ron Holbach of Employee Benefit Administration Company; Ms. Ann Lovegrove of Home Insurance Company; and Mr. Jon Gice of St. Paul Fire and Marine Insurance Company.

We would like to express a special note of appreciation to Dr. Douglas Fenderson, director of the National Institute of Handicapped Research, for his unceasing leadership in early intervention on behalf of the disabled worker.

Finally, Project Retain could not have been started without the considerable efforts of City Colleges of Chicago and Schwab Rehabilitation Hospital in Chicago.

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PREFACE

Executive Summary

Increasing evidence indicates that more and more workers who become disabled will return to work sooner and often to their previous job if returning to work can be established as their objective as early as possible during the recovery process. It is essential that the worker invests himself in this objective and that the environment supports his or her efforts toward this end.

In the following pages, "return-to-work" is used not only to identify the process of returning an injured or ill worker to the work force, but also to define an attitude that must be cultivated more widely in the minds of all who are affected by the economic, physical, and socio-psychological disruptions of worker disability.

The target of "return-to-work" encompasses those workers who cannot work due to injuries or illness regardless of occupational cause and who are delayed in their return to work due to: (1) their own unrealistic fears and doubts or secondary gains (2) employers' concerns about reemploying them (3) medical professionals' reluctance to release patients for fear of negligence proceedings (4) legal needs to preserve disability evidence (5) unions' rules regarding seniority and transfer rights or (6) a vocational counselor's penchant for actualizing clients' full potential at the expense of simply restoring workers to the work force. Workers who are not impeded by one of these obstacles will return to

work as soon as they can anyway. Those who cannot return due to their disability alone are not the concern of this review.

This review describes disability in today's work force and the rehabilitation system designed to address disabled workers' problems. It focuses on the evolution of how workers are returned to work and reviews theoretical and empirical arguments for developing better strategies whose central objective is return-to-work. Current attitudes, misconceptions, policies, and legislation are examined to identify incentives and disincentives that influence whether a worker returns to the workforce. Attitudes and policies are shifting throughout the vocational rehabilitation system, and return-to-work programs are emerging even while important obstacles remain. In conclusion, more research is needed to establish how and where return-to-work strategies could be effectively applied.

The authors provide a far reaching review of current return-to-work programs and strategies in rehabilitation medicine, union bargaining agreements, employers' in-house programs, and private vocational rehabilitation services. These programs all need more careful research scrutiny to be appropriately adapted to other settings.

Finally, the Rehabilitation Research and Training Center's "Project Retain," a demonstration program of return-to-work services, is introduced. This program calls for community-based coordination of medical, counseling, and personnel professionals to make the earliest possible intervention which would remove obstacles impeding the worker's reemployment. The Rehabilitation Research and Training Center will

evaluate "Project Retain" and eventually recommend where and how "Project Retain" services can best be applied. Concluding the monograph, several existing structures are identified as potential delivery vehicles for "Project Retain" or programs like it.

A. INTRODUCTION

1.0 Methodology

Current research and theory indicates that more and more workers who become disabled will keep their jobs or return to work sooner if rehabilitation professionals intervene earlier. These workers include all who incur some functional limitation involving their physical, emotional, mental, or sensory systems which interferes temporarily or permanently with their performance of expected roles and tasks in their socioeconomic environment (Nagi, 1980). This approach for returning employees to work is not new. In fact, early intervention strategies are now being implemented and research projects are investigating their potential. However, more needs done to cull and demonstrate to a wider audience the most positive components of existing programs as well as the fruits of continuing research. Early interventions should focus on helping disabled workers and their former employers understand, accept, and be creative with their new circumstances. It is now time to increase efforts to research and develop alternative delivery models for the earliest possible interventions.

These statements are derived from a far reaching review of current literature from relevant professional groups. Several steps were taken to compile the working bibliography. Abstracts of relevant materials concerning medical and vocational rehabilitation, personnel management, and disability were reviewed over the last five years. In addition, U.S. Government documents of the past

five years were searched. To ensure thoroughness, a computer search of NARIC's database was commissioned. Key terms included "employment programs," "employment re-entry," "retraining," and "disabled workers." Our bibliography is international in scope covering the theory, research, and practice concerned with return-to-work problems and early rehabilitation intervention strategies.

1.1 Estimating the Return-to-Work Population

Nationwide, the number of Americans who could benefit from expanding the use of early intervention strategies can only be estimated. A very conservative estimate, derived from a study by the Rehabilitation Research and Training Center at The Menninger Foundation, indicates that every year more than 400,000 American workers sustain an injury or physical illness which disables them for at least one month (Hester and Decelles, 1985). Approximately half of these people never return to work, although half of those who do not return will live for more than 10 years. Of those people who do eventually return to work, 40% are off work more than a year.

Other sources put this information into perspective. In 1982, accidents alone accounted for 1.9 million on-job and 2.6 million off-job worker injuries within the 100 million person American work force (National Safety Council, 1983). If serious illnesses were added, the number of incidents would increase. Unfortunately, the rehabilitation literature contains a remarkable dearth of specific information on workers who have to leave work

temporarily or permanently due to serious illness. Consequently, this group cannot be represented statistically. Still their need for rehabilitation and return to work is just as great.

Not all of the injured and ill will be able to return to work. For example, of the 1.9 million on-job injuries cited above, 11,200 were fatal and 70,000 resulted in some permanent impairment. Similar statistics for the group of workers affected by off-job injuries and serious illness are not available. Those who will be able to return to work include those who survive without a totally disabling impairment and those who are not dismissed while recovering or find new employment.

1.2 Estimating the Cost of Worker Disability

On-job accidents burdened the 1982 economy with an estimated $31.7 billion in both direct and indirect costs. After adding the $24.9 billion cost of off-job accidents (about one third of which was borne by employers), the 1982 total rose to $56.6 billion. During that year, an estimated 100 million lost workdays resulted from disabling injuries and another 40 million lost days were caused by disabilities from prior years.

Based on the most recent national figures for compensation paid to workers (National Safety Council, 1983), American workers in 1980 received nearly $13.4 billion of which $3.9 billion went for medical and hospital costs and $9.5 billion for wage compensation.

In addition to the economic effects of lost production and income losses, disabilities burden both employers and workers with social and psychological costs.

1.3 Benefits of Returning Workers to Work

Returning to routine activities as soon as possible is now considered therapeutically important to assure and quicken medical recovery from disabling illnesses and injuries. With regard to heart ailments, Cousins (1983), Byrne (1982), and Cay, et.al. (1981), recommend working with the patient's mental state to avoid depression. They all encourage heart attack patients to return to activities as soon as possible. In fact, Cay, et al., found that 80% of their treatment group, myocardial infarction patients, were back to work faster than controls. The experimental condition in this study consisted of education about heart disease and its risks, help with social problems, and treatment of emotional upset. Many cancer patients can be expected to realize their potential more fully if they can return to an active life sooner (Goldberg and Habeck, 1982). Workers suffering orthopedic disabilities also respond well to shorter delays before returning to work (Phillips, 1964). They complain less and experience physical improvements. In treating mental illness, a gradual return-to-work strategy has become one of the principal therapeutic modalities (Black, 1970).

Likewise, the psychosocial impact of disability can be positively managed by a return to activity, a recovery step that boosts self-

esteem and social prestige. One's work may be the most important activity to resume. Franco (1965) claims that work is the best form of rehabilitation, especially if the worker can be returned to his or her former job. Personal and vocational counseling can smooth the transition. Since individual adjustment to a handicap is complicated by many social and psychological factors, everyone can benefit from help in developing constructive, positive attitudes toward his or her future (Wright, 1980). Each individual needs to achieve self-acceptance, adaptability, and in many cases, a sense of contributing to oneself, as well as to the common good (Bardach, 1977).

1.4 Plan of This Review

Any intervention strategy that might reduce these costs warrants further research and broader application. The plan of this review is to outline the return-to-work problem and present theory and research indicating the importance of earlier interventions. It also discusses the incentives and disincentives for return-to-work, describes current programs of return-to-work services, and summarizes the more progressive components of vocational rehabilitation now being used. Finally, research recommendations are made and "Project Retain," an early intervention demonstration program, is suggested along with potential delivery vehicles to further demonstrate and promote early interventions for "return-to-work."

B. THE EMERGENCE OF THE RETURN-TO-WORK PHILOSOPHY

2.0 Scope of Worker Disability: Disruptive Effects

Bowe (1983) reports that among working age Americans, 16 through 64 years old, more than 13 million are disabled. Based on Current Population Survey results, the percentage of disabled workers in the work force roughly doubles at ten-year intervals after age 44 (McNeil, 1982). In March, 1982, disabled persons comprised 7.1% of the 35-44 age group, 12.3% of those 45-54, and 24.1% of those 55-64. Bowe thinks that by the turn of the century one-half of the U.S. population will be physically disabled, chronically ill, or over 65 years of age. This puts a heavy burden on active workers in the remaining half. As this date draws near, keeping as many people as possible able and working will become even more important not only to individuals but also to the American economy.

Injuries, illnesses, and the disabilities that may result are a constant threat to American workers and their employers. Surely, employers do all they can to prevent accidents and illness at least at the workplace. As each new safety or health improvement is made practical, employers will no doubt begin making the necessary changes to ensure safety and promote good health for their employees (Russell, 1973). Federal and state governments encourage these steps through the Occupational Safety and Health Act and the Worker's Compensation laws. Nonetheless, the workplace remains somewhat hazardous, and even if it were

perfectly safe, the threat of off-job disabilities would still exist.

It was stated above that 4.5 million 1982 accidents occurred among the 100 million American workers at an estimated $56.6 billion cost, and accounted for 100 million lost workdays. It was also estimated that annually more than 400,000 workers are off work for at least a month following a disabling incident. Considering these facts, it is easy to understand that disabilities can seriously disrupt employers' production. Similarly, it is easy to imagine the disruption that disability can cause in workers' lives. Such disruption occurs regardless of whether the onset of disability is immediate or gradual and no matter how long the employee is absent.

The employer's problems are not only measured in terms of production losses (Russell, 1973), but also in terms of human resources including the expense of hiring, training, supplying benefits, and paying salary (Connolly, 1982). These expenses are incurred once when hiring and breaking in the employee who becomes injured or ill and again to replace him or her temporarily or permanently. However, employers are obliged to withstand these hardships to meet their legal responsibilities (Conley & Nobel, 1979) and their moral ones (Galloway, 1979). These factors should encourage employers to actively ensure the quickest and most effective rehabilitation of injured and ill employees.

Paul Ashton (1979), rehabilitation program supervisor for Minnesota Mining and Manufacturing Company, summarizes the basic interests of the worker and employer faced with potential disability. He also indicates the benefits of rehabilitation and return-to-work.

> When a worker becomes injured, ill or otherwise incapacitated, the employer and worker alike become acutely aware of the production which had been expected. The employee wants to be compensated during the incapacity and, usually, to get back on the job. If this can be arranged, the company can reduce its insurance and related costs (legal obligations) while helping the worker and his or her family (moral obligations) adjust to permanent or temporary changes resulting from the disability (p. 27).

In the worker's case, the person not only suffers physically and financially but also psychosocially. One's work role is so integrally related to one's self-image, values, and life-structure that forced unemployment can threaten one's mental health (Kelvin, 1981). Unemployment due to disability can also threaten family cohesion even in the most stable families (Versluys, 1980). This threat to a worker's primary support system has received little direct attention in rehabilitation literature.

The maintenance of a worker's network of family and friends is known to affect positively the motivation necessary to recover and return to productive activities (Ray, 1984). The breakdown of this system quickly becomes a stressful interference with rehabilitation. Sussman and Hagan (1979) highlight the importance of continued family relations during recovery.

> The significance of family structure for vocational rehabilitation is as follows: (1) the rehabilitation system while treating individuals who have a

> disability is actually engaging a group, in most instances a family. Since the problems of family members are ultimately relegated to the family, as both legal and moral responsibilities, disability and rehabilitation are a family concern; and (2) how the rehabilitation client responds to the system, maintains a motivational level sufficient to complete the rehabilitation regimen, pursues and achieves vocational objectives, will be a function of his participation in the family group, his role and status within it, their acceptance of the member's disability, their willingness to act as a buffer between the disabled family member and the provider system, and the impact the disability may have upon all other family members. Increasingly, the entire family system will be viewed as the natural key to the effective functioning of one of its members who has come to be labeled "disabled" (p. 50).

These authors explain that while it is the natural source of support, the family is also subject to destructive stress when one of its members must recover from injury or illness.

> Yet, it is to the family one turns when in trouble. It would be naive to assume that all members of the family respond joyously to the responsibilities of caring for ill or disabled members over long periods of time. Moreover, there is some evidence that already shaky marriages tend to dissolve after serious crises occur such as illness and disability--a situation which suggests that individual claimants' needs for maintenance and rehabilitation should be considered in relation to the larger unit, the family (Sussman and Hagan, 1979, p. 51).

If the family is strong enough to survive the initial impact of worker disability, the need to adjust to the strain of recovery and whatever permanent limitations that exist will also demand great strength. The family may require professional assistance in addition to the usual rehabilitation services given to the worker (Aja, 1983).

The whole family must adjust its schedule, its finances, and the rest of its resources to accommodate the newly dependent member. "Currently, the extensive network of service programs is geared primarily to assist the individual and does not consider sufficiently the social and economic impact, and costs to the family or household" (Sussman and Hagan, 1979, p. 52).

2.1 Today's Rehabilitation System and Return-to-Work

The disability rehabilitation system operating in the U.S. today addresses the problems of employers and workers. This system is shaped by personnel policies covering the disabled individual, occupational and rehabilitation medicine, public and private disability insurance, laws governing worker compensation and occupational health and safety and, of course, public and private vocational rehabilitation services. Many of the results of these efforts are positive. People do recover from disability and may even return to work. Those who do return to work begin paying taxes, cease claiming wage compensation and, according to a 1979 study concerned with medical costs of severe injuries, will likely require considerably less medical attention than those who remain unemployed (Stout Vocational Rehabilitation Institute, 1983).

While this rehabilitation outcome is desirable, the reemployment of disabled workers may involve complex issues. Some of these issues are summarized by Conley and Noble (1979).

> Reemployment means the restoration of the worker to a suitable job. Usually, it is desirable for the worker to be reemployed by the firm in which the injury or illness occurred. There are, however, many exceptions

> to this rule. If the worker is permanently impaired, his or her limitations may disqualify the worker for any available job within the firm. Small employers may be unable to hold open the worker's job during a long convalescence. Even when the original firm could reemploy the injured or ill worker, more desirable jobs may exist in other firms, particularly in the case of workers who suffer permanent work limitations. Last in an economy where labor mobility is normal, some workers will prefer employment in firms other than the one in which the injury or illness occurred (p. 81).

From the point of determining the permanency and extent of a disability and throughout all phases of medical and vocational rehabilitation, every person who comes into contact with the disabled worker will influence whether a worker regains his or her previous job and productivity level. These contacts will also influence how soon return-to-work can take place. Indeed, the quality of these contacts may extinguish hope and diminish motivation; or if carefully designed, an intervention may ease the shock of temporary or permanent loss of function and accelerate the adjustment process (Hohmann, 1975). It has already been mentioned that employers, insurers, rehabilitation professionals and even the disabled person may carry negative attitudes and misconceptions about the potential of a disabled worker. The actual impact of these contacts depends heavily on the receptivity, motivation, and creativity of the worker and his or her support system which includes the family, employer, insurer, and all rehabilitation agents (Stout Vocational Rehabilitation Institute, 1983).

2.2 Vocational Rehabilitation Services for Return-to-Work

Traditionally following medical recovery, vocational rehabilitation professionals have offered disabled workers much needed counseling, occupational adjustment or retraining, and placement. They may have also provided technical assistance to employers advising them about what accommodations can be made to retain or rehire the disabled worker. Current practice has evolved from the time of the industrial revolution. It has seen advances in medicine, vocational counseling, and in legal and moral understandings of the shared responsibility of employers, insurance carriers, workers, unions, and governments for the problems of worker disability (Hutchinson, 1973). Indeed, the momentum of the field now moves toward creating independent living situations whenever possible, which implies economic self-sufficiency. This momentum motivates Projects With Industry, the new wave in rehabilitation, which is dedicated to the idea that working and one's job are the primary means toward economic self-sufficiency (Magee, et al, 1982).

Another evolutionary development in vocational rehabilitation has to do with the timing of interventions and the way the field views itself. Along with the evolution in medicine shifting its focus from curative and restorative interventions to preventative ones, vocational rehabilitation has shifted its orientation. Since WWII, the role of vocational rehabilitation has expanded beyond the so-called "third phase" of medicine that concentrates on

restoration. In recent years, it has grown to include curative and preventative goals (Jarvikoski, 1980). Regardless of when vocational rehabilitation is introduced, return-to-work seems to be an appropriate objective whenever possible.

Broadly defined, the idea of return-to-work embodies an attitude held not only by many vocational rehabilitation professionals, but some employers, insurers, and unions as well. This attitude serves to guide policies and programs regarding employees who must leave the job for any length of time due to disability. To be truly effective though, the worker and his or her family must also embrace this attitude (Wright, 1980).

2.3 Return-to-Work in Worker's Compensation

The confluence of interests linking the disability support system together has placed employers, insurers, unions, government, and rehabilitation professionals in a working relationship that has produced beneficial responses to debilitating injury or illness despite each party's special interests. These special interests tend to be in constant opposition. On the one hand they seek to contain the expense of disability and limit liabilities, and on the other hand they fend for the rights and well-being of affected workers.

Legislation and the courts have established who has what responsibility for whom in the event of worker disability. Current laws requiring equal employment opportunities, affirmative

action, and worksite accommodations have influenced how the responsible parties are to deal with such incidents. The influence of workers' compensation laws has done much to mold current practice in rehabilitating disabled employees. Having spawned in the wake of the industrial revolution, these laws were originally designed to set guidelines for work-related disability claims and to quicken reasonable settlements for workers. Today, there are six basic objectives at the heart of these laws,

> 1) to provide sure, prompt, and reasonable income and medical benefits to injured workers or their dependents regardless of fault; 2) to provide a single remedy and reduce court delays and costs; 3) to relieve public and private charities of financial drains; 4) to eliminate payment of fees to attorneys and witnesses as well as time consuming trials and appeals; 5) to encourage employer interest in safety and rehabilitation through an appropriate experience-rating mechanism; and, 6) to promote a frank study of the causes of accidents which lead to a reduction in accidents and human suffering (Ross, 1979, p. 21).

In recent years, a few states have extended workers' compensation coverage to include temporary disability insurance (even to unemployed workers) (Schrock, et al., 1980) and all states have now established second injury funds to relieve disputes concerning what proportion of responsibility any of the concerned parties should have for a second injury and to encourage the employment of disabled people (Larson, 1973). Recent recommendations include even more options for rehabilitation and reemployment (Sussman and Hagan, 1979), while most programs continue to concentrate on limited compensation for injury including coverage of some medical expenses and compensation for wage loss (Conley and Noble, 1979).

A few states now have legislation sometimes bolstered by judicial decisions which requires rehabilitation plans for all worker compensation recipients who in turn must cooperate with the plan or receive no compensation (Ehrenreich, 1982). This is only a beginning toward correcting the problem of rehabilitation for workers' compensation cases. Otherwise, even when it is clearly appropriate, rehabilitation will not likely be required, much less offered (Kiser and Larson, 1973). For employers who are simply required to insure compensation, the way they cover their risks and the amount and types of coverage vary from state to state (Stout Vocational Rehabilitation Institute, 1983). On the other hand, the demand for rehabilitation services among claimants also varies greatly (Makarushka and Johnson, 1979); recent estimates range from 5% to 20% (Kiser, 1973).

2.4 Rehabilitation Decision Making: Public and Private Agencies

Decisions about who provides what services in worker compensation cases are often made solely by an insurance company claims adjuster or a representative of the employer. These people are likely to be more knowledgeable and better oriented in risk management than in rehabilitation. The claims adjuster may rely on his or her company's own rehabilitation department if one is established. Small insurance companies are unlikely to have this resource and must depend on private rehabilitation providers or the public vocational rehabilitation service. The employer's representative would have the same options plus an even greater incentive to put the worker back on the job (Ashton, 1979). In

both cases, the motivation is to restore the worker to employment and curb the costs of medical expenses, wage compensation, and lost production due to the absence of a trained worker. Additional costs may include training a replacement worker (Kiser and Larson, 1973; Smith, 1973).

Disability management decisions are necessarily limited by what services are available where and at what cost. Also, the level of enthusiasm, creativity, and knowledge in these contact people, as well as that of the injured or ill worker, may further limit the amount and quality of services that may be recommended. These limitations will be compounded by the complexity of need determination.

In an early study, Makarushka and Johnson (1979) comment on this compounding factor in their survey of rehabilitation services in conjunction with worker compensation in five states.

> The determination of the need for rehabilitation services is a complex question which involves the extent of impairment, job skills, labor market, and client interest. Need is also related to the goals of rehabilitation. Ideally, the goal of rehabilitation is to restore the impaired worker to a preinjury level of physical, emotional, occupational and social functioning. In fact, this may be impossible or possible only at the cost deemed too great by the client or provider. In this study, the main goal of rehabilitation was defined as the prevention of disability; disability was defined as unemployment as a result of physical impairment (p. 26).

Once disability is determined, the worker may be served by private or public rehabilitation agencies. Evaluating the adequacy of

private services five years ago, the Makarushka and Johnson (1979) study suggests that they were limited and sometimes ineffective.

> When short- and long-term unemployment were used to test the effectiveness of the services provided, the available data were suggestive rather than conclusive. The analysis indicated that some workers who might have been reemployed were not provided with rehabilitation assistance, that in some cases services were provided but were limited or inappropriate and did not effect recovery from disability, and that provision of services to those most severely impaired may reduce the apparent effectiveness of services when reemployment is used as the measure of success (p. 33).

They also explain that while the programs in their study may not be representative since all states differ, the result should raise some questions about other programs. More recent evaluations, however, indicate that private rehabilitation services are growing in strength and effectiveness.

Matkin (1982) discovered that the vocational rehabilitation professionals who staff private agencies offer a broad range of services most frequently including vocational counseling, job analysis, job placement, job development, case monitoring and labor market follow-up surveying, vocational evaluation, medical case management, vocational testimony and job restructuring consultations. It is expected that these services and others will continue to be offered with greater frequency and efficiency as the private, for-profit agencies proliferate (Davis, 1982; Workman, 1983).

Private vocational rehabilitation agencies are seen as steadfastly employment oriented. Yet, they are sensitive to the importance of

preventing disability dependence (Workman, 1983). The charge that they are not humanistic can be disputed by their high dedication to clients and their goal of preventing dependency. The value of this goal is further acknowledged by Lewin, et al. (1979), who noted that private rehabilitation has only encouraged the provision of vocational rehabilitation services in worker compensation cases. Private companies work to resolve claims by returning workers to work quickly.

Any lack of effectiveness in public rehabilitation services for workers' compensation cases may be due to program gaps. Ross (1979) explains the basic philosophical difference between the rehabilitation and the compensation programs. The public rehabilitation program will seek to maximize an individual's vocational potential, while the compensation program will be primarily interested in restoring the individual to his or her predisability employment or, secondarily, to a work status as near as possible to that condition. This fundamental difference can inadvertently produce unnecessary delays in a disabled worker's return to work if service comes from public rehabilitation; in effect, these services may foster disability dependence. Ross further explains that state rehabilitation programs usually suffer "Funding limitations, shortages of personnel trained to handle workers' compensation cases, and mandates of legislation for client eligibility..."(p. 23) all causing incompatibility with the compensation program. As a result, private services are considered best suited to the workers' compensation cases; and public rehabilitation programs have come to rely on making

referrals to private services, leaving themselves to concentrate on the severely disabled who may have never had a job.

The growth of private rehabilitation has been most rapid in recent years, especially in the for-profit sector. This growth results from the needs of employers wanting to contain the costs of disability (Welch, 1979). It was facilitated by changes in workers' compensation laws. Presently, private companies that thrive owe it to producing return-to-work outcomes at the earliest possible time (Ross, 1979). Their standard goals are prioritized as follows: (1) return to work--same job--same employer (2) return to work--different job--same employer (3) return to work--different job--different employer" (Welch, 1979, p. 25).

While the competition among private providers may produce improvements in rehabilitation practice, there is some fear that the profit motive may jeopardize quality services. This risk will be avoided, however, by the necessity of maintaining good relationships with industries according to rehabilitation industry leaders like George Welch (1979). Reinforcing this opinion, a medical director for one private rehabilitation company describes their program as very sensitive to both the psychological and physical needs of patients referred by insurance companies (Spitz, 1983).

Whatever the criticisms, private vocational rehabilitation appears to be important in preventing disability dependence. Their services are not only provided through independent agencies, but

also through insurance companies and by self-insured employers. The employer-based programs may be growing as fast as independent agencies (Ashton, 1979; Pati, et al., 1981).

2.5 Probability of Actual Return-to-Work

Presently, the probability of disabled workers returning to work has been estimated by several studies. For example, in a five-year study of Illinois Social Security Disability Insurance (SSDI) recipients, The Menninger Foundation's Rehabilitation Research and Training Center found that 6% of the annual allowed cases received vocational rehabilitation services through the state agency. Of these, 62% returned to work. Other studies have identified key "risk factors" for the probability of returning to work and linked early intervention to positive outcomes.

In a New York study, Akabas, et al. (1979), found that 16% of 6,000 short-term disability insurance claimants never returned to work. Only about half of the rest lost over a month's work time. This study discovered several "risk" factors, namely: "People hospitalized more than 3 weeks had only a 55 percent likelihood of returning to work, while hospitalization between 2 and 3 weeks raised the probability of return to only 75 percent" (p. 21). Without controlling for length of stay in the hospital the return-to-work rate was 84%. In addition, having multiple diagnoses, being 65 years of age or more, and being part-time employed, or earning less than $8,000 annually were each negative indicators for any return to work at all.

In a 1982 nationwide study of 5,620 cases referred by compensation insurers, International Rehabilitation Associates demonstrated a correlation between "services provided" and "return to work" regardless of the type of disability (O'Brien, 1983; Spitz, 1983). If the referral to rehabilitation counseling was within three months of their injury, 47% returned to work. If it was four to six months after injury, the proportion returning was 33% and only 18% if referral was made a year after injury. This company believes that timeliness of treatment is the single most important consideration in rehabilitating an injured employee.

In another 1982 study, 100 recently closed cases of Minnesota's Rehabilitation Services Office were analyzed (Atkinson, 1983). These cases were subject to the current state worker's compensation law which requires employers to make referral within 30 days of medical notification of a worker's inability to return to employment. The total being referred to the Rehabilitation Service Office comprise 8% of annual claims. The study found that 82% of referred cases returned to work. Of these, 59% returned to their previous employer, many resuming their old job, and 28% found work elsewhere. Of those who did not return to work, 75% were referred to vocational rehabilitation services 150 or more days after injury. The average cost of all the cases studied jumped incrementally by 17%, 27%, and 49% as the time between injury and receiving services lengthened from less than 90 days to 90–120, 121–150, and over 150 days respectively. These researchers conclude that "... the later an injured employee

enters the rehabilitation system, the more his chances for return to work are decreased, and, likewise, the cost of rehabilitation is increased" (p. 27).

Since the results of these studies are not directly comparable due to population differences and possible overlapping, all four must be understood as distinct points of view suggesting that 5-10% of all disability cases are now being served by vocational rehabilitation professionals and of these 60-85% are returning to work.

This research identifies the importance of early intervention for returning disabled workers to jobs. These investigators consistently conclude that the timing of vocational rehabilitation intervention is critical to positive outcomes. While not every disabled worker will be able to return to the work force, indications are that early interventions would not only help more workers return to work but also quicken the return of many who would otherwise require more time away from productive employment. The number of disabled workers now returning to work after receiving vocational rehabilitation services can be roughly estimated at 60-85% of those referred. Now, the challenge is to increase and accelerate return to work outcomes for disabled workers. This will require both redirecting the existing rehabilitation system and refining current programs.

2.6 Return-to-Work, a Special Problem

Research indicates that the special problem of return-to-work centers around attitudes toward disability and toward disabled persons along with the policies which reflect these attitudes. Research is now showing that these attitudes need not remain obstacles. At present, changing them is becoming more a necessity with current upward trends in morbidity and survival rates. These points may now be elaborated.

C. THE IMPORTANCE OF EARLY INTERVENTION

3.0 Disabled Worker's Strengths and Obstacles to Return-to-Work

While work disabilities range widely by type and degree, each disabled person can still be seen in light of his or her residual abilities. In fact, the worker retains all skills, training, and experience that existed before the disability except to the extent that one or more of these qualities has become impaired. The worker should not automatically become identified as someone who suddenly and totally cannot work. Yet today, disabled workers who could return to work and even resume their former jobs too frequently are prevented or unnecessarily delayed due to uncreative, negative attitudes toward or misconceptions about their new condition (Livneh, 1982).

Such attitudes and misconceptions have negative effects on disabled workers' beliefs about themselves (Eaton, 1979; Bardach, 1977; Wright, 1980); on rehabilitation counselors' beliefs about these workers (Kaplan, 1982); on employers' beliefs about having them at the work place (Brantman, 1978; Nathanson, 1977; Sears, 1975); and on policy decisions built into this country's disability management system (Berkowitz, 1981; Eaton, 1979; Walls, 1982). Meanwhile, the literature suggests that changing such attitudes and correcting such misconceptions could lead to more workers keeping their predisability jobs or gaining a more suitable one (Nathanson, 1977; Nathanson & Lambert, 1981; Pati, et al., 1981). Doing so should also lead to shorter recoveries and

quicker returns to work, especially through earlier involvement of vocational rehabilitation professionals.

In some cases, the most pronounced ramifications of the strength of negative attitudes and misconceptions become the "worker's disability syndrome" according to Hanson-Mayer (1984) of Comprehensive Rehabilitation Associates. A worker may develop a psychological state that becomes the foremost obstacle in any return-to-work effort. This frame of mind is shaped by a variety of factors stemming from either legitimate medical problems or psychological ones. The worker may feel entitled to a certain amount of compensation of time and money or develop secondary gains from the disability. All of these factors are better addressed early.

> While the personality characteristics of the injured worker and his or her predisposition to prolonged disability are important factors, other factors which play an important role include: (a) the real and permanent residuals of an injury, (b) the attitude of the employee toward the employer and vice versa, (c) issues related to job security, and (d) the presence or absence of disabling medical problems such as depression and drug or alcohol addiction. Another important contributing factor is the way in which an injured worker views the purpose of the compensation system. Many clients believe that, as a result of being injured on the job, they are entitled to a significant amount of money as a means of acknowledging their injury and as compensation for pain and suffering. Until this struggle is resolved, these clients find it extremely difficult to focus their energy and efforts on returning to health and work (Hanson-Mayer, 1984, p. 51).
>
> When worker's disability syndrome is determined, treatment of both the physical and psychological aspects of the syndrome is necessary. Rapid psychiatric intervention is indicated for the purposes of allowing the patient to recognize the psychiatric aspects of the problem, minimizing the physical symptoms, and minimizing the development of secondary gains (Hodge, 1971, p. 248).

A full appreciation of a disabled worker's immediate circumstances is crucial to understanding his or her psychological vulnerability. Behan and Hirschfeld (1966) point out that the industrially injured worker commonly enters a highly suggestible state just following a disabling incident. Stout Vocational Rehabilitation Institute (1983) concludes that this window of suggestibility is the key to rehabilitation success and speed.

> This window of suggestibility goes beyond the contact the industrial injured worker has with his treating physician. The window includes co-workers, family members, employer, claim adjuster and other members of several other professions with whom he or she may come into contact....The first important factor is that the injury affects the whole person. The second important point is that the rehabilitation process for the injured worker begins immediately at the time of injury from both the psychological and medical aspect. The injured worker's immediate response to his injury is an important one....Another important factor is the injured worker's ongoing psychological response to the injury. If the psychological response continues to be a positive one, the injured worker continues to progress through the rehabilitation process toward a successful completion.... The longer the "non-work" situation exists, the easier it becomes for the injured worker to respond negatively to it. When the ongoing psychological responses to the injury and to the surrounding environment become increasingly negative, the injured worker's chances of successfully returning to a productive, meaningful life are significantly decreased (Chapter IV, p. 9).

3.1 Research and Policy Supporting Early Intervention

The case for early intervention is being made in a variety of sources. Rehabilitation practice is now extending its sphere of responsibility beyond its customary orientation in restorative and curative goals toward serving the immediate needs of the newly disabled (Jarvikoski and Lahelma, 1980). Sunshine (1979) asserts

that successful rehabilitation generally depends on: (1) a prompt start of the process (2) a rehabilitation team who is fully informed about the client's work history, present conditions, and vocational desires and (3) the conditionality of disability benefits on actual rehabilitation attempts. Andrews (1981) encourages a quick response with a more holistic approach to rehabilitation so that clients can be saved from any tendency to believe they are now powerless in the face of their circumstances and not responsible for their recovery., The Federation of the Handicapped (1980) writes about the experience in Project Outward Bound noting that the sooner community services are available to the newly disabled, the less chance there is for dependency or depression to develop.

Over ten years ago, recommendations to update state worker's compensation policies and programs marked some early support for the early intervention philosophy. Lewis (1973) suggested taking a more comprehensive view of the disabled worker's ill fortune by expanding efforts in compensation to include restoring each injured worker to his or her prior physical and economic status. Since then, private insurance carriers who handle workers' compensation cases and the private rehabilitation agencies who serve them have responded to the need for early intervention and often succeed in accomplishing quick returns to work (O'Brien, 1983). Stout Vocational Rehabilitation Institute (1983) highlights this point.

> Today, many companies have "early warning systems" which trigger immediate reports to their Home Office should a catastrophic injury occur. Also, many companies have "prompt contact programs" on all non-

> catastrophic injury cases, both under Workers' Compensation and Automobile. History has shown that if the injured person is contacted early in the case, the "disability process" is often avoided and a prompt return to work is possible.
>
> This concept provided positive results regardless of what law was applicable or what type of policy was in effect that covered the injury and resulting disability. Most private rehabilitation specialists have accepted these concepts and have geared their approach to comply with these prompt contact programs. They do not wait for the end of the "healing period" to make contact as do some state rehabilitation programs. It behooves the private rehabilitation specialist to zero in on replacement and the preservation of the employee's job when possible. Because this model, and its flexibility, have shown positive results, it has also been adopted by many non-profit agencies, self-insurers, and in some state rehabilitation programs such as New York (Chapter V, p. 23).

The future seems to hold even more technological growth and expansion.

New rehabilitation research projects both in this country and abroad are developing methods for early and preventative rehabilitation for workers with disabling injuries and illnesses. Part of their impetus springs from an appreciation of the value of work to members of industrial societies. In the U.S., legislation has laid a foundation to build better linkage between industry and rehabilitation agencies based on the value of work to individuals.

> The latest Rehabilitation Act [Amendments of 1978, Sec. 202 (b) 5] refers to prevention as well as restoration, and practitioners are beginning to reconsider the timing of the rehabilitation effort.
>
> Our own efforts at the Regional Rehabilitation Research Institute of the Industrial Social Welfare Center of Columbia University School of Social Work have focused on making connections between service providers and work place representatives (labor leaders and corporate managers) and their institutional arrangements (trade union and employing organizations) in the interest of maintaining

physically and emotionally disabled persons at work. These efforts have been based on two main assumptions:

1. It is easier to maintain (accommodate) someone on a job than to find the person another job. It is easier to move someone to another job than to return the person to work with a new employer.

2. Work, as the outcome of the developmental process, is usually a conflict-free, ego enhancing activity which supplies economic and psychological support for an individual and connection to a life space which offers routine, purpose, companionship, and a sense of mastery.

We conclude, therefore, that work is a fundamental human activity and effort should be invested in helping a newly disabled person remain at his or her work place (Akabas, 1980, p. 51).

In Finland, a new project confronts problems of progressive illnesses and alternatives to disability retirement.

> Rehabilitation aims at the maximum integration and independence of persons with disabilities. Meaningful employment is one of the most valuable means of achieving this integration and one of the most significant indications that it has been achieved. A person who is excluded from the labor market usually has great difficulty in returning to work. To prevent such exclusion, rehabilitation can be initiated while the individual is still employed. We believe it is possible to achieve this goal, even though it requires a redefinition of the tasks of rehabilitation and reexamination of standards prevalent in the labor market (Jarvikoski and Lahelma, 1980, p. 2).

A research project in the United States is also looking at alternatives to disability retirement by testing a model...

> ....for reducing the incidence of unacceptable job performance resulting from emerging physical or mental impairments. Similarly, the model's goal is to enhance employees' abilities and to reduce through the early detection of emerging impairments the number of trained employees who retire or resign prematurely due to disability (Lawrence Johnson & Assoc., 1983).

Such projects are in part a reaction to recent trends in morbidity in industrialized societies. With improving medical technology and the consequent saving of lives, however impaired, an increasing number of totally or partially disabled people will help make up our society. This increase will be reflected not only in the number of people who depend on wage earners to support them through taxes (Bowe, 1978), but also in the number who should be kept in or returned to jobs.

A return-to-work philosophy seems to be an appropriate guide for attitudes and actions of employers, insurance carriers, and rehabilitation professionals who must respond to workers' disabilities. Both medical and vocational rehabilitation professionals have discovered that early returns to work can be therapeutic; hence, they strongly support return-to-work policies. Currently, the vanguard of vocational rehabilitation is developing services for early interventions and preventing disability. Next, these recommendations must be translated into modifications of the existing rehabilitation system. Then, these new efforts must be tested further to anticipate their potential impact on disability in today's work force.

D. RETURN-TO-WORK INCENTIVES AND DISINCENTIVES

While the trend of new developments in today's disability management system leads to earlier intervention and prevention by vocational rehabilitation professionals, the system itself carries both incentives and disincentives that impinge on efforts to increase returns-to-work.

4.0 Employee Attitudes and Misconceptions

Changes in the disability management system are necessary to build in greater return-to-work incentives and eliminate disincentives. For example, restructuring insurance payments could reduce the magnitude of this problem. From a rehabilitation counselor's point of view...

> ...it seems that the work disincentives introduced by insurance payments to the disabled have necessitated the rehabilitation counselor to re-evaluate which clients are capable of and motivated to work despite receipt of third party payments. Study of the problem posed by such payments, in terms of incongruence of rehabilitation goals and negative incentives to work, must continue to gain emphasis if disabled individuals are to become self-sufficient employed persons in the labor force. Further research into the psychovocational ramifications of fiscal third parties is sorely needed (Schlenoff, 1979, p. 58).

A significant disincentive to recovery for injured or ill workers can be the fear of losing benefits and health insurance. It is the primary obstacle for a substantial number of people with spinal cord injuries who want to return to work (Weidman and Freehafer, 1981). While numerous psychosocial factors can be

identified, it is the threat to one's esteem and prestige that may be more destructive to a person's ability to function than any physiological threat (Weihofen, 1976). Early intervention may be the best tool for averting these psychological threats, while advances in the cooperative relationship between employers, rehabilitation specialists, and insurance carriers will be fundamental to averting socioeconomic threats.

4.1 Employer Attitudes and Misconceptions

The people in these roles may have to overcome restrictive policies or attitudes which may even originate from misconceptions or ignorance (Galvin, 1983; Nathanson, 1977; Nathanson & Lambert, 1981). Some employers, for example are afraid that malingerers would take advantage of the programs or that disabled workers assigned to sheltered or transitional workshops would prefer that type of work to a standard job.

Job designers may strenuously resist making any accommodations once work techniques have been developed for economic efficiency even though the actual expense of any modification would be quite low. The way a job must be done may even be incorporated into labor agreements which would prohibit modifications. Seniority clauses may also prevent transfer agreements. Addressing individual employee needs may conflict with egalitarian, personnel policies. Serving the disabled employee could make irregular demands on the rehabilitation staff who resist unconventional practices. All of these issues result in real concerns. However,

the ones that stem from prejudicial attitudes and simple resistance to change should not rule the fate of an impaired worker who is able and willing to work.

4.2 Disability Dependence

Financial and psychological dependence comes suddenly to workers who become disabled. The duration of their dependency may be indefinite. A few may enjoy being out of work especially if they were not satisfied with their job. Over time, they may become accustomed to not working. Insurance plans, and government programs, while intended to compensate for losses and replace wages, end up supporting unemployment (Eaton, 1979; Schlenoff, 1979).

For example, when a worker is eligible for SSDI, his or her benefits may be jeopardized in whole or in part (regardless of 1981 modifications to encourage return-to-work) by demonstrating the capacity to engage in substantial gainful activity. For workers who are determined ineligible, a process which can take months or years in appeals, the prospects for return to work become very bleak as the worker slips through the gaps in the present disability management system. While this may affect only a few, still other disabled workers may encounter different reemployment disincentives.

Disabled workers may be uninformed or hold misconceptions about their rights and benefits under the wide variety of current

insurance and compensation policies. This may result in their reluctance to cooperate in rehabilitation even though no real threat to benefits exists. In other cases benefits are delayed by legal disputes and lawyers who discourage rehabilitation to preserve evidence of disability (Eaton, 1979). While many cases could benefit from a gradual return to activity, any attempt to arrange for a partial work load is discouraged by the hardships of reduced wage compensation or the confusion it may create on the worksite.

Another rehabilitation disincentive for disabled workers is the offer of early retirement, an option which is sometimes pushed by the disability management system. In cases where retirement is not really the worker's desire, pushing it may threaten the motivation needed to return to work.

4.3 Critical Factors in Returning to Work

If the disabled worker is not adversely affected by these systemic pitfalls, then the outcome may eventuate in reemployment at the same job or in otherwise suitable work. Nonetheless, their return-to-work depends on four basic factors: (1) the work-related limitations resulting from the disabling condition (2) whether suitable work is available (3) the worker's desire for reemployment and (4) whether appropriate supportive services are available to help the worker set and achieve his or her goals (Conley and Noble, 1979). All of these may simply depend on the effective combination of services like surgery and physical

therapy, psychological and vocational counseling, and perhaps training and placement services, which all hinge on trends in the job market.

4.4 Obstacles Remain While Attitudes Shift and Programs Emerge

Today's disability management system is marked by growing shifts in attitudes supporting earlier interventions and facilitating more returns to work. In addition, some actions are being taken toward these ends. Disability as defined in the first paragraph of this review, leads to the objective of returning disabled workers to socioeconomic independence, while attitudes and misconceptions toward the disabled population hinder the return-to-work of individual clients. Delays in providing vocational rehabilitation services decrease the probability of this outcome. Current rehabilitation practice acknowledges the need for early intervention and even preventative measures. This shifting attitude is being conveyed to insurers, employers, and disabled workers through the involvement of rehabilitation professionals in case management and technical assistance. It is further supported through worker's compensation and rehabilitation legislation, as well as the "bottom line" necessities of private rehabilitation agencies, insurance companies, and employers. Meanwhile, the disability determination and benefit eligibility guidelines of financial support systems both public and private, tend to support disability dependency. The "disability syndrome" can obstruct therapeutically valuable returns to activity. The adequacy of

services and attitudes of service providers may also preempt successful outcomes.

Indicating its growing sensitivity to the dangers and expense of delayed interventions, the disability management system now includes several basic return-to-work models, as well as operating programs, from which the best components can be drawn for empirical examination and possibly reformulated into a standard model for wider use.

E. PROGRAMS NOW PROMOTING RETURN-TO-WORK

Today, American employers' concern for the quality of work life has become an important management concept especially for public relations and recruitment. In the world market place, it may now be a necessity for remaining competitive (Naisbitt, 1982; Ouchi, 1981). These employers are also concerned, understandably, that shifting their attitudes and policies in this direction may obligate them to keep employees who are marginal producers. That could create a potentially substantial liability in their competitive world, which is always subject to fast changing economic trends (Shamir and Bargal, 1982).

5.0 Tradition of Occupational and Rehabilitation Medicine

Meanwhile, employers' concern for the quality of work-life supports efforts to promote health and safety and encourage professional growth at work, as well as to establish programs for retaining disabled workers. This may come in the form of...

> ...disability management and early intervention, rehabilitation of the industrially injured at the workplace, employee assistance programs, and collaborative programs between industry and government (Galvin, 1983).

Their concern is by no means new. Indeed one area where employers have sometimes been involved in rehabilitation is in their own medical services. Yet, even in the established programs, innovations are coming quickly and with important benefits. Carle (1982) explains that rehabilitation medicine, now separate from

occupational medicine, serves recovering injured or ill workers when they can begin their return to work. Today, a large employer can establish an industrial medical team to: (1) evaluate prospective employees for any company job (2) evaluate the job itself considering physical requirements and the environment (3) encourage fitness programs for employees and (4) evaluate the ability of injured workers to return to work by measuring the extent of impairment and recommending any necessary personal or worksite accommodations. Alternatively, these services may be provided by an independent occupational and rehabilitation medical team serving a number of employer patrons. This blend of prevention, treatment, and rehabilitation provides a holistic complement of services to meet the needs of employers and their employees.

5.1 Union Contracts and Services

In addition to employer efforts, some union programs now serve the special needs of their disabled members. Pati, et al. (1981) review the new trend in union bargaining agreements which provides protection for members who might otherwise be discharged following an occupational disability. The AFL-CIO in particular is changing the emphasis of its demands from mere compensation toward adding rehabilitation assurances. The New York City Central Labor Council, AFL-CIO (1970), incorporated this change into its bargaining platform which now calls for job pools of disabled applicants and selective placement priorities for the retention and reemployment of disabled members. District Council 37,

American Federation of State, County, and Municipal Employees, AFL-CIO, offers its members short-term financial support for non-occupational disabilities and has established a risk-management service to help the short-term disabled union member avoid long-term absences from work (Yasser, 1980). The ACTWU developed a union-based Affirmative Action model under a RSA grant outlining three main aims: "(1) maintaining their present members in the workforce following the onset of disability (2) returning to the workforce union members who've withdrawn due to disability and (3) promoting the new entry of handicapped persons into unionized jobs" (Enteen, et al., 1979). The main service components include case identification (reaching out to help the "silent disabled" declare their special needs) and liaison services between vocational rehabilitation agencies and employers.

The International Association of Machinists and Aerospace Workers (1984) sponsors a Projects With Industry that concentrates on returning disabled workers to work. These Disabled Worker Programs now operate at nine locations nationwide and have placed over 450 disabled workers in secure, well-paying jobs during their four year history. The IAMAW cultivates working relationships with other Projects With Industry and local rehabilitation professionals to place workers in the aerospace industry.

Union programs still need comprehensive evaluation, however, as Gordon Associates, Inc. (1979) notes, the Bureau of Labor Statistics shows that 1,607 major collective bargaining agreements (out of the 1,724 studied, which represent nearly eight million

workers) generally provided for some employee health and safety measures, 437 stipulated that a worker who meets job longevity criteria and becomes too impaired for his or her old job has transfer rights to a job suiting the new capacity where such jobs exist. Two-thirds of these agreements with transfer rights benefit disabled workers regardless of source of injury while the remaining one-third exclude all but job-related disabilities. One hundred eleven (111) of these agreements include provisions for disability leaves of absence (Gordon Associates, Inc., 1979). Beyond the prevalence of labor contract clauses which aid in return-to-work, Peterson (1982) concludes that rehabilitation professionals should take the responsibility to link together the efforts of labor and management with services of vocational rehabilitation in order to serve disabled workers most effectively.

5.2 Employers' Return-to-Work Programs

While the most visible employer concern for impaired individuals still comes in the form of compliance with government regulations concerning equal employment opportunities, affirmative action, and worksite accessibility, an apparently growing number of employers maintain their own rehabilitation office usually staffed by a coordinator. This is only possible for employers whose resources permit them to self-insure against worker compensation claims. Pati, et al., (1981) explain that these in-house rehabilitation offices come in a variety of forms offering different services. For example, Sears Roebuck and Company has a long history of

recognizing the value of trained workers and responding quickly to put disabled employees back to work. McDonnell Douglas Corporation provides a special program to educate and sensitize its supervisors so that attitudinal barriers do not stand in the way of disabled employees. The Tennessee Valley Authority has hired career assistance counselors to help in career replanning if disability disrupts an employee's ambitions. In addition, several major companies provide broader specialized services.

For example, E.I. duPont deNemours and Company (1982) has maintained an elaborate record keeping system to document the facts of disability costs to the company. They have found that insurance does not increase; that worksite accommodations are usually minor and inexpensive; that the safety record of disabled workers outflanks the whole workforce; that disabled workers do not require special privileges; and that integration problems are minimal (Wolfe, 1973; Sears, 1975).

The Aluminum Company of America is credited with having changed its attitude toward disability (Wardrop, 1984). Their old idea that disabled workers should not return to work until they can do the same job at the same productivity level has given way to the policy of bringing them back when they are able to do some job at some level as an aid in their recuperation toward regaining their predisability capacity. ALCOA expected to save more than 20% of their anticipated 1983 disability costs. In 1982, they had spent $12.7 million.

Galvin (1983) reviews an international selection of innovative programs in disability management and industry-based rehabilitation. All of these work toward retaining employees who become impaired or quickly returning those who must temporarily leave work due to disability. Most of them use a team of professionals, either established within the organization or from the community, who design and facilitate individualized rehabilitation programs for employees. He includes among these programs:

1. The city of Helsinki (Finland) which used an in-house team to identify cases in need of rehabilitation and help them with medical services, vocational counseling, and job accommodations to prevent absences or dismissal from the labor force

2. Burlington Industries (USA) which provides a specialized identification and rehabilitation service in an effort to "minimize the impact of functional limitations" for its employees who contract arthritis at the workplace

3. The Victorian Railway Company (Australia) which has established a rehabilitation office to work with disabled hirees and with injured employees

4. Volvo (Sweden) which has organized "adjustment groups" involving employees unions, government, and speciality professionals as needed to adjust jobs to handicapped persons which may mean the assignment of an "assistant at work," a person who helps blind, wheelchair bound, and mentally retarded employees

5. Herman Miller, Inc., (USA) which has developed a transitional work center to offer disabled employees a gradual transition back into jobs

6. Control Data Corporation (USA) which has a "policy guaranteeing absolute return to work to every disabled employee..." and which, after implementing this policy successfully, has established a subsidiary company to provide consultation to other businesses wanting to do likewise

Perhaps one of the best publicized employer operated rehabilitation programs is at Minnesota Mining and Manufacturing Company. Much of its philosophy and operation may set the standard for return-to-work programs.

Paul Ashton (1979), 3M's rehabilitation program supervisor, lists the basic services of his Rehabilitation Committee as: (1) accepting referrals (2) soliciting evidence of need for services (3) reviewing the employee's case to plan rehabilitation steps (4) reviewing the job to assess accommodation or transfer needs and (5) following up to monitor employee progress and address any special supervisory needs. The committee represents eight departments, all concerned with employee relations, benefits, and services.

Ashton describes one incident where 3M not only retained a veteran employee through in-house rehabilitation, but also netted a $100,000 savings in their potential workers' compensation liability. He also draws several conclusions from 3M's experience with in-house rehabilitation.

1. 3M's results, and public interest in them, indicate that internal rehabilitation programs are an idea whose time has come.

2. Internal programs probably can be implemented more successfully in firms with over 1,000 employees. Smaller firms are likely to find staffing and operating such a program to be uneconomical and inefficient.

3. Private rehabilitation services are a valuable supplementary resource for internal programs. This includes their supplying specialized support and also serving outlying company facilities.

4. A team approach is the best one to provide comprehensive rehabilitation services. This involves coordination of internal and external components of a single program.

5. Smaller companies can profitably use private suppliers for rehabilitation services--as they would a consulting engineer, legal counsel or other professional resource.

6. An internal program can be cost effective, as proven by 3M's experience over eight years. This conclusion is based on an analysis of 3M case histories and insurance expenditures (Ashton, 1979, p. 29).

However, this report falls short of providing anything beyond anecdotal evidence of 3M's success or lack of it.

The major shortcoming of employer-based programs, even as thorough as 3M's, is the availability of the disability management staff when an employee needs services. Since only large organizations can afford these in-house services, many of their workers may be in remote locations with respect to organizational headquarters where the rehabilitation staff is probably located. While this staff will surely do its best to meet the needs in distant workplaces, it will necessarily be limited. Considering that response time is so closely tied to the probability of return-to-work, the proximity of services to the client becomes an important issue.

5.3 Return-to-Work through Private Rehabilitation Programs

During the last decade with improvements in workers' compensation laws, private vocational rehabilitation programs have emerged to meet the need to restore workers to jobs and manage claims by

keeping down medical and recovery costs. The success of private rehabilitation in providing return-to-work services is probably under represented in the literature.

One company, International Rehabilitation Associates, has been written about extensively (O'Brien, 1983; Spitz, 1983; Welch, 1979; Wilson, 1983). This company uses a formula to identify which cases may eventually cost less if rehabilitation services are provided. Wilson (1983) explains that this company follows five guidelines: (1) does the exposure exceed $15,000 (2) has the disability lasted longer than forecasted (3) has the forecast been stated as "indefinite" (4) has the disability lasted longer than 90 days and (5) is the diagnosis or prognosis indefinite.

Wilson also reports on the use of a "tracking service." To provide this service, a rehabilitation specialist is assigned to a case and begins by visiting the injured or ill worker at home to assess the worker's recovery environment and attitudes toward disability and return-to-work. Specialists work to establish trust with the worker, the employer, the treating physician, and other service providers involved in the rehabilitation process. Out of this relationship, the worker's return to work can be accelerated through coordination of the necessary services and reemployment. Case managers working for the employer or insurer are encouraged to refer clients for these services as soon as possible. According to Spitz (1983), the sooner referral takes place, the more likely the worker will return to work.

Regardless of whether a program is in-house, external, union-based, or public, the effectiveness of each one needs careful review in order to guide the establishment of new programs. Even while this research is needed to refine policies and techniques, current theory and research have already established the appropriateness and desirability of providing more effective return-to-work services. At this time, a basic model can be constructed complete with suggestions for the delivery of services.

F. PROJECT RETAIN: A RESEARCH AND DEMONSTRATION PROGRAM

Our review of the literature reveals that early intervention strategies for return-to-work programs can reduce the cost of disabilities not only in economic terms, but also in terms of physical and psychosocial suffering. The major barrier to implementing these strategies as they develop consists of negative attitudes and misconceptions with regard to having impaired workers moving back into their old jobs or more suitable ones as soon as they can after making any necessary but reasonable accommodations.

Reducing fears and correcting misconceptions can be done. Pati, et al., (1981) review several strategies for improving such attitudes. They find that changing behavior will lead to attitude change and this can be done through education, increased interaction, and increased knowledge concerning the object of the attitude. Successful programs based on this principle have been developed for changing negative attitudes toward the handicapped. Authors include Leopold and Associates, Inc., the Pennsylvania Bureau of Vocational Rehabilitation, and the Texas Rehabilitation Commission.

Simply disseminating the results of research can start this educational process. The Menninger Foundation's Research and Training Center develops and disseminates a unified body of knowledge and programs which enhance the prevention or elimination of disability dependence of disabled workers who are still capable

of gainful employment. Currently, the center is developing Project Retain, a research and demonstration program for early intervention.

6.0 Program Design and Implementation

Project Retain is designed to reflect the best of current research and practice. It is a community-based model with the flexibility necessary to meet the needs of employers by drawing on whatever resources are locally available (Hester and Hood, 1984). It requires a trained vocational rehabilitation counselor to serve as the contact person who can start an injured or ill worker in the return-to-work process. At the same time, this counselor coordinates a team of rehabilitation professionals from the community that are needed to meet the challenges of any particular case.

The coordinator develops and maintains a collaborative relationship with employers and insurers to assure immediate notification when a serious illness or accident occurs so that the quickest possible contact with the worker can be made. This avoids any unnecessary obstacles to the worker's earliest possible return to the job. Such obstacles might include the "sick role" trap (Wright, 1980), employer resistance (Akabas, 1977), or unsubstantiated fear of losing benefits (Weidman and Freehafer, 1981). Once the worker starts through Project Retain, it is the coordinator's responsibility to ensure efficient case management while involving the client in decisions regarding each step in the

process. All the on-going planning and arrangements that are needed before the worker is securely back in the workforce are geared toward the client not only returning to work but also retaining the job to which they return, a problem discussed by Duncan (1983).

The Project Retain coordinator may offer or arrange for technical assistance to assess and recommend worksite, job, or scheduling modifications which support the return of disabled workers. Technical assistance could also deal with accommodations to help prevent disability (Akabas, et al., 1979; Lawrence Johnson and Associates, Inc., 1983).

Comprehensive rehabilitation services will be provided by a professional drawing on available resources from in-house or the community. As a result, team membership may vary from company to company and from case to case. This basic approach is now being recommended by researchers concerned with the rehabilitation of certain disability types, e.g., aphasiac stroke victims (Raderstorf, et al., 1984), head trauma victims (Long, et al., 1984), cancer patients (Goldberg and Habeck, 1982), and multiple sclerosis victims (LaRocca and Holland, 1982). Having a team coordinator will ensure case progress and prevent the inefficient use of other team members' time and expertise.

In the process of delivering Project Retain services, the coordinator will apply current vocational rehabilitation knowledge and techniques as well as have the opportunity to incorporate new

ideas. For example, McMahon and Bartley (1981) recommend the use of flexible work schedules to help a disabled worker gradually regain his or her productivity. They specifically suggest flextime, permanent part-time, and compressed work week schedules as options.

6.1 Program Outcome

Project Retain is being tested in the Chicago area in cooperation with Chicago City Colleges and Schwab Rehabilitation Hospital. A private rehabilitation counselor is working as services coordinator for several self-insured employers in the Chicago area.

This project is expected to further demonstrate the value of early intervention as well as where and how it might be effectively applied. This community-based strategy will be recommended for delivery not only through the structure just described, i.e., using a sponsoring agency and contracted counselor services, but also as an expansion of Projects With Industry, Employee Assistance Programs, and specialized private rehabilitation agencies.

6.2 Potential Delivery Vehicles

Projects With Industry are founded on the premise that government and business must work together toward shared goals and practical objectives that are intended to place or return disabled people in

the work force (Pati and Morrison, 1982). Over 100 have been established since their legislative birth in 1970. Up to now these programs have provided three basic services: (1) job placement (2) work adjustment and (3) skills training (Kaplan and Hammond, 1982). Beyond that, they serve a vital role in linking handicapped people with jobs, a role for which traditional government sponsored vocational rehabilitation has been ill-suited, lacking the partnership of employers (Phillips and Smith, 1982; Roessler and Rubin, 1979). Having this partnership, Projects With Industry become a logical vehicle for promoting efforts to retain recently injured or ill workers and return disabled workers to jobs (The Menninger Foundation, PWI Program, 1981). As research determines the rehabilitation methods and program designs that best serve return-to-work objectives, selected Projects With Industry should receive added funding to include these services.

Meanwhile, many employers have already installed Employee Assistance Programs. Increasingly, they are designed to respond to a wide variety of employee difficulties interfering with productivity. No Employee Assistance Program is now known to provide rehabilitation services other than to alcoholics, the problem for which Employee Assistance Programs were originally conceived. However, these programs operate with the understanding that each employee is part of a complex human system comprised of the workplace, the family, and the community (Scherr and Tainter, 1982). Incorporating return-to-work services can easily be viewed as a logical extension of the usual services provided by Employee

Assistance Programs. Such expansion may only work in companies with a sufficiently large number of employees and would either warrant additional staff trained in vocational rehabilitation or make it worthwhile to train existing staff in vocational counseling practice.

Regardless of who adopts the Project Retain model, whether it be Projects With Industry, private rehabilitation teams, employer or insurer sponsored programs like Employee Assistance Programs, or even public rehabilitation agencies, it can be expected to reduce the expense and disruption caused by worker disabilities.

G. REFERENCES

Aja, J.H., "The Family System in the Work Adjustment Process," in R.A. Lassiter, M.H. Lassiter, R.E. Hardy, J.W. Underwood, & J.G. Cull, eds., Vocational Evaluation, Work Adjustment, and Independent Living for Severely Disabled People, Springfield, IL: Charles C. Thomas Publisher, 1983, 217-230.

Akabas, S.H., "Preventative Rehabilitation at the Work Place: A View from the Regional Rehabilitation Research Institute," in A. Jarvikoski & E. Lahelma, Early Rehabilitation at the Work Place, New York: World Rehabilitation Fund, Inc., 1980, 51-53.

Akabas, S.H., Gottlieb, A., & Yasser, R., "Preventive Rehabilitation: Untapped Horizon for VR Agencies," American Rehabilitation, 1979, 5(2), 20-23.

Akabas, S.H., "Jobs through Technical Assistance," American Rehabilitation, 1977, (March-April), 29-32.

Andrews, H.B., "Holistic Approach to Rehabilitation," Journal of Rehabilitation, 1981, Apr.-June, 28-31.

Ashton, P.C., "Rehabilitation in a Major Corporate Setting," Journal of Rehabilitation, 1979, July-Sept., 26-29.

Atkinson, F.G., ed., "New Study Affirms Cost Effectiveness of Rehabilitation Services in Minnesota," Rehabilitation Forum, 1983, 10(3), 24-27.

Bardach, J.L., "Psychological Adjustment of Handicapped Individuals and Their Families," in White House Conference on Handicapped Individuals, Awareness Papers, Vol. I, Washington, D.C.: (the conference), May, 1977, 107-117.

Behan, R.C., & Hirschfeld, A.H., "Disability Without Disease or Accident," Archives of Environmental Health, 1966, 12, 655-659.

Berkowitz, M., "Disincentives and the Rehabilitation of Disabled Persons," in E.L. Pan, T.E. Backer, & C.L. Vash, eds., Annual Review of Rehabilitation, Vol.II, New York: Spring Publishing Co., 1981.

Black, B.J., Principles of Industrial Therapy for the Mentally Ill, New York: Grune & Stratton, 1970.

Bowe, F., Demography and Disability: A Chartbook for Rehabilitation, Fayetteville, AR: University of Arkansas, 1983.

Bowe, F., Handicapping America: Barriers to Disabled People, New York: Harper & Row, 1978.

Brantman, M., "What Happens to Insurance Rates When Handicapped People Come to Work?" Disabled USA, 1978, 1(8), 16-18.

Byrne, D.G., "Psychological Responses to Illness and Outcome after Survived Myocardial Infarction: A Long Term Follow-up," Journal of Psychosomatic Research, 1982, 26(2), 105-112.

Carle, T.C., "Industrial and Rehabilitation Medicine as they Impact the Injured Worker," in Rehabilitation Institute of Chicago, ed., Placement of the Injured Blue-Collar Worker, Chicago: (editor), 1982.

Cay, E.L., Philip, A.C., & Stuckey, N.A., "Ten Years in Cardiac Rehabilitation," Psychiatria Fennica, 1981 Supplement, 19-31.

Conley, R., & Noble, J., "Workers' Compensation Reform: Challenge for the 80's," in Research Report of the Interdepartmental Workers' Compensation Task Force, Vol. 1, Washington, D.C.: U.S. D.O.L., Employment Standards Administration, 1979.

Connolly, J.F., "Investment Valuation of Disabled Workers: Review and Model," Journal of Rehabilitation, 1982, July-Sept., 31-34.

Cousins, N., The Healing Heart: Antidote to Panic and Helplessness, New York: W.W. Norton & Co., 1983.

Davis, D.H., "One Way to Control Disability Expenses," National Underwriter-Property and Casualty Insurance, 1982, 86(Nov. 19), 58-59.

Duncan, K.A., "Job Retention: The Next Step in the Placement Process," Professional Supplement (NRA Job Placement periodical), 1983, Jan., 1-6.

E.I. duPont deNemours & Co., Equal to the Task, Wilmington, DE: (author), 1982.

Eaton, M.W., "Obstacles to the Vocational Rehabilitation of Individuals Receiving Workers' Compensation," Journal of Rehabilitation, 1979, 45(2), 59-63.

Ehrenreich, M., "New Insurance Tool in Claims Cases," National Underwriter-Property and Casualty Insurance, 1982, 86(July 9), 21+.

Enteen, R., Tramm, M., & Herman, R., "Unions and Affirmative Action for Handicapped Individuals," Rehabilitation Literature, 1979, 40(7), 196-200 & 206, and in A.D. Speigel & S. Podair, Rehabilitating People with Disabilities into the Mainstream of Society, Park Ridge, N.J.: Noyes Medical Publications, 1981, 294-303.

Federation of the Handicapped, New York, Project Outward Bound, Washington, D.C.: National Institute of Handicapped Research, 1980.

Franco, S.C., "Re-employment or Retirement," Archives of Environmental Health, 1965, 11, 835-840.

Galloway, M., "3M: An Overall Approach," Disabled USA, 1979, 2(4), 8-9.

Galvin, D., "Health Promotion, Disability Management, and Rehabilitation at the Work Place," The Interconnector (Newsletter of the Michigan State University Center for International Rehabilitation), 1983, 6(2), 1-6.

Goldberg, R.T., & Habeck, R., "Vocational Rehabilitation of Cancer Clients: Review & Implications for the Future," Rehabilitation Counseling Bulletin, 1982, 19, 18-28.

Gordon Associates, Inc., "Re-employment Programs for Disabled Workers," in Research Report of the Interdepartmental Workers' Compensation Taskforce, Vol. 5, Washington, D.C.: U.S. D.O.L., Employment Standards Administration, 1979.

Hanson-Mayer, T.P., "The Worker's Disability Syndrome," Journal of Rehabilitation, 1984, 50(3), 50-54.

Hester, E.J., and Decelles, P., The Disability Support and Rehabilitation System: A Dynamic Analysis of the Model, Topeka, KS: The Menninger Foundation Vocational Rehabilitation Research and Training Center, 1985.

Hester, E.J., and Hood, L.E., Project Retain, Topeka, KS: The Menninger Foundation Vocational Rehabilitation Research and Training Center, 1984.

Hodge, R., "The Whiplash Neurosis," Psychosomatics, 1971, 12, 245-249.

Hohmann, G.W., "The Insider-outsider Position and the Maintenance of Hope," Rehabilitation Psychology, 1975, 22(2), 136-141.

Hutchison, M.K., "A Look at Rehabilitation," in M. Berkowitz, ed., Supplemental Studies for the National Commission on State Workman's Compensation Laws, Vol. II, Washington, D.C.: (the commission), 1973, 397-402.

International Association of Machinists and Aerospace Workers, Rehab Report, 1984, 1(1), 1-4.

Jarvikoski, A., & Lahelma, E., Early Rehabilitation at the Work Place, New York: World Rehabilitation Fund, Inc., 1980.

Kaplan, I., & Hammond, N., "Projects With Industry: The Concept and the Realization," American Rehabilitation, 1982, Nov.-Dec., 3-7.

Kaplan, S.P., "Rehabilitation Counselor's Attitudes Toward Their Clients," Journal of Rehabilitation, 1982, Oct.-Dec., 28-30.

Kelvin, P., "Work as a Source of Identity: The Implications of Unemployment," British Journal of Guidance & Counseling, 1981, 9(1), 2-11.

Kiser, L., "Demand for Rehabilitation in Workman's Compensation," in M. Berkowitz, ed., Supplemental Studies for the National Commission on State Workman's Compensation Laws, Washington, D.C.: (the commission), 1973, 363-382.

Kiser, L.L., & Larson, L.W., "Rehabilitation in Workman's Compensation," in M. Rosenblum, ed., Compendium on Workman's Compensation, Washington, D.C.: National Commission on State Workman's Compensation Laws, 1973, 161-180.

LaRocca, N.G., & Holland, N.J., "Vocational Adjustment in Multiple Sclerosis," American Rehabilitation, 1982, 8(2), 9-13.

Larson, L., "The Role of Subsequent Injury Funds in Encouraging Employment of Handicapped Workers," in M. Berkowitz, ed., Supplemental Studies for the National Commission on State Workman's Compensation Laws, Washington, D.C.: (the commission), 1973, 403-419.

Lawrence Johnson & Associates, Inc., Alternatives to Disability Retirement: Training Program, Washington, D.C.: U.S. Government Printing Office, 1983.

Lewin, S.S., Ramseur, J.H., & Sink, J.M., "The Role of Private Rehabilitation: Founder, Catalyst, Competitor," Journal of Rehabilitation, 1979, July-Sept., 16-19.

Lewis, J.H., "A Workman's Restoration System," in M. Berkowitz, ed., Supplemental Studies for the National Commission on State Workman's Compensation Laws, Washington, D.C.: (the commission), 1973, 499-516.

Livneh, H., "On the Origins of Negative Attitudes Toward People with Disabilities," Rehabilitation Literature, 1982, 43(11-12), 338-347.

Long, C.J., Gouvier, W.D., & Cole, J.C., "A Model of Recovery for the Total Rehabilitation of Individuals with Head Trauma," Journal of Rehabilitation, 1984, Jan.-Mar., 39-45.

Magee, J.T., Fleming, T.J. & Geletka, J.R., "The New Wave in Rehabilitation: Projects With Industry," American Rehabilitation, 1982, 7(4), 21-24.

Makarushka, J.L., & Johnson, W.G., "The Rehabilitation of Injured Workers: Organization and Distribution of Services in Five Workers' Compensation Jurisdictions," in Research Report of the Interdepartmental Workers' Compensation Task Force, Vol. 5, Washington, D.C.: U.S. D.O.L., Employment Standards Administration, 1979, 10-34.

Matkin, R.E., "Rehabilitation Services Offered in the Private Sector: A Pilot Investigation," Journal of Rehabilitation, 1982, Oct.-Dec., 31-33.

McMahon, B.T., & Bartley, P.A., "Alternative Work Patterns and Rehabilitation," Rehabilitation Literature, 1981, 42(1-2), 14-17.

McNeil, J.M., Labor Force Status and Other Characteristics of Persons with A Work Disability, Washington, D.C.: U.S. Government Printing Office, 1982.

The Menninger Foundation, PWI Program, " Employee Rehabilitation: Extending PWI Services to Restore Injured & Ill Workers to Competitive Employment," unpublished, 1981.

Nagi, S.Z., "Early Rehabilitation and the Role of Industry," in A. Jarvikoski & E. Lahelma, Early Rehabilitation at the Work Place, New York: World Rehabilitation Fund, Inc., 1980, 59-69.

Naisbitt, J., Megatrends: Ten New Directions Transforming Our Lives, New York: Warner Books, 1982.

Nathanson, R.B., "The Disabled Employee: Separating Myth from Fact," Harvard Business Review, 1977, 55(3), 6-8.

Nathanson, R.B., & Lambert, J., "Integrating Disabled Employees into the Workplace," Personnel Journal, 1981, 60 (Feb.), 109-113.

National Safety Council, Accident Facts, 1983 ed., Chicago, IL: (author), 1983.

New York City Central Labor Council, AFL-CIO, Job Development Project--Final Report: Demonstration of a Union-Based Selective Placement Program for Disabled Workers, Washington, D.C.: D.H.E.W., Social Rehabilitation Service, 1970.

O'Brien, R., "Responsible Rehabilitation: Cost Containment," unpublished paper delivered for International Rehabilitation Associates at the Risk and Insurance Managers Society Conference, Los Angeles, CA, April 26, 1983.

Ouchi, W.G., Theory Z: How American Business Can Meet the Japanese Challenge, New York: Avon, 1981.

Pati, G.C., Adkins, J.I., Jr., & Morrison, G., Managing and Employing the Handicapped: The Untapped Potential, Lake Forest, IL: Brace-Park: The Human Resources Press, 1981.

Pati, G.C., & Morrison, G., "Enabling the Disabled," Harvard Business Review, 1982, 60(4), 152-168.

Peterson, R., "The Labor Union: Friend or Foe of Vocational Rehabilitation," in Rehabilitation Institute of Chicago, ed., Placement of the Injured Blue-Collar Worker, Chicago: (editor), 1982.

Phillips, E.L., "Some Psychological Characteristics Associated with Orthopedic Complaints," Current Practice in Orthopedic Surgery, 1984, Feb., 165-176.

Phillips, R.J., & Smith, R.D., "Improving Communications Between Counselors and Employers," Journal of Rehabilitation, 1982, Oct.-Dec., 54-56.

Raderstorf, M., Hein, D.M., & Jecsen, C.S., "A Young Stroke Patient with Severe Aphasia Returns to Work: A Team Approach," Journal of Rehabilitation, 1984, Jan.-Mar., 23-26.

Ray, M.P., "Factors Affecting the Recovery and Reemployment of Injured Workers in Washington State," (Grant application from Washington State University to U.S. Dept. of Agriculture, May 14, 1984).

Roessler, R.T., & Rubin, S.E., "Knowledge of the World of Work: A Necessity for Rehabilitation Counselors," Journal of Rehabilitation, 1979, Oct.-Dec., 55-58.

Ross, E.M., "Legislative Trends in Workers' Compensation Rehabilitation," Journal of Rehabilitation, 1979, July-Sept., 20-23, 70.

Russell, L.B., "Pricing Industrial Accidents," in M. Berkowitz, ed., Supplemental Studies for the National Commission on State Workman's Compensation Laws, Vol. III, Washington, D.C.: (the commission), 1973, 27-52.

Scherr, M.L., & Tainter, P.M., "Health Promotion in the Workplace: The Sheppard Experience," The Psychiatric Hospital, 1982, 13(3), 92-93.

Schlenoff, D., "Obstacles to the Vocational Rehabilitation of Individuals Receiving Worker's Compensation," Journal of Rehabilitation, 1979, 45(2), 59-63.

Schrock, J.L., Beecham, J.M., & Brown, B.V., Review of State Temporary Disability Insurance Programs, Rosslyn Station, VA: National Commission on Unemployment Compensation, May, 1980.

Sears, J.H., "The Able Disabled," Journal of Rehabilitation, 1975, 41(2), 19-22.

Shamir, B., & Bargal, D., "Occupational Welfare and Organizational Effectiveness: Some Theoretical Notes," Administration in Social Work, 1982, 6(4), 43-52.

Smith, R.S., "An Analysis of Work Injuries in Manufacturing Industries," in M. Berkowitz, ed., Supplemental Studies for the National Commission on State Workman's Compensation Laws, Vol. III, Washington, D.C.: (the commission), 1973, 10-26.

Spitz, L.K., "Winning at Cost Containment in Rehabilitation," Risk Management, 1983, July.

Stout Vocational Rehabilitation Institute, Private-Public Rehabilitation: A Better Understanding, Menomonie, WI: University of Wisconsin-Stout, Research and Training Center, 1983.

Sunshine, J., Disability, Washington, D.C.: OMB (Staff Technical Paper), 1979.

Sussman, M.B., & Hagan, F.C., "Worker's Compensation and Rehabilitation: Policy and Program Recommendations," in Research Report of the Interdepartmental Workers' Compensation Task Force, Vol. 5, Washington, D.C.: U.S. D.O.L., Employment Standards Administration, 1979.

Versluys, H.P., "Physical Rehabilitation and Family Dynamics," Rehabilitation Literature, 1980, 41(3-4), 58-65.

Walls, R.T., "Disincentives in Vocational Rehabilitation: Cash and In-Kind Benefits from Other Programs," Rehabilitation Counseling Bulletin, 1982, 26(1), 37-45.

Wardrop, R.G., "Curing Your Company's Health Care Headaches," Nation's Business, 1984, Jan., 50-51.

Weidman, C.D., & Freehafer, A.A., "Vocational Outcome in Patients with Spinal Cord Injury," Journal of Rehabilitation, 1981, Apr.-June., 63-65.

Weihofen, H., "Rehabilitation for the Injured Client," Journal of the Legal Professions, 1976, 1 (Spring).

Welch, G.T., "The Relationship of Rehabilitation with Industry," Journal of Rehabilitation, 1979, July-Sept., 24-25.

Wilson, J.M., "Compensation and Benefits," Personnel Journal, 1983, 62(12), 946-950.

Wolfe, J., "Disability is no Handicap for duPont," The Businessmen's Alliance Review, 1973, Winter.

Workman, E.L., "Vocational Rehabilitation in the Private, Profit-making Sector," in E.L. Pan, T.E. Backer, & C.L. Nash, eds., Annual Review of Rehabilitation, Vol. 3, New York: Springer Publishing Co., 1983, 292-320.

Wright, B.A., "Developing Constructive Views of Life with a Disability," Rehabilitation Literature, 1980, 41(11-12), 274-279.

Yasser, R., "A Trade Union Perspective," in A. Jarvikoski & E. Lahelma, Early Rehabilitation at the Work Place, New York: World Rehabilitation Fund, Inc., 1980, 54-55.

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The Menninger Foundation

Preventing Disability Dependence

Vocational Rehabilitation
Research and Training Center

New Directions in Disability Management: A National Perspective

Research Utilization Conference Proceedings
September 18, 1984

Topeka, Kansas
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Columbia University

Robert Dole
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Gabriel R. Faimon
The Menninger Foundation
Conference Director

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EXECUTIVE SUMMARY

Our economy reveres the value of productive work. Our society ironically espouses assumptions that disabled persons can not or should not work. These assumptions are evident when workers who become disabled but could work often are kept in hospitals, shunted into nursing homes, or suppressed at home through many programs and services that essentially manage persons with a disability rather than help manage the disability. Consequently, the assumptions help make disabled people dependent.

The Menninger Foundation Rehabilitation Research and Training Center on Preventing Disability Dependence held a research utilization conference, "New Directions in Disability Management: A National Perspective." The purpose of the conference was to report and discuss possible new directions in disability management and new potential for employment and independence of workers who become disabled.

New directions arising out of the conference included: develop employment-oriented incentives; establish rational, systematic linkages between concepts, policies, and programs dealing with work and disability; reinforce the work ethic in workers who become disabled; expand rehabilitation-industry-labor early intervention partnerships; unify family, peer worker, and community support for efforts to return to work; increase dissemination of successful return to work strategies and practices; and recognize compatability between partial disability and partial work.

Conference presentations focused on the need for, strategies of, and pathways to disability management. A wide variety of public and private sector perspectives was shared, characterized by a consensus statement: "Disability Management is truly a conceptual enigma. To start with, defining who is disabled can lead policy makers into battle."

In addition to citing monetary and demographic data, discussion of financial and human needs for new directions in disability management addressed concern that persons with disabilities participate fully in society, including attainment of their rights as consumers in the nation's market place. Expression of human need was characterized by discussion regarding the therapeutic aspects of returning to work to counter the psychological cost to the worker who becomes disabled and that worker's immediate family, including loss of self-image, anxiety and frustration of forced unemployment, and resultant conflict with established work ethic. Expression of financial need was characterized not only by comments regarding the growing cost of disability compensation but also by comments regarding cognizance and accountability for such cost, anticipated changes in the socioeconomy, costs of advancing technology, and opportunity loss associated with not applying advanced technology to enhance disability management.

Discussion of the genesis of programs and services for the worker who becomes disabled raised a question whether a systematic approach to disability management currently does exist. Comments on this issue were

characterized by statements alluding to the lack of rationality and linkage between eligibility criteria, the absence of a thrust to prevent dependency, and recognition that the issue is a multifacited problem. Questions were raised regarding the efficacy of disability definitions contained in a medical model based upon functional limitation and whether providers such as physicians, rehabilitation counselors, and social workers were sufficiently aware of specific job demands to accurately establish whether a worker could or could not return to work.

In the context of the worker who becomes disabled, discussion brought forth a wide range of perspectives regarding rationalization of public policy. Issues such as inadequacy of and conflicts within an alleged "system"; whether it was promoting dependence, compensation, or rehabilitation; and whether public policy should be revised or developed from a new philosophical base were raised. A conceptual model to organize the causes, options, processes, and programs affecting a worker who becomes disabled was presented. From the conceptual model, an analytical model was outlined to provide a map of current and projected flows of workers who become disabled to analyze the effect of proposed prevention and intervention strategies and assist in analysis of alternative policies. In the context of these two models, conferees noted that current efforts of analysis focus on the cumulative costs at the tail-end of the process rather than examine the issue on a systematic basis to determine what can and should be done to decrease the "flow" of persons into a state of dependency. The ramifications of such an approach were explored, including the need for demonstrating new concepts and approaches, securing valid research data, and disseminating proven results through a training strategy which enacted change.

The conference did achieve its purpose to report and discuss indications for new directions in disability management. However, the indications also raised questions for future investigation. New directions are expected from answers to: what are specific causes of disability dependence and the relationship between them; how could employers and organized labor jointly assume a more active role in returning the worker who becomes disabled to work; how should educational programs for training new providers be modified; how should the concept of partial work and partial disability be rationalized in society and in the workplace; should wellness and employee assistance activities integrate into this effort; and how should policy change be approached to develop community support for return to work with economic and human benefits which are more attractive than compensation benefits? Throughout the conference, these questions and the comments which prompted them indicated that revision of strategies and development of new strategies for a rational system of disability management is starting to emerge.

G.F.

CONFERENCE OVERVIEW

Gabriel R. Faimon, M.P.A.

This is the first research utilization conference sponsored by The Menninger Foundation Research and Training Center on Preventing Disability Dependence. The Research and Training Center is funded in part by a grant from the National Institute of Handicapped Research of the U.S. Department of Education. The Center's goal is to develop and disseminate a unified body of knowledge and programs which enhance the prevention or elimination of disablity dependence of disabled workers who are still capable of gainful employment. Adults who have participated in the labor market and become disabled by traumatic injury or severe illness constitute the target population of the Research and Training Center.

Business and industry participates in this national project by cooperating to identify and/or develop prevention or intervention models to retain or promote successful return of the experienced injured or ill employee. The Research and Training Center also assists employers by providing training to implement return to work or worksite modification strategies and programs.

These efforts reduce disability dependence through continued gainful employment of experienced disabled workers, help employers contain costs for workers compensation and long-term disability programs, and reduce the tendency for disabled individuals to be dependent upon Social Security and other transfer payment programs.

Recognizing that research is of little benefit if its findings are not disseminated and utilized, the purpose of this conference is to report and discuss indications for new directions in disability management and new potential for employment and independence of workers who become disabled.

This conference, "New Directions in Disability Management: A National Perspective," includes objectives to:

1. Relate national public and private sector financial and human needs for new directions in disability management

2. Discuss how existing disability management approaches are historical and legislative accretions leading to sometimes disparate and conflicting results

3. Describe a conceptual model to unify and harmonize private and public sector efforts toward disability management

4. Describe a systems model of research to address the determination, entry and flows of disabled workers through existing programs and assess the impact of disability dependence

5. Discuss the private insurance perspective of disability management issues for preventing disability dependence

6. Discuss public sector perspectives of disability management issues for preventing disability dependence

7. Discuss existing concepts and practices of early intervention to encourage disabled workers to return to work

8. Discuss practical training approaches for implementing programs to prevent disability dependence

9. Develop a summary of conclusions, ideas, and issues presented in the conference

In the order of their presentations, the faculty assembled for this conference includes:

Gabriel R. Faimon, M.P.A., Director, Research and Training Center, The Menninger Foundation

Virginia Knauer, Special Adviser to the President for Consumer Affairs

The Honorable Robert Dole, United States Senator

William Gellman, Ph.D., Director, Council of Rehabilitation Affiliates

Edward J. Hester, Ph.D., Director of Research, Research and Training Center, The Menninger Foundation

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Benjamin F. Jones, Chairman of the Board, Monarch Capital Corporation

James Jeffers, Associate Commissioner, Governmental Affairs, Social Security Administration

Robert Granzeier, Former Director, Department of Rehabilitation Services, State of Illinois

John T. Steward, Ph.D., Dean of Economic Development, Skills Career Program, City Colleges of Chicago

John D. Downs, M.A., Director of Training, Research and Training Center, The Menninger Foundation

Sheila H. Akabas, Ph.D., Director, Industrial Social Welfare Center, Columbia University

WELCOMING COMMENTS

Virginia Knauer

The theme of this meeting, New directions in Disability Management: A National Perspective, is of special significance to most of us because it affects the quality of life of more than 50 million disabled and elderly Americans as well as, indirectly, millions of family members and friends.

In addition, the public and private monetary costs of disability, reported to be in excess of $200 billion annually, have a serious impact upon the economic vitality and well-being of our nation. Although these costs frequently represent progress in medical science or may be unavoidable, it is crucial that we are expending our resources efficiently and effectively.

I am pleased that you will be addressing these issues from a total perspective, taking into account both preventive as well as corrective measures. I believe that the overriding goal of this Administration--a widening of choice and a return to self-reliance--was aptly expressed by President Reagan himself in his proclamation last year of National Employ the Handicapped Week:

> All across this Nation, disabled people are striving to obtain more control over their lives through choices that minimize their reliance and dependence on others. They are taking charge of their own lives and becoming responsible for their own affairs. They are participating in the day-to-day life of the community and fulfilling the whole range of social roles possible in our society.

As the President's Special Adviser on Consumer Affairs, I am particularly concerned that full participation in our society by disabled people includes the attainment of their full rights as consumers and their emergence in our nation's marketplace as a viable and profitable market.

"Consumerism" naturally encompasses disabled consumers because they have special needs and unique requirements for products and services. For the disabled, accessibility to the marketplace, to work, to recreational opportunities, to education, and to the voting booth are major concerns that often require "tailor-made" solutions.

Management of disability, in general, requires a comprehensive strategy because of the complexity and range of considerations that must be addressed. From a single perspective, the task of performing essential activities of daily living, such as getting to and from work, are important considerations in promoting "independence" and preventing "dependence."

Hearing aids, wheelchairs, crutches, prostheses of all kinds, specially equipped automobiles, adaptive telephones, and countless other health and therapeutic devices are important consumer products, and often vital, daily necessities of disabled consumers.

Products falling into these categories and the services that must frequently accompany many of them are often expensive because of research and development costs and demanding custom-made requirements. To insure "reasonable and fair" prices, marketplace competition is obviously a necessary ingredient. In an effort to stimulate this development, my office has been working with Sears, AT&T, and many other companies to "press for quality products at fair prices."

Consumerism's involvement in the private sector can uniquely qualify as a catalyst for advancing the disabled consumer's needs in the marketplace and for encouraging the creation of constructive mutually beneficial profitable partnerships between the disabled community and business. The outcome of this natural relationship could very well lead to increased job opportunities, as well as foster other tangible, positive benefits. Ultimately these partnerships may promote independence as well as economic self-sufficiency for the disabled.

Let me take a few moments to describe some of the activities of my office, the U.S. Office of Consumer Affairs, in relation to the disabled community. With the Electronic Industries Association and Foundation, the National Rehabilitation Association, Sears, AT&T, the American Association of Retired Persons, and other profit-making and nonprofit groups, we have helped to make consumer goods and services more conveniently available to disabled people and to increase competition in their quality and price.

In addition, USOCA also works cooperatively with many federal and state agencies, including the Departments of Education, Labor, Health and Human Services, the Veterans Administration, and several state vocational rehabilitation agencies, as well as such varied groups as the National Rehabilitation Association, IBM, Bell & Howell, American Express, the International Association of Machinists and Aerospace Workers, and Goodwill Industries of America, to assist disabled people to achieve independence through rehabilitation, training, and employment.

I believe the federal government has a unique responsibility to demonstrate that it stands ready to help individuals with disabilities achieve their fullest potential, and stands ready to help those who want to serve the needs of the handicapped better. My office understands that obligation and we have participated in a number of governmental activities designed to promote self-sufficiency and access to the marketplace for disabled consumers.

The Office of Consumer Affairs has published and distributed over 100,000 copies of the Federal Directory of TDD Numbers for use by speech and hearing impaired consumers who have access to telecommunications devices for the deaf. The directory is also referenced in USOCA's publication, Consumer's Resource Handbook.

Consumer's Resource Handbook targets a broad range of information for the disabled consumer. It also provides a directory of public and private sources that may be contacted for additional information and services. Because of its particular usefulness for handicapped consumers, the recent annual meeting of the President's Committee on

Employment of the Handicapped, attended by over 5,000 disabled consumers and others, featured Consumer's Resource Handbook among its select exhibits.

Since 1982, the Office of Consumer Affairs has sponsored National Consumers Week in an effort to promote consumer awareness. Among the activities for disabled consumers featured during the 1984 National Consumer Week, was an AMTRAK display of specially equipped sleeping car accommodations for wheelchair passengers at Union Station in Chicago. The Rehabilitation Institute of Chicago also arranged an event showing disabled consumers taking part in therapeutic exercises and activities designed to promote physical self-sufficiency and independent living. The Department of Health and Human Services, as well as the Veterans Administration, similarly highlighted activities and services available to enhance the quality of life for disabled consumers.

My office helped coordinate the planning and development of Administration activities during the National and International Years of the Disabled. We are currently performing a similar role for the Decade of the Disabled in an effort to expand ongoing consumer activities and develop new initiatives.

As chairperson of the Consumer Affairs Council, a Presidentially-mandated organization of top level consumer affairs officials of more than 40 federal departments and agencies, I arranged for one of the council's 1984 quarterly meetings held at the White House to focus on the disabled consumer.

We provide support, encouragement, and leadership on the Projects With Industry Partnership initiative, a federally sponsored program managed mainly by the Department of Education in association principally with state vocational rehabilitation agencies. This program embraces a national network of more than 100 funded projects involving more than 10,000 partners representing national corporations and small businesses as well as leading trade associations, labor unions, colleges and universities and rehabilitation facility systems. Importantly, since the start of this most successful public and private partnership initiative, placement of disabled persons will approach the 100,000 mark with annual earnings estimated to be reaching the billion dollar level.

The computer age offers many disabled consumers hope for independence, but it is also cloaked in mystery because of the perceived degree of difficulty associated with computerization. In an effort to remove the cloak of mystery, we are helping AT&T publicize its brochure, Products from the AT&T Special Needs Center. This publication lists and describes available products designed to assist persons with hearing, speech, vision, or motor impairments.

With the Electronic Industries Foundation (EIF), we are working to meet the consumer needs of the disabled by adapting modern electonic advances to increase access to the marketplace, by promoting education and training, and by developing technology to enhance quality of life factors--such as hearing aid improvements, electronic wheelchairs, and a multitude of electronic advances. Additionally, with our support for their Projects With Industry partnership initiative, nearly 3,000 disabled individuals have obtained jobs ranging in salary from $7,000 to

$42,500, in the electronics and allied industries. Now, EIF has recently expanded this successful, nationwide project to include the insurance industry, in cooperation with Guarantee Mutual Life, Mutual of Omaha, and about a dozen other major Nebraska firms.

The National Restaurant Association is cooperating with us to advance consumer needs of the disabled in the restaurant industry. The association is working, not only to increase accessibility, but also to promote increased employment of disabled individuals in the restaurant and allied industries.

Finally, we are helping the International Association of Machinists and Aerospace Workers create and expand job opportunities for the handicapped in the aerospace industry. The results across the nation are certainly impressive. The average salary of new disabled workers at Lockheed, Boeing, Beach and other aerospace industries is $15,000 a year, in a range extending upwards to $40,000. These are permanent career-oriented jobs that are important to the disabled and the productive capacity of the nation.

All of these activities are targeted at increasing the income of disabled people through employment and giving them choices as consumers and better opportunities in the marketplace.

The discretionary income of handicapped consumers can be meaningful only if they are allowed access to the marketplace--shopping malls, office buildings, public facilities and transportation, and places of entertainment--as well as access to the media upon which we all rely for information and entertainment.

"Access" is not solely a matter of physical accommodations for wheelchair people. Access also means elimination of barriers raised by negative public attitudes toward handicapped members of our society.

Because of its enormous impact on popular attitudes, the media has the capacity to become a powerful force in overcoming negative stereotypes of disabled citizens. The print, broadcast, and entertainment media can demonstrate to millions of Americans that disabilities in one area don't limit capacities and competence in others. The media can help reverse prejudicial and ignorant attitudes toward handicapped people by dramatizing the injustice and oppressive impact of unfair stereotypes and by portraying the abilities of those with handicaps.

The yardstick we must use to measure the progress we have made toward opening the doors of opportunity for the disabled is this: Within the limits of individual abilities, does a handicapped person have the same opportunities to live, learn, work, and play? To maximize these possibilities, the marketplace must be responsive to the needs of the handicapped. These are consumer-related issues, whether we are speaking of consumers of government services and benefits--such as public transportation or education--or commercial products and services.

Let me cite a few examples of recent progress in promoting accessibility. Most states have enacted laws establishing special parking privileges for disabled individuals. Typically these are parking spots located nearest the entrance of business establishments.

In order to park in these locations, an individual must display a symbol of identification that he or she is handicapped. Unfortunately, the states have not adopted uniform symbols of identification. This has led to inadvertent ticketing of handicapped individuals who have traveled to jurisdictions with different symbols of identification.

A congressional resolution expressing the sense of Congress that states should be encouraged to adopt the Uniform Symbol of Access as their symbol of identification was enacted last year. It also expressed the sense of Congress that license plates, placards, and signs would all be recognized to allow handicapped drivers maximum flexibility and protection in identifying their vehicles as handicapped vehicles. This small measure should help facilitate travel for handicapped people, as well as prevent unfortunate hassles.

It is tragic, but some disabled Americans are denied one of their most basic constitutional rights--the right to vote--simply because of a few small steps, small print ballots, or some other type of accessibility barrier to the polling place. Because polling places need not be accessible under current law, we have, in effect, conditioned the right to vote upon a physically mobile body. Unfortunately, absentee ballots do not offer the same degree of effective participation in the electoral process because they often must be requested far in advance of an election and, in some states, are only obtainable with a doctor's certification.

Legislation entitled Equal Access to Voting Rights would require that polling places be made temporarily accessible for all federal elections beginning in 1985. This bill has passed both the Senate and the House and is expected to become law this fall. Senator Dole should be commended for his leadership role in securing Senate passage of this important legislation.

My office intends to explore the possibility of working with the FEC and states that already have accessibility laws to inform handicapped citizens of the new legislation and to advise state and local governments about options for accessibility.

Lastly, I remind you of tax deductions for removal of architectural barriers, a legislative initiative originally developed and introduced by our keynote speaker, Senator Dole. Prior to 1983 businesses were allowed a maximum deduction of $25,000 for removal of architectural barriers to their business premises. This provision expired in 1982, but thanks to Senator Dole has been reinstated for two years. The new provision permits a deduction of up to $35,000 for removal of architectural barriers.

Unfortunately, the availability of this deduction is not known by many businesses, even today. My office is currenty looking at plans for a conference on ways business can better respond to handicapped consumers which would include information about the architectural barrier removal deduction, as well as handicapped parking symbols and handicapped voting rights, in addition to other consumer issues.

The long and short of it is that American consumers, whether handicapped or not, want the same marketplace opportunities: convenient access to

products and services, the rights and benefits of the public sector, and a fair shake from sellers and providers.

The more handicapped people talk to business people, the faster the free enterprise system can resolve the special problems of America's handicapped consumers. Each will gain--business from developing new markets and profits, and the handicapped consumer from better products and services, at fair, competitive prices.

Importantly, it is well to acknowledge the broad implications of "disability" on the American scene. Economic, social, and political considerations must be addressed from a total perspective in a climate offering opportunity for disabled people to achieve goals commensurate with our democratic ideals, values, and principles.

Clearly, President Reagan has a vision of the American dream which includes all Americans, regardless of race, ethnic background, gender, age, or handicap. And to help realize that dream, consumerism with its broad mandate can help foster opportunity and progress for the disabled consumer.

DISABILITY MANAGEMENT: NEED

The Honorable Robert Dole

The years 1983 through 1992 have been proclaimed as "The Decade of the Disabled." It is not the decade of the handicapped. This distinction is important, for a disabled person is only handicapped so long as he or she is prevented from achieving a goal, earning a living, realizing a dream. Throughout my life, I have known persons who might have been physically disabled but who attained great accomplishments of the mind and of the spirit. I have known in my own life the call to self-discovery that comes with a physical disability, and I learned many years ago that sympathy is no substitute for a chance to develop one's skills.

There are thirty-five million other Americans who have learned--or will learn--that same lesson: they represent a vast and largely untapped human resource. They ask for nothing but a chance to share their talents. And, because disabled people are as varied in ability, temperament, and personality as able-bodied people, many will succeed. Others will not. Disabled persons, however, should not be set up for failure by means of a system which creates artificial barriers (architectural, economic, or psychological) nor should they be sheltered from "the right to fail."

I am proud that Kansas plays host to a vocational research and training center focusing on the improvement of rehabilitation services for the severely disabled, particularly those who are likely to become SSDI recipients.

Disability poses problems for millions of adults, most of whom are not working. Government and private industry spent an estimated $70 billion on disability transfer payments in 1981, plus an additional $114 billion for health care costs to persons with disabilities in the same year.

A close look at the mosaic of programs impacting on disabled Americans, however, brings one to the conclusion that most have been established independently; do not relate in a holistic fashion; and, in many cases, are contingent upon dependence through unemployment.

At the federal level, fiscal year 1983 expenditures for service programs which enhanced the independence of disabled persons totaled $3.3 billion while income maintenance expenditures totaled $36.5 billion.

The Menninger Research and Training Center is concentrating its efforts on those adults who have been participating in the labor market and have become disabled by traumatic injury or severe illness, and the approaches to disability management that ensue through major programs such as workers compensation, private sector long-term disability insurance, and SSDI. In looking at the needs of persons with disabilities, I recently reviewed an article containing data collected by the National Center for Health Statistics. I would like to share this information with you.

In 1979 over 31 million persons or 14.6 percent of the civilian noninstitutionalized population reported some degree of chronic activity limitation. Seventeen percent of this group were classified as having work disabilities. The percentage of persons reporting activity limitations rose sharply with age; severe limitations rose even more sharply with age.

Furthermore, a review of the Social Security Administration, 1978 survey of disability and work indicates that: among the 22 million persons within the civilian noninstitutionalized population (age 18-64), estimated to have work disabilities in 1978, 12 million were not in the labor force at that time. Overall, these individuals had a 44 percent labor force participation rate as compared to the 83 percent participation rate for persons without disabilities. Nearly sixteen million adults (12.4 percent of the working-age population in the United States) reported that because of health-related impairments, they were either unable to work or unable to work at the job held at the time of onset of their disability. The vast majority of disabled persons not in the work force had held employment at some earlier time. In fact, two-thirds of this group had been employed at the onset of disability.

Disability management is truly a conceptual enigma. To start with, defining who is disabled can lead policy makers into battle. At the federal level, dozens of programs provide income maintenance or services to persons with disabilities, each subscribing to its own eligibility rules. The Social Security Administration, in determining participation in either the SSDI program or the SSI program, uses the following definition:

> An individual must have a medically determinable physical or mental impairment which, when modified by demographic factors, renders him or her unable to engage in any "substantial gainful activity" (SGA), work in the national economy, regardless of whether a specific job vacancy exists or whether one would be hired if one applied for work.

Then, of course, there are the various definitions used to determine eligibility by programs under the Veterans Administration, Railroad Retirement Disability and Survivor Benefits, Civil Service Retirement, Black Lung Benefits, Vocational Rehabilitation, and other public and private pension plans.

Most definitions are based on a medical model which addresses functional limitation. This in itself mitigates against the universality of any disability definition. While medical advances have moved forward at record pace, our physicians are not soothsayers and cannot always accurately predict individual physical capacity. The contributing factors to client success are numerous and varied. Early intervention, mental attitude, the involvement of family and friends, economic status, the availablility of new technologies, to name but a few, can turn our best textbook predictions into a shell game.

An offshoot of the problem of definition is the recognition that while some populations are covered by more than one program, others fall

through the cracks. Of the 15.8 million persons reporting a work disability in 1981, only 2.8 million received SSDI and 2.3 million received SSI. The temporary nature, less than 12 months, of a disability or the assessment of the medical condition as being only partially disabling causes many to be deemed ineligible for income maintenance payments. Furthermore, because of financial constraints and program fragmentation, the continuum of services needed to surmount the barriers confronted by a disabled person is frequently unavailable or unobtainable in a timely fashion.

All groups involved in the disability system are aware of the need for change. Legislators, policy makers, care providers, and consumers alike continue to collect and analyze what may seem to be a confusing array of information on persons with disabilities. I think that a true measure of our progress to date is our appreciation of the enormous and complex task yet ahead.

Recognition of the total needs of persons with disabilities has been increasing. Clearly we need a system which is flexible enough to meet all of these different needs and one which enables disabled Americans to fully participate in all facets of our society, including gainful employment. There are, however, basic conflicts in our values which mitigate against an easy remedy.

We are a people who revere the value of productive work: "Work hard and you will receive your just due." Notwithstanding this value, we also have a belief that the less fortunate should not be forced to live below a minimumly adequate standard of living. But should we let an individual who is gainfully employed, disabled though he might be, continue to receive benefits not available to his able-bodied counterparts? And, if we do, which benefits--income maintenance, services, health care--how much, and for how long?

Due to improved medical care, impairment and disability will continue and possibly increase. Infants who would have previously died at birth or during their childhood years will live on to adulthood. Moreover, over twenty million older Americans are confronted with severe illness and disabling conditions which frequently accompany the aging process. The number of persons over age 65 is expected to increase 40 percent by the year 2000 and another 60 percent by 2025. The population of those 85 and older is projected to grow even faster, with a startling 91 percent increase by the year 2000. As you well know, the implications of this growth in this population are enormous for the system as a whole and for disability programs in particular.

In my position as chairman of the Senate Finance Committee, I am constantly reminded that the problems of disabled persons are quite real. My office is innundated daily with correspondence from those who question the viability of existing programs. Efforts to provide for the fiscal needs of the disabled have been increasingly successful over the past 27 years with the adoption of the disability insurance and supplemental security income programs.

A major obstacle, however, of rehabilitation is the problem of disincentives. Prior to the enactment of the 1980 amendments, a

disabled SSI recipient generally ceased to be eligible for SSI when his or her earnings exceeded $300 monthly, the level which demonstrates substantial gainful employment (SGA). Under section 1619 of the Social Security Act, enacted in the Disability Amendments of 1980, disabled recipients who work and earn more than SGA may receive a special SSI payment and maintain medicaid coverage and social services.

I am pleased to report that last week House and Senate Committee staff were able to work out a draft agreement on the Social Security Disability Amendments of 1984. I expect early approval of the amendments by conferees and Congress. Passage of the '84 amendments, which will affect the lives of hundreds of thousands of disabled people, will end two years of conflict over disability reviews conducted by Social Security Administration. Since the reviews began in 1981, nearly half a million people have received initial termination notices. More than 40,000 appeals have reached the courts.

The amendments offer much needed reform of the Social Security Disability review process and include a series of provisions designed to improve the accuracy of disability determination, the uniformity of decisions between different levels of appeal, and the consistency of such decisions with federal law and standards. The key element of the compromise dealing with the issue of medical improvement is agreement that once a person has been found so severely disabled that he is unable to perform any job in the economy, Social Security in most cases may not remove him from the rolls unless it can show that there is medical improvement in his condition. A procedure has been established by which the individual must supply evidence on his medical condition and the Social Security Administration must then make a determination based on that and the law. Reviews started since 1981, now in the administrative pipeline or before the courts, will be remanded for reconsideration if they involve medical improvement.

The amendments also reauthorize section 1619 through June 30, 1987. In addition, the secretaries of HHS and Education will be required to establish training programs on section 1619 for staff personnel in SSA district offices and state VR agencies, and disseminate information to SSI applicants, recipients, and potentially interested public and private organizations.

The Social Security Act provides for the appointment of a 13 member Quadrennial Advisory Council on Social Security. The council is responsible for studying all aspects of the Social Security and Medicare programs. The 1984 amendments direct the next Quadrennial Advisory Council to study and make recommendations on various medical and vocational aspects of disability, including alternative approaches to work evaluation for SSI recipients, the effectiveness of vocational rehabilitation programs for SSI recipients, and the question of using medical specialists for completing medical and vocational forms used by state agencies. The council will be authorized to convene task forces of experts to deal with specialized areas.

It would be unfair to you assembled here today not to suggest that the continued escalation of the cost of health care needs to be examined in further depth. We need a solution which supports the poor, the elderly,

and the disabled, and simultaneously maintains the highest quality of care in the world.

In 1982, health expenditures in the United States totaled $332.4 billion, or 10.5 percent of gross national product, the highest such share in history. The increase in medical costs was 12.5 percent, about twice the general rate of inflation.

Government spending--federal, state, and local--totaled 42 cents out of every dollar of national spending for health. Three-quarters of that came from the federal government for medicare and medicaid.

Persons with chronic activity limitations, while representing 15 percent of the population, accounted for 58 percent of the hospital days recorded by the civilian noninstitutionalized population in 1979. Physician visits by the group are more than twice the average of the noninstitutionalized population.

I hardly need to remind anyone in this room that we live in a time of fiscal austerity. The federal budget is under seige to some hard economic realities. The federal government itself is trying to restore the historic concept of Federalism before the foundation of American self-rule is smothered beneath Washington's deficits, Washington's rules, Washington's regulations, and Washington's smug conviction that it knows best.

The demands on our dollars have never been greater. But that does not mean any diminution in the needs of the disabled. What is just in a time of heavy spending remains equally just in a time of belt-tightening. Fortunately, I can report that programs for the disabled have, by and large, escaped the budgetary axe. The Reagan administration is clearly sensitive to the needs of disabled Americans. I see no desire--and no possibility--for a retreat of the commitment of recent years.

What I do see is a greater reliance on partnerships between government and private industry. Government no longer has all the answers or the available resources to cope with the diversity of problems and needs within our society. Only by harnessing the energies and talents of all sectors of America can we successfully restore both human dignity and self-reliance to the lives of America's 35 million disabled.

It is absolutely vital that programs benefiting persons with disabilities in this country run effectively and efficiently. Compassion for the people served will be shown by improved management which will both preserve the integrity of the program and earn the support of the American people as a whole.

We have come a long way. We still have a long distance to go. But we have a clear and worthy goal: to reduce the growing costs of disability compensation and enable more persons with disabilities to lead productive lives through increased work opportunities while providing benefits for those who cannot work. Together I know that we will be able to correct operational weaknesses and implement needed legislative improvements and make this a better America for all our disabled citizens.

DISABILITY MANAGEMENT: STRATEGIES

William Gellman, Ph.D.

The definition of disability management that I plan to use is the reduction or elimination of disability payments through the employment of disabled persons who are capable of gainful employment. This definition includes the problems posed by Mrs. Knauer and Senator Dole, the human and economic costs of disability. The definition views disability management as a form of vocational rehabilitation.

The presentation covers three aspects of disability management. First, the socioeconomic framework within which rehabilitation and disability management occur. Second, strategies for improving state vocational rehabilitation programs. Third, changes in policy and procedures suggested by the strategies.

For human service programs, such as disability management, the economy is severe and will continue to be so for the remainder of this decade. The faltering economy results in limited resources for human service programs. This has been true for the past 10 years and apparently will continue to be true for the next 5 to 10 years. In addition, changing industrial patterns and the transition to an economy of technology are narrowing educational and rehabilitation options for marginal or poorly prepared job applicants.

The social climate is and has been negative toward human service programs for the past 15 years. The continuance of this negative attitude suggests the reappearance of social Darwinism with its emphasis on the survival of those who succeed in the socioeconomic sector.

Inflation is endemic. Even though it is under control now, the costs of human service programs will continue to increase at a more rapid rate than the resources available for service.

The problems of the return to work of disabled persons become more difficult because of the effects of the transitional labor market. There are changes in the nature and composition of the job pool which reflect a changing pattern of industry. More important, there is a loss of unskilled, semiskilled, lower level, and marginal jobs, the traditional fields of work for disabled applicants.

Let me take England as an example. In England during the past 17 years, there has been a decrease in the number of such jobs from 4 million to 2 million. This means that it is becoming more difficult for marginal and disabled job applicants to enter the employment market.

Another factor is polarization: the deskilling of manufacturing and middle management jobs and an increase in the professional jobs. Polarization eliminates upward paths of mobility for large numbers of marginal persons.

The implications of these socioeconomic changes are: (1) greater pressure on employers and agencies to become more efficient and to reduce costs (2) limited resources for agencies will reduce the possibilities of providing full and adequate rehabilitation services to all clients and (3) higher educational and training requirements for jobs will decrease employment possibilities for persons with disabilities.

The socioeconomic changes and their consequences imply that our clientele face more intense competition for a smaller number of jobs and require a tremendous amount of vocational training. In fact, marginal and disabled persons will require training to secure work, further training to retain employment, and continuous training if they are to have any opportunities for promotion.

Senator Dole stressed the increasing costs of disability and the inability of our socioeconomy to continue disability payments at the present level. Given these difficulties, what are the strategies for vocational rehabilitation and disability management?

There are three assumptions underlying the development of strategy. First, financial incentives motivate disabled persons to seek work and employers to hire disabled persons. Second, the insecurity of disabled persons regarding continuance or resumption of benefits after employments must be allayed during the period of umemployment or partial employment. In other words, the insecurity of the system acts as a disincentive for disabled persons to seek employment. Third, the reduction or elimination of occupational marginality in the disability management clientele requires the provision of training and support in the social and work sectors, including the full use of the work environment and work culture as rehabilitation tools.

Now the strategy. First I would suggest developing community support for work and the work ethic. Despite ambivalent feelings towards the work ethic, I believe it is necessary for us to organize a campaign to develop and support values which underlie the drive to work. These are the work ethic, economic independence, which Mrs. Knauer mentioned, the motivation to work, and a sense of artisanship. Another method for strengthening the work ethic is to help community support groups direct their efforts toward work and the rehabilitation of disabled people. We have tended to treat the disabled as isolated individuals. This approach will facilitate the use of peer groups, social groups, and religious groups to support the movement towards rehabilitation and the drive toward economic independence.

Second, the strategy should provide economic benefits for disabled job seekers who secure work. All of us know the marginality of the disabled: less income, less education, older, poorer health, poorer motivation. The severly disabled feel that long term planning is difficult because their lives are limited and precarious. Equally as important, the multiplicity of problems in a variety of sectors make insecurity a normal part of the disabled person's life pattern. It is suggested that we increase the economic benefits of work for disabled persons.

In a capitalistic country, we should use financial incentives. This can be done by providing partial benefits for partial work. If a client secures full time work, add a modicum of benefits to ensure a net gain. If a client looses his job, arrange for immediate resumption of benefits if job replacement is protracted or difficult.

I would now like to turn to the rehabilitation process. One strategy is to make rehabilitation coterminous with disability: it should begin when disability begins and continue through and past the period of unemployment until there is adjustment on the job.

If a client has a predisability employment history, I believe we should focus on returning the client to his place of former employment. What I am suggesting as strategy is the use of the work environment for rehabilitation. The presence of peer workers with whom one has had contact provides a different and stronger approach to resuming work. The use of functional assessments and evaluations can speed and improve the placement process. Another strategy involves the use of transitional work programs, utilizing all types of work: supported work, part time work, temporary work, sheltered work, and on the job training. Supported work is emphasized because of the financial incentive for clients. Training and vocational development should be stressed in rehabilitation planning. One of the weaknesses of rehabilitation programming at the present time is the tendency to place disabled persons in marginal jobs. Once placed they remain in marginal work and are subject to the loss of work. The PWI process should be extended to provide assistance to clients for a protracted period after they find employment.

Further, I would suggest two additions to vocational rehabilitation programs. First, strengthen preventive rehabilitation, develop and apply methods for locating, analyzing, and restructuring jobs which generate excessive stress or disablement. If we can work with employers to identify and restructure these jobs, we will improve the placement and replacement of disabled persons.

The second addition is job replacement. We have tended to forget the people we place. We should realize the precarious nature of the marginal jobs in which we place disabled persons, and be prepared to replace them in employment if and when they lose their jobs. We should provide supported work during the job hunting period and resume benefits if the process is protracted.

The last area in vocational rehabilitation is one in which we are just beginning to enter (and I think The Menninger Foundation is showing the way). We need to create a more hospitable work environment for persons with severe disabilities. We spend more time working with people--its nice, its helpful--and far less time working with employers who provide the jobs. I'm suggesting that we reverse the process and increase financial incentives for employers hiring persons with severe disabilities. More important for this program, we should provide a premium to employers who rehire severely disabled persons or continue them in employment after disablement.

A second way of making the work environment more hospitable to disabled persons is to provide more complete assistance to firms hiring or

employing persons with severe disabilities. I would suggest a full range of services: worksite modification, work adjustment groups, job assistance, counseling. We should change employer relation programs to employer assistance programs and help employers to establish and maintain formal programs to hire disabled persons.

A third strategy is a formal program of work with employers to improve personnel practices for disabled and non-disabled persons. The assumption is that if an employer's personnel practices are good, the possibilities of the firm hiring and using disabled persons will increase. The British Manpower Service Commission is using this technique.

Lastly, I would increase the number of PWI employer groups, and extend their functions to include improving the organizational work culture with respect to the hiring and use of persons with severe disabilities. It would involve firms in a PWI group functioning as a single unit for purposes of placing, replacing or promoting disabled persons. PWIs would offer functional analyses of jobs and guidance in vocational development to member firms. This would help disabled persons who face greater difficulties in securing promotions than able bodied persons.

In conclusion, the socioeconomy poses very difficult problems for disability management and rehabilitation. These are the problems of rising costs, the problems of limited resources, and, more important, the problems of job placement. I suggest increasing community support for the work ethic; revising and extending rehabilitation programs; modifying the work environment to create more receptivity for disabled persons; and expanding the services of Projects With Industry. We are in a period of transition and change. Disability management requires both revision of strategies and the development of new strategies.

DISABILITY MANAGEMENT: PATHWAYS

Modeling the Disability-Rehabilitation System

Edward J. Hester, Ph.D.

The Menninger Foundation Research and Training Center has developed a conceptual model to organize the causes, options, processes, and programs effecting a worker who becomes disabled in this country. The model articulates key elements and shows their relationships.

Figure 1 presents a preliminary analysis of the process by which a person moves through disability to either economic independence or dependence. This model considers the worker who is employed at the onset of disability. Variations of this model would consider the other two important conditions, namely, the worker who is unemployed at the time of injury or illness and the entrepreneur.

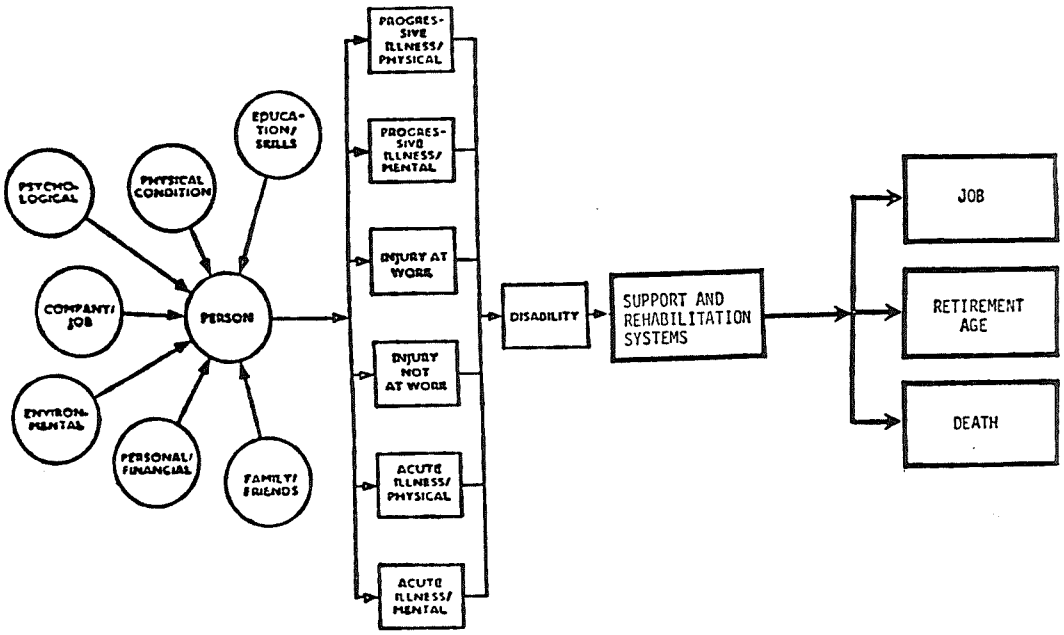

Figure 1. The Inflow and Outflows of the Disability Support and Rehabilitation Systems.

Figure 1 begins with the depiction of the predisability conditions which have an effect on the person prior to becoming disabled. These conditions may or may not affect his or her chances of being rehabilitated. Even though these conditions are shown as affecting the person only prior to the onset of the disabling condition, these same conditions affect the person all the way through the rehabilitation process albeit to different degrees. These changes may be in a positive or negative direction.

Psychological factors are such things as the person's intelligence, general mental health, work ethic, philosophy of life, proneness to chemical abuse, and risk-taking ability. We also suspect that the individual's predisability attitude towards the handicapped is a major factor affecting the way an individual responds to a disability. If individuals have believed that disabled people are useless, it will be harder for them to return to productivity after they themselves become disabled.

The person's predisability, physical condition may not only affect his or her chances of becoming disabled but may also relate to how well the person recovers from the injury or illness.

Certainly the support, both positive and negative, received from family and friends will have an effect upon recovery and subsequent rehabilitation.

Certain personal characteristics such as age or sex influence the outcome of rehabilitation. For instance, we know that fewer women than men return to work after the onset of disability.

It is quite obvious that disabled individuals with a good basic education are more likely to be rehabilitated than those who are educationally deficient. Likewise, those who have a broader range of skills are more likely to be employed after incurring a disability than someone with a narrow range.

The person's attitude toward his or her job and employer is definitely related to the success of rehabilitation. For instance, the chances of lower back pain becoming a disabling condition are directly related to a person's satisfaction with the job. This is highly significant insofar as low back pain is a major cause of long-term work incapacity as reflected in the cost of compensation insurance and Social Security Disability Insurance (SSDI).

Another very significant factor is the employer's policy toward disabled employees. For instance, Control Data Corporation has a very explicit policy regarding the rights of employees who become disabled to return to work as soon as it is medically permissible. If a person cannot perform his or her previous job, the job will be modified or another job in the company will be made available. Currently, this type of policy is not very common in American industry. Where it is actively implemented, this policy has resulted in a very high rate of return to work.

In addition to the employer's policy in regard to return to work, the size of the employer and the type of industry appears to be highly significant. The larger the employer, the more likely it is that an appropriate job can be found for the person who sustains a disability. Also, an employer engaged in heavy industry, logging, mining, etc., is less likely to be able to retain a disabled worker than one engaged in light industry.

In the past, researchers and program evaluators have tended to study disabled people as a group unless they were studying a specific disability classification. In our model we are most concerned with how the worker becomes disabled according to six routes.

Some significant aspects of each disability path are as follows:

1. Progressive Illness--Physical

   An important distinction here is whether the disability is considered to be occupationally related, such as black lung disease, or an illness not currently considered to be work related such as multiple sclerosis. Other major progressive conditions are arthritis, rheumatism, hypertension, diabetes, emphysema, and sometimes loss of vision or hearing. These enter the person into the disability system only when the illness progresses to the point where the person can no longer perform his or her job. The distinction between occupationally related or unrelated is important for two reasons. First, the person may be encouraged to maximize the degree of limitations in order to obtain a more favorable settlement. Second, conditions such as black lung disease may be considered normal for the industry. Therefore, it becomes the norm to work until becoming disabled and then to retire on the disability benefits. On the other hand, it is less likely that a self-employed individual will become unemployed due to a progressive physical disability, e.g., arthritis, than other workers.

2. Progressive Illness--Mental

   This covers the broad range of mental or emotional problems including chemical abuse and stress-related disorders. These may be said to be related to occupations, for example, to air traffic controllers, or they may be unrelated. There is an important distinction between physical and mental progressive conditions. It seems that persons with progressive mental problems are far more likely to be terminated prior to the establishment of the fact that a definable disablity exists. This means that by the time the disability is identified and treated, the person does not have a job to which he or she can return.

3. Injury at Work

According to the National Safety Council, loss time occupational injuries average 1.9 per one hundred full-time employees. There are, of course, condsiderable differences between various industries and companies. Rehabilitation for a disability sustained at work takes longer than for the same disability occurring elsewhere. No doubt litigation plays a part in this increased amount of time in returning to work. However, other factors, e.g., bitterness toward the job and the company, may be influential.

4. Injury Not at Work

The National Safety Council indicates that 2,600,000 workers per year are injured off the job. This means that there are 2.6 injuries not at work for every one hundred full-time workers.

5. Acute Illness--Physical

Many disabilities, such as cancer and cardiac problems, have characteristics of acute as well as progressive illnesses. We are distinguishing these primarily by the amount of work time lost at the first recognition of the problem. In other words, if the first diagnosis of cancer results in extensive surgery and treatment which keeps the person off work for several months, the illness will be considered as acute. It seems that a possible factor in the person's successful return to work is whether the employer or the person sees the disease as terminal.

6. Acute Illness--Mental

This category covers a broad range of mental or emotional illnesses. Obviously, if the "break" occurs at work it could be harder for the person to return to work after receiving treatment.

As we can see from Figure 1, a person who is unable to engage in work due to injury or illness enters into the disability support and rehabilitation system. There are only three ways of leaving this system: through employment, reaching the official retirement age, or death. In our model, once a person reaches the official retirement age, the person becomes a retired worker rather than a disabled worker. The logic for this decision follows that used by the Social Security system.

After the onset of disability there are various financial support programs. First there is sick time, and then for many workers there are short-term disability payments after the individual has expended his or her sick time. Depending upon the policy, short-term disability payments may be received for six months to two years. Normally, it is no more than one year. If the disability is clearly job-related, the person will probably receive Workers' Compensation.

Sometime after the onset of the disability a vocational decision will be made by the individual, the physician, or the employer. The person may return to work at his or her previous job, either with or without worksite modification. On the other hand, the person may return to work at the same employer but on a different job which is more suited to the person's residual abilities. While this latter alternative seems ideal, there are often reasons why it cannot or is not being done. It may be that, because of the small size of the employer or the type of industry, there are not any openings in appropriate jobs. When there are appropriate jobs, the employer's policies or a union agreement sometimes prevent movement to other and less strenuous jobs.

The person who is terminated but wants to return to work has several options for financial support until he or she can find appropriate employment. Generally, the person who is terminated due to disability is not eligible for unemployment compensation. However, some states, such as California, New York, and New Jersey, offer state cash sickness benefits. If the person lives in a state which does not have these benefits and is not covered under long-term disability insurance, he or she may be able to qualify for Public Assistance, particularly if the person has dependent children to support.

The terminated worker who is eligible applies for SSDI benefits. This application process may take from five months to two years, depending upon the number of appeals involved.

If the person is denied SSDI benefits, he or she will continue to receive other kinds of financial support, depending upon other eligibility criteria. These people are eligible to apply for vocational rehabilitation services, in fact, a portion of them are referred to state agencies from Disability Determination. However, they may receive limited services if they are not considered to be severely disabled.

For those who are accepted for vocational rehabilitation services, there are two possible outcomes--a rehabilitation closure or a non-rehabilitation closure. Those who are closed as non-rehabilitated, like those who are not accepted for services, will probably become long-term SSDI recipients.

Of those who are closed as rehabilitated, only a portion will become financially independent and be terminated from SSDI benefit status. Social Security Administration and Vocational Rehabilitation have differing definitions of success as well as different periods for closure. A person can be closed by VR as an unpaid family worker. These persons are not substantially gainfully employed by SSA standards and thus retain their SSDI cash benefits. Also, VR can close a person as successfully employed after two months on the job. On the other hand, the trial work period for the SSDI client is at least 9 months in duration. Therefore, if a person works for five months but loses the job, that person would be considered a rehabilitation closure by VR but would not be terminated from benefits by SSDI.

DISABILITY MANAGEMENT: PATHWAYS

Modeling the Compensation and Rehabilitation Systems for the Disabled Population

Alexander H. Levis, Sc.D.

1. INTRODUCTION

The utility of the conceptual model of the disability support system for the employed person who becomes disabled (presented by Dr. Hester) is enhanced, if a quantitative, analytical model can be formulated. Such a model could have several uses:

a. Provide a map of the current and projected flows of disabled persons through the existing compensation and rehabilitation systems

b. Provide the means for analyzing the effect of proposed prevention and intervention strategies

c. Assist in the analysis of alternative policies that affect programs serving the disabled

A modular representation of the structure of the quantitative model that represents Hester's conceptual model is shown in Figure 1.

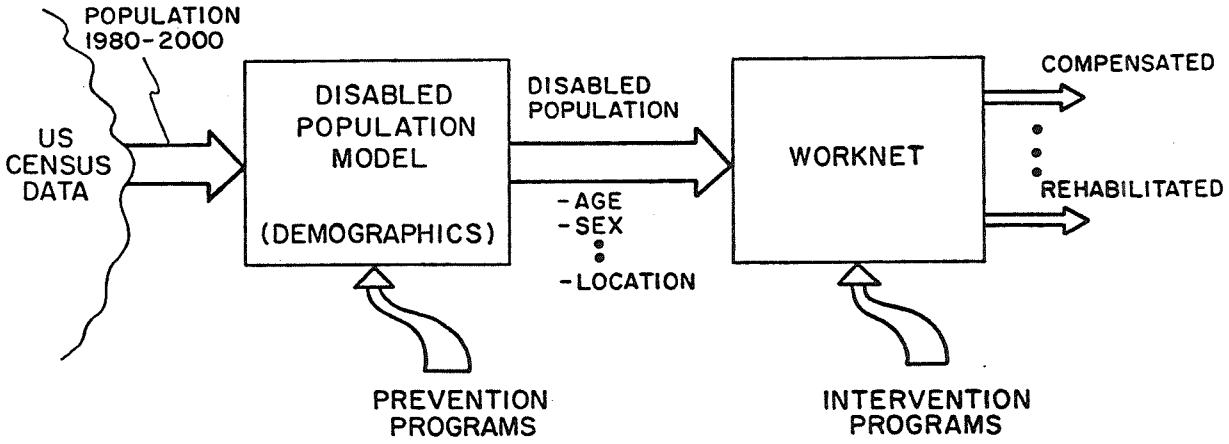

Figure 1. Conceptual Representation of Modeling System

The quantitative model consists of two basic modules: the model that generates time series of the disabled population and the model of the compensation and rehabilitation systems that are available to disabled persons. Since the focus of the overall effort is on return to work of disabled workers, the latter model has been named WORKNET. It contains such systems as the SSDI Appeals and Determination process, state Vocational Rehabilitation systems, and public as well as private Long Term Disability (LTD) compensation systems.

Three other aspects of the model are shown in Figure 1. The projections for the disabled population are based on the U.S. Census projections. Census data have also been used to determine the distribution of the population by age, sex, and geographical area. The figure also emphasizes that prevention programs affect the incidence of disability and the characteristics of the disabled population, while intervention programs affect the rehabilitation of disabled persons. Effective intervention programs will increase the probability that a disabled worker returns to work; successful prevention programs reduce the probability that a worker will become disabled in the first place. While intervention programs have a more direct, measurable effect, prevention programs have a more significant, long term impact.

2. THE POPULATION MODEL

Changes in the population of the United States will have a direct impact on the size and composition of the disabled population. This, in turn, will affect the need for rehabilitation services and the management of compensation programs. For these reasons, a set of simple models was developed that generates population series for the years 1983 to 2000. The first step in the development of the time series was the determination of the resident population from 1970 to the year 2000. The series for male and female residents were also obtained, as well as the distribution of the population by five-year age groups. Since the emphasis of the research project is on the work force, the series for the resident population aged 16 to 64 for the years 1980 to 2000 were also obtained. Projections by race were also developed, because race is one of the attributes of interest in analyzing the disabled population.

These projections, together with the data from the 1982 Current Population Surveys and the analyses by Dr. Frank Bowe form the basis for the models projecting the disabled population aged 16 to 64 (or 74 in some cases) from 1980 to 2000. Projections were made on a national basis as well as for two states, Illinois and Kansas. The same procedures can be used to produce the series for other states as well as for regions consisting of several states.

The results of these analyses have been stored in a specially designed data base to be used in conjunction with the models in WORKNET. They can also be presented graphically in a variety of forms. Typical results follow.

Figure 2 shows the projections of total resident population as well as the male and female population for 1970 to 2000. The rate of population increase is shown to be decreasing during the last decade of this century.

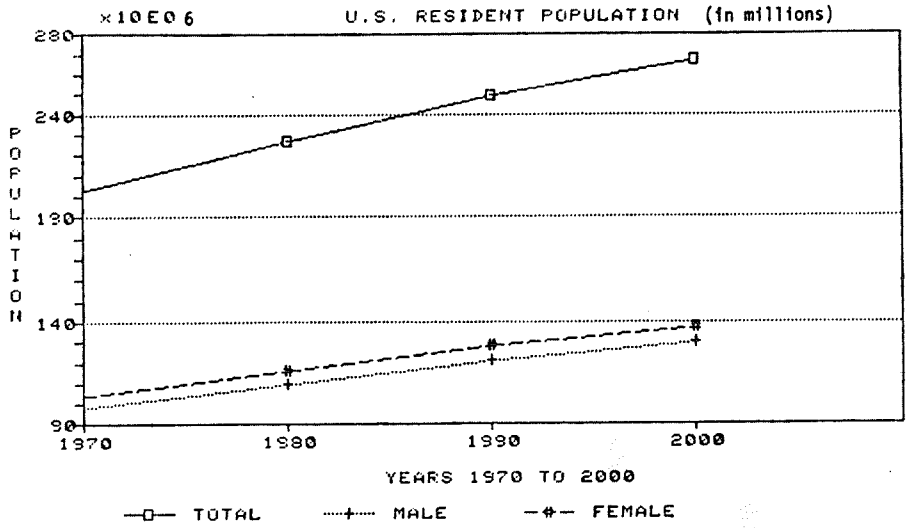

Figure 2. U.S. Resident Population, Total and by Sex: 1970 - 2000

A more interesting projection is the population distribution by five-year age groups (Figure 3). This figure shows quite clearly the aging of the work force. The large increase in the age group 0-19 that appears in the distribution for the year 1970 has already changed the age distribution of the work force by 1980 and will continue to have a strong impact on the work force beyond the year 2000.

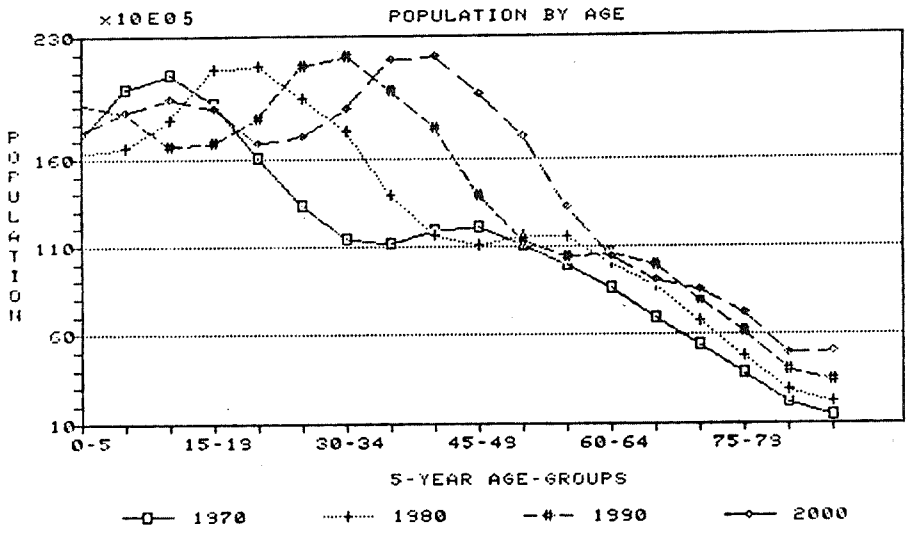

Figure 3. Population Distribution by Five-Year Age Groups

The next bar graph, Figure 4, shows the distribution of the working age population (16 to 64 years) by race and by sex over time. These results are useful in projecting the disabled population because there is substantial variation in the incidence of disability among racial groups.

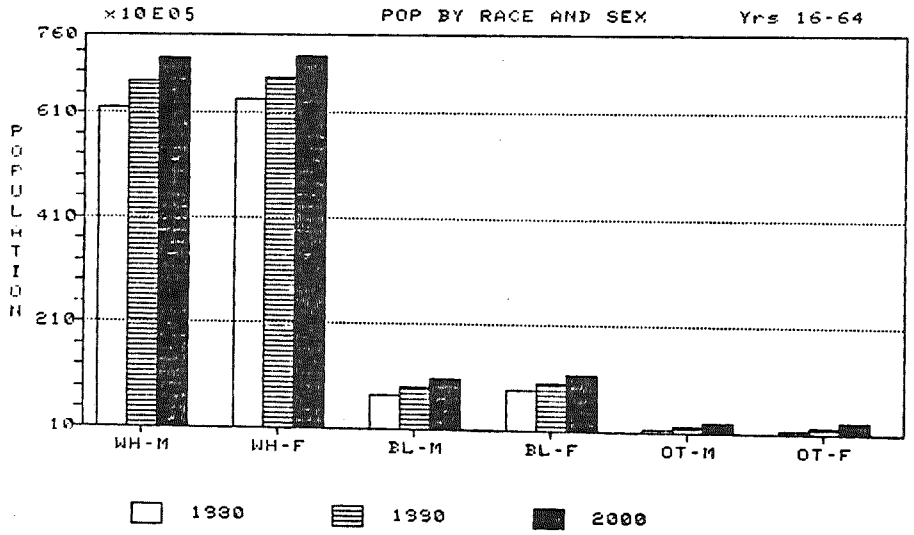

Figure 4. Population Aged 16 to 64, by Race and Sex for 1980, 1990 and 2000

Because the labor force participation rate drops sharply after age 65, most studies have been concerned with the status of persons aged 16 to 64. As the retirement age is expected to increase in the future, the characteristics of the age group 65–74 will become important and should be considered in analyzing prevention and intervention strategies. For this reason, the ten year cohort 65–74 has been included in many of the projections of the disabled population.

Figure 5 shows in a rather striking manner the effect that the changes in the age distribution of the labor force will have on the size and age distribution of the disabled population. The two effects, the aging of the labor force and the much higher incidence of disability for the older age groups, combine to produce a much larger disabled population in the year 2000 that will continue to have a significant impact for thirty more years.

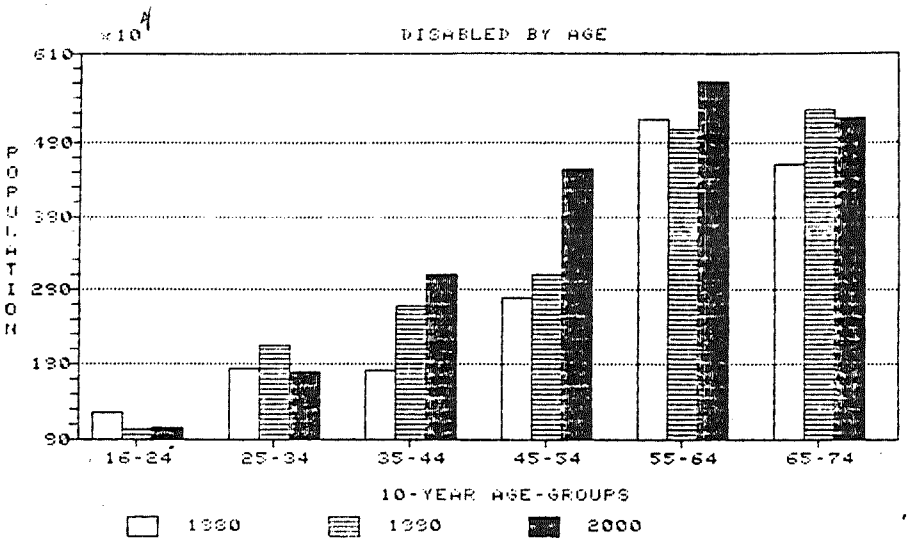

Figure 5. Distribution by Age for Disabled Population Aged 16 to 74 for 1980, 1990 and 2000

If the distribution of the disabled population aged 16 to 64 by race and sex is plotted for the years 1980, 1990, and 2000, a bar graph (Figure 6) is obtained that corresponds to the bar graph in Figure 4. The higher expected rates for the incidence of disability for the black population are evidenced quite clearly when the relative heights of the bar graphs in Figures 4 and 6 are compared.

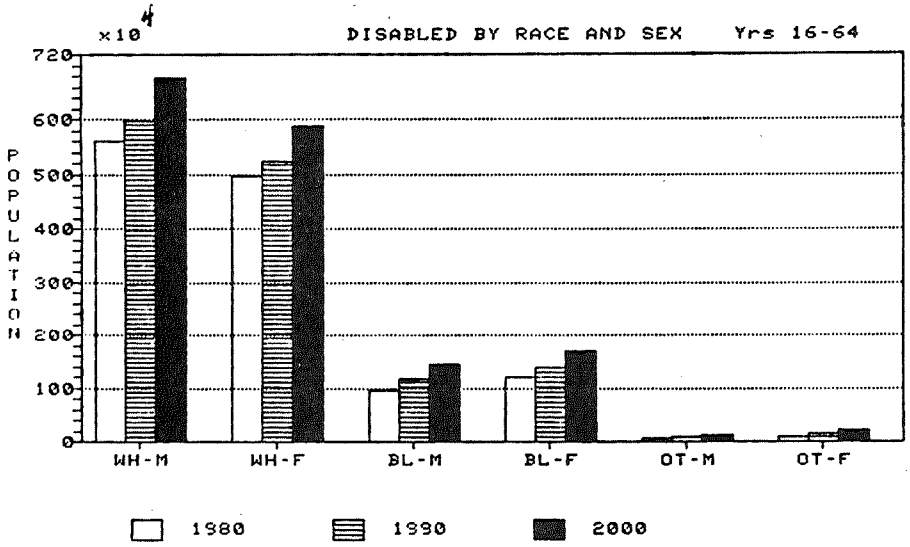

Figure 6. Disabled Population Aged 16 to 64, by Race and Sex, 1980-2000

Since prevention and intervention strategies can be analyzed and tested only in a specific context, an early decision was made to concentrate on the states of Illinois and Kansas and develop detailed data bases for both states. Series corresponding to the national series highlighted in the first part of this presentation were developed for both states. The detailed results can be found in the "WORKNET Annual Progress Report" available from the R&T Center at The Menninger Foundation.

3. WORKNET

WORKNET, the second module in the quantitative model, represents a computer-based approach to the modeling of the structure and flows of complex service delivery systems. The underlying methodology is being developed as a means for analyzing the potential effects of proposed programs and as a policy analysis tool.

The specific objectives of WORKNET are (a) to map the current and projected flows of disabled persons through the compensation and rehabilitation systems and (b) to analyze the effects of prevention and intervention strategies on these flows. The methodology is based on the notion of flow graphs--graphs that depict the flows in a system. Graphs consist of two elements: nodes and links or branches. A node represents a status, while a link represents a process by which status can change. Each compensation or rehabilitation system can be represented by a directed flow graph in which the direction of the flows are indicated on each link. Since individuals may be eligible for compensation from more than one program and can receive rehabilitation services by different programs, the representation of the whole system, whether at the local, state, or national level, can be obtained by interconnecting the graphs of the individual systems. WORKNET is the graph representation of the whole system.

The input to WORKNET is the population series, as shown in Figure 1. As stressed earlier, prevention programs change the flow of disabled <u>into</u> the compensation and rehabilitation systems. Intervention programs, on the other hand, affect the flow of the disabled <u>within</u> the compensation and rehabilitation systems and, consequently, the resolution of each case.

Once the basic projections have been developed and the incidence rates, by age group, sex, and other descriptors, have been estimated, the effects of different prevention programs can be analyzed. This is accomplished by determining the effect these programs may have on the incidence rates, recomputing the appropriate coefficients and their changes over time, and running the population model to obtain the revised projections. A set of such changes constitutes a scenario that can then be evaluated using WORKNET.

The WORKNET modeling system can be divided into three parts: a data base, a set of flow graph models, and a set of simulation programs.

The Data Base* is designed to serve a number of purposes. First, it contains the information generated by the population model. This part of the data base has been implemented and is operational. A second part of the data base will contain parameters such as incidence rates of disability, or classification of disabilities, success rates for programs, etc. Utility programs already designed can transfer this information to the appropriate simulation programs; they can also transfer the results from the simulations to the data base and have them stored there. The last part of the data base contains a set of report formats that can be used to display the data. Two types of reports have already been designed and implemented. Additional report formats will be created as WORKNET is developed further. The goal of the data base design is to make it possible for the user to interact with WORKNET through the data base.

The set of flow graphs contains the structural models of the various compensation and rehabilitation systems. At this time, two such flow graphs and their variants have been developed. The one represents the Social Security Disability Insurance (SSDI) Appeals and Determination program, and the second is a representation of a state vocational rehabilitation (VR) system, specifically, of Illinois. As the project progresses, more systems and subsystems will be modeled and the resulting flow graphs will reside in this part of WORKNET.

The third part consists of all the programs that are written to carry out simulations and analyses. Such simulation programs use one or more flow graphs, access data from the data base and, through simulation or other techniques, produce answers to specific "what if" questions. At this time, several such programs have been written for the two flow graphs, the SSDI system and the Illinois VR system. These two models will be described briefly in order to illustrate the WORKNET methodology and the kinds of results that can be expected.

3.1 The SSDI Model

The SSDI model is based on the description contained in Committee Print CP 97-16. That document describes the Disability Determination and Appeals procedure for initial applications. Caseload data for 1981 are given, as well as average processing times for most stages of the overall process.

The stucture of the process is presented in Figure 7. Potential applicants consider whether they meet the eligibility requirements (first decision point in Figure 7) and either apply or do not enter the system. What follows is the initial consideration of the case by the Disability Determination Service (DDS). If the case is allowed, then it is sent for review prior to the issuance of benefits. If the case is denied, the client can appeal within 60 days or leave this particular system. The process continues through appeal to the second determination by the DDS, to an Administrative Law Judge (ALJ), to the Appeals Council and, finally, to a Federal District Court. Each case is either allowed at some stage or the applicant leaves the system following denial of the application.

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*The data base being developed is programmed in dBASE II and is implemented on an IBM personal computer with two disc drives.

The representation of the system shown in Figure 7 in the WORKNET format is accomplished by defining a set of nodes and a set of links. This particular representation of the system has been named DIMOD (for Disability Insurance Model). Its representation as a directed flow graph, i.e., in the WORKNET format, is shown in Figure 8.

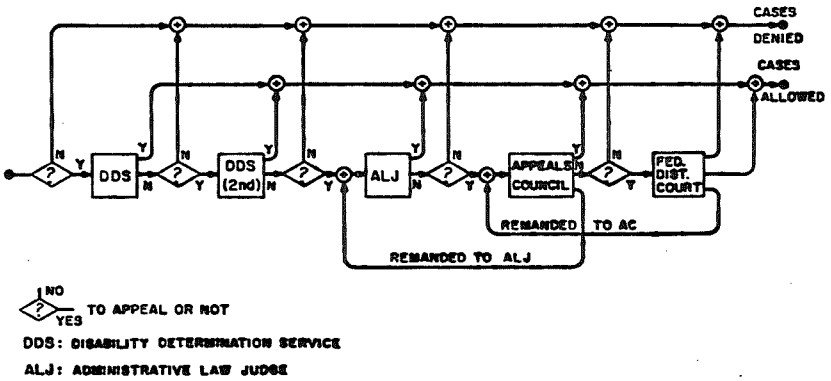

Figure 7. The Disability Insurance Appeals and Determination Program

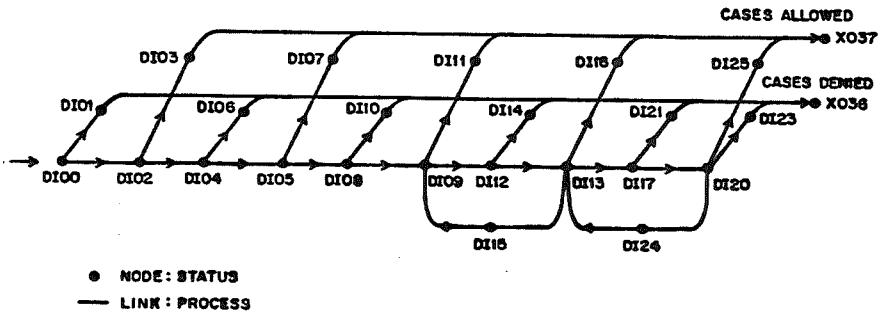

Figure 8. Flow Graph Representation of SSDI System

Two feedback loops are presented. In each case, a higher appeal level remands the case back to the level it came from. For example, the Administrative Law Judge considers cases that have appealed the findings of the state level DDS determination as well as the cases remanded to him by the Appeals Council. While the feedback loops allow for the possibility of cases recirculating within the system, most of the time, remanded cases receive a final determination.

The computer simulation program has been written in MICROSOFT BASIC so that it can be used readily in a wide variety of personal computers*. The program produces results in three forms: (a) on the screen, during and after program execution (b) hard copy, through a printer, at the end of the execution and (c) in a sequential file, stored on the data diskette.

The sequential file can be accessed from the Data Base and transferred there for permanent storage and for report preparation.

The Committee Print (CP 97-16) provides an almost complete set of aggregate data for fiscal year 1981. There were 985,801 initial DI determinations. Therefore, if the monthly input is taken to be one twelfth of the annual rate, the SSDI Appeals and Determination program can be simulated using the model shown in Figure 8. The simulation starts with the system totally empty. It takes nine iterations for every node to have non-zero flow. It takes about 18-20 iterations for steady-state to be reached, i.e., for all flows in the system to have reached a constant value. From that point on, the effect of changes in the system, whether changes in the input or in the parameters, can be studied. Thus, the steady state conditions obtained after the first 18-20 iterations represent the operating conditions of the system in 1981.

If the rate of applications is 985,801 per year, then 460,913 cases (or 46.8%) are allowed, while 524,855 (or 53.2%) are denied. The distribution of allowed cases by source, i.e., by the point in the system that allowed the case, is shown in Figure 9. It is clear from that chart that many initial determinations are reversed on appeal at the Administrative Law Judge level.

An additional result that is of interest is an estimate for the average time it takes to process an allowance within the SSDI system, i.e., up to and including the Appeals Council. This calculation is done at the aggregate level by considering the average length of time in each stage and the number of cases in each stage. If the time to file an appeal is taken to be 60 days, average time is 140 days. A second result is the total number of cases pending within the system, 428,053. This number is based on 1981 data. The long delays between and at the various stages create queueing and produce a much larger active caseload. If an applicant applied for determination and then appealed all the way to the Appeals Council, then, on the average, it would take him 495 days. This effect results in a very large number of cases being at some stage of processing (i.e. pending) and has, clearly, implications on the management of the DI system.

*For IBM personal computers and compatibles and for personal computers running under CP/M operating system (e.g., Northstar Advantage).

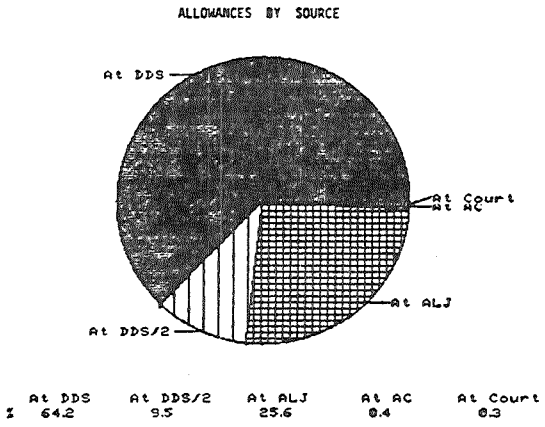

Figure 9. Allowances by Source

The model for the SSDI system has been enhanced to be able to simulate an arbitrary number of years in sequence. This makes it possible to use the results from the population model to obtain projections for SSDI allowed and denied populations for the years 1982 to 2000. Furthermore, if flow coefficients are obtained that distinguish by age, sex, and race, then detailed projections can be obtained. This is a future task.

3.2 The Illinois Vocational Rehabilitation System

The second system for which a flow graph representation was developed is the vocational rehabilitation system for the state of Illinois. The case flow through it is described in the client services manual for the state of Illinois. The manual is organized according to the case flow and it identifies six more major stages in addition to referral: application, extended evaluation, program development, delivery of services, closures and post employment services. The rehabilitation process may consist of two stages only (referral to immediate closure) or it may involve all seven stages.

A client enters the system through referrals; this is the first step in every case. The client is provided with information about the agency's services and then he either applies for rehabilitation services or moves directly to closure. The application begins when the referred individual actually applies for services and ends when the VR counselor determines that the applicant is eligible for services (in which case he moves to the program development stage) or that the applicant needs extended evaluation, or that the applicant is ineligible for services and the case should be closed.

During extended evaulation, the VR counselor tries to determine whether the applicant is indeed eligible for services, in which case he is moved to program development, or whether the case whould be closed because of ineligibility.

In the program development stage, the client and the counselor develop together the Individual Written Rehabilitation Program (IWPR). This is the blueprint for the services to be received by the client. On occasion, because of unforeseen events, a client may be unable to receive the services and the case is closed. The delivery of services is the most important stage in the VR system. The IWRP is executed in its original or modified form, as appropriate to the case. From this stage, a client moves to closure either rehabilitated or non-rehabilitated.

Some services are delivered after closure. Post-employment services are provided to clients who may need certain routine services in order to continue satisfactory employment after their case has been closed as rehabilitated. These services may be planned at the time of closure or may be added later as the need arises.

The manual identifies twenty distinct statuses. Because of the flexibility of the system in the delivery of services, the number of possible links--transitions between statuses--is quite large (55) compared to the number of nodes. The resulting flow graph is shown in Figure 10.

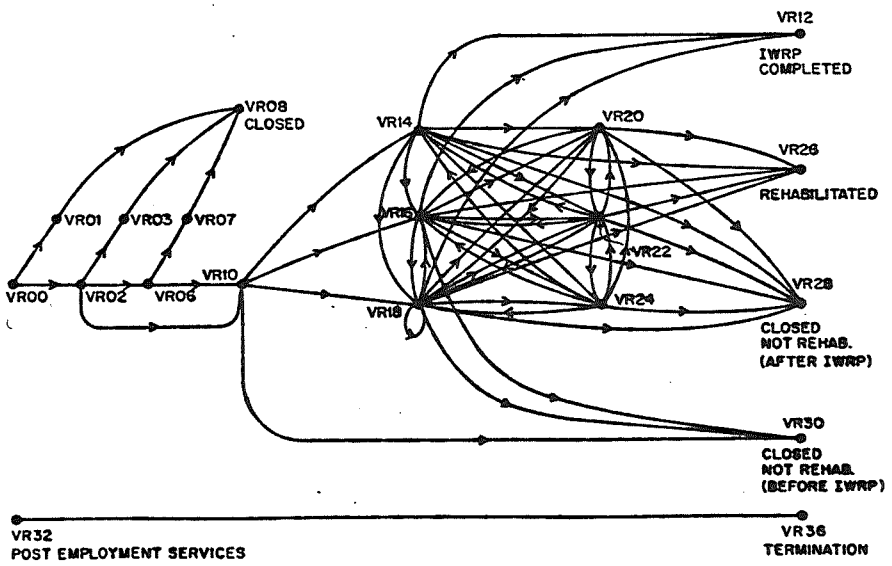

Figure 10. The Illinois Vocational Rehabilitation System: Flow Graph Representation

No data were available about the flows in each and every link in the system and, therefore, the flow coefficients associated with each link could not be calculated. At the time of the construction of the model, no data were available about the average time spent by a client in each status. Obtaining these data is a future task. However, a substantial amount of analysis can be done using data provided by the Illinois division of Rehabilitation Services. An equivalent aggregate representation of the system can be developed that emphasizes the input-output properties of the process and deemphasizes the individual paths clients can take through the system. This representation is shown in Figure 11.

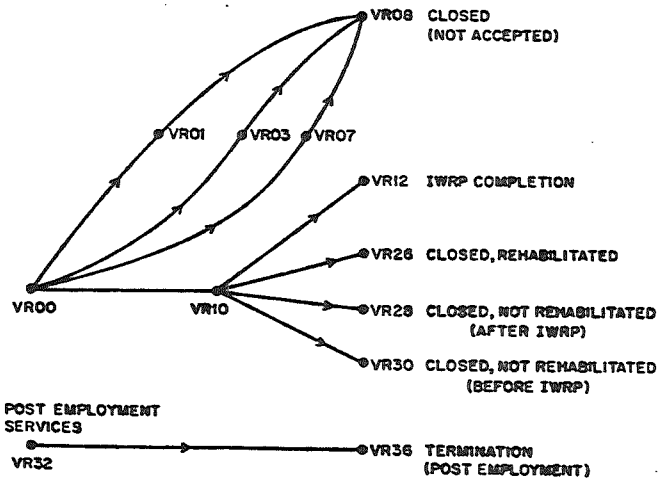

Figure 11. Aggregate Representation of the Illinois VR System

Since the input to this model is the number of referrals to the Illinois VR, the appropriate series had to be developed. A sequence of simple linear models was used to obtain the series shown in Figure 12. The results are consistent with the population trends projected for Illinois.

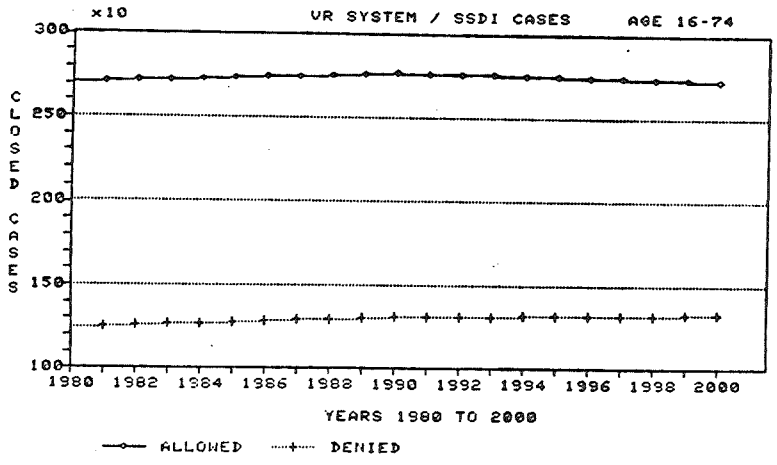

Figure 12. Referrals to Illinois VR: 1980-2000

Finally, the model of Figure 11 is used to determine the case closures by type for the years 1980 to 2000. A case can be closed anywhere in the system. The various types of closure are distinguished by assigning a different status number to each one.

The four types of interest are:

a. VR08: closed after referral or extended evaluation
b. VR26: closed, rehabilitated
c. VR28: closed, not rehabilitated, after IWRP initiated
d. VR30: closed, not rehabilitated, before IWRP initiated

The results are shown, in graphical form, in Figure 13.

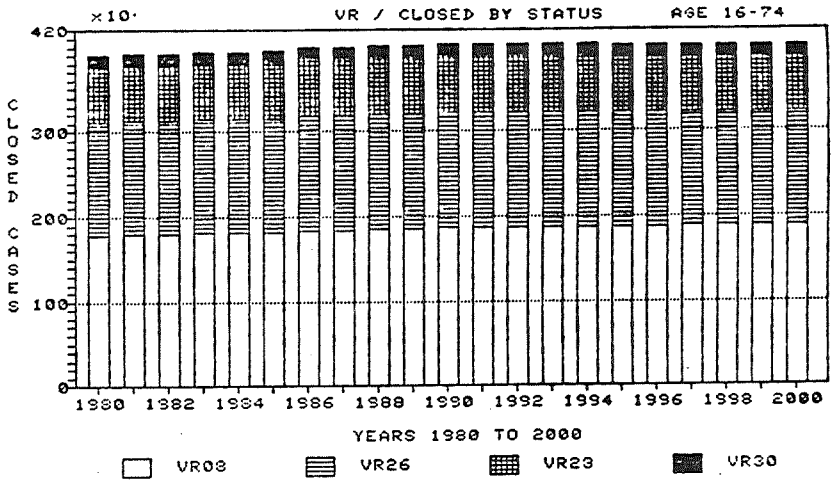

Figure 13. Illinois VR: Total Closures and Distribution by Status, 1980 - 2000

The effects of intervention strategies would manifest themselves by changing the totals in Figure 13 and, more importantly, changing the distribution of closures by increasing the fraction of cases that are rehabilitated.

4. CONCLUSION

During the first year, substantial progress has been made towards the development of WORKNET.

First, emphasis was placed on public compensation and rehabilitation programs. Contacts were established with various agencies and organizations and descriptive information was collected. The two systems studied and modeled in some detail were the SSDI Appeals and Determination Service and the Illinois Vocational Rehabilitation system.

The second focus of the research effort was the development of a population model that yields the series for the years 1980 to 2000 that are needed in the simulations. For the resident population, the disabled population was projected both at the national and state level. Since it is of interest to obtain projections with respect to age, sex, and race, the corresponding distributions were estimated for both the resident and the disabled population. Finally, since the systems studied serve the work force, the various series for the population aged 16 to 64 were derived.

These series can be used as inputs to the various subsystem models. For example, the series characterizing the disabled population can be used in conjunction with the SSDI model (DIMOD) to project the number of applicants that are allowed and denied SSDI benefits on an annual basis. Similarly, the corresponding series at the state level can be used with the vocational rehabilitation model (VRMOD) to estimate the number and type of closures on an annual basis.

The third focus was the development of a consistent methodology for describing the compensation and rehabilitation systems. A flow graph representation was chosen that allows the interconnection of subsystems to construct the total system.

Finally, a data base system has been designed that will serve three functions: (a) store and display data (b) support the data requirements of the various models in WORKNET (c) provide an interface between the user and all the components of WORKNET.

The specific objectives for the second year include the further development of the data base system, the modeling of other components of WORKNET, and the development of the interconnections between subsystems. The work of the first year has established the feasibility of these objectives.

PRIVATE SECTOR PERSPECTIVES

Benjamin Jones

The subject of my remarks this afternoon will be the private sector perspective and the various ways in which we address those critical issues which prevent disability dependence.

While there are certain advantages that the private sector has over public plans, I am not at all convinced that either has demonstrated the capacity to successfully influence the management of our disabled population.

I feel a little bit like the minister who is talking to his faithful congregation. You are all aware of most of this, but I am going to go through it anyway, and maybe part of it will be something that you have not thought of before.

Most people I talk to are in complete agreement that this nation needs a new national, broad-based program which identifies, coordinates, and delivers appropriate services to our disabled on a rational basis.

The objective would be to help solve financial, physical, and personal problems created when a person, prior to reaching normal retirement, is too sick or hurt to work. I would like to offer some general observations on issues which should be addressed in the development of a broad-based national plan.

The first has to do with the area of national awareness of the importance of wellness.

There is ample evidence that wellness programs prevent unnecessary disability by informing the public that what they do and don't do, how they do it, when they do it, can have an enormous impact on their own physical well-being.

This country can no longer afford the luxury of taking care of physical illiterates or physical abusers. Somehow, some way, we must begin the process of motivating people to become responsible for their own good health.

Senator Dole talked about the financial condition of the Medicare program. He did not say that bankruptcy was inevitable, but the figures indicate that it is. It will occur unless something very dramatic happens. The attempt at band-aiding the program by preventing cost shifting with the DRG (Diagnostic Related Groups) plan or with the prospective payment program (providing medical care on a fixed fee basis) is not going to work over the long haul.

I want to call your attention to a book containing two articles, one by John Englehardt and another by Roger Knowle, on the prospective payment program and its viability. It is Issues in Science and Technology published by the National Academy of Sciences. It is extremely

interesting and underscores the real problems and the difficulty of developing easy solutions.

The self-prevention of disability and the bankruptcy of Medicare are an intertwined problem. The only long term solution is to convince people that they are in control of their physical condition, that they can get well and stay well. The Medicare problem can be addressed by changes in benefit design, quality claim administration, physical and vocational rehabilitation, and incentives to return the disabled to the workplace.

An important part of the wellness concept are the employee assistance plans (EAPs) which seek to attack problems before they get out of hand. The ones that I am familiar with conduct very informative clinics relating to diet, weight control, cancer detection, smoking cessation, management of stress, and a wide range of other issues which if left untended are sure to end up in long term disability.

This is one area where I believe the federal government can play an important role. National attention must be focused on the broad base of our disabled population. Most states have affirmative action plans, as does the government, dealing with this subject, but there is much more to be done. Employers and the disabled somehow must increase their respect for one another. The disabled must become visibly acceptable in the workplace and be treated as productive members of the work team. Technology has created many new opportunities where disabled people can perform with distinction. We should develop the ability to successfully market disabled people as we have with veterans and minorities.

A nationwide awareness of the importance of wellness and affirmative action plans that are embraced by employers and personnel officers would help create an environment where people worked hard to be healthy and where those who recovered were welcomed when they were physically and emotionally able to return to their workplace.

We talked about the <u>employee</u> assistance program; I would also strongly endorse an <u>employer</u> assistance program. Dr. Gellman helped me focus on this point when he suggested that a premium be paid for rehires. Make it very attractive for a employer to rehire a former disabled employee.

Jim Jeffers and I were talking at the break, and he told me about some companies that he was aware of that guaranteed a job to their disabled employees. It would be at the same level of pay even if not the same job.

These things can be done! I think the Menninger group is ideally suited to focus on these issues. The PWI program is exciting. I am chairman of the Private Industry Council in the greater Springfield area. We have as part of our mandate the placement of disabled people. We approached employers and asked them to accept quotas. We estimated the number of people that they were going to hire in a given year, and then asked if they would agree to hire a certain percentage of people that the Private Industry Council trained and made job ready.

Over half agreed to accept reasonable hiring objectives. Those that did not were at least asked to explore the matter. My guess is that by next year we will have the whole group accepting quotas.

The private sector is keenly interested in performing. They want to take a leadership role and they will if a reasonable program is developed and presented to them. Also, don't forget that employers like the idea of tax incentives. That's why the targeted jobs tax credit is so very important.

At the beginning stages of disability, the two key words that emerge again and again, are, "early intervention." If it is performed successfully, the stage is set for eventual, full and complete recovery.

The psychological, social, and financial problems compound as time passes. They get worse and worse, and "think work" must be established early on. This is the most effective when there is an opportunity to go back to work with the previous employer.

We have already discussed the critical importance of workplace attitude. People want to be productive with career paths open to them. That was mentioned this morning. It is terribly frustrating and mind-numbing to work in a job with normal desires to grow, to do well, and have your career path blocked because of a physical disability. Somehow or other that has got to be addressed. People want to resume their normal working status, but they have lost so much--lots of money, and perhaps their working capabilities have been impaired. They are afraid that the disability may recur. Their confidence and their skills to resume normal work must be restored, and that process can take place between the employer and the disabled person if the linkage is correct.

This is a bridge on which Menninger ought to concentrate its resources. If that can be established, everything that I have ever heard about rehabilitation can work in a much more efficient way. If there is an active EAP program, and the employer and employee cooperate, the chance for success is multiplied.

Looking at these issues requires us to think objectively about the disincentives in both the private and the public plans. Where disincentives exist, no amount of bridge work is going to work. I would like to give special consideration this afternoon to financial disincentives. Money motivates people; there can be no mistake about it.

In 1975, the Health Insurance Association of America formed a committee to study this very intricate problem, and I happened to be its chairman. This is what we found: (1) depending on the nature of the disability, the circumstances under which it occurs, where it occurs, on land or sea or in what state, in an automobile or a public carrier (2) whether it involved a negligence claim, workers' compensation or liability suit (3) depending on your current or prior occupation or status as a veteran, a federal, state, or municipal employee (4) depending on the amount of group long term or short term individual coverage (5) whether you had accumulated sick leave, hospital benefits, or qualified for Social

Security--based on these and other variables, we found that individuals were grossly over-insured, reasonably insured, under-insured or, believe or not, in some instances had no protection at all.

Our study shows that there were more than 40 separate benefits that under certain circumstances would be available to disabled people. Each one of those was created with a specific benefit in mind for certain individuals without regard to any other benefit. Each in effect was created in a vacuum.

Each of the 40 directed coverage at one target population unmindful that benefits overlapped. As a result, there is a tremendous potential for excessive benefits, as well as no benefits at all. Neither situation is acceptable, and therefore the total system fails to deliver a rational, reasonable, or predictable program of protection to our disabled population.

A viable rehabilitation program designed to prevent disability dependence simply can't thrive in an environment where the rewards for not working exceed those of working, nor can it work when there is any other major disincentive in place.

Studies done by the Research Subcommittee of the Disability Committee of the HIAA offered a number of suggestions which could have an impact on the disincentives. It suggested, for example, that a mandatory cap be placed on the total amount of benefits that a disabled individual could receive. The cap might be operative when the total amount of all public and private benefits received exceeded 90 percent of previous net earned income.

Some might argue that 90 percent is too high. Perhaps, but some incentive must be built in to motivate returning to work.

America might well go up in flames if there was no cap on the amount of fire insurance that one could purchase on a home or business.

This is the only kind of insurance protection where there is no top limit on benefits. You can receive all you purchase. Even so, there are still loopholes and you can end up with little or no benefits at all. Over-insurance is a problem, but no less important than under-insurance. Some minimum level of financial support is essential to create the financial environment for rehabilitation to take place.

I'm from Massachusetts. The public pension system there leaves a lot to be desired. In 1983, the legislature finally required that increased pension reserves be created. This was necessary because the Commonwealth's disability pension program provided over-generous benefits, liberal eligibility provisions, and lacked any incentive for beneficiaries to return to work or accept rehabilitation. The Massachusetts Round Table had studied the disability provisions of the pension plan and recommended that they be separated from the retirement benefits so as not to destroy it.

That is a very important recommendation. When you commingle disability and retirement benefits into one package, you can't get the data you need to evaluate one as opposed to the other.

In summary: they concluded that disability benefits should be reduced to a level not exceeding net income before disability.

The definition of disability should be modified to reflect the physical potential of individuals who may be unable to perform all the duties of their normal occupation, but who are capable of employment in other occupations. Modified benefit should be established for those who are only partially or temporarily disabled. This is a void in the state and municipal plans as well as Social Security. Finally, apropriate provisions for rehabilitation and re-employment must be implemented.

The critical problem in Massachusetts and elsewhere is the fact that the unfunded liability is totally out of control. If it is not corrected in Massachusetts, 31 percent of payroll will go to the deficit created by the pension's unfunded liability in just ten years.

Returning to work may create other financial hardships for the disabled besides the loss of tax free income. The best example of this is the loss of Medicare, which is a most valuable benefit.

It becomes clear as you study the issues that the disability compensation system in the United States must be revised. It simply has got to be evaluated by people who are not politically motivated. Maybe this is the group. Financial and rehabilitation incentives must be built into the total network or this vitally important issue can not be resolved.

I was interested in developing some information for this meeting on the results of mandatory workers' comp rehabilitation programs. In Massachusetts, it is voluntary and the programs appear to be designed to create controversy just for the purpose of forcing dollar settlements as opposed to preparing people to return to work. Mandated programs, theoretically, should work better, but hard data was not available. I would like to know what happens when people are told that they must enter a rehabilitation program or not be paid.

The Social Security disability program has a number of well-documented deficiencies, not the least of which is the extended time required to qualify for it. Every time Alex Levis shows the systems design of SSDI, I wonder how it works as well as it does.

But once you fight your way through the maze, you have won something that is worth a great deal, and no one is going to give it up unless there are reasonable assurances that the trade-off is well worth it. Compounding the whole situation with Social Security is its total inflexibility. You are in or you are out: there is no middle ground, partial disability, and no easy rational way to engage in trial work. The perception that Social Security benefits are payable for life is also counterproductive. Once you qualify, you expect benefits to go on

forever. It is very difficult to create disability independence under such circumstances.

The program I like the best, is the veteran's disability plan. You present your medical information, reports from your own physician, your employer, and everything else that's required. Your physical capacity is carefully reviewed by qualified physicians based on their medical examination.

The award continues for a predetermined period of time after which it will be reviewed. You can work or not as you wish and still receive the benefits. It is easy to administer. It may not solve all the problems, but at least it cuts through most of the problems that you see in the charts that were shown earlier.

Let's talk just briefly about the private sector perspective. There are a number of options available in privately underwritten plans that can influence the degree of disability dependency.

In most cases, disability plans stand alone. They are not part of pension or life insurance programs. You can develop accurate experience, not distorted by non-disability influences. This is a distinct advantage.

We are able to select risks. We can accept or reject individuals or groups. This is inappropriate for federal or state plans. We are able to classify and rate risk based on physical, financial, and occupational data developed. We can use inspection reports, physical examinations, and prior medical history. We have the ability to evaluate each risk very carefully. The definition of total disability in the private sector permits a high degree of flexibility. It makes it much easier to deal with the realities of the disability and the workplace. Private sector policies require immediate notification of claim. So, early intervention is possible. The claims management process, utilizes inspection reports and even surveillance. Is the individual actually disabled--is he able to work? Independent medical examinations are used effectively in determining current physical condition.

Additionally, we have the opportunity to offer lump sum settlements as an option. We also encourage trial work. We stress the importance of vocational and physical rehabilitation programs. We offer flexible benefits which include partial disability, a very worthwhile benefit permitting payments when working part time.

The problem of preventing disability dependence is compounded by the fact that disability itself tends to be subjective. If someone says he is totally disabled and is not working, it is very difficult to prove otherwise. Physicians usually agree with patients who categorically deny they are able to work even though the precise reasons may not be medically determinable. So, if I say I am disabled, I am disabled. It might take time to find a physician who will agree, but it can be done.

Senator Dole talked about the issue of pain. It can be a major factor in determining disability, but difficult to evaluate.

Preventing disability dependence has the best chance for success when negotiations are handled by individuals who are sensitive to all the issues and have available to them a variety of constructive options. A new federal disability management program should address the issues of appropriate benefits, financial disincentives, physical and vocational rehabilitation, and the availability of meaningful work.

Disability benefits, except under unusual circumstances, should not be promised for life. Instead, based on severity, benefits should be offered for a limited period of time. Beneficiaries would know this in advance. They would expect medical re-evaluation. It is essential that meaningful work be perceived as the most desirable status for our disabled population. Couple that with employers accepting the obligation to rehire their own disabled workers and the most troublesome issues will be solved.

Most people have a built-in motivation to work. They refused to take hand-outs when they were working, and it is only when they are faced with extraordinarily difficult, personal, financial, and physical problems that they turn their hands over and accept what heretofore they had perhaps perceived as charity.

Once that act has occurred--that bridge crossed--it is extremely difficult to reverse the process. Preventing disability dependence is an enormous challenge. I am pleased that this group is willing to address it with such vigor.

PUBLIC SECTOR PERSPECTIVES

James Jeffers

As we begin to focus upon the costs of the management and maintenance of services and programs that benefit people with disabilities, it challenges us to look for ways and means of reducing those costs, for sure, but hopefully reducing those costs in a way that allows those individuals who receive reduced benefits to function in an independent and dignified fashion in society. I think it does offer us opportunities to accentuate a positive future.

In looking at issues, I feel that it might be most valuable for this group to have some knowledge of where the public sector, at least the federal public sector, is focusing its attention with respect to disability maintenance and disability management in the next ten to twenty years.

Therefore, I would like to share with you what the National Institute of Handicapped Research (NIHR) has identified as areas of focus over the next several years. These areas are directly and intimately involved with the prevention of disability and the reduction of the need for expanding services for handicapped individuals. They focus on the concept of prevention and rehabilitation.

Estimates are that 50 to 75 percent of disabled persons are of working age and unemployed. For some groups, such as the severely retarded and multiply handicapped, the proportion is much higher.

In a monograph on rehabilitation of industrial accident claimants released by one of the research and training centers, the disability system was characterized as a disabling system. This has led leaders of business, industry, labor, and industrial and rehabilitation medicine to question the current fragmented approach to disability management.

Preliminary results of the NIHR sponsored research suggest that there are enormous physical, psychological, and economical advantages inherent in beginning the rehabilitation process at the time of injury, which assures both the worker and the employer of the most expeditious return to employment.

Now this does not appear to be an evasive conclusion that requires extensive research, but in terms of dealing with individuals who are not familiar or cognizant of the concept of disability and rehabilitation, it is very important to be able to document to employers the need for early intervention.

I think, in terms of employers, there is a tendency to want to be very compassionate to employees who happen to incur a disabling condition, and they feel the need to let them leave the labor market. Although that is a sympathetic emotion, if you will, it is one that is not necessarily the most positive with respect to returning that individual to the work sector and a productive self respecting environment.

We heard this morning a litany of the problems with respect to disincentives that are part of our disability system in the federal government, and how we might look at addressing those disincentives and providing incentives for employers to rehire workers who become disabled. That whole process of rationalizing public policy on disability is an area of focus that NIHR has also identified.

Another area of concern is the focus on where the jobs might be in the next 5, 10, 15, or 20 years. They are not necessarily the jobs that exist today or the jobs that existed a year or two ago. We are experiencing very rapid and dramatic changes in our economic work system, and it is estimated that 50 or 60 percent of the jobs in the future will have a direct or indirect relationship to computers.

So it offers again an opportunity, I think, to look at ways and means of focusing on training programs and job placement programs for disabled individuals that heretofore have not existed.

The final area under the broad category of employment is the area that has been most dramatically articulated by Madeleine Will, who is the Assistant Secretary for Special Education and Rehabilitative Services. She speaks to the whole issue of transition from school settings to vocational and subsequently to work environments. It is an initiative that she has trumpeted and will, I am sure, continue to do so in the months ahead.

It really is a critical area. Looking only at the cost of disability dependency we simply must ensure that special education graduates are not at the end of the line. There is a real need at that point for intervention through the vocational process.

The second major category of NIHR identified research activities in the next five years is the area of physical functioning and ways and means of enhancing various physical abilities.

Again, as in employment, the timely application of treatment is very critical. It is not what we don't know, it is what we do know, needing wider and quicker application. For those of us who happen to have a spinal injury, there are a whole host of secondary disabling conditions that crop up if adequate and timely treatment is not provided. In many of the treating professions, I think, we need to look again at effective dissemination of information that we already have.

A third area under the category of physical functioning is the area of diagnosis and quantification of functional performance. NIHR is working with SSA on a method to evaluate and assess physical functioning for individuals who suffer from disease, or injury, or a disabling condition. An improved measurement system to a degree will allow us to make a more appropriate eligibility determination in the first instance and evaluation of vocational applications as well.

Finally, under the area of physical functioning, early intervention will prevent unnecessary deterioration and institutionalization which oftentimes occurs again as a result of lack of adequate information and service.

The third area of focus for NIHR, in addition to employment and restoration of physical functioning, is the whole area of community integration. It is an interesting area for me I must say. I was reflecting with a friend a couple of days ago, a young friend, a newly disabled friend, who was complaining about how terrible things were for someone getting around in a wheelchair. It suddenly occurred to me (I have reached the point of being wise by virtue of the fact that I have stayed around for as long as I have) that 22 years ago community integration, the ability to function with the general population, was very, very primitive.

We have made great strides in the area of deinstitutionalization, with some problems, admittedly, in terms of support systems, but there is a real recognition that it is okay to be out and about. So NIHR is focusing and is continuing to focus attention on physical barriers, social barriers, promoting integration of disabled persons in all aspects of society.

The fourth general area is an area that our friends at NIHR, and most particularly NASA and VA, have focused on, and that is the area of technological aids. Some of the activities, particularly at the Veterans Administration, stand to assist providers of rehabilitation services with increased and enhanced tools in the future in terms of allowing application of rehabilitation and restoration services that heretofore have not been part of the system.

Finally, the issue of research utilization and research dissemination. This kind of conference and other such activities and forums provide information that will be helpful in assisting disabled individuals in rehabilitation programs.

The five general areas of employment, physical functioning, community integration, technological aids, and research utilization are the areas that the National Institute of Handicapped Research is studying to assist in the general area of gaining disability independence.

In conclusion, there is a host of new books on the market that deal with management, management in general, that I support. The most recognizable is <u>In Search of Excellence</u>.

These books seem to have discovered a new theory or thesis with respect to what makes for successful management in private industry and corporations. They have come to the conclusion that what makes for good management is to construct your business from the bottom up, and start off by asking the customer what he or she wants. Then you build your organization, and you build your product or service, and then you will be successful.

This is perhaps something that the disability community might also use as a principle of looking at revising our programs, focusing on consumers, focusing on the individual details. Large systems in and of themselves have a tendency to become lethargic and unproductive.

I think that focus on the customer and the individual might lead us in the right direction.

PUBLIC SECTOR PERSPECTIVES

Robert Granzeier

I was very pleased to hear Senator Dole--I don't remember his exact words--allude to the fact that not all things were taken into consideration in removing and reevaluating people on the Social Security disability rolls. I want to describe some aspects of the problem caused at the state and local levels by this legislation. I don't think that Illinois is much different from any other state, and I am sure that my colleagues across the country have met with similar difficulties.

Prior to the legislation, the SSDI population was recognized as one of the most difficult for vocational rehabilitation services primarily because of built in disincentives and the severity of the disability. In Illinois, prior to the enactment of the legislation, we were fifth or sixth in the nation in the number of rehabilitated individuals who came out of the program. One of the first problems, prior to even thinking about the number of individuals who may be taken off the rolls, was the loss of advance funding and the fact that we would only be reimbursed for those individuals that were actually rehabilitated.

This automatically caused closer scrutiny of disabled individuals that may be too severe to go through the vocational rehabilitation process. The legislation created a tremendous workload for disability examiners. They went from 5,599 redeterminations in Fiscal 1980 to 20,000 in Fiscal 1983 with a reduction in staff. All claims went from 108,665 to 125,478, again with a reduction in staff.

The economy being as it was, the governor of Illinois put a cap on hiring to reduce the number of employees in the state, regardless of whether they were federally funded. That hiring freeze is still in place today because of the economy and because of the shortage of dollars. As a result, turnover among disability adjudicators went from 10 to 12 percent to 15 to 20 percent. This added to the backlog of claims and naturally caused problems for the agency regarding the accuracy and the timeliness of processing cases.

We had a severe shortage of medical consultants. This was a local problem in Illinois. Prior to any increase in fees for the medical consultants, physicians, medical treatment, X-rays, surgery, or anything of that nature, approval by a rate review board was necessary. We could not increase the rate, for example, to have a psychiatric consultant, a position which is federally mandated by SSA. Losing medical consultants, Illinois turned to the high volume medical providers to get information. The reports that we received from high volume groups were not as good as we would like, but we used them in order to maintain the best possible accuracy and timeliness needed in processing cases.

We were getting reports from community mental health centers, glowing reports as to what the patients could do. As a result of such reports, the bottom line indication was that the person could, in fact, go to work. What we found out was, yes, these persons could take care of themselves now. They could dress themselves, they could cook, and they could do all kinds of things, even use transportation. What it doesn't say in the report is that there has to be somebody with them all the time. So we had to go out to the community programs and say, "Tell us the facts. If the person can do these things, what are the circumstances involved?"

We attempted twice to decentralize the program, to put the disability examiners in the Chicago area so that they would be closer to the medical resources, closer to the physicians, but could not. At the congressional hearing with Senator Heinz, a disability examiner, who was the president of the Federal Region 5 National Association of Disability Examiners, admitted for the record that disability examiners felt that they were under such pressure from the Social Security Administration to have accuracy and timeliness that, regardless of what the medical report said regarding the severity of the disability, they were taking the persons off the rolls.

There were problems with administrative law judges. Illinois VR experienced an 80 percent reversal rate. We found that many times administrative law judges were not working with the same information as the disability examiners. Many of the legal aid societies and legal counsels that were representing clients had information that had not been furnished to VR. More recent information regarding the medical situation was available to the legal counsel, and, when presented to the administrative law judge, the original decision would be overturned.

There is confusion regarding administrative cost reimbursement for administering the program. Under the SSA regulations, you have to demonstrate that a person is successfully employed for a period of nine months; under the federal vocational rehabilitation regulations, the period is 60 days. In some cases, reimbursement may take as long as six years. A student with a severe disability takes about five years to get through college. Then the student has to be employed for a period of nine months after that before reimbursement can be claimed. The severely disabled is a very costly population to serve. It takes much longer. Each step is more costly, and rehabilitation is slower. The result is that fewer persons are served.

The governor made a very difficult decision. He declared a moratorium in the state of Illinois on processing Continuing Disability Reviews (CDRs). It was not a popular decision for him to make, nor an easy decision, but he really had no alternative. As a result, one of the things called for by the Social Security Administration, the face to face interview process, had to be held off. The problem impacted on the Department of Public Aid--when you take people off the disability roles, they go on the public assistance rolls. It had a potential impact on child abuse situations. Individuals who were taken off the rolls could take it out on children. It could lead to increased teenage pregnancy.

Here is a father who has been taken off the rolls, he is angry. The teenage daughter wants to get out of the house, and one way to get out is to become pregnant. Some law enforcement agencies maintained that the number of crimes increased. Reports indicate that individuals under this kind of stress and strain, who may have been on the road to recovery, could end up back in hospitals or institutions. These are some of the problems in Illinois. My colleagues throughout the country have experienced some of the same.

Some things are planned in Illinois to help improve the situation. An ombudsman program is being developed with designate staff to relate to individuals on a one-to-one basis.

An advisory committee, is being established consisting of representatives of legal aid, advocacy groups, and consumers, to advise the department of procedures that we may be able to put in place that could improve the system and not be contrary to the federal rules and regulations.

Illinois definitely plans to implement the face-to-face interview process, and I think that is going to be very meaningful. I am confident that more realistic decisions will be made regarding an individual's continued eligibility as a result of this process.

There has been an increase in the quality assurance activity. More cases will be scheduled for a Quality Assurance Review.

Fee increases have been approved for medical and psychiatric consultants. The situation has definitely improved.

This is pretty much what I have to report to you about the legislation as it affected Illinois. I know that we need to find a way to remove those people who are on the rolls inappropriately, that are riding the rolls. They should be off, no one can deny that. However, I hope those individuals with severe disabilities will continue to receive the financial support they so desperately need.

RETURN TO WORK

John T. Steward, Ph.D.

The case for early intervention is being made in a variety of ways. Rehabilitation practice is extending its responsibility beyond its customary orientation toward restorative and curative goals to include the immediate needs of the newly disabled.

Over ten years ago, recommendations for updating state work compensation policies and programs marked some early support for the early intervention philosophy. Along with the legislative changes at the federal and local levels, support came from the private sector, including large and small proprietary entities, and from the professional communities, which encompassed the medical, legal, educational, and rehabilitation fields. The insurance companies have had a major impact on return to work and, of course, collective bargaining groups or unions have a major influence on how soon the disabled worker returns to work.

Thus the return to work philosophy is strongly seated as an appropriate guide for the attitudes and actions of employers, insurance carriers, and rehabilitation professionals who must respond to workers' disabilities. Both medical and vocational rehabilitation professionals have discovered that early return to work can be therapeutic. Hence, they strongly support the return to work policies.

Currently, the vanguard of vocational rehabilitation is developing services preventing disability cases and cases of progressive illness. Next, these recommendations must be translated into modifications of the existing rehabilitation system. Finally, these new efforts must be tested for their potential impact on disability in today's work force.

My personal or professional, if you wish, involvement in the return to work movement stems from my position as dean of economic development with the City Colleges of Chicago. In this capacity, I am deeply concerned with the disadvantaged student and his or her vocational training needs.

Dr. Hester and I have cooperated in the past by developing vocational training programs for both the disadvantaged and the disabled. Our relationship on the projects has generated positive results. When Project Retain emerged, Ed requested that we work together on it as a demonstration model. It is promising to become a major force against short and long term disability. With that, I would like to describe the structure and the direction of Project Retain.

Much of the cost of supporting disabled workers is borne by American industry through taxation, short term disability, long term disability insurance premiums, workers' compensation, and paid sick time. Not only does this put a tremendous burden upon industry, but it also represents a loss of skilled employees during their prime work years.

In addition to these concerns, forced unemployment due to a disabling condition causes serious personal problems for the disabled workers. So much of their self-image, values, and structure in life are involved in the worker role that unemployment due to a disabling condition is extremely traumatic.

In order to ameliorate the problem, some large corporations such as Control Data Corporation, ALCOA, and 3-M have instituted return to work programs. The premise behind these programs is the diverse immediate needs of both the employer and the disabled worker. The employee's needs for rehabilitation, including motivation, and an employer's desire to hold the cost down can best be met in the same step.

Although the employer's responsibility for provision of rehabilitation services is outlined under workers' compensation legislation, the rationale for more comprehensive involvement in rehabilitation, not protected under the workers' compensation guidelines, can be considered an economic one.

Assistance to the disabled worker should begin as soon as possible after the onset of the disability. National studies have discovered that worker personality characteristics, particularly those relating to independence, begin to change within 60 days of an injury.

Norman Cousin affirms, "Depression almost universally affects people who have had heart attacks, generally in the hospital, when the realization hits that life is in serious jeopardy, and again during the recovery period when the invalid psychology takes hold."

In general, the longer the injured worker is forced to cope with a non-working situation, the more difficult it becomes for the person to maintain a strong, positive, and realistic psychological response.

When cardiac patients were provided counseling services within two weeks after suffering a heart attack, one study found that 80 percent return to work faster than those patients who were in a control group and did not receive counseling.

Not every company can afford or desires to operate its own return to work program. Therefore, a program entitled Project Retain has been established. Project Retain is being funded in part by the National Institute of Handicapped Research and jointly operated by the Office of Economic Development of the City Colleges of Chicago, the Vocational Rehabilitation Research and Training Center of The Menninger Foundation in Topeka, and Schwab Rehabilitation Hospital in Chicago, Illinois.

Project Retain is being staffed by Susan Entenberg, a rehabilitation counselor, who has experience in private practice in working with insurance carriers, employers, physicians, and attorneys. Participating employers have agreed to notify the project as soon as they are aware that one of their employees has suffered a potentially serious injury or illness.

The Project Retain counselor will obtain the necessary background information on the worker from the participating firm's department and schedule a meeting with the person's supervisor as soon as possible. When the counselor meets with the supervisor, she will analyze the person's job, and with the supervisor she will learn the level of the individual's pre-disability performance. Of course, the counselor will have previously become familiar with the company's policies regarding sick leave, return to work, and disability benefits.

As soon as the person is out of the intensive care unit, but after the meeting with the supervisor, the counselor will visit with the patient and his or her physician subject to agreement by the patient. The Project Retain counselor will provide a communication link between the patient and the employer to ensure the prompt return to work of the disabled worker.

In the event that the disability precludes returning the worker to his or her old job, the counselor will work with the personnel department to find a more appropriate job in the company. Lastly, if there are no appropriate jobs within the company, then the counselor will work with the person to help him or her find a job with a different company.

Those companies which decide to participate in Project Retain will be asked to sign a cooperative agreement which will delineate the responsibilities of the project sponsors and the company.

One of the company's responsibilities will be to provide the project with data concerning extended loss time injuries or illnesses which have occurred to their employees either on the job or off the job within the last two years.

Also the counselor should be introduced to the workers' compensation and STD and LTD insurance carrier representatives so that she can explain the project to them. This will also hold true for union representatives if the employer operates under a labor management agreement.

The data concerning the company's experience over the last two years will form the control group for the experimental study of this project.

Rather than go into the project any further, there are probably some questions. We have the entire staff here who is involved in Project Retain. Between us we should be able to answer any questions.

DR. HESTER: There are a couple of points that I would like to add. We have found employers, and they are not necessarily the owners of the company but people who are high up in the company, looking at disability benefits as a benefit. The employee has earned it. How can we go and deprive employes of their benefits? Another current attitude is, if the company is laying off people and somebody becomes disabled, you can put them on disability and you don't have to lay off somebody else. The problem here is cost. For instance, The Menninger Foundation guarantees 60 percent of a person's former income as their long-term disability. If the Foundation is paying $10 an hour to have a job done and the worker becomes disabled, they bring in someone else at $10 an hour to do

that job. The job now is costing $16 an hour because there is $6 for the person who is sitting at home.

When I was at Michigan State University for the international conference, I think the person from Finland said regarding their national policy that they believe in stirring the pot. Their national policy is that they don't have full employment, but everybody should have the chance to work once in a while. They don't mind having some people laid off so that others can get back to work. They want every family to have a tradition of work at least part of the time to pass down to the kids. They avoid developing a hard core of unemployed, people who never knew anyone who was employed, which is the problem we have in certain segments of our country. Their policy of getting the disabled back to work gives them at least some return to work experience even though the job may be eliminated three years down the road.

QUESTION: What is the difference between what your counselor does in Project Retain versus the counseling of the state rehabilitation agencies?

DR. STEWARD: It is basically a difference of timing; get to the patients before they begin to think of themselves as disabled.

QUESTION: If I could, from an insurance company standpoint, let me say that I can appreciate much of what is being said here about the reluctance of the individuals perhaps to go back into the work force. This is a benefit to which I am entitled, I have worked for it, and all that type of thing. But I have to say truly, and I have been involved in rehabilitation work for many, many years, I feel that the moral fiber of the people tends toward work. Individuals want to work, to pay their own way. They are self-respecting. The majority of people welcome the opportunity to get back to work.

DR. STEWARD: That is what the project is about. It is also a study. We hope to use the two previous years of experience with the employer as a control group to be compared with these efforts of Project Retain.

QUESTION: I am in the private sector, and I think the return to work concept is excellent. I think we should promote return to work as a benefit. I liken it to group insurance. We have group insurance where I am. It is one thing I hope my wife never collects, but it is nice to know that should something happen to me, it is there. To me the return to work is the same thing. As an employee, I would hope that I would never have to use a return to work counselor, but it is nice to know that should I have a disabling injury or illness my company would stand behind me and assist me with the return to work counseling.

I think that we need to sell the return to work program as a benefit.

DR. STEWARD: I think Ben Jones has alluded to that earlier in many other ways, too. It is true for many people in the hospital that the last person they hear from is the employer. It would be nice if the employer were one of the first.

DR. GELLMAN: One of the values, I think, is that early intervention prevents the process of disablement. In addition, having the employer accept this principle to move fast makes the prospect much more simple and permits you to follow through. You really have a very good design.

DR. STEWARD: I was happy to be associated with it.

DR. HESTER: Speaking of design, after the conference, we will distribute a brochure describing the project.

QUESTION: What are your plans to approach labor unions and involve them?

DR. STEWARD: They would be involved, there is no question about it.

QUESTION: Has labor been involved in the initial planning?

DR. HESTER: As much as we can. Guy Stubblefield, for instance, from the Machinists and Aerospace Workers contributed some ideas to it, but is is really going to come when we get into a particular plan with a company and a union. We will explain that we are not trying to take a benefit away from their members, but that we simply want to get the person back to work.

QUESTION: People are very concerned about going in too early. What do you do, the guy is lying there with tubes up his nose, and you are talking about going back to work.

DR. STEWARD: We wouldn't want to go in there and insist that somebody go back to work before the person is ready. Naturally, the physician would be in attendance right from the beginning, and he would be apprised of everything.

TRAINING FOR ACTION

John D. Downs

In the field of rehabilitation, there is not so much a lack of useful knowledge as there is a lack of application. Dr. Douglas A. Fenderson, director of the National Institute of Handicapped Research, identified the gap between research and application in his guest editorial, "Rehabilitation Research--Principles and Process," published in the Journal of Rehabilitation Administration, August 1984. Presenting a list of seventeen rehabilitation topics researched from 1967 to 1983, he said:

> Even a casual inspection of the list suggests to an informed observer at least two major conclusions: (1) we have come a long way; and (2) much that is useful is often not applied.

Lack of funds, resistance to change, fear of failure, lack of opportunity--all can block the transition of knowledge into action. But even when these factors are removed or reduced, there is still a gap between knowing and doing. One is not the other; one does not necessarily lead to the other.

The gap is apparent in common experience. A child studies her friends skating and hears her father say, "Slide one foot before the other." But, as she stands to skate for the first time, she hesitates. She doesn't know what to expect. She pushes off, falls, and rises in search of the patterns of motion. The transition between knowing and doing is more difficult when many are involved. A choreographer blocks the dance, but the dancers practice hour upon hour before they perform the moves together, almost without thinking.

In rehabilitation, the transition from knowledge to action is especially difficult because: (1) rehabilitation is a multi-dimensional problem and (2) principals come from different fields: medicine, vocational rehabilitation, engineering, government, labor, education, business, insurance. In any community program, the players will have different sets of methods, values, goals, techniques, and procedures. Though each may have useful knowledge about disabled persons, they will hardly have a way to act together in a single program.

The Menninger Research and Training Center uses a model of training called Training For Action to establish community-based, rehabilitation programs for the disabled. Over the past year, the model has structured and initiated transitional employment programs, child-care programs, and train-the-trainers seminars. The model has been used to establish new programs, initiate pilot projects, and confirm existing programs.

Training For Action closes the gap between knowing and doing in rehabilitation. It addresses both the knowledge and the action.

From a complex body of knowledge, the model selects what is useful and prepares it for application to a program. For example, to know that targeted jobs tax credits are available to employers hiring the handicapped is important, but for this knowledge to be useful, the local

vouchering and certification processes must be delivered including forms, names, telephone numbers, schedules, and mailing practices. Most of the selection and preparation of knowledge is done before training, but some can be accomplished during the session.

Training For Action also closes the gap from the other end. It studies an action to determine the parts and how they go together to make a whole. It identifies the essential elements and aligns them toward purpose. It assigns the parts to principals committed to the program and prompts them to make a start. The model recognizes that people more readily go into action if they know what is expected of themselves and others. Shared expectations fixed in the minds of the principals comprise the structure of the action.

The model may be expressed in terms of a formula: useful knowledge + structure + expectations = action.

In process, Training For Action takes three steps. A front-end analysis determines whether the essential elements of the action are available within a community. It identifies the community needs and resources. It selects and gains the commitment of necessary principals from rehabilitation agencies, community institutions, and business. The commitment may be expressed in the form of employment positions, referrals, management, support, placement, counseling. The front-end analysis always yields knowledge that leads to the immediate refinement of the action.

Secondly, Training For Action calls the principals together, usually for the first time; it delivers the knowledge and the structure of the action. The model gets the principals thinking together about the structure, the purpose and the flow of activities; feeling together about the need and the rewards; and talking together in a new network of communication and teamwork. Finally, it gets them to start the action by taking the first step in doing their respective parts.

Training For Action addresses the barriers of prejudice, fear, and resistance to change. Knowing the effects of these barriers on participants and principals helps clarify expectations. Sometimes, identification of an attitude leads a principal to withdraw from the program. Sometimes, training is enough to put an attitude in abeyance for the sake of the program--"I'll give it a try." Training does not change attitudes. Pursuant action often does.

Thirdly, Training For Action forecasts the problems that may be detrimental to the key elements of the structure. It leaves the principals with problem solving methods and with a time-action plan to guide the growth and development of the program.

Training For Action has modeled the initiation of transitional employment programs in six communities in states other than Kansas, including Kentucky, Colorado, Louisiana, Illinois, and California. The structure in each of these programs is basically a partnership between rehabilitation professionals and managers of hospitality sites. Referring agencies send persons with disabilities to a hotel property where they train under a transitional employment specialist in salaried positions for four to six months. These sites are still operating after

nearly one year and have withstood changes in management and supervision.

The model recently stuctured an action to lead young women (16-18) from state care to self care. The action was structured as beginning, middle, and end. The beginning has two parts: a weaning from institutional and inappropriate behavior and making a start toward an end. The end is return to family, a group home, college, military, or career. The middle is the consistent exercise of activities that lead to the end. The young women and the counselors know the essential elements of the program and set their expectations accordingly.

A train-the-trainers session was delivered to rehabilitation professionals from Kansas City and Topeka. A session is currently being planned to structure the use of worksite modification as a means of re-employing persons supported by long-term disability insurance.

Training For Action has established a successful track record in initiating programmed actions. Its strategy of closing the gap between knowing and doing by making the knowledge useful and structuring the action seems to be effective. Establishing clear expectations about the action as a whole and its parts in the minds of the principals is moving them beyond inertia and into action.

PARTICIPANT REACTIONS AND SUMMARY

Sheila H. Akabas, Ph.D.

There is something wrong with disability management, there cannot be any question about that. We clearly need to look at what is wrong and what we might be able to do about it. I applaud The Menninger Foundation in making this effort and the National Institute of Handicapped Research in funding it.

What is wrong? The system's goal, we are told, is to return disabled persons to work. We have all agreed that the system is costly and that it is not accomplishing the goal. Then, on the other hand, we hear that not only do we need more money to provide better incentives for people to return to work, but there is no money for those incentives. We are in a hard pressed socioeconomic period, as Dr. Gellman said, in which the major objective is to cut budgets. How do we really reconcile that with bringing additional incentives to employers and employees?

A second kind of question is that we need to have new ways of helping people get back into the world of work, but there are no jobs there. Many of us who have been in rehabilitation are aware that there are limitations in the job market in this country today and all over the world.

Are we ready to buy the idea, which I think has been suggested very creatively here today, of partial disability payments to be accompanied by partial employment? People can graduate from being totally disabled to being partially disabled. Can we help them graduate by saying, yes, you can get a partial payment, and if you turn out to have more problems in the future you will go back on full payment. If you need medical care, we will provide that if your employer will not. In other words, how much flexibility can we build into the system as a social policy?

In Belgium, once you are employed, you are forever eligible for unemployment insurance. You are always an unemployed worker if you lose your job for whatever reason. That is the mind set that we have been talking about today--people should be workers and should be perceived as workers and should see themselves as workers. How can we protect disabled people from seeing themselves as handicapped and unemployed?

What is the role of trade unions in this whole process? One out of every five workers in the United States belongs to a trade union. Unions have an important role to play in the workplace. We have learned in rehabilitation that consumers are important, that we ought to consult consumers about what they want to do with their lives before we make plans. In those workplaces where there are trade unions, we need to follow the same process--not to tell unions what to do after we have made our plans, but involve the trade unions in the active development of those plans.

I thought a very creative idea was started in the early morning with Dr. Gellman who said that the rehabilitation system should be dealing with employers. We don't invest enough in employers, in working with

employers, in educating employers, in providing incentives to employers, and helping employers know what accommodations might be possible.

Employee assistance programs in workplaces throughout the country have the means available to do prevention of job loss as well as rehabilitation. Counselors in these programs get troubled workers referred to them. Some of those troubled workers may be physically disabled workers or may be emotionally troubled workers or people who are having family problems. In fact, the employee assistance program can be very vital in trying to develop job retention and rehabilitation services in the workplace.

I think there is a lot of financial incentive to achieve retention and rehabilitation. There is moral incentive in this country and a lot of caring about people and what happens to them in the workplace. We need to figure out how to make good use of these positive intentions and what kind of methods work best. It is not just a matter of saying to an employer: "Come on, take back your workers who are disabled." We need to document carefully what it is that employers should be doing, what it is going to cost them to do it, and what it will cost not to do it.

The workplace can save money by good disability management for other than its employees as well. I refer to dependents. We have just finished a project at Columbia in which we looked at newborns who are disabled: infants born with a handicap. We have tracked the medical costs that those newborns have precipitated in the health insurance system that insures their working parents and them as dependents. It turns out that there are a lot of medical costs. We have talked to the families and found that a lot of people are dropping out of the workplace because they have disabled children and are having very severe problems in obtaining care and treatment for their children. We are beginning to talk to a couple of employers about flexible jobs. We suggest a pool of flexible jobs, jobs which parents can do at home as well as at the workplace or that they can do at different hours during the day so that the care for the disabled children will be possible. We believe it is important to help the workers to maintain their work roles, be able to keep their income and health benefits that will allow them to take better care of those children without relying upon public care services. We have been pleased at employers who consider designating jobs that do allow that kind of flexibility. We are beginning to develop pools in a number of workplaces.

This is just one example of what might be possible. It is an open area, and we need to try out in a very systematic way the creative ideas that have been brought to bear here today. I invite those of you who are sitting here to comment or to ask questions and in fact to get involved in a dialogue that should end any such conference that has generated so many ideas.

MR. FAIMON: Mr. Jones referred to Senator Dole's comments on the growth of Social Security expenditures for medical care and stressed the need to convince people that they are in control.

Once somebody becomes Social Security eligible, he or she can potentially tap the whole system. Wouldn't it be better to look at a strategy more in the context of the private sector, so that if the

individual's condition does improve, basically he or she is not worried about losing the benefits that support dependency.

MR. JONES: I think that would be of value because the Medicare is so precious a commodity. If you once have it and you lose, you are looking at bills. There is just no way to measure the value of that program. So it is a huge disincentive.

QUESTION: We seem to have gone back and forth over the question of programs today, from speakers who talked about the Social Security Disability Program and other compensation types of programs to insurance benefit programs, giving us a picture of what happens when a person does separate by one of those circumstances. Then we had other speakers who emphasized the disability management concept, what can be done to structure interventions within the employment setting. My question is, how much do we need to focus on both of these types of phenomena. Thus far, we have concentrated on what has been the easier subject to study, the aggregate data and knowledge of what happens to people after they become disabled.

What we ought to study is what happens to people as they are having a disability emerge, and while they are still employed, before they separate. What are the strategies and the efforts that we need to focus on during this early period and to what extent can we really model that and define that when it is a different sort of animal. It is taking place in smaller settings, whether it be business or large corporations like AT&T. If you were advising the manager of a unit, what would you tell him to focus on, to go in all directions looking at the benefit system that people get into or to look at the early intervention aspect?

DR. GELLMAN: I think you would have to see that as a multi-faceted problem, rather than a single one. If it is a problem in which a firm, a family, an individual, the agency involved in terms of rehabilitation, and society play a role, that would be wonderful.

The second point I would make is that we know the ingredients that would help to make a better program, early intervention is one. What would be of value would be some controlled studies in which we have put these ingredients together and asked ourselves whether it does create a difference.

Lastly, I would suggest, I think it is very important that we work with employers to set up ongoing, long range programs for accepting and working with the disabled.

DR. LEVIS: May I respond to that question?

Let's look at this flow-chart (page 25) for a second and see the implications of your question. On the left side is represented the disabled population which moves through the system for compensation or rehabilitation. There we have recognized the serious problems: the large caseloads, the long delays, the disincentives that are occurring, the intervention programs trying to bring people back to work.

As a systems person, I would say that this is the wrong way of doing things. We are working at the tail-end of the process, after you have incurred all the costs of bringing the people through the systems.

In prevention programs, knowledge of which is not very clear, you try to work with the person who has been either physically impaired or mentally impaired but has not yet been declared disabled. You have to look at the multiplicity of programs, the government programs that Ben has indicated, state and local programs, long term, and you have to decrease the flow of persons through the system. There is no way that society can support an increase in the flow.

My personal feeling is that we can't look at the one as opposed to the other. We have to look at both sides to bring some rationality to the whole thing. Thank you.

DR. AKABAS: We are moving also to a period when some of the problems may solve themselves. There are fewer young people coming into the labor market. The demand for labor will actually sop up some of the people who are becoming disabled as we go along because there won't be enough new young people to fill the jobs.

DR. LEVIS: You make a very, very good point. I look at the numbers, and the creation of programs that will bring people back to the work force will be effective as time goes on. The catch is that in the meantime, for the next ten years, the number of disabled, as the age of the population increases, will be growing disproportionately from the population. Can the systems afford that? If the delays go from four months to 17 months in such matters, they are going to increase even further.

DR. AKABAS: It did sound that way; didn't it?

MR. FAIMON: I think another aspect, a different arena, but dealing directly with employers, is workers' compensation. Basically, Alex has been studying the national systems, those prescribed for federal parameters. When we get into the workers comp arena, we are dealing basically with 50 different systems because they are governed by state statutes.

There are two subsets, those employers who are self-insured and those who are covered through insurance carriers. Just within one subset, we have discovered a tremendous range of approaches by self-insured employers in their approach to the injured worker. Some have a very laid back approach, although they are their own risk managers, and others have a very positive approach.

A tremendous amount of information needs to be gleaned out of the private sector related to workers' compensation strategy. How does that strategy relate to those employers who are bound by a labor management agreement? How does it relate in one covered industy compared to another?

MR. GRANZEIER: I know that it is like being against the flag and motherhood, but the time has come where we need to take a very close

look at the vocational rehabilitation process and counseling. We have thousands of trained professionals in the field who are providing services to the disabled, as you showed. Perhaps that focus needs to be changed so that they get more into the intervention process rather than at the end of the spectrum.

I will speak for Illinois. The counselor today is primarily the purchaser of services. The time spent actually counseling the client on a one-to-one basis is minimal. I think this is something that research should certainly look into. Vocational rehabilitation has been a very successful program. Times are changing. What the counselor is doing today is far different from ten years ago. That role has changed very much. To continue to be a successful program, maybe that focus needs to be on intervention.

MR. FAIMON: I think you see some of that already occurring in the area of workers compensation. In states where the workers compensation statute encourages, provides, or recognizes rehabilitation, rehabilitation counselors in private practice are moving into that arena. In states where the workers compensation environment is not favorable, the private provider is not going in. That also is reflected in the fact that existing federal vocational rehabilitation legislation establishes eligibility based on an assumption that the disabled individual has not been participating in the labor market and is attempting to access it. The legislation is not preventive in nature.

MR. GRANZEIER: That is why I say that the focus needs to be changed.

DR. AKABAS: It is part of the whole package, there is something wrong here, you are right.

QUESTION: If we look carefully, we aren't looking at role models. The private rehabilitation movement is nothing more than state agency counselors doing something for a fee for service, using the same tools, the same case management criteria, the same organizational processes, except doing it a little more aggressively with a few more parties involved.

So, what we have to do is look at what services are needed, and what intervention is needed in the acute care phase versus afterwards. If we really address that issue, then we will make some impact. But if we use the same model just three months earlier, it won't work; it is not going to be effective. So, we have to be very sensitive to not dressing in new clothes, but that we do something different.

DR. AKABAS: I think we have to be careful not to throw out the baby with the bathwater. It is certainly true that we haven't paid any attention at the front-end.

Diane Woods was mentioning that a company in Philadelphia is looking at their people who have retired on disability over five years ago. The company is interested in their coming back to work if they can be accommodated. Many, many people said, yes, I want to come in and talk about it. It is not clear that all rehabilitation will take place early on, and we should not lose those people who some time afterwards come to a point where they want to return to work, or when new technologies make

it possible for people to come back to work. For example, rheumatoid-arthritic patients are getting surgical procedures that restore an enormous amount of already lost function, and in some cases we have a new person.

MR. FAIMON: The International Association of Machinists in Wichita faced a situation where somebody was laid off, and then became disabled: a displaced, disabled worker. The International Association of Machinists, with their grant, concentrates on the union membership that becomes disabled, but because of the layoff process there isn't opportunity to get that individual employed with the old firm.

It is a very slow process just in educating the union leadership, the employers, to the whole idea that a service can be provided through the labor organization to help that individual transition to a new occupation, to a new lifestyle because of disability.

QUESTION: Could I have a clarification on the population that this project is addressing?

MR. FAIMON: We are attempting to concentrate primarily on the worker or the individual who has labor market experience and because of injury or illness becomes disabled.

DR. AKABAS: Bill Gellman talked about a "hospitable working climate," where the work climate accepts its own disabled personnel and finds new ways of accommodating them. It is a climate where they also begin to understand the needs of the new job entrants who might be disabled. There is a lot of spinoff, and that is something that we haven't talked about. What is the impact on a family when someone does return to work? What are the differences between the children and families where a disabled worker has been permanently retired or has been returned to work? There are real social costs that we don't calculate when we do not succeed at the rehabilitation process.

The fact that somebody has a good solid work ethic and suddenly winds up, because of an accident or illness, unable to work, the toll, the trauma psychologically not only on the individual but also on the direct and immediate family members is something that I think is virtually immeasured at this time.

We have done measuring with the unemployed. Maybe we should do the measuring with the disabled. There are some models that we might be able to translate.

MS. SCHWARTZ: I think we have many tasks ahead of us in terms of reaching employers. I think probably the first one is to illustrate to the employer community how much they are currently paying in disability costs basically to keep their employees at home.

I think probably the second task would be to encourage companies to develop corporate strategies for disability management.

We are lucky to have Jay Rockwell from AT&T with us, but I don't think that AT&T is representative of the other major employers that exist

around the country. I think they are far more advanced in some of their programs.

QUESTION: Gail, why don't you introduce yourself.

MS. SCHWARTZ: I am Gail Schwartz with the Washington Business Group on Health. I direct the Institute for Rehabilitation and Disability Management. The idea of this new institute is to promote corporate involvement in rehabilitation and disability management and also to urge reemployment of the disabled. So we are very interested in this conference. Usually when I attend meetings, I hear very little discussion about employers.

One other comment is that many of the efforts that exist around the country to promote employment of the disabled exist through the affirmative action departments of companies. What we are trying to do is a little bit different. We are trying to promote corporate involvement in disability management through very senior corporate decision-makers in major employers around the country.

MR. GRANZEIER: I would like to do that, emphasize the role of employers, but I also think there should be emphasis on the physician who handles the disabled from day one of their illness or injury and are setting them up as the person who could become disabled.

I would add to the employers, the physicans, particularly the practictioners, the GPs, those persons who have an impact on the disability.

DR. AKABAS: As an educator, I can't resist the fact that most educational institutions never talk about the issues that the practictioners are really going to have to face and deal with out there. The educational institutions ought to be training people to think a little more about how you maintain people at work, and the roles of professionals in relation to employers and trade unions. I say that 20 times a day, but I am not sure how many hear it.

MS. SCHWARTZ: I agree with you completely about the physicians. I also want to add that a lot of growth in the corporate community in disability management is stemming from the affirmative action departments. They are very active in monitoring short term disability and absenteeism. I am really in a key position to seek corporate involvement in other divisions of the company.

MR. MITCHELL: A good example of what we are talking about, Sheila, is that we did some work with rheumatology. We took resident doctors from the rheumatology department out into the plants to evaluate people with arthritis. The day before, one resident had given three people permission to be on disability. He had cleared them for Social Security disability. We happened to go out to the plant where they had worked. The resident had such little comprehension of what the job was that he was appalled at how the job was told to him by the employees. He went back and changed his report. Just that simple piece of information, knowing a little bit about the workplace, made him much more accurate in his evaluation.

You are absolutely correct. The least thing that physicians do well is make decisions regarding disability versus impairment.

DR. AKABAS: When we first started a project in the men's clothing industry, we recruited psychiatrists and took them through the garment factories. They said to us: " The first patient I see, I am going to tell him to get out of this industry." They had chosen not to be in the real world by their very choice of being doctors, and they were concerned about the steam irons and the heat, and everything else.

We said to them, "What should the person do after they get out of the industry?" So many professionals, including rehabilitation counselors, social workers, doctors, unfortunately are isolated from the world of work and do not understand how people function in that world. Their lack of knowledge undermines the potential for rehabilitation of too many clients.

MR. FAIMON: Sheila, thank you very much. A special thanks to each and everyone of you. I think we have come up with more questions than we did answers. I think that our new directions in disability management are validated in the discussion.