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13th Annual National Disability Management Conference and Exhibit, October 27-29, 1999:
"Rehearsing Your Future: Healthy People, Healthy Companies" [report] [2]

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13

Divider Title: _____

8:30-10:15 Friday
Plenary Session

C. Everett Koop National Health Awards

Always addressing the controversial issues that face the American healthcare system – and never from a single vantage point – C. Everett Koop, MD returns to highlight the Friday morning program. His National Health Awards will again be presented to employers, providers, and communities who have demonstrated excellence and cost-effectiveness in health promotion and disease prevention programs.

Carson Beadle
President
The Health Project

C. Everett Koop, MD
The Health Project

Carson Beadle is President of Carson E. Beadle, Inc., a strategic planning firm. He is Vice Chairman of National Health Enterprises, Inc., a TV and Internet health network and is Director of Security Mutual Life Insurance Company and of Security Equity Life Insurance Company of New York. Mr. Beadle is President of The Health Project, the White House-supported organization that presents the C. Everett Koop National Health Awards for programs that encourage better health behavior and informed use of health care services. He is retired from William M. Mercer, Inc. where he served as a Director for 25 years, during which he headed the company's New York and Eastern Canada regions.

C. Everett Koop, MD was Surgeon General of the United States from 1981 to 1989. In this capacity, he oversaw the activities of the Public Health Commissioned Corps and advised the public on health matters such as smoking and health, diet and nutrition, environmental health hazards, and the importance of immunization and disease prevention. He also became the government's chief spokesperson on AIDS. He continues to educate the public about health issues through his writings, the electronic media and as Senior Scholar of the C. Everett Koop Institute at Dartmouth. Dr. Koop is Honorary Chairman of The Health Project.

Healthtrac Prize

George D. Lundberg, MD
Former Editor
Journal of the American Medical Association

...for his lifetime of major accomplishments in health improvement in the U.S. and throughout the world as an educator, scientist, program innovator, activist, and medical journalist...

George D. Lundberg, MD is best known for his accomplishments as the Editor-in-Chief for Scientific Information and Multimedia of the American Medical Association and Editor of the Journal of the American Medical Association (JAMA) from 1982 to January of 1999. He is widely credited with having taken JAMA from an established but not particularly influential status to a journal meriting global respect and prestige. Among the best recognized of his measurable achievements as Editor-in-Chief was the juxtaposition of clinical medicine and public health in the same journal with focus on such issues as the prevention of nuclear war, guns and violence, caring for the uninsured, molecular medicine and genetics, disease prevention and health promotion, emerging microbial threats, quality care, managed care, boxing, and tobacco.

Most recently, Dr. Lundberg has become Editor-in-Chief of *Medscape* and Editor of *Medscape* General Medicine, the world's first fully automated, primary source, peer-reviewed general medical journal. Through *Medscape*, Dr. Lundberg hopes to promote the patient-physician relationship by enhancing communication of relevant clinical information shared freely among physicians, other health professionals, and patients through a common medical internet site that adopts several levels of sophistication to enhance better health promotion, disease prevention, treatment of sickness, and chronic disease management.

Visit the *Medscape* website at www.medscape.com.

1999 WINNERS OF THE C. EVERETT KOOP NATIONAL HEALTH AWARDS

Honoring Health Promotion and Disease Prevention Programs With Demonstrated Savings from Improving Health Behaviors

Aetna, Inc. The Aenhance Program

This program is available to Aetna's 33,000 employees through the company's benefits department. A 24-month study comparing the medical costs of fitness center participants to non-participants showed a saving of \$282 per participant in the year after joining the fitness center. Extrapolation of these findings to the entire fitness center population would result in savings of \$1.55 million annually. A corporate lactation program has resulted in 53% of participants breast feeding for six months or longer compared to a national norm of 14% for working mothers. The fitness program resulted in 57% decrease in the number of inactive program participants and a 28% increase in the number of participants exercising three or more times per week.

Glaxo-Wellcome Inc. Occupational Health Services

A preventive approach to workplace hazards resulted in a reduction in the OSHA incident rate from 6/2000 work hours in 1996 to 2/2000 work hours in 1998. Of 90 smokers who joined the smoking cessation program, 43% quit after one year. Health improvements were noted in the areas of nutrition, stress management, and physical activity. The program has achieved impressive clinical screening rates for skin cancer, breast cancer and hemochromatosis. An integrated disability management program has resulted in a reduction of 20,000 lost work days for medical leave since 1996, the equivalent of adding 100 full time employees to the payroll.

UNUM Corporation Integrated Health Safety and Disability Management Program

Fitness facility members incurred \$720 per year lower medical claims costs compared to non-members. Medical claims cost for members were \$348 lower after joining the program. Additionally, members were absent four fewer days per year after joining the facility. Survey results showed improvements in the following health risks: sedentary lifestyle, smoking, stress, overweight, cholesterol, and seat belt usage. In 1998, the program returned 91% of employees with disabilities to work through reasonable accommodations (flex time, assistive technology, job redesign, and job placement).

Pfizer Premier Employee Program

This program has achieved impressive participation rates with 85% of New York City based employees participating in one or more programs. Self-reported productivity measures show that participants in the Ergonomic Program experienced a 1.5% increase in productivity post program, which translates to over \$1.1 million in net savings. Self-report data from program participants indicate the on-site physical therapy program saved the company \$590,000 in

potential lost work time. A lipid intervention program achieved significant positive improvement in total cholesterol, HDL, LDL, triglyceride, and TC/HDL ratio values for employees identified with abnormal lipid profiles.

San Jose City Fire Department *Wellness Program*

Since 1995, when the wellness program was instituted, participation levels have steadily increased to 70% of the total population. Compared to 1994 base year, overall benefits program utilization and cost trends have been positive. Lost workdays have been reduced 22% and medical payment cost rates have declined 12%. Additionally, medical payments have remained relatively flat since 1995. Since 1997, disability payments have been considerably lower for program participants compared to non-participants, with participants consistently incurring about a third of the costs of non-participants. High-risk program participants showed improvement in body composition dynamometer scores, push-ups, flexibility ratings, and abdominal curls when comparing post-program to pre-program measures.

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Divider Title: _____

**10:45-12:00 Friday
Plenary Session**

***The Unintended Consequences of the
Americans with Disabilities Act***

Since the enactment of the Americans with Disabilities Act (ADA) in 1992, employers have implemented a variety of accommodation and accessibility provisions that are intended to “level the playing field” for persons with disabilities. Critics have suggested that the cost of these provisions sometimes outweighs the benefits that accrue to those with disabilities. Employment statistics would appear to bear out at least one of these criticisms as the employment rate for people with disabilities remains at less than 30%. Have the “unintended consequences” of the ADA benefited those with disabilities or just employment law attorneys? Our panelists, both widely known for their views on the ADA, will sharpen our focus on the prospects for full inclusion of people with disabilities in the workplace and in society.

Moderator: Ann Elizabeth Reesman
General Counsel
Equal Employment Advisory Council

Speakers: Peter D. Blanck, PhD, JD
Professor & Director of Law, Health Policy & Disability Center
University of Iowa

Walter Olson
Senior Fellow
The Manhattan Institute

Peter D. Blanck, PhD, JD is Professor of Law, of Preventive Medicine, and of Psychology at the University of Iowa; he is also a member of the President’s Committee on Employment of People with Disabilities and a former commissioner on the American Bar Association Commission on Mental and Physical Disability Law. He has written widely on the implementation of the Americans with Disabilities Act, and has received grants to study its implications. Dr. Blanck received his PhD in psychology from Harvard University and his JD from Stanford Law School.

Walter Olson is an author and commentator on the American legal system. His 1991 book The Litigation Explosion helped spark a national debate and led the Washington Post to dub him an “intellectual guru of tort reform”, while his 1997 book The Excuse Factory, was the first book to offer a popular critique of the modern revolution in employment law. A senior fellow at the Manhattan Institute, a think tank in New York City, Mr. Olson graduated from Yale with a degree in economics.

Ann Elizabeth Reesman serves as General Counsel of the Equal Employment Advisory Council (EEAC), a national non-profit association of private sector employers established to promote sound approaches to the elimination of discrimination in employment. In this capacity, she supervises the filing of EEAC’s “friend of the court” briefs and advises member companies on EEO-related compliance matters. Ms. Reesman developed the trainer’s manuals for Equity at

Work and Understanding the Americans with Disabilities Act. She received her undergraduate degree from the University of Pittsburgh and her law degree from the Dickinson School of Law.

Feature Article

Empirical Study of Disability, Employment Policy, and the ADA¹

Peter David Blanck

As our society approaches the next millennium, critical questions are emerging about the nature, composition, and qualifications of the American work force of the 21st century. These questions include:

- What types of work skills will be needed for American employers to remain competitive in the United States and abroad?
- Will our increasingly diversified and aging work force include millions of qualified persons with disabilities?
- What will be the characteristics, capabilities, and qualifications of the work force of persons with disabilities?
- What types of job training and supports will be available to that work force?
- How will the dramatic public policy changes that have occurred in the last quarter of the 20th century in disability law and in educational, welfare, and technological reform affect that work force?

Peter David Blanck, Professor of Law & of Medicine at The University of Iowa, earned his Ph.D. in psychology from Harvard University and his J.D. from Stanford Law School. He currently serves as a member of the President's Committee on the Employment of People with Disabilities. He served as a senior fellow of the Annenberg Washington Program and a Commissioner on the American Bar Association's Commission on Mental & Physical Disability Law.

The program of research described herein is supported, in part, by grants from The University of Iowa College of Law Foundation; the National Institute on Disability and Rehabilitation Research; the U.S. Department of Education; the U.S. Social Security Administration; and Iowa Creative Employment Options. For copies of referenced research reports and materials or other information, contact Professor Blanck, Director of the Law, Health Policy, and Disability Center, The University of Iowa, 431 Boyd Law Bldg., Iowa City, Iowa, 52242-1113; call 319/335-9043; fax to 319/335-9098; or e-mail to Peter-Blanck@uiowa.edu.

To begin to address these and related questions, the 1998 Presidential Task Force on Employment of Adults with Disabilities has undertaken a comprehensive study of the political and ideological bases of attitudes toward persons with disabilities in employment, housing, transportation, and other areas of daily life.² This article highlights mine and my colleagues related empirical investigations as they affect the emerging work force of persons with disabilities.³

Substituting Data for Myths About Disability and Work

In the past 25 years, disability law and policy, as reflected most directly by the passage of the Americans with Disabilities Act of 1990 (ADA), have undergone a dramatic shift from a model of charity and compensation to medical oversight and then to civil rights.⁴ The studies highlighted in this article suggest, as former Governor and U.S. Attorney general Dick Thornburgh has articulated, that laws like the ADA are playing a central role in enhancing the labor force participation of qualified persons with disabilities and in reducing their dependence on governmental entitlement programs.⁵

Despite advancements, however, there is little definitive evidence that American disability law and policy alone will result in substantial increases in the numbers of qualified persons with disabilities participating in the workplace. My colleagues and I have attempted to examine these issues through our studies of thousands of job applicants and workers with disabilities, and of many of their employers.

Systematic empirical study on the work lives of persons with disabilities is lacking. The promise of the ADA and related anti-discrimination laws to prevent the exclusion from society of millions of qualified Americans with disabilities makes this lack of information troubling. In assessing our empirical studies, Senator Bob Dole has commented:

Some people think that evaluating the ADA is irrelevant, given that its purpose is to establish certain rights and protections. But I believe that we have an obligation to make sure our laws are working. At the very least, we need to know that all people affected by the ADA are aware of their rights and responsibilities and that its remedies are in fact available and effective.⁶

The research studies highlighted have three goals:

1. *Dialogue*: To foster a meaningful and productive dialogue about the hiring and equal employment of qualified persons with disabilities;
2. *Awareness*: To raise awareness about persons with disabilities in terms of their (a) work capabilities and qualifications and (b) value to employers and the American economy; and
3. *Fairness*: To enhance the effective and fair implementation of the ADA and related anti-discrimination laws by providing information to (a) facilitate employers' understanding of the law and of related initiatives in educational, health care, and welfare reform and (b) help informally resolve employment-related disputes when they arise.

Study 1: The Hiring of Persons with Disabilities—The 1998 Manpower Study

In 1998, my colleagues and I released a case study of Manpower Inc., the nation's largest staffing employer.⁷ Manpower annually provides temporary employment opportunities to almost two million people worldwide, maintaining 2,800 offices in 83 countries. Manpower's revenues have nearly doubled since 1991, with sales of \$8.9 billion for 1997. The U.S. Bureau of Labor Statistics estimates that between the years 1994 and 2005, temporary employment opportunities will grow by 55 percent.

The Manpower study examines the employment opportunities available to persons with physical and mental disabilities. The initial study explored the importance of hiring and job training opportunities as strategies that provide a bridge to full-time employment for qualified persons with disabilities. Interviews of Manpower employees with a range of serious impairments, who worked for various employers across the United States, suggest the company's investment in individualized training programs, job skills assessment techniques, and career development strategies has been a critical element of its success in hiring and retaining workers with disabilities.

Moreover, the study identifies aspects of its corporate culture that foster equal employment opportunities for qualified persons with disabilities, including a belief that (1) there are no unskilled workers; (2) every individual has job skills and aptitudes that can be measured; and (3) every job may be broken down into essential tasks. Job training is focused on matching worker skills and host business needs. The study also identifies the ways in which the staffing industry supports the employment of workers with disabilities, showing that (1) individualized training and job placement are available; (2) above minimum wages and health insurance benefits are provided; and (3) there is opportunity for career advancement, self-advancement, self-learning, and transition to full-time competitive employment.

The Manpower study highlights one important bridge from unemployment to employment for qualified workers with disabilities. The implications of the study may be summarized as follows:

1. *Prompt Transition from Unemployment to Employment*. Manpower effectively and promptly transitions people with disabilities from unemployment to employment. Ninety percent of the individuals studied were at work within 10 days of applying to Manpower.
2. *Workplace Accommodation Costs Minimal*. The direct costs of accommodating workers with disabilities is low. There were no direct costs to Manpower or its customer companies in accommodating the workers studied.
3. *Staying at Work*. Sixty percent of the individuals studied moved from no employment to permanent employment. Annually more than 40 percent of Manpower's entire work force transitions to permanent work that is the direct result of the temporary job placements.
4. *Safety at Work*. For the employees with disabilities studied, there were no incidences of work site injury, and, thus, no additional costs to the employer due to workplace safety issues.
5. *Choice in Work*. Ninety percent of the individuals studied were placed in a job or industry in which they expressed an interest, and job placements were consistent with individualized work skills.
6. *Retaining Work That Pays*. Ninety percent of the employees studied remained in the work force from the time of their first job assignment, earning above the minimum wage, either through a series of temporary job assignments or permanent employment.

These implications suggest ways for policy makers, employers, health professionals, and others to expand employment opportunities for qualified individuals with disabilities consistent with the ADA's goals.

Study 2: Labor Market Trends of Persons with Disabilities—1990-97 Longitudinal Research

Since 1990, my colleagues and I have been studying the labor market trends of more than 5,000 persons with mental retardation and related impairments living in Oklahoma.⁸ The investigation focuses on changes in the participants' employment and economic positions as indicators of progress during initial ADA implementation. Several measures are used to assess employment

and economic trends, including the participants' personal and educational backgrounds; job capabilities, qualifications, and training; involvement in community, citizenship, and advocacy activities; and perceptions of ADA effectiveness.

The investigation's core findings may be summarized as follows:

1. *Attaining Employment, Integration into Competitive Employment, and Retention of Employment.* From 1990 to 1997, roughly half of the participants (43 percent) remained in the same type of employment; roughly half (44 percent) engaged in more integrated and competitive employment settings; and somewhat more than one tenth (11 percent) regressed into less integrated employment settings.
2. *Employment of a New Generation of Workers with Disabilities.* Younger relative to older participants, and those individuals with better job skills showed substantial gains in employment.
3. *Drop in Unemployment Levels.* Relative unemployment levels for all participants declined by 24 percent, dropping from 38 percent in 1990 to 14 percent in 1997.
4. *Income Growth.* From 1990 to 1997, the gross and earned income of all participants rose substantially, with younger participants showing substantial increases in income. Better job skills, greater independence in living, and more involvement in self-advocacy activities related to higher earned income levels.
5. *Substantial Individual Growth.* From 1990 to 1997, participants improved substantially in their job capabilities and qualifications, lived in more integrated settings, became more involved in self-advocacy and citizenship activities, and reported enhanced accessibility to society as defined by the ADA.
6. *Black Hole Effect.* More than three out of four (78 percent) of those participants not employed or employed in segregated non-integrated settings in 1990 remained in those settings in 1997.⁹

Though encouraging, these findings suggest a good deal of work lies ahead to ensure equal employment opportunity for qualified workers with serious mental and physical impairments. The gains in employment, income, individual growth, independent living, and ADA awareness, however, reflect "a core, common cause—the drive for independence and integration of people with disabilities."¹⁰

Study 3: Economics of Accommodating Persons with Disabilities—The 1994 and 1996 Sears Studies

One aspect of the ADA that has received extensive attention involves the law's affect on employers' ability to provide workplace accommodations for qualified job applicants and employees with disabilities.¹¹ Critics suggest the ADA's accommodation provision creates for persons with disabilities an employment privilege or subsidy and imposes upon employers an affirmative obligation to retain less economically efficient workers. Others argue the costs of accommodations are especially high for large employers, who may be held accountable for extensive modifications because of their greater financial resources.¹²

The research to date does not show that the ADA's accommodation provision is a preferential treatment initiative that forces employers to ignore employee qualifications and economic efficiency. My colleagues and I have conducted a series of studies, finding companies that are effectively implementing the law demonstrate the ability or "corporate culture" to look beyond minimal legal compliance in ways that enhance their economic bottom lines. The low direct costs of accommodations for employees with disabilities produces substantial economic benefits in terms of increased work productivity, workplace injury prevention, reduced workers' compensation costs, and workplace effectiveness and efficiency.

We have conducted a series of studies at Sears, Roebuck and Co., a company with approximately 300,000 employees, examining more than 600 workplace accommodations provided by the company during the years 1978 to 1998.¹³ Our findings show that most accommodations sampled required little or no cost—more than 75 percent required no cost; somewhat less than one quarter cost less than \$1,000; and less than 2 percent cost more than \$1,000. The average direct cost for accommodations was less than \$30.

The following implications may be drawn from the Sears studies:

1. *Compliance Linked to Culture, Attitudes, and ADA Transcendence.* The degree to which Sears and other companies examined comply with the ADA's accommodation provision appears to have more to do with their corporate cultures, attitudes, and business strategies than with meeting the law's minimal obligations.
2. *Benefits of Workplace Accommodations Outweigh Costs.* The indirect cost of not retaining qualified workers is relatively high, with the average administrative cost at Sears per employee replacement of \$1,800 to \$2,400—roughly 40 times the average of the direct costs of workplace accommodations for qualified workers. Sears also provides accommodations that require minor and cost-free workplace adjustments, which are

implemented directly by an employee and his or her supervisor. Sears is realizing positive economic returns on the accommodation investment by enabling qualified workers with disabilities to return to or stay in the work force, reducing the risk of workplace injury and lowering worker absenteeism.

3. *Unintended Economic Benefits to Employers, Workers Without Disabilities, and Workers Who May Become Disabled in the Future.* Accommodations involving universally designed technology enable employees with and without disabilities to perform jobs productively, cost-effectively, and safely (for example, reducing the potential for workplace injury). The costs associated with the technologically-based accommodations studied (for example, computer voice synthesizers) enabled qualified employees with disabilities to perform essential job functions. These strategies create a corporate "ripple effect," as applications increase the productivity of employees without disabilities. The direct costs attributed to universally designed accommodations are lower than predicted when their fixed costs are amortized over time.

The findings from the Sears studies suggest that many economic and social benefits and costs, intended and unintended, associated with the ADA's accommodation provision remain to be discovered and documented. Studies, such as Sears and Manpower, illustrate that companies already expend large sums of money accommodating the needs of workers without disabilities (for example, through flexible scheduling of work hours, child care support, and Employee Assistance Programs), and that these costs are substantially greater than those associated with accommodations for workers with disabilities. Analysis of these strategies shows that they complement cost-effective accommodation strategies for workers with disabilities.

Study 4: Resolving ADA Disputes—The 1996 Sears Study

Another major critique of the ADA is that it fosters unintended and costly employment litigation. It has been suggested that a large source of indirect costs associated with ADA implementation is related to expenses for administrative, compliance, or legal actions.

The Sears study examined both the formal ADA Title I charges filed with the Equal Employment Opportunity Commission (EEOC) against Sears from 1990 to mid-1995 and informal disability-related disputes raised by employees.¹⁴ The findings include the following:

1. *Formal ADA Charges.* Almost all of the formal charges filed with the EEOC (98 percent) were resolved without resort to extensive trial litigation.

2. *Informal ADA Disputes.* More than three quarters (80 percent) of the informal disability-related disputes were resolved through informal dispute processes that enabled qualified employees with disabilities to return to productive work.

3. *Nature of Impairment.* Almost half (41 percent) of the employees who filed charges with the EEOC evidenced an impairment before their employment at Sears; more than one quarter (29 percent) who filed charges were injured on the job; and 18 percent who filed charges were injured off the job. The findings do not support the view that the charges filed reflect issues that would otherwise be raised under traditional workers' compensation laws.

4. *Settlement.* Of the formal ADA charges studied, the average settlement cost to Sears was \$6,193, exclusive of attorneys' fees.

These findings highlight that analysis of the costs and benefits associated with ADA implementation, enforcement, compliance, and related litigation is needed on a national scale.¹⁵ Nevertheless, discussion limited to EEOC charges associated with ADA implementation tends to focus analysis on the failures of the system, as opposed to efficient and fair workplace strategies that enhance the productive work force participation of persons with disabilities.

Study 5: Unintended Economic Consequences of the ADA—A Case Study of Technological Innovation and Inventive Activity

Independent of the civil rights guaranteed by the law, estimating the costs and benefits of ADA implementation is a complex undertaking. To illustrate the importance of studying the unintended consequences of ADA implementation, my colleagues and I recently completed the first study of economic activity in the assistive technology (AT) market, using data derived from the United States Patent and Trademark Office (PTO).¹⁶

The findings suggest that ADA implementation is fostering technological innovation and economic activity in the AT consumer market. As the regulatory shifts imposed by the ADA expand the market for goods that improve accessibility to society, inventors and manufacturers are responding to meet the needs of consumers with disabilities.

The core findings include the following:

1. *Economic Activity.* Assistive technology patent numbers have shown substantial annual increases since 1976.
2. *ADA Awareness.* Although reference to civil rights legislation is atypical of patent records, from 1990 through mid-1998, the number of patents citing the ADA has increased substantially, totaling 139.

3. *Unintended Economic Benefits.* Inventors who cite the ADA are a geographically diverse group, many unaffiliated with large corporations. From 1990 to mid-1998, patents were granted for a wide range of assistive devices with uses for a wide array of consumers with disabilities.

These findings are consistent with those suggesting that the ADA is affecting the AT consumer market, including persons with and without disabilities, in economically positive ways and is creating profit-making opportunities for inventors, manufacturers, and employers that were unanticipated when the law was passed.

Conclusion: Studying the Emerging Work Force of Persons with Disabilities

Empirical evaluation of the legal, policy, and economic implications associated with the emerging work force of persons with disabilities is needed for several reasons, including:

1. *Effective and Fair ADA Implementation.* Study of the labor force participation of persons with disabilities will aid in long-term ADA implementation and interpretation of related initiatives such as welfare, educational, health care, and dispute resolution reform.
2. *The Emerging Work Force.* Study is needed of the extent to which ADA implementation has coincided with larger numbers of persons with severe disabilities entering the labor force. In 1996, the U.S. Census Bureau released data showing that the employment to population ratio for persons with severe disabilities increased from roughly 23 percent in 1991 to 26 percent in 1994, reflecting an increase of approximately 800,000 additional people with severe disabilities in the work force.
3. *Existing Challenges.* Despite encouraging trends, study is required of the underlying causes of high unemployment levels facing persons with disabilities. A 1998 survey by the National Organization on Disability (NOD) and the Louis Harris and Associates Organization found significant participation gaps between people with and without disabilities in employment and other aspects of life.¹⁷ Of the persons with severe disabilities surveyed, more than two thirds (approximately 67 percent) were unemployed and out of the work force compared to less than 10 percent of all Americans. Forty percent of the individuals with disabilities surveyed lived below the poverty line versus 18 percent of all Americans. Additional analysis of the 1998 NOD/Harris survey, excluding those individuals in the sample who were retired or unable to work, reveals that more than half of the remaining individuals (approximately 62 percent) were working either full or part time.¹⁸
4. *Call for Collaboration.* Meaningful discussion among scholarly disciplines is needed to fully inform policy makers, employers, members of the disability community, and others about the complex issues related to the intended and unintended consequences of ADA implementation in ways that articulate the values and goals of the nation's policies affecting persons with disabilities.¹⁹
5. *Call for Research.* The conclusions from any single research study, or even from series of studies, are insufficient for drawing sweeping conclusions about persons with disabilities and employment law and policy. Future large scale and case study research is required to provide a springboard for further discussion about evolving disability law and policy.²⁰

In this last regard, in 1998 my colleagues and I were awarded a grant from the National Institute on Disability Research and Rehabilitation (NIDRR) to establish a Rehabilitation and Research and Training Center on work force investment and employment policy for persons with disabilities.²¹ The Center's goals include conducting large-scale and case study of the effects of federal and state policies on the employment of persons with disabilities, such as the ADA, the Temporary Assistance to Needy Families (TANF) program, and the Workforce Investment Act. Through empirical and policy analysis, the Center's overriding goal is to expand and improve disability and generic policy to impact positively equal employment opportunities for Americans with disabilities.²²

Useful and credible information about the issues that I have highlighted, and many others, must be derived from study of core values related to our sense of individual worth and identity, self-respect, fairness, and economic common sense. The articulation of these values by persons with and without disabilities will shape the lives of the next generation of children with disabilities who have experienced integrated education and who will become part of the competitive work force of the next century.

Notes

1. This article is derived, in part, from Professor Blanck's statements on October 5, 1998, before the U.S. House of Representatives Committee on Education and the Workforce, and on November 12, 1998, before the U.S. Commission on Civil Rights Public Hearings on the Americans with Disabilities Act.
2. PRESIDENTIAL TASK FORCE, RE: CHARTING THE COURSE: FIRST REPORT OF THE PRESIDENTIAL TASK FORCE ON EMPLOYMENT OF ADULTS WITH DISABILITIES (1998). To receive a free copy of the report, call 202/219-6081. To view

- the report on-line, go to http://www.dol.gov/dol/_sec/public/programs/ptfead/rechart/sat5PTFEADfinalwp.htm.
3. The research sources discussed are drawn, in part, from PETER DAVID BLANCK, *THE AMERICANS WITH DISABILITIES ACT AND THE EMERGING WORKFORCE* (American Association on Mental Retardation, Washington, D.C. 1998).
 4. See John Parry, *Civil Rights for Persons with Mental and Physical Disabilities*, in forthcoming ABA BLUE-PRINT FOR DISABILITY LAW AND POLICY (American Bar Association Commission on Mental & Physical Disability Law 1999).
 5. See Dick Thornburgh, *Ensuring Equal Opportunity for Individuals with Disabilities Through the ADA*, in forthcoming ABA BLUE-PRINT FOR DISABILITY LAW AND POLICY (American Bar Association Commission on Mental & Physical Disability Law 1999).
 6. Bob Dole, *Are We Keeping America's Promises to People with Disabilities?—Commentary on Blanck*, 79 IOWA L. REV. 927, 928 (1994).
 7. See PETER DAVID BLANCK, *THE EMERGING ROLE OF THE STAFFING INDUSTRY IN THE EMPLOYMENT OF PERSONS WITH DISABILITIES: A CASE REPORT ON MANPOWER INC.* (The University of Iowa Law, Health Policy, and Disability Center, Iowa City, Iowa 1998).
 8. For a review, see Peter David Blanck, *supra* note 3.
 9. Thus, 25 percent of those participants not employed in 1990 remained unemployed in 1997, and 33 percent of those participants in sheltered workshops in 1990 remained in those settings by 1997. In comparison, only one percent of those participants in supported employment in 1990 remained in those settings in 1997, and one percent of those participants in competitive employment in 1990 remained in those settings in 1997. See Blanck, *supra* note 3 (discussing longitudinal study findings). Future analysis is needed of the role of ADA Titles I and II, particularly in the context of the macro-economic trends in the U.S. economy, in fostering the equal employment of qualified workers with disabilities in integrated settings. *Id.*
 10. See Bob Dole, *supra* note 6. See also Tom Harkin, *The Americans with Disabilities Act: Four Years Later—Commentary on Blanck*, 79 IOWA L. REV. 936 (1994) (commenting that "Our challenge, as I see it, is to reach the participants in Blanck's 'black hole' and to continue the positive momentum that he charts.").
 11. See Peter David Blanck, *Transcending Title I of the Americans with Disabilities Act: A Case Report on Sears, Roebuck and Co.*, 20 MENTAL & PHYSICAL DISABILITY L. REP. 278 (1996).
 12. See Peter David Blanck, *The Economics of the Employment Provisions of the Americans with Disabilities Act: Part I—Workplace Accommodations*, 46 DEPAUL L. REV. 877 (1997).
 13. See Peter David Blanck, *Communicating the Americans with Disabilities Act, Transcending Compliance: A Case Report on Sears, Roebuck & Co.*, THE ANNENBERG WASHINGTON PROGRAM REPORTS (Washington, D.C.: The Annenberg Washington Program in Communications Policy Studies of Northwestern University 1994); Peter David Blanck, *Communicating the Americans with Disabilities Act, Transcending Compliance: 1996 Follow-Up Report on Sears, Roebuck & Co.*, THE ANNENBERG WASHINGTON PROGRAM REPORTS (Washington, D.C.: The Annenberg Washington Program in Communications Policy Studies of Northwestern University 1996).
 14. See Peter David Blanck, *supra* note 13, 1996 Follow-Up Report on Sears, Roebuck & Co. (studying 141 formal EEOC charges and 20 informal disputes).
 15. See Bill Lann Lee, *Enforcing the ADA: The Department of Justice's Role*, in forthcoming ABA BLUE-PRINT FOR DISABILITY LAW AND POLICY (American Bar Association Commission on Mental & Physical Disability Law 1999).
 16. Assistive technology is any item, piece of equipment, or product system—whether acquired commercially, modified, or customized—that is used to increase and improve the functional capabilities of individuals with disabilities. See Heidi M. Berven & Peter David Blanck, *The Economics of the Americans with Disabilities Act, Part II—Patents and Innovations in Assistive Technology*, 12 NOTRE DAME J. L. ETHICS & PUB. POL'Y 101 (1998).
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 18. When excluding those 351 individuals surveyed between the ages of 18 and 64 years who were retired or unable to work due primarily to their disability or health condition from the total sample size of 621 persons, roughly 62 percent of the remaining individuals report that they are employed either full or part time. More than half (approximately 68 percent) of persons reporting that they are unable to work would like to have a regular job. Subsequent analysis is required to assess the nature of the participants' impairments and conditions and whether many of these individuals are (1) persons with disabilities for purposes of the ADA and (2) capable of employment with the provision of workplace accommodations or personal assistant services.
 19. See EMPLOYMENT, DISABILITY, AND THE AMERICANS WITH DISABILITY ACT: ISSUES IN LAW, PUBLIC POLICY, AND RESEARCH (forthcoming, Peter David Blanck ed., Northwestern University Press, Evanston, Ill. 1999).
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PERSONS WITH DISABILITIES: A CONCEPTUAL AND DEMOGRAPHIC OVERVIEW

Impairment and disability are distinct concepts. An *impairment* is a "deviation from normal in a body part or organ system and its functioning; any loss or abnormality of psychological, physiological, or anatomical structure or function."⁵⁹ "Normal" is not an absolute term, and typically there is a range on the distribution of normal in a population with variations in age, gender, and other factors.^{17,18} Impairment is assessed and measured by health care providers, although many impairments do not require medical treatment.

In contrast to impairment, *disability*, as a medical term, refers to the inability to perform an activity or task, reflecting an alteration in an individual's capacity to meet personal, social, or occupational demands because of an impairment.² A medical disability arises from the interaction between an impairment and external requirements. Disability refers to limitations in activities or functions that are part of everyday life: seeing, hearing, walking, caring for oneself, and other functions. Work disability refers to the effect of impairment on ability to work, either in one particular job or in a range of jobs.

A worker who cannot engage in any work because of a medical condition is considered medically to be *totally disabled*. *Partial disability* refers to the ability to engage in some work, but an inability to perform all of the activities required of one's usual job. As long as a resolution of the disability is expected, a work disability is considered to be *temporary*. A *medical end-result*,

however, implies that no significant functional improvement is expected, even if some change in symptoms may occur over time. Once a medical end-result has been determined, health providers regard a disability as *permanent*. A *permanent partial disability* implies that a worker has a permanent inability to do some types of work, but retains the capacity for gainful employment. Although a conceptual distinction exists between impairment and disability in the scientific and legal literature, this distinction is not as clear for health provider agencies, particularly when health benefits are linked directly to the presence of an impairment. In this article, the focus is on persons with disabilities, especially on those who have a medical disability affecting the ability to work.

Impairments, even those that result in a functional limitation, do not inevitably lead to disability, either medically or legally defined. People who have impairments (e.g., slight hearing losses or visual deficits that are corrected by glasses) are not necessarily disabled. Whether an individual with an impairment becomes significantly disabled depends not only on the nature of a condition and its severity, but also on the perceptions and response to the condition by the individual as well as his family, employer, and community.⁵⁵ Other factors include physical access to facilities, employment training opportunities, social supports, and the extent to which the community is willing to accept and accommodate persons with a given impairment. The results of these factors together determine whether or not a person with a disability is an equal member of society, fulfilling their desired role.⁵²

Attempts have been made to quantify and classify those with disabilities in the working-age population. The lack of a uniform conceptual basis for diagnosing disability and varying definitions of disability used in studies have led to inconsistent estimates of the size of this population.⁵³ The Survey of Income and Program Participation uses a definition of disability that includes any limitation in ability to perform one of several specified activities or a socially defined role. Based on this survey, 19.4% of the U.S. population was disabled and 9.6% had severe disability—i.e., was unable to perform one or more specified activities, had a specific impairment, or used an assistive mobility device (e.g., cane, wheelchair, walker, or crutches)—in 1991 and 1992.⁴¹

The National Health Interview Survey, a household survey sponsored by the National Center for Health Statistics, sampled more than 45,000 households in 1992 and included questions about chronic illness, impairments, and activity limitations.⁴⁰ This survey led to an estimate of 39 million persons in the U.S. (about 15% of the noninstitutionalized population) who have a chronic condition that limits their ability to perform some activity. Of these persons, about one third had conditions that prevented them from carrying out a major activity typical for someone their age, such as playing or going to school for those under age 18, working or keeping house for those 18–69, and self-care for those over age 70. Another one third were limited, but able to carry out age-specific major activities. The remaining one third also were able to carry out age-specific major life activities, but were limited in ability to participate in hobbies or social and community activities.

Among those aged 18 to 69, more than 31 million persons were restricted to some extent in the major life activity of working, although over half of these persons were able to work.³⁹ Chronic disease—commonly musculoskeletal and connective tissue disorders (17% of all conditions), circulatory conditions (17%), respiratory conditions (8%), and neurologic conditions (7%)—limited work ability in 73% of those able to work. About 27% of the conditions limiting work were classified as chronic impairments, these included orthopedic impairments (16%), visual impairments (2%),

and hearing impairments (1%).²⁰ Conditions that caused work limitations were more than three times as common in those over 55 than in younger persons, and were more common in those in lower income brackets. People with less than 8 years of formal education had a work disability rate that was twice as high as that of high school graduates.

A subset of those who report inability to work are receiving income replacement support. In 1990, Social Security programs for disabled workers provided medical benefits and income replacement for approximately 4.4 million persons.⁴¹ There is a range of eligibility criteria for benefit programs targeting disabled persons. For example, Social Security Disability Insurance is available to those who have a medical condition with a specified level of severity that is expected to last a year or more or result in death and that prevents "any substantial gainful activity."⁵⁴

THE CHANGING SOCIETAL APPROACH TO WORKERS WITH DISABILITIES

The societal approach to those with disabilities prior to the 1960s focused on providing social support, income replacement, and access to health care through a variety of public and private entitlement programs. These programs sought to replace lost wages and to ameliorate the poverty associated with disabling conditions. In some ways, these entitlement programs served to reinforce disability, as benefits would cease if a recipient returned to work. Rehabilitation services designed to enable gainful employment and self-sufficiency for persons with specific conditions (e.g., deafness, blindness, amputation) attained varying levels of success, but often in low-income jobs.^{15,16}

The Vietnam War era saw the growth of technologies and broad-based job training programs to enhance the ability of persons with disabilities to return to work. Motorized wheelchairs, more powerful hearing aids, computers and communication aids, and powered prostheses allowed greater mobility and physical access to society for disabled persons.^{6,7} Improvements in medical treatment and overall health extended the average number of working years and the life span of those with chronic conditions, enabling many to participate in the workplace. Rehabilitation services that initially were developed and offered through private foundations became the purview of state and Federal programs, guaranteeing greater access to these services for qualified individuals.

This also was an era of social change in the United States, when civil rights groups began to target traditional discriminatory attitudes and practices. The concept of those with disabilities as a minority group began to develop through a **disability rights movement**. Disabled persons recognized that discriminatory attitudes and practices, economic and societal barriers, and prior approaches that focused on entitlement rather than access barred them from equal participation in society, including work. The independent living movement, which began in the early 1970s in California, asserted the civil rights of persons with disabilities to self-sufficiency. Activists recognized that technological successes in rehabilitation engineering that enabled improved mobility and communication were not being translated into changed employer practices and were not removing barriers to governmental and public services. Using tactics that had worked for the civil rights movement to demonstrate visibly the barriers they faced, disability activists gained a broad base of support and advocated effectively for legislative remedies.³⁵

These early advocacy efforts were in large part responsible for the passage of the **Rehabilitation Act of 1973**, representing a significant shift in U.S. disability

policy.⁴⁷ The 1973 Act applied to public and private employers that received over \$10,000 per year of Federal funds. Section 504 of the act banned discrimination on the basis of disability and was modeled after previous laws targeting discrimination on the basis of age, race, and gender. For the first time, exclusion of persons with disabilities was recognized legally as discrimination, and persons with disabilities were viewed not as discrete groups of individuals with specific diagnoses, but as a social minority group.

Passage of the 1973 Act was only a first step, however, as the federal government was slow to issue regulations implementing the act, and efforts to rescind Section 504 appeared as part of the President's Task Force on Regulatory Relief in the early 1980s. The need for sustained and effective advocacy strengthened the disability rights movement and led to development of organizations representing the legislative interests of those with disabilities in collaboration with civil rights organizations. This experience reinforced the need for broader, effective legislation, as the Section 504 employment regulations were interpreted narrowly by the courts and applied only to larger federal contractors (see www.disabilityhistory.org).

The **Americans with Disabilities Act of 1990 (ADA)** was the product of a new generation of disability rights activities, based on growing public and congressional support. The ADA applies the Section 504 protections to more workplaces, creates workplace accommodation requirements for employers, and provides for equal access to a variety of public services. ADA Title I is meant to promote economic equality in employment, whether defined in terms of wages or career opportunities, and to confront attitudinal preferences and unjustified discrimination faced by qualified employees and job applicants with disabilities.¹² Most states have similar laws prohibiting discrimination against persons with disabilities in the workplace. These laws seek to guarantee persons with disabilities the same rights to equal employment and advancement as others without disabilities, by prohibiting disability discrimination, requiring and supporting reasonable accommodations, and providing a mechanism for resolution of disputes. Although the ADA was intended to resolve the ambiguities in the Section 504 regulations, many aspects of the law were left to the courts to interpret. This has resulted in the ongoing case-by-case interpretation of the scope of coverage and requirements under the ADA.

The legal definition of a person with a disability is a critical aspect of the ADA, as not all persons with impairments are protected by this legislation. Under the ADA, those protected by the Act:

1. Have a known physical or mental condition or impairment that substantially limits a major life activity
2. Have a record of a physical or mental condition, or
3. Are regarded as having such a condition.¹²

The first prong of the definition of disability is directed toward individuals with actual and substantial impairments or conditions, such as those with visual or hearing impairments, cancer, mental illness, physical paralysis, or HIV disease. This prong employs a functional definition of disability that is determined on a case-by-case basis.²³ Determination requires not only a diagnosis of an impairment, but also demonstration of a substantial effect of the impairment on the individual's life.

During the early years of ADA implementation, some courts held that employees with serious but asymptomatic impairments, for instance the early stages of HIV disease, were not disabled for purposes of the ADA, as the limitations in life activities were not "substantial."⁴⁹ There also has been considerable disagreement among various lower courts as to whether the severity of the impairment should be

evaluated with or without medication, prosthesis, or other interventions that mitigate its effect.^{1,12}

In 1998, the U.S. Supreme Court resolved some interpretation issues regarding the ADA's definition of disability in the case *Bragdon v. Abbott*. The Court concluded that HIV disease, whether symptomatic or asymptomatic, constitutes a disability from the moment of infection and during every stage of the disease under the ADA. Thus, many daily activities—for instance reproduction, breathing, thinking—are major life activities for the purposes of the ADA.¹⁹

Federal courts have issued a variety of opinions on whether or not an inability to do a particular job is a qualifying disability for purposes of the ADA. The definition of disability does not mean that an individual must be able to work at the job of his or her choice to be covered by the law. Rather, to fall under the definition, the individual's access to the labor market (reflected in a wide variety of jobs) must be limited by the impairment or condition. In *Weiler v. Household Finance Corp.*, for instance, the court concluded that an individual did *not* have a covered disability when he was incapable of satisfying the demands of a particular job but was not prevented from working in a class or range of other jobs.⁵⁷ Other decisions have addressed the level of restrictions that constitute inability to perform a major life activity. Several courts (but not all) have decided that a permanent restriction from lifting more than 20 pounds does not constitute a substantial limitation in a major life activity.¹² As mentioned, an individual may demonstrate a substantial limitation in a major life activity other than working and thereby be classified as a person with a disability for purposes of the ADA's employment protections.²³

The second and third prongs of the definition of disability are meant to prevent employment discrimination based on biased attitudes toward individuals with often asymptomatic or nonvisible conditions (e.g., persons with a history of cancer, back impairment, or mental illness) or on an incorrect assumption that a person is disabled.¹¹ When an employment action is made because of a worker's perceived disability or risk of future injury and not current worker qualifications, the economic value of the worker to the employer is distorted in a discriminatory manner.⁴²

Even if an individual has a disability under the ADA, he or she must be qualified for the particular job to obtain Title I protection. This means that the person must satisfy the prerequisites for the job, such as educational background or employment experience, and can perform essential job functions with or without accommodations. The employer has considerable latitude in establishing job qualifications, but must apply them consistently to all employees. Title I does not require an employer to hire or retain individuals with disabilities who are not qualified, or to hire or retain individuals with disabilities over equally or more qualified individuals without disabilities.^{11,58} Employers are not discouraged from searching for the most qualified individuals with or without disabilities. Nor are employers required to incur burdensome efficiency or productivity losses and opportunity costs in retaining nonqualified workers with or without disabilities. Exact definitions of job functions that are essential and related requirements for workplace accommodations have not emerged from the courts. However, the courts have clarified that regular attendance, appropriate behavior, and ability to respond to emergency situations can be essential job requirements.^{12,51}

Despite increased social recognition and legislative successes, persons with disabilities often are unable to participate equally in work activities and continue to face a variety of challenges.⁴ These include inadequate job training, employer prejudice,

varying levels of resources to accommodate their conditions, and lower wages.¹⁴ Data from the Survey of Income and Program Participation demonstrate a strong negative association between wages and disability. In those aged 35–54 who had no disabling condition, mean monthly earnings were \$2446, compared to workers with disability, whose monthly earnings averaged \$2006. The negative associations between disability, discrimination, and education account for some of this disparity.⁴¹

In a truly competitive labor market, the economic value to an employer of a worker's labor should equal or exceed the worker's wage.²⁷ A worker's value is contingent upon the worker's productivity, workplace design efficiencies, and employers' and consumers' attitudes about the worker.³⁰ Labor market discrimination against persons with disabilities often results more from inadequate information regarding worker productivity than from overt prejudice. Studies suggest that increasing numbers of individuals with perceived disabilities are entering the workforce and are denied employment opportunity solely on the basis of biased attitudes and prejudice about their impairments.³⁹ Attitudinal bias may be reflected in unstated negative views of a worker's ability to perform a job or risk for workplace injury, even though the individual with a perceived disability presently may be asymptomatic and qualified to perform the job in question.¹²

Many employers have recognized the value of workers with disabilities and have translated these positive attitudes to proactive programs to encourage their equal employment. A 1995 Harris Poll of 400 business executives found that 79% of those surveyed believe that the employment of qualified people with disabilities is a boost to the economy, while only 2% report it poses a "threat to take jobs" from people without disabilities.³⁷ Despite encouraging trends, unemployment levels for persons with disabilities are estimated to be higher than 50%.³⁸ Some studies suggest that during 1970–1992, there was no significant net change in the labor force participation rate among persons with disabilities.¹¹ Baldwin found that the annual losses to workers with disabilities resulting from discrimination in the labor market are substantial, with \$28 billion attributed to discrimination in employment and \$11 billion attributed to discriminatory wages.³

DISABILITY AND WORK: THE HEALTH CARE PROVIDER'S ROLE

The disability rights movement has confronted traditional practices in occupational medicine that have discriminated against persons with disabilities. Congressional testimony prior to passage of the ADA recognized that many industrial medical clinics denied equal employment to disabled persons on the basis of medical conclusions about ability or risk that were scientifically unfounded, based on generalizations about an entire group of persons, or reflected an employer's desire to reduce insurance costs or risks. The ADA's Title I and subsequent interpretative guidance by the Equal Employment Opportunity Commission address employment-related medical examinations. Employers are prohibited from conducting examinations prior to a conditional offer of employment, yet retain the responsibility for deciding whether or not an applicant is medically qualified. This decision must be based on objective medical fact and should incorporate input from examining health care providers as well as others familiar with the applicant, including the applicant him- or herself.¹⁸

The ADA changes the role of the occupational health provider from gatekeeper to facilitator in the pre-employment/periodic surveillance setting. Ideally, a provider should follow a scientific protocol for decision-making and develop a thorough understanding of job and legal requirements and available accommodations. As a

patient advocate, the occupational health provider can obtain a detailed medical history and act as an intermediary, interpreting scientific and medical issues for employers. In these situations, the ethical mandates to preserve appropriate privacy and confidentiality and to advocate for patients are especially important.²¹

Risks of Injury on the Job

One of the primary motivators for passage of the ADA was the finding that qualified persons with disabilities were being excluded from equal employment based on unfounded assumptions about risks of injury on the job. Several authors have concluded that the limited scientific research suggests that physicians are not able to definitively identify those who will be able to safely perform a given task.¹² The physician's main contributions, however, are to identify risk factors, advocate for a consideration of their importance to job functions, and determine the need for workplace accommodations.⁴⁸

The ADA prohibits exclusion of qualified disabled persons from a job unless there is objective medical evidence that they pose a "direct threat" to themselves or others in the workplace. Under the ADA, a direct threat means that there is a high degree of certainty that a specific and serious adverse event will occur in the near future, whether or not accommodations or modifications are made. This concept excludes risks that are speculative, remote, or not supported by objective medical evidence.¹² The ADA does not require that a medical examination or test be conducted to assess a direct threat when objective evidence is available.²⁹ However, employers are required to make an individualized and objective determination of a purported direct threat based on the employee's current ability to perform essential job functions safely. Under the ADA's direct threat analysis, a balance is struck between protecting individuals and society from unacceptable health and safety risks and protecting workers with disabilities from discrimination rooted in prejudice or fear.¹⁹ Blanket exclusions by employers of applicants or employees on the basis of a perceived direct threat from a disability are prohibited under the ADA.¹⁷

The scientific basis for evaluating the presence of a "direct threat" often is not apparent. Some researchers find an increased overall risk for those with disabilities for subsequent work-related injury, or absence from work for other reasons.¹³ Zwerling and his colleagues reviewed National Health Survey data and found that workers with certain sensory impairments had an elevated risk for occupational injury.⁶¹ Future study may show that the workers tracked by Zwerling may not be representative of workers with disabilities covered by the ADA and of those who have been accommodated effectively.¹³

Other studies of specific disabilities and their effect on job risks have yielded a variety of conclusions. For a few conditions, the relationship between clinical severity, measured by objective medical data, and risk for a particular job has been documented. Thus, visual impairments that result in severely restricted width of visual field are associated with higher driving risk. In contrast, long-standing complete loss of vision in one eye, with normal vision in the remaining eye, has not been associated with increased risk.⁴⁵ Return to heavy lifting occupations in those who have had lumbar discectomy leads to a substantial risk of recurrent significant injury, unless the lifting requirements of the job are addressed by workplace accommodations.⁶⁰ The literature on driving and alcohol use demonstrates the relationship between level of cognitive impairment and degree of risk.

For most conditions, however, existing research on risk for workplace injury in relation to a particular diagnosis is not definitive. The risks of insulin use, seizure

disorders, and driving have been explored through studies that suggest that the risks are associated with unanticipated alterations of consciousness and significant comorbidity, rather than the presence or absence of a particular diagnosis.^{33,56} Use of a substance or medication that potentially leads to cognitive impairment does not necessarily establish increased risk for injury on the job. Factors such as dose, duration, timing, and coexisting medical conditions must be considered.

Diabetes presents a unique challenge, as optimal medical control may lead to increased incidence of hypoglycemia and associated risk when driving.³⁶ Courts have recognized the importance of individualized medical assessments, even challenging the Department of Transportation's assumptions about the excess risk of diabetic drivers. In several decisions, courts have found that insulin-dependent diabetic commercial drivers may be accommodated safely by measures to ensure that the underlying condition is stable and that hypoglycemia does not occur at work.^{25,50}

Workplace Accommodations

Workers with disabilities and their employers recognize that new rehabilitation technologies allow for a greater range of work capabilities than was once thought possible. One of the goals of the ADA is to encourage employers to offer accommodations to enable equal employment of qualified persons with disabilities. Occupational health providers must become knowledgeable about the emerging types of accommodations and resources available.¹²

ADA Title I requires employers to provide "reasonable" workplace accommodations for qualified job applicants and employees with disabilities. An accommodation is a modification or adjustment of a workplace process or environment that makes it possible for a qualified person with a disability to perform essential job functions. Examples include physical modifications to a work space, flexible scheduling of duties, or assistive technologies to aid in job performance.¹⁰ To be eligible for an accommodation, an employee must make his disability known to the employer and request an accommodation. Once the request is made, the employer retains the right to choose the accommodation, as long as it is effective and the employee has a good-faith opportunity to participate in the process.²²

Title I does not require an employer to provide accommodations that impose an "undue hardship" on the operation of the business. An undue hardship requires significant difficulty or expense in relation to the accommodation or the resources of the company. An employer may legitimately shape an employee's work or production requirements as long as those requirements are job-related and not a pretext for discrimination against persons with disabilities. The employer's right to structure jobs, however, may not violate Title I's requirement that the employer provide reasonable accommodations for a qualified employee with a disability.¹²

A common critique is that accommodations for qualified individuals create hardships that are costly and burdensome for employers. Yet studies show that the direct costs of accommodations are low, and they produce substantial economic benefits to companies in terms of increased work productivity, injury prevention, reduced workers' compensation costs, and workplace effectiveness and efficiency. In a series of studies conducted at Sears, Roebuck and Co. from 1978 to 1997, a time period before and after Title I's effective date, nearly all of the 500 accommodations sampled required little or no cost: 75% required no cost, 23% cost less than \$1000, and 2% cost more than \$1000. The average direct cost for accommodations was less than \$30.^{8,11} The Job Accommodation Network (JAN) found that more than two-thirds of effective accommodations implemented as a result of a JAN consultation

cost less than \$500.⁴⁶ Almost two-thirds of the accommodations studied result in savings to the company in excess of \$5000.

Accommodations may benefit not only the worker with a disability, but others as well. Accommodations involving universally designed technology enable groups of employees with and without disabilities to perform jobs productively, cost-effectively, and safely. These strategies create a **corporate ripple effect**, as related applications increase the productivity of employees without disabilities. Thus, ergonomic job modifications for employees with lifting restrictions significantly decrease risk for others who perform the same tasks.^{6,7}

In contrast, the costs of not accommodating qualified workers with disabilities can be high. Studies of accommodation costs at Sears show that the indirect cost of not retaining qualified workers is roughly forty times the average direct costs of workplace accommodations; the average administrative cost per employee replacement is \$1800 to \$2400.¹⁰ Chirikos found that the productivity and job tenure of workers with disabilities are related directly to the provision of effective workplace accommodations.²⁶ Over time, accommodations may increase and help maintain employment rates by enabling newly disabled workers to retain employment.⁴³ Studies show that accommodations for workers' health conditions extends their work life an average of 5 years.²⁴ Those workers who cannot be accommodated at their usual place of employment suffer significant losses in income and job security.³⁴

Physicians who are familiar with an individual's impairment, job skills, and work requirements can effectively act as advocates for continued employment. Although most physicians have little training in workplace accommodations, ample expertise is available from a variety of public and private agencies. Each state has an agency or commission devoted to rehabilitation that maintains a list of consultative experts; these include occupational and physical therapists, vocational and rehabilitation engineering specialists, and other health care providers. These resources provide important information to providers and employers, as well as to disability advocacy groups. Several national organizations also are available to provide assistance.³¹

EFFECTIVENESS OF EFFORTS TO PROMOTE EQUAL ACCESS TO EMPLOYMENT

The effectiveness of the efforts to date is difficult to evaluate, given changes in work and employment participation rates in the U.S., demographics, economic conditions in the populations of persons with disabilities, and evolution of employer practices. Progress in medical science, rehabilitation engineering, computer technology, and shifts from blue-collar manufacturing jobs to technologically-intensive computer-linked work have created many new opportunities for employment of persons with disabilities.¹⁴ Questions remain as to what extent the potential for equal employment of disabled persons will be fully realized and in what ways our society's performance in this area will improve. Effective measurements require reliable and valid methods of enumerating persons with disabilities, longitudinal data on their economic and vocational status, and experience with work. No single consistent source of information exists to capture this data.

For these reasons, among others, the implementation and effectiveness of ADA Title I have been the subject of intense debate among employers, courts, policy makers, academics, and persons with and without disabilities.²⁷ Supporters of the law stress the overarching importance of the civil rights guaranteed by Title I's anti-discrimination provisions. Critics cast the law as overly broad, difficult to interpret, inefficient, and preferential. Others question whether the law's economic benefits to

employers, persons with disabilities, and society outweigh its administrative burdens. The present lack of study hinders accurate analysis and interpretation of Title I by both proponents and critics of the law.⁴⁴

Some evidence exists that supports the effectiveness of the ADA. The results of a 1995 Harris Poll of business executives show that more than 75% of those surveyed report *minimal* increases in costs associated with the provision of accommodations (median direct cost for accommodations was \$233 per covered employee). During 1986–1995, the proportion of companies providing accommodations rose from 51–81%.³⁷

RECOMMENDATIONS FOR THE OCCUPATIONAL PHYSICIAN

The occupational health care provider has a significant and positive role in the work life of persons with disabilities. This role depends on the provider's knowledge, level of involvement, and willingness to become an informed and effective advocate. Those who act as sources of scientifically-based decisions and emphasize accommodations over restrictions may significantly improve employment outcomes.^{8,9}

Support for reasoned decision-making and advocacy is not the only role that occupational providers play. Their involvement in the delivery of health care services has a significant impact. On-site health care services provide regular treatments and support that can enable those with certain disabilities, such as serious mental illness, cystic fibrosis, congestive heart failure, and cancer, to remain at work. Some occupational health care providers play a key role in establishment of work training programs at large companies for those with developmental and cognitive disabilities, in part by providing on-site medical support. On-site emergency services provide rapid response that enables employers to retain individuals with potentially life-threatening disorders, who may need immediate medical attention. The Family and Medical Leave Act requires employers to allow intermittent, scheduled leave for medical treatment, such as for dialysis or chemotherapy, enabling qualified employees to keep their jobs despite brief absences. Occupational physicians can educate employers about the appropriateness of these initiatives and their importance to the equal employment of workers with disabilities.

RECOMMENDATIONS FOR FUTURE RESEARCH

Several lines of research are necessary to understand employment barriers faced by persons with disabilities and identify areas where changes in social policy can lead to improvement in work outcomes. Future research should address the social and cultural factors and structural and cyclical changes in the labor market and economy that influence employment opportunity for persons with different disabilities.⁵ The prevalence, nature, costs, and benefits of workplace accommodations should be assessed on a population-wide basis.¹¹ Information is needed on the effects of accommodation on productivity, risk of workplace injury, workers' compensation costs, job tenure, and work life. An area ripe for study is recent welfare-to-work programs, directed by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform law), which ended Aid to Families with Dependent Children.¹⁶ Some of those who are at risk of losing health insurance benefits have multiple disabilities and present new challenges as they enter the workforce.³²

Relevant and credible medical research is needed to address the complex issues raised in this article. There is a significant need for study of various disease risks, the factors most important in determining related risks of workplace injury, and the role of accommodations in decreasing these risks and enhancing safe employment.

Studies of commercial drivers are important, for instance, as current regulations that mandate a number of disability-based exclusions lack strong scientific support. The positive effects of work on the health of persons with disabilities and the resulting economic benefits should be documented.

Progress in rehabilitation research and methods of workplace accommodation spurs a need for effective methods of disseminating this information to persons with disabilities and occupational health care providers. As the disability rights community develops and fosters links to occupational medicine, there is potential for a productive alliance to improve the equal employment potential of persons with disabilities.

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Defining 'disability' after *Abbott* and *Sutton*

by Stephen S. Pennington and Jamie Ray*

It appears at first glance that the **U.S. Supreme Court** decisions in *Bragdon v. Abbott*, 118 S.Ct. 2196, 12 NDLR ¶ 227 (U.S. 1998) and *Sutton v. United Air Lines, Inc.*, 15 NDLR ¶ 127 (U.S. 1999), place disabled workers between the proverbial rock and a hard place. There are few impairments that can be compared with HIV, and most can be corrected to some degree — like partial vision loss and high blood pressure. The immediate reaction to *Sutton* has been to suggest that all but the most obvious employment disability discrimination cases should be pursued under the "regarded as" prong of the definition of disability. This approach is unwarranted and will have the unintended consequence of shifting the focus of Title I of the ADA from accommodating individuals with disabilities at work to the more narrow case of challenging an adverse employment action based upon the employer's perception of disability. A more reasoned approach is to view *Abbott* and *Sutton* as representing the extremes of a difficult issue, leaving sufficient middle ground, nonetheless, to establish an individual's right to accommodation.

In *Abbott*, the court recognized that disability was not defined solely in terms of functional limitation. An impairment need not have present symptoms to be a disability. Rather, the analysis of disability requires consideration of the overall impact of the impairment on one's life. In *Abbott*, non-symptomatic HIV was a disability because it substantially limited the individual's decision to engage in the major life activity of procreation. In other words, the very nature of the impairment substantially limited how *Abbott* chose to conduct her life. The benefit of *Abbott* is that impairments such as hepatitis, sickle cell disease, certain forms of cancer and hemophilia can be compared to HIV in terms of causing substantial limitation despite the lack of present symptoms.

This does not mean that consideration of the functional limitations caused by an impairment is irrelevant to determining disability. Where no other limitations exist, functional loss may be the primary basis for establishing disability. This was the case in *Sutton*, where the Court found that because the individuals' functional loss had been corrected, no impairment remained. This case is unique, however, because the corrective measures eliminated all of the functional loss caused by the impairment. Similar to HIV, but illustrating the other end of the spectrum, corrected vision can be compared to few other disabilities. Most corrective measures eliminate some but not all functional limitations.

These decisions show us that while an impairment cannot be defined simply in terms of functional loss, a finding of substantial limitation is required nonetheless. In *Abbott*, non-symptomatic HIV was found to create a substantial, albeit non-functional, limitation. *Sutton* simply reinforces this point by requiring proof of a present impairment. This requirement does not represent a change in the ADA, and is consistent with its primary purpose, of helping individuals

with disabilities get and keep jobs. It stems from the affirmative obligation of employers to accommodate individuals with actual disabilities.

The Court's analysis of actual disability in *Sutton* does not suggest that the "regarded as" prong of the definition is now the more favored approach. The fact that a "regarded as" plaintiff does not have to show a present impairment is misleading. In the first place, an individual "regarded as" disabled does not have a right to accommodation, given the lack of functional limitations. These cases are limited to situations where an adverse employment action is based upon the mistaken perception that the individual is substantially limited in a major life activity. This is difficult to prove and usually focuses on the major life activity of working. In this situation, an individual faces the daunting task of showing that the employer perceived him or her as unable to do a broad range or class of jobs. Such proof is forthcoming only in cases where typically the employer believes that the individual is unable to do any job.

The most significant aspect of these cases is the recognition that while an individualized approach to determining disability is required, so is the consideration of society's overall understanding of disability. This approach enabled the Court in *Abbott* to recognize that the devastating impact of non-symptomatic HIV rendered it a disability and the Court in *Sutton* to exclude those who did not have a present impairment. With this in mind, it is difficult to understand how some courts have found that impairments such as bipolar illness, diabetes, cancer, depression and hemophilia are not disabilities. None of these are fully corrected by mitigating measures, and each has significant non-functional limitations. As in *Abbott*, such a finding would not be tantamount to declaring that these impairments are disabilities per se. Rather, it would simply recognize that some impairments are inherently substantially limiting. The remaining analysis would still need to be made in light of the individual's circumstances.

Abbott and *Sutton* do not narrow the first prong definition of disability. An individual must have an actual disability to receive accommodations. More importantly, these decisions require that courts consider the overall impact of the impairment on the individual's life and not reduce the determination of disability to solely an analysis of functional limitation. To establish a present impairment, we must look beyond the obvious to understand the full range of limitations that those who comprise the 43 million individuals with disabilities experience on a day-to-day basis. ■

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GRIST INDEPTH

THE WASHINGTON RESOURCE GROUP OF WILLIAM M. MERCER, INC.

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HEALTH PLAN EXCLUSIONS FOR INFERTILITY TREATMENT — CHALLENGES UNDER THE ADA

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Summary: The New York District Office of the Equal Employment Opportunity Commission (EEOC) recently issued a “determination letter” concluding that there was “reasonable cause” to believe an employer had violated the Americans with Disabilities Act (ADA) by excluding coverage for certain infertility treatments under its health plan. The EEOC letter has generated a lot of publicity and raised questions from employers concerned with the legality of their own health plan infertility limitations. However, the letter issued by the EEOC’s New York office does not appear to reflect EEOC national policy, and case law addressing the application of the ADA to benefit plan limitations supports the ability of plan sponsors to impose infertility limits within their health plans.

HEALTH PLAN EXCLUSIONS FOR INFERTILITY TREATMENT — CHALLENGES UNDER THE ADA

The EEOC letter was issued as a result of a complaint filed by an employee who incurred approximately \$20,000 in expenses related to treatment of her infertility. Under the terms of the infertility exclusions in her employer’s self-insured health plan, only about \$3,000 of these expenses were reimbursed. The employee complained to the EEOC that the denial of benefits for infertility treatment violated the ADA. The employer responded that the exclusion applied equally to disabled and nondisabled individuals, and therefore, did not violate the ADA. However, the New York office of the EEOC agreed with the employee and issued a letter stating that it had reasonable cause to believe that the employer had violated the ADA.

When the EEOC issues a reasonable cause letter, it is then required to pursue conciliation between the two parties. If the two parties cannot agree on a voluntary settlement, the EEOC can pursue the charge in litigation. The court hearing the case would not be required to give any deference to the EEOC’s letter — and might not even admit it into evidence. This is in contrast to agency positions stated in the form of regulations — a court generally must follow the agency’s regulatory interpretations. No charges have been filed yet in this case.

EEOC Policy on Infertility Exclusions

In 1993, the EEOC issued Interim Enforcement Guidance on the applicability of the ADA to health plan exclusions. The guidance states that “disability-based” distinctions in health plans violate the ADA, but that limitations “that are not based on disability, and that are applied equally to all insured employees” do not violate the ADA. Limitations that apply to both disabled and nondisabled individuals, even if they may have a more significant effect on disabled individuals, are not “based on disability” and are permissible. (See GRIST #19980784, 7/30/98.)

Representatives in the EEOC national office have previously expressed their informal views that infertility limitations were permissible under the ADA because infertility is sometimes the result of disability and sometimes the result of age. Thus, limitations on treatment for the condition apply to both disabled and nondisabled individuals and are not “disability-based distinctions.”

While EEOC national office staff have not stated their specific views on infertility exclusions since the reasonable cause letter was issued, they have confirmed that their views are still consistent with their 1993 guidance, and that the letter was issued by the New York office without review or approval by the national office. The national office apparently has not targeted infertility exclusions for litigation (as they have mental health limits in long-term disability plans).

Courts' Views on Infertility Exclusions

Thus far, only one court has specifically addressed the application of the ADA to health plan infertility exclusions (*Krauel v. Iowa Methodist Medical Center*, 1996 US App. LEXIS 23833 (8th Cir. 1996)). That court stated that insurance distinctions applying equally to all insured employees — both those with disabilities and those without — do not discriminate on the basis of disability. So, because the infertility exclusion applied equally to all covered individuals — no one, disabled or not, received infertility treatment — it did not violate the ADA.

However, this decision also relied on the court's other conclusion — that reproduction was not considered a “major life activity,” so impairment of that activity (infertility) was not a disability under the ADA. Last summer, the Supreme Court ruled that reproduction is a major life activity, and that impairment of that activity (caused by HIV infection, in that instance) is a disability under the ADA (*Bragdon v. Abbott*, 1998 U.S. LEXIS 4212 (1998); GRIST #19980727, 6/29/98). The Supreme Court's decision suggests that infertility, even unrelated to HIV infection, is a disability under the ADA, and in the minds of some casts doubt on the reliability of the *Krauel* decision. But even after *Bragdon*, *Krauel*'s remaining holdings provide strong support for health plan infertility benefit limitations.

This strong support exists because even if infertility is considered a disability under the ADA, there is a growing body of case law which rejects the notion that health plan limitations on particular kinds of treatments violate the ADA (see GRIST #19980821,

8/27/98). Most recently, the Seventh Circuit concluded that health insurance policies that applied lower lifetime caps to AIDS and AIDS-related conditions did not violate the ADA (*Doe v. Mutual of Omaha Ins. Co.*, 1999 U.S. App. LEXIS 11229 (7th Cir. 6/2/99)).

Although the courts have applied a variety of theories to reach their conclusions, the result (once the cases reach the appeals court level) has been the same — the ADA requires equal access to health plan coverage for disabled individuals, but not necessarily equal value from the coverage. Thus, *Doe* is the latest in an unbroken string of appellate court decisions upholding treatment limitations on specified disabilities under the general reasoning that ADA does not require all forms of disability to be treated equally.

Most employers don't feel that AIDS limitations are economically necessary or worth either the employee or public relations consequences. Nevertheless, the *Doe* decision is viewed by some as especially significant. In part, this is because the decision did involve AIDS, which is viewed as a politically sensitive ailment. Some believe that if courts will allow AIDS limits, then just about any condition can be limited. Secondly, the AIDS exclusion in the case was broader than many limits (such as infertility) in that it covered not just AIDS, but also certain AIDS-opportunistic infections as well.

Implications

A review of the case law suggests that health plan infertility limitations do not violate the ADA. However, courts in some jurisdictions have not yet addressed the issue, and it is possible they could reach conflicting conclusions. And the publicity generated by the New York EEOC Office's reasonable cause letter is likely to result in an increase in employee complaints regarding infertility limitations.

So each employer with infertility limitations in its health plan must weigh its risks — the potential costs of litigation and negative employee relations (even if the employer wins the case) against the costs of covering infertility treatments. These costs will be different for each employer, depending upon the location of the employer and its employees (are they in a jurisdiction where favorable case law exists?), the demographics of the workforce, and the type of coverage offered under the health plan. A careful analysis of these factors will help an employer decide whether to retain its health plan infertility limitations. Some employers who favor offering infertility benefits might use the New York EEOC letter as a rationale to provide the benefits. But others will prefer to retain limitations on the benefits, and for the present, no one can say definitively that infertility treatment limits are unlawful.

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GRIST INDEPTH

THE WASHINGTON RESOURCE GROUP OF WILLIAM M. MERCER, INC.

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MANY HEALTH PLAN EXCLUSIONS ALLOWABLE UNDER THE ADA

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Summary: Recent judicial interpretations applying the ADA to health plans that limit or exclude organ transplants, mental health benefits, and/or infertility treatment reveal an emerging judicial trend (in at least four federal circuit courts of appeals) toward the view that the ADA does *not* prohibit internal or inside plan limits on benefits and/or treatment, so long as the limits are equally applicable (at least in form) to all plan participants (not just to disabled participants). Of course, it's not assured that the other federal circuit courts will reach the same conclusion, and it's always possible that some of the courts that have already ruled on the issue will change their view. Also, we expect the EEOC to continue arguing that certain inside limits violate the ADA. Finally, an employer considering inside health plan limits should consider certain employee relations and other non-legal factors before proceeding.

MANY HEALTH PLAN EXCLUSIONS ALLOWABLE UNDER THE ADA

As employers continue to search for ways to control health care costs in the face of data suggesting costs are beginning to heat up again, the question of what benefits and treatments can be excluded from a health plan takes on increasing currency. A particular concern in this regard is whether an exclusion will be prohibited by the Americans with Disabilities Act (ADA). We have reviewed the application of the ADA to long term disability plans (see InDepth #19980808, 8/14/98) and have described the EEOC's interpretation (as expressed in an information letter) of ADA's applicability to health plans, noting that most courts that have ruled on the question disagree with the EEOC (see InDepth #19980784, 7/30/98).

Recent decisions in four federal circuit courts of appeal (i.e., Third, Sixth, Eighth, and DC Circuits) applying the ADA to inside plan limits on organ transplants, mental health benefits, and infertility treatments reveal an emerging judicial trend toward the view that the ADA does *not* prohibit inside plan limits on benefits and/or treatment, so long as the limits are equally applicable (at least in form) to all plan participants (not just to disabled participants).

Organ Transplants: Covering Some But Not Others

Many health plans cover some, but not all, transplant operations. Plaintiffs have tried to pry open this restriction inside a health plan by charging that it is a violation of ADA for a plan to cover some but not other transplant surgery. Their argument is that the value of such plans to a participant depends on the type of condition they suffer from. But one federal circuit court has held such limited transplant coverage to be acceptable under ADA. The Sixth Circuit recently upheld a plan's heart transplant exclusion because the same exclusion applied to all employees when they first became eligible, whether or not they were disabled at that time (*Lenox v. Healthwise*, 1998 U.S. App LEXIS 15087 (6th Cir. 7/8/98)). The court went on to say that the fact that some may become disabled for different reasons does not amount to discrimination. According to the court, the ADA only prohibits discrimination between the disabled and non-disabled, and not discrimination among people with different disabilities.

Mental Health Benefits

Another area where the courts have sanctioned disparate levels of coverage inside a health plan is mental health. Courts cite the ADA's legislative history in support of lower levels of mental health benefits. For example, the Senate Labor and Human Resources Committee stated:

[W]hile it is permissible for an employer to offer insurance policies that limit coverage for certain procedures or treatments, e.g., only a specified amount per year for mental health coverage, a person who has a mental health condition may not be denied coverage for other conditions such as for a broken leg or for heart surgery because of the existence of the mental health condition. A limitation may be placed on reimbursements for a procedure or the types of drugs or procedures covered e.g., a limit on the number of x-rays or non-coverage of experimental drugs or procedures; but that limitation must apply to persons with or without disabilities. All people with disabilities must have equal access to the health insurance coverage that is provided by the employer to all employees.

Courts also feel that their permissive interpretation of the ADA is supported by Congress' passage of the Mental Health Parity Act (MHPA). They note that if Congress felt that ADA already governed the design of insurance policies and required parity between mental and physical illness, the enactment of MHPA would not have been necessary.

On the application of the ADA to mental health limits, see *Ford v. Schering-Plough Corp.*, 1998 U.S. App. LEXIS 10315 (3rd Cir. 5/22/98). (This case was further discussed in InDepth #19980784, 7/30/98.) Although this case involved long-term disability rather than medical coverage, a similar rationale applies to health plan coverage. (See also *Moddero v. King*, 1996 U.S. App. LEXIS 8817 (D.C. Cir. 1996), as cited in the 5/14/96 Daily Report and Doc #96113.)

Infertility

The equal-applicability reasoning has also been used to defeat the claim of an employee alleging that the exclusion of infertility treatment from her employer's medical plan violated the ADA (*Krauel v. Iowa Methodist Medical Center*, 1996 U.S. App. LEXIS 23833 (8th Cir. 1996)). The court stated that insurance distinctions applying equally to all insured employees — both those with disabilities and those without — do not discriminate on the basis of disability. So, because the infertility exclusion inside the plan applied equally to all covered individuals — no one, disabled or not, received infertility treatment — it did not violate the ADA.

EEOC's Own Rules Support the Different Benefits

Although EEOC's oral and informal advice (see InDepth #19980784, 7/30/98) tend to overlook it, the EEOC's own formal guidance supports the view that coverage or benefit distinctions inside a health plan do not impermissibly discriminate on the basis of disability if they apply equally to all employees — with or without disabilities.

[S]ome health insurance plans provide fewer benefits for "eye care" than for other physical conditions. Such broad distinctions which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities, are not distinctions based on disability. Consequently, although such distinctions may have a greater impact on certain individuals with disabilities, they do not intentionally discriminate on the basis of disability and do not violate the ADA.

(*EEOC: Interim Enforcement Guidance on Application of ADA to Health Insurance* (6/8/93)).

Blanket Limits on Disabled People are Not Allowed

A case involving individual medical insurance illustrates the type of limitations the ADA presumably was intended to prevent. That Illinois case (*Doe v. Mutual of Omaha*, 1998 U.S. Dist. LEXIS 4894 (4/3/98)) concerned individual medical policies with lower aggregate lifetime limits for people with AIDS. The court indicated that, under the plan's limits, if a person with AIDS contracted pneumonia, charges for treatment of the pneumonia — and the charges for the treatment of all other conditions — would be subject to the lower limit. The court viewed this lower overall limit as impermissible under the ADA because it resulted in inferior coverage for disabled participants than for non-disabled participants.

Conclusion — Bringing It Together

Although employees may complain that a health plan provides different coverage for different disabilities, the emerging trend among the courts is to find that such disparities or variations *inside a plan* are acceptable under the ADA so long as they are equally applicable

to all participants in the plan. The trend is more clearly evident where the limited benefits or treatments are of relevance to both disabled and non-disabled participants. But one federal circuit has concluded (and logic would seem to support this view) that the ADA does not prohibit an inside limit that is equally applicable (in form) to all participants even though the limited benefits or treatments are of relevance primarily (or even only) to disabled participants (e.g., heart transplants).

The key seems to be that the inside plan limit be drafted so that it is applicable only to particular treatments and benefits for all plan participants — without regard to whether the participants are disabled. This is the case even if only disabled participants are likely to need the treatments or benefits in question. Thus, it's important to analyze a plan's inside limits to be sure they are targeted at particular benefits or treatments and are not stated in terms of participants with particular conditions. Also, the inside limits should not be drafted in such a way that they inadvertently limit overall coverage. For example, a plan would violate the ADA if it were drafted to apply lower overall health plan limits to employees with a particular disability (e.g., \$10,000 lifetime maximum on all claims for participants with AIDS). But under the emerging trend, a plan would likely pass muster under the ADA if it failed to cover particular treatments for all participants, even if the particular treatments were of relevance only to participants with AIDS. In some cases, the difference between passing or failing the ADA may well come down to expert plan drafting.

Even if the emerging trend becomes the accepted interpretation of the ADA throughout the United States, the ADA will continue to affect employers' health plans. For example, the ADA will continue to prohibit excluding employees from plan eligibility and participation on the basis of disability, charging disabled employees more than non-disabled employees for plan coverage, and providing one or more disabled employees with limited benefits inside a plan with the intent to cause the employees to quit employment or to otherwise alter the terms of the employee's employment (outside the plan). (Of course, many of these practices are now also prohibited by the health status nondiscrimination rules enacted by HIPAA.)

Again, keep in mind that this area of law is not fully developed — other courts may reach different decisions, and some of the courts that have already addressed the inside limit issue may change their views. This may occur as courts come to realize that the current judicial trend — broadly applied — would allow some plans to discriminate against disabled individuals through properly drafted inside plan limits, even though the ADA would prohibit essentially the same result when it is in the form of a plan eligibility requirement or an overall plan limit. Also, we expect that the EEOC will continue to bring lawsuits against plans with inside limits in certain "high profile" situations. For example, while the judicial trend would seem to allow limits on particular cancer treatments, such as autologous bone marrow transplants, we expect that the EEOC may continue to bring ADA-based actions against these and similar inside limits.

Finally, employers should be aware that employee relations, politics, public perception and practicality may well be more limiting than the ADA. (The advocacy groups for disabled

individuals are well aware of the ADA and are generally very effective at representing disabled individuals both legally and otherwise.) For example, a plan might well be legally able under the ADA to cap at \$5,000 specific treatments of relevance only to participants with a specific condition. But we expect that not only might the EEOC challenge this sort of inside limit, but also the employer might well incur employee relations and publicity costs greater than the medical savings achieved through the limitation.

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Supreme Court "Clarifies" Who is Disabled Under the ADA

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Recent actions by the Supreme Court which attempt to further define what it means to be a "disabled" worker under the *Americans with Disabilities Act* (ADA) have implications for workplace disability management practice, but fewer than it may seem at first glance. The Supreme Court voted by a margin of 7-2 on June 22 not to expand the definition of disability under the ADA to include health impairments such as high blood pressure or poor eyesight, whose negative effects can be controlled by medication or some other assistive device. The Court applied this same reasoning to all three disability discrimination cases before it.

Case Summaries

These three Supreme Court cases were:

- ① *Sutton v. United Air Lines* – Twin sisters Karen Sutton and Kimberly Hinton of Spokane, Washington, wanted to be United pilots but were rejected because they are nearsighted. The sisters have 20/20 vision with corrective lenses, but United requires uncorrected vision of 20/100.
- ② *Murphy v. United Parcel Service* – Vaughn Murphy, a Kansas mechanic, was fired by UPS due to the high blood pressure condition he acquired at age 10. Murphy's physician said he was unable to lower his blood pressure below the Department of Transportation's required level without serious side effects.
- ③ *Kirkingburg v. Albertson's* – Hallie Kirkingburg, a truck driver from Portland, Oregon, was fired by the Albertson's supermarket chain subsequent to a failed vision test. He was unable to meet vision requirements for commercial drivers, even with corrective lenses.

In making their decision in these three cases, the Supreme Court rejected the argument of both the Justice Department and the Equal Employment Opportunity Commission that the "mitigating effects" of any medication or device that could control a mental or physical impairment should be ignored when determining whether an impairment is severe enough to be considered a disability under the ADA.

Justice Sandra Day O'Connor, who wrote the majority opinion in these disability cases, argued that the provisions of the ADA are not applicable to people with correctable or controllable conditions because: (1) a corrected impairment does not "substantially limit a major life activity" which is the disability threshold under the ADA; and (2) the text of the ADA, which states that approximately 43 million Americans have a mental or physical disability, is proof that Congress did not intend to include those with correctable disabilities under the ADA. If this were not the case, the 43 million figure would be much higher.

Reactions

Employers were generally pleased with the ruling because they felt it was congruent with the original intent of the ADA and would head off an explosion of ADA-related lawsuits. The U.S. Chamber of Commerce general counsel, Steve Bokar, hailed the rulings as "common sense" and the Society for Human Resources Management's Susan Meisinger expressed the hope that the decisions would shift the focus back to "the ADA's true beneficiaries—those who truly have disabilities but who can and want to work..."

Disability advocates were less satisfied with the Supreme Court's stance and vowed to keep fighting to expand the ADA's reach. Sen. Tom Harkin (D-IA) has promised to help them in this effort and is investigating legislative avenues to override the Supreme Court's decisions. The EEOC was quick to add that the Court ruling "did not suggest that any conditions are *per se* excluded from ADA coverage" and that "some people who use mitigating measures may still be substantially limited in some major life activities." The agency announced that it would begin drafting instructions for commission investigators that will apply an "individualized approach to the assessment of ADA

Supreme Court Cases

(continued from page 3)

coverage" in investigating and resolving ADA charges.

The EEOC also noted that in *Cleveland v. Policy Management Systems*, another recent Supreme Court ADA case decision, the Court unanimously agreed that people who seek disability benefits are not precluded from bringing ADA claims, thus reinforcing employers' obligation to consider reasonable accommodation for employees who apply for Workers' Compensation, STD, LTD, and/or Social Security Disability Income.

Implications of Supreme Court Ruling for Workplace Disability Management

These decisions will shape disability management practice in several ways:

- ① The definition of disability under the ADA was not viewed by the Court as broadly as once thought applicable. As a result of this decision, employees with correctable conditions are not entitled to reasonable accommodation and employers are not obligated to provide such services for them despite the impairment that their condition may impose without correction.
- ② The use of reasonable pre-employment standards for job applicants is supported by these Court decisions. They reaffirm the fact that prudent concern for the safety and well being of employees with disabilities or other individuals is a permissible reason to exclude someone from working in positions with inherent work risks (such as drivers, pilots, machine operators, etc.).
- ③ Job accommodation efforts can be more clearly focused on work related concerns. Disability managers should be able to determine when the application of some job specific technology might enable a person with a disability to work (or return to work) without an individual's personal "mitigating measures" clouding the process. For instance, the Court's decision makes it abundantly clear that an employer would not have to purchase glasses or pay for medications as "reasonable accommodations", only services or equipment that specifically relate to the job.

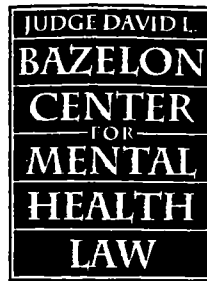
Although disability management practitioners may find that the mildest forms of some disabilities now may not qualify for coverage under the ADA, most disabling conditions with which they are familiar still impose limitations of major life activities which will require an individualized assessment of

abilities and limitations as well as an interactive dialog regarding accommodation options. For example, diabetes, epilepsy, and HIV, while controllable to a degree with medication, all impose additional life activity limitations (e.g. dietary restrictions, cognitive or motor impairments associated with drug side effects, reproductive disruption, etc.) that will likely fall under ADA protection. And mental illness, while responsive to medication and therapy in some cases, is rarely 100% controllable, with recurrences and cyclical exacerbation characterizing the course of this disability regardless of the treatment regimen.

Future Outlook

It is expected that the battle over the scope of the ADA will continue particularly because reasonable accommodation job reassignment rights, mental health parity in disability coverage, and health plan provisions/exclusions have all been raised as potential ADA issues which may ultimately require Supreme Court intervention. For disability management professionals, the current cases simply reinforce the need for good disability management practice that includes an individualized approach to evaluating each case. As well, progressive employers will continue to rely on disability management programs that promote return to work and accommodation as the most cost-effective ways to manage workplace disability and maintain workforce productivity regardless of the "ADA definitions" of disability.

Bruce G. Flynn, M.S., CRC, is the director of disability management for the Washington Business Group on Health, Washington, DC, the largest non-profit research and public policy organization representing the interests of large businesses on health and disability issues. He can be reached at flynn@wbgh.com.



MEMORANDUM

To: Disability Rights Advocates

From: Jennifer Mathis and Mary Giliberti, Bazelon Center for Mental Health Law

Re: Limitations on Major Life Activities caused by Psychiatric Disabilities

Date: August 9, 1999

I. Implications of the *Sutton*, *Murphy*, and *Kirkingburg* Decisions

As you may be aware, the Supreme Court recently issued a series of three decisions concerning who is covered by the protections of the Americans with Disabilities Act (ADA).¹ The Court held that, in determining whether a person has a disability under the ADA, any measures taken to control the effects of the person's impairment – such as medication or therapy – must be considered. For example, a person who controls the effects of her depression through medication may be unable to claim the protections of the ADA, even if she is discriminated against because of her depression.

As a result of these decisions, many individuals who use such mitigating measures may be at risk of losing the protections of the ADA. **The mere fact that an individual takes medication or other mitigating measures, however, does not mean that he is not a person with a disability.** Determining whether someone has a disability now requires a very careful analysis of what limitations the person continues to experience despite medication and/or therapy. Individuals may need to look at a much broader universe of limitations than was previously necessary.

II. List of Limitations on Major Life Activities

In order to assist consumers, advocates and attorneys in assessing whether an individual with a psychiatric impairment is a "person with a disability" for purposes of the ADA, the Bazelon Center has compiled a list of some limitations on major life activities that may be experienced by individuals with psychiatric disabilities. We created this list with the assistance of psychiatrists, psychologists, researchers, consumers, and attorneys. The list is not intended to be an exclusive list of limitations, but may be used as a tool to help focus on limitations that may remain even if other limitations are controlled by medication or therapy.

A note of caution: the major life activities mentioned in the list are not necessarily ones

¹ *Sutton v. United Air Lines, Inc.* No. 97-1943, 119 S.Ct. 2139 (June 22, 1999), *Murphy v. United Parcel Serv.*, No. 97-1992, 119 S.Ct. 2133 (June 22, 1999), and *Albertsons, Inc. v. Kirkingburg*, No. 98-591, 119 S.Ct. 2162 (June 22, 1999).

that have been established as major life activities through caselaw. Persuasive arguments may be made, however, that each of the activities included on the list is a major life activity. Whether the limitations on major life activities are substantial will vary from one individual to another. The list of limitations is simply intended to provide suggestions about what types of limitations may arise for individuals with psychiatric disabilities.

Attorneys should be extremely cautious about bringing claims based on an individual being substantially limited in the major life activity of working. While our list includes limitations on work activities, **we urge that you focus on substantial limitations on major life activities other than working**, as the viability of claims based on work limitations has been severely limited by the Supreme Court's decisions. It is important to remember that the greater a person's limitations in work activities, the more likely it is that she will be found to be unqualified to perform the essential functions of her job. Thus, even if an individual is substantially limited in performing a broad range of jobs, it is helpful to focus instead on his limitations in other major life activities, such as eating, sleeping, reproduction, muscle impairments, and speech impairments, to the extent possible.

Attorneys should also be cautious about claims that an individual is substantially limited in major life activities that are strongly *related* to work performance – for example, concentration, maintaining attention, interacting with others. As with claims that a person is limited in working, these claims pose risks that the individual may be found unqualified to perform the job.

More expansive lists of potential limitations on life activities may be found in the World Health Organization's *International Classification of Impairments, Activities and Participation* (ICIDH-2), available on the WHO website, <http://www.who.int/icidh/>, and the DSM IV Primary Care Version, available from the American Psychiatric Association.

III. Who Is Still Protected by the ADA

The Court's decisions, while severely limiting the population of people protected by the ADA, nonetheless leave room for many people who use mitigating measures to be covered by the law. The ADA defines a person with a disability as: (1) someone who is substantially limited in major life activities (including working), (2) someone who has a record of being substantially limited in major life activities, or (3) someone who is regarded as substantially limited in major life activities even though she is not actually so limited. Despite the Supreme Court's directive to consider mitigating measures, many individuals, including the following, may still be covered by the ADA even though they use such measures:

(A) individuals who are currently substantially limited in major life activities, either because:

(i) the measures they use do not fully control the effects of their impairments (for example, a person with depression whose depression substantially limits him in self care, even while he is taking medication),

(ii) the measures do generally control the effects of their impairments, but the individuals face **intermittent periods during which they are substantially limited** (for example, a person with bipolar disorder whose symptoms are generally controlled by medication, but whose symptoms periodically arise even while taking medication), or

(iii) the **side effects of the mitigating measures themselves substantially limit the individual in major life activities** (for example, a person who takes medication that alleviates delusions caused by schizophrenia, but who is substantially limited in mobility due to muscle stiffness caused by the medication). The substantial limitation may be caused by a combination of the side effects of the mitigating measures and the effects of the impairment itself.

(B) individuals who have a record of being substantially limited in major life activities, such as individuals who are currently taking measures that control the effects of their impairments but who have previously experienced a period of substantial limitation. For example, a person who had substantial limitations before finding an appropriate combination and/or dosage of medication that alleviated the limitations, or before achieving control over his limitations through therapy, would be covered. Advocates should rely on information demonstrating a specific substantial limitation of a major life activity. Merely demonstrating a record of a prior hospitalization for an impairment, for example, may not be sufficient.

(C) individuals who are regarded as substantially limited in major life activities even though they are not, in fact, so limited. Attorneys should proceed with caution if claiming that a person is regarded as substantially limited in working. Many courts have interpreted the "regarded as" prong as requiring proof of someone else's state of mind, and proving that an employer regarded someone as substantially limited in performing not only the job in question but a class of jobs or a broad range of jobs as well is an extremely difficult task. The Supreme Court's decision in *Sutton* makes this type of claim even more difficult. The Court interpreted the ADA to require a substantial limitation in performing an extremely broad class of jobs. The Court also held that an employer's use of job criteria does not, by itself, establish that the employer regards someone who fails to meet those criteria as substantially limited in working. In light of the difficulty of bringing claims based on substantial limitations in working, arguments that an employer has regarded a person as substantially limited in other major life activities will generally fare better, provided that there is evidence to support them.

IV. New Directions: Untested Theories

One theory that may be particularly useful for showing that an individual with a psychiatric impairment is covered by the ADA is the argument that, while the effects of his impairment are generally controlled by medication and/or therapy, he does experience substantial limitations on major life activities on an intermittent, or periodic, basis. This may occur, for example, when changes in medication become necessary or when particular events occur that cause old or new limitations to arise. This theory has not been tested in the courts, but for some individuals, it may be the best method of demonstrating that they are individuals with disabilities

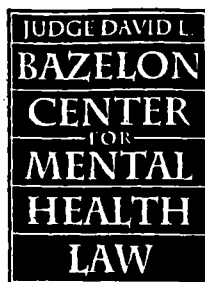
in light of the *Sutton*, *Murphy*, and *Kirkingburg* decisions.

Another approach that attorneys may wish to consider: even if an individual uses mitigating measures to control her disability, when a covered entity does not allow her to use those measures as an accommodation, those measures should not be considered in determining whether she is a person with a disability. For example, if a child with insulin-dependent diabetes is denied admission to a day care center because the day care center refuses to administer insulin injections, then the day care center cannot defeat an ADA claim by arguing that the child's diabetes is controlled by insulin and therefore is not a disability. As the Court noted in *Sutton*, the person's *actual* circumstances must be considered. If she is not actually able to take insulin at the day care center, then for purposes of her claim against the day care center, the determination of whether she has a disability must be made without considering the insulin. Similarly, if an individual is denied the workplace accommodation of a flexible time schedule or an absence needed for purposes of psychiatric treatment, then the determination of whether he has a disability should be made without considering the availability of the treatment.

Advocates should note that individuals who are covered by the "record of" prong may have claims for reasonable accommodations. For example, an individual with a history of depression who no longer experiences symptoms of depression may require ongoing treatment, including medication, to prevent the depression from recurring. The person may require the accommodation of a flexible work schedule due to the side effects of her medication or to permit her to make appointments with a treating professional.

Finally, advocates should consider the possibility of bringing a "regarded as" claim based on a covered entity's generalized fears and stereotypes about particular conditions. For example, an individual with a psychiatric impairment may be regarded as substantially limited in working due to generalized fears about psychiatric impairments expressed by an employer. If the employer refuses to hire an individual with schizophrenia because of a perceived fear that individuals with schizophrenia are likely to engage in workplace violence, then the employer regards the individual as substantially limited not only in performing the job in question but also in most other jobs.

Updates on significant developments in this area will be posted on the Bazelon Center website, <http://www.bazelon.org>.



MEMORANDUM

To: Disability Rights Advocates

From: Jennifer Mathis and Mary Giliberti, Bazelon Center for Mental Health Law

Re: Limitations on Major Life Activities caused by Psychiatric Disabilities

Date: August 9, 1999

Following is a list of ways in which psychiatric disabilities may limit major life activities. While the list is not exhaustive, it is intended to assist advocates in analyzing whether a person with a psychiatric impairment is a "person with a disability" under the ADA.

I. Limitations on Major Life Activities:

Social/Emotional:

- * interaction with others (e.g. speech difficulties such as pressured speech, lack of clarity, withdrawal or responding with difficulty or too quickly; self absorption; inability to relate to or listen to others, including inability to relate due to paranoia, delusions, hallucinations, obsessive compulsive ideation, negativity; inability to regulate mood and anxiety; inability to maintain appropriate distance from others)
- * forming and maintaining relationships with others
- * communication with others (e.g. answering questions, following directions, using intelligible speech, recognizing and expressing emotions appropriately, expressing needs, following a sequence)

Cognitive:

- * concentration (as a major life activity itself and also resulting in limitations on other major life activities, such as interaction with others, self care)
- * making decisions
- * complex thinking (e.g. planning, reconciling perceptions from different senses (seeing and hearing), sorting relevant from irrelevant details, problem solving, changing from one task to another)
- * abstract thinking (e.g. difficulty generalizing or transferring learning from one setting to another, such as difficulty transferring skill of cooking in one kitchen to another kitchen)
- * memory (long or short term)
- * attention
- * perception
- * distinguishing real from unreal events
- * initiating and completing actions
- * processing information

Physical:

- * taking care of personal needs, such as eating, dressing, toileting, bathing, hygiene, household chores, managing money, following medication or treatment regimens, following safety precautions
- * eating (e.g. inability to regulate amounts appropriately or to maintain appropriate diet; need for strict eating schedule)
- * sleeping (e.g. inability to fall asleep, obtain restful sleep, or sleep without interruption; excessive sleeping)
- * reproduction
- * sexual activity
- * traveling

II. Limitations caused by Medications:**Social/Emotional:**

- * interaction with others (due to agitation, flattened affect, or withdrawal caused by medication)
- * concentration
- * ability to perform daily activities

Cognitive:

- * concentration
- * thinking (e.g. slowed thought process)

Physical:

- * seeing (e.g. blurred vision)
- * reproduction (e.g. sexual dysfunction or possibility of birth defects)
- * sexual activity (e.g. sexual dysfunction)
- * writing, grasping, lifting (e.g. loss of fine motor control, uncontrolled muscle movement, or muscle rigidity)
- * speaking (e.g. slurred speech)
- * sleeping (e.g. inability to fall asleep, obtain restful sleep, or sleep without interruption; excessive sleeping)
- * eating (e.g. restrictions on types or amounts of foods or eating times due to medication regimes, or due to liver damage or high blood pressure caused by medication)
- * eliminating waste (e.g. incontinence, diarrhea, urgency or frequency of need to urinate or defecate)
- * walking/ambulation (e.g. excessive weight gain, muscle rigidity)
- * driving (e.g. drowsiness, loss of fine motor control, uncontrolled muscle movement, or muscle rigidity)
- * self care
- * working (e.g. most of limitations listed above)

III. Limitations on Work Activities:

Social/Emotional:

- * giving directions
- * requesting clarification
- * initiating interpersonal contact
- * asking for feedback on job performance
- * responding appropriately to negative feedback
- * initiating corrective action
- * providing explanations
- * describing events
- * using intelligible speech
- * responding appropriately to supervision
- * maintaining relationships with supervisors
- * responding appropriately to supervisors
- * maintaining relationships with coworkers
- * responding appropriately to coworkers
- * adapting to a new supervisor

Cognitive:

- * understanding, remembering, carrying out directions
- * assessing own performance
- * making decisions
- * seeking information
- * exercising judgment
- * setting work priorities on a daily, weekly or monthly basis
- * problem solving capacity (managing multiple pressures or stresses, balancing work and home life, solving routine problems that make it possible to work -- e.g. getting up on time, taking public transportation, wearing appropriate clothing, doing laundry)
- * recognizing when to stop doing one task and move on to another
- * learning new tasks
- * transferring learning
- * adapting to a change in work assignment (e.g. in corporate re-organization)
- * focusing on multiple tasks simultaneously
- * screening out environmental stimuli (e.g. noise, visual distractions, etc.)
- * processing information (e.g. understanding, analyzing or synthesizing)
- * maintaining boundaries of responsibility

Physical:

- * maintaining fixed work schedule (e.g. need for flexible schedule or breaks or modified hours due to the impairment, the effects of medication, or the need for appointments to receive treatment; need for leave to receive acute treatment)
- * maintaining work pace
- * maintaining stamina throughout the work day

IV. Limitations Remaining Despite Mitigating Measures:

- * any of the above may recur intermittently despite medication or therapy
- * may be at risk of any of the above occurring despite medication or therapy
- * any of the above may be residual limitations remaining despite medication or therapy



DEPAUL LAW REVIEW

**THE ECONOMICS OF THE EMPLOYMENT PROVISIONS
OF THE AMERICANS WITH DISABILITIES ACT:
PART I—WORKPLACE ACCOMMODATIONS**

Peter David Blanck

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**THE ECONOMICS OF THE EMPLOYMENT
PROVISIONS OF THE AMERICANS
WITH DISABILITIES ACT:
PART I—WORKPLACE
ACCOMMODATIONS**

*Peter David Blanck**

INTRODUCTION

Since its July 26, 1992 effective date, the implementation and effectiveness of Title I of the Americans with Disabilities Act ("Title I") has been the subject of intense debate among employers, courts, policymakers, academics, and persons with and without disabilities.¹ Supporters of the law stress the overarching importance of the civil rights guaranteed by Title I's antidiscrimination provisions. Critics cast the law as overly broad, difficult to interpret, inefficient, and as a preferential treatment initiative. Others question whether the law's economic benefits to employers, to persons with disabilities, and to society outweigh its administrative burdens. These and related issues have fueled the debate, some argue a backlash, of Title I.

This Article examines one aspect of the ongoing evaluation and debate regarding Title I implementation, that is, arguments based primarily in economics.² Presently, there exists limited systematic empirical study of Title I implementation in general, and of the economic impact of the law on employers and others in particular. This lack of study hinders accurate analysis and interpretation of Title I by

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This Article is based on a presentation given on January 31, 1997, at *DePaul Law Review's* Symposium entitled *Individual Rights and Reasonable Accommodations Under the Americans with Disabilities Act*.

1. For a review, see Peter D. Blanck & Mollie W. Marti, *Attitudes, Behavior, and the Employment Provisions of the Americans with Disabilities Act*, 42 VILL. L. REV. (forthcoming 1997) (developing related aspects of the present article).

2. The Article attempts to examine the economic implications of Title I in ways consistent with prior cost-benefit analysis of the law suggested by economists. As mentioned in Part II of the Article, however, this approach is not meant to suggest that other disciplinary or non-utilitarian views of the law are less valid or useful for assessing the impact of the law on employers, persons with disabilities, or society. See *infra* notes 174-76 and accompanying text.

both proponents and critics of the law.³ Part I of this Article examines the major economic justifications and critiques of Title I, in light of existing empirical information on the law's implementation. Part II of this Article explores the economics of workplace accommodations required under Title I, in particular as reflective of efficient business practices with applications to persons with and without disabilities.

I. ECONOMIC IMPLICATIONS OF TITLE I

There are several economic efficiency justifications linked to the provisions of Title I, each of which may be cast in support or opposition to the purposes of the law and which may impact in significant and measurable ways the American economy. This Part examines these views with reference to the central provisions of the law and the existing, but limited, empirical study.⁴ The implications explored relate to the following propositions that are open to empirical verification:

1. *Definition of Disability.* Title I's statutory definition of disability affects the value of labor in the American work force;
2. *Qualified Individual with a Disability.* Title I affects employers' ability to hire and retain "qualified" employees and to define essential job functions and production requirements and, thereby, employers' labor market efficiencies;
3. *Reasonable Accommodations.* Title I impacts employers' decisions to provide effective and economically efficient "accommodations" for job applicants and employees with and without disabilities; and
4. *Undue Hardship.* Title I's economic impact varies for employers of different sizes and in different labor markets.

A. Definition of Disability

Proponents and critics of Title I argue that the statutory definition of disability impacts, in either economically efficient or inefficient ways, the "value" of labor to employers in different segments of the

3. See NATIONAL COUNCIL ON DISABILITY, *ACHIEVING INDEPENDENCE: THE CHALLENGE FOR THE 21ST CENTURY—A DECADE OF PROGRESS IN DISABILITY POLICY SETTING AN AGENDA FOR THE FUTURE* 6 (1996) (recommending that accurate data about people with disabilities be collected, analyzed, and reported).

4. For a prior discussion of the provisions of Title I, see Peter D. Blanck, *Employment Integration, Economic Opportunity, and the Americans with Disabilities Act: Empirical Study from 1990-1993*, 79 IOWA L. REV. 853 (1994).

American work force.⁵ In a truly competitive labor market, the value to an employer of a worker's labor should equal or exceed the worker's wage.⁶ Nevertheless, as Professor Donohue has suggested, a worker's value is often contingent upon a worker's output and his employer's and relevant consumers' attitudes about him.⁷ Thus, to a given employer, worker value may equal output or productivity plus a degree of attitudinal preference, or conversely disfavoring discrimination, toward the particular worker.⁸

Worker value is linked also to relevant labor market biases or customer attitudes and preferences. A particular geographic market may have a high percentage of persons with disabilities, the elderly, or others who value or require physical accessibility to retail establishments. This demand may lead to a preference by these individuals to shop at accessible stores, in addition to the hiring by the stores of individuals with similar needs as those in the relevant market.⁹ In such a market there may be increased value to employers (for example, greater profits) associated with retaining workers and serving customers with disabilities.

In a series of empirical studies discussed in greater detail in Part II below, my colleagues and I have illustrated how an employer's sensitivity to disability-related preferences and customer attitudes may lead to enhanced economic efficiency for a particular business.¹⁰ Pro-

5. Worker "value" may be assessed in terms of the net dollar profit to employers of hiring or retaining a worker in a given labor market. See John J. Donohue III, *Employment Discrimination Law in Perspective: Three Concepts of Equality*, 92 MICH. L. REV. 2583, 2585 (1994) (noting the implicit conception of equality that "a worker's wage should equal the market-determined value of the individual's labor").

6. See Frederick C. Collignon, *The Role of Reasonable Accommodation in Employing Disabled Persons in Private Industry*, in *DISABILITY AND THE LABOR MARKET* 196, 205-11 (Monroe Berkowitz & M. Anne Hill eds., 2d ed. 1989) (stating that "[t]he wage to be paid the worker would, in a competitive labor market, be equal to the worker's marginal contribution to the value of the firm's product"); Donohue, *supra* note 5, at 2585.

7. See Donohue, *supra* note 5, at 2585 (defining this concept as "contingent equality").

8. Cf. William G. Johnson, *The Future of Disability Policy: Benefit Payments or Civil Rights?*, 549 ANNALS AM. ACAD. POL. & SOC. SCI. 160, 164 (1997) (arguing that labor market discrimination against persons with disabilities results more from inadequate information regarding their productivity than from prejudice and that Title I defines worker value to employers in terms of productive use of resources).

9. See, e.g., Bill Wolfe, *Shopping Trip-Ups: How Accessible Are Local Stores to People with Disabilities?*, COURIER-JOURNAL, Dec. 23, 1996, at 01E (linking retail store accessibility to shopping preference by consumers with disabilities).

10. See PETER D. BLANCK, COMMUNICATING THE AMERICANS WITH DISABILITIES ACT, TRANSCENDING COMPLIANCE: 1996 FOLLOW-UP REPORT ON SEARS, ROEBUCK AND CO., ANNENBERG WASHINGTON PROGRAM REPORT (1996) [hereinafter SEARS II]; PETER D. BLANCK, COMMUNICATING THE AMERICANS WITH DISABILITIES ACT, TRANSCENDING COMPLIANCE: A CASE REPORT ON SEARS, ROEBUCK AND CO., ANNENBERG WASHINGTON PROGRAM REPORT (1994) [hereinafter SEARS I].

ponents of Title I argue that the antidiscrimination law promotes economic equality in employment, whether defined in terms of wages or career opportunities, and confronts attitudinal preferences and unjustified discrimination that is faced by qualified employees and job applicants with disabilities in different labor markets.¹¹

Under Title I's three-prong definition of "disability," a person with a disability covered by the law must have a known physical or mental condition or impairment that "substantially limits major life activities,"¹² "a record of" a physical or mental condition,¹³ or is "regarded as" having such an impairment.¹⁴ The first prong of the definition of disability is directed toward individuals with actual and substantial impairments or conditions, such as those with visual or hearing impairments, cancer, mental illness, physical paralysis, or HIV. This prong employs a functional definition of disability that is determined on a case-by-case basis.¹⁵ The first-prong definition of disability is not only based on the diagnosis of the impairment but also on the effect of the impairment on the individual's life.¹⁶ Physical characteristics, such as hair color or left-handedness, and temporary conditions, however, are not covered disabilities, nor are an individual's economic, environmental, or cultural disadvantages.¹⁷

11. In *Alexander v. Choate*, 469 U.S. 287 (1985), the United States Supreme Court recognized that discrimination against people with disabilities is "most often the product, not of invidious animus," but rather of thoughtless and indifferent attitudes. *Id.* at 295. See generally MARTHA MINOW, *MAKING ALL THE DIFFERENCE* (1990) (describing the benefits of reshaping societal perceptions of disabled persons).

12. Major life activities include "caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 29 C.F.R. § 1630.2(i) (1996). A "substantial" limit on the major life activity of working means the individual is significantly restricted in the ability to perform a class of job activities as compared to an average person with comparable training, skills, and ability. *Id.* § 1630.2(j)(3)(i).

13. A record of disability means that one "has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities." *Id.* § 1630.2(k). An employer must rely on the record of disability in making employment-related decisions to be held liable under Title I. *Id.* § 1630.2(k) app. at 341.

14. 42 U.S.C. § 12102(2) (1994). Title I also prohibits discrimination on the basis of an association with a person with a disability. *Id.* § 12112(b)(4). To help evaluate the meaning of discrimination under Title I, the EEOC has issued interpretative guidance. See EEOC Compl. Man. (BNA) § 902 (Mar. 5, 1995) (defining the term "disability").

15. See ROBERT L. BURGDORF, JR., *DISABILITY DISCRIMINATION IN EMPLOYMENT LAW* 129-30 (1995) (noting that disability is not necessarily based on name or diagnosis of impairment, but rather on the effect of that impairment on the life of the individual).

16. 29 C.F.R. § 1630.2(j) app. at 339; cf. *Murphy v. United Postal Serv.*, 946 F. Supp. 872, 881-82 (D. Kan. 1996) (finding high blood pressure impairment that is controlled by medication not a covered disability).

17. See BURGDORF, *supra* note 15, at 145-46 (noting several conditions expressly excluded from coverage as a disability, including transvestism, homosexuality, and illegal drug use).

Under the first prong of the definition, disability is interpreted to mean that the individual is substantially limited in a major life activity, for instance, in the ability to work in a class or range of jobs.¹⁸ Findings from the 1992 National Health Interview Survey show that nineteen million working-age adults, roughly twelve percent of the population between the ages of eighteen and sixty-nine years old, are restricted in the major life activity of working.¹⁹

The first-prong definition of disability does not mean that a covered individual must work at the job of his choice.²⁰ Rather, to fall under the first-prong definition, the individual's "access" to the relevant labor market must be substantially limited by the impairment or condition.²¹ Put differently, an individual's failure to qualify for one job in a given labor market, even because of a substantial impairment or condition, does not necessarily mean that the individual has a covered disability for purposes of Title I analysis.²² A court must still assess whether the individual's impairment or condition creates a significant barrier to employment or to a particular labor market.²³ Factors considered in determining whether an impairment substantially limits the major life activity of work and is, therefore, a covered disability, include the individual's access to a geographic area, the number and type of jobs requiring similar training or skills (for example, the class of jobs in the relevant labor market), and the number and type of jobs

18. See, e.g., *Weiler v. Household Fin. Corp.*, 101 F.3d 519, 526 (7th Cir. 1996) (holding that an individual did not have a covered disability when incapable of satisfying demands of particular job); *Gordon v. Hamm*, 100 F.3d 907, 912 (11th Cir. 1996) (holding that while side effects of chemotherapy treatment may be an impairment, the side effects did not substantially limit an individual to work in a class of jobs or in a broad range of jobs in various classes).

19. See STEVE KAYE, *DISABILITY WATCH: STATUS REPORT ON THE CONDITION OF PEOPLE WITH DISABILITIES 2* (Disability Rights Advocates and Disability Statistics Center (Dec. 19, 1996)) (on file with the *DePaul Law Review*) [hereinafter *DISABILITY WATCH*] (noting that more than half of this group—10.9 million people—report that they are unable to work). For extensive analysis of factors related to work limitation, see MITCHELL P. LAPLANTE & D. CARLSON, *DISABILITY IN THE UNITED STATES: PREVALENCE AND CAUSES, 1992* (Disability Statistics Report No. 7: U.S. Dept. Ed., Nat'l Institute Disability Research 1996).

20. See, e.g., *Knapp v. Northwestern Univ.*, 101 F.3d 473, 480-81 (7th Cir. 1996) (holding that major life activity of working does not necessarily mean working at the job of one's choice); *Welsh v. City of Tulsa, Okla.*, 977 F.2d 1415, 1417 (10th Cir. 1992) (same); see also *Weiler*, 101 F.3d at 524-25 (holding that an individual did not have a covered disability when she was incapable of working under a particular supervisor because of anxiety or stress related to job review).

21. See, e.g., *EEOC v. Joslyn Mfg. Co.*, 5 Am. Disabilities Cas. (BNA) 1220, 1226 (N.D. Ill. 1996) (noting that impairment excluded individual from a wide variety of jobs at employer in question). However, an individual may show a substantial limitation on a major life activity other than working and thereby be a covered person with a disability. *BURGDORF*, *supra* note 15, at 156-57.

22. See 29 C.F.R. § 1630.2(j)(3)(i) (1996) (stating that the inability to perform a single, particular job does not constitute a substantial limitation in the major life activity of working).

23. See *Joslyn*, 5 Am. Disabilities Cas. (BNA) at 1225 (citing cases in support).

not requiring similar training and skills (for example, the range of similar jobs in the relevant labor market).²⁴

The access to labor market test associated with the first prong of the definition of disability suggests that in cases where an employer fails to hire a job applicant with an actual impairment that forecloses the individual from working within a broad range of jobs in an industry or in a large company (for example, a blind person or a person with mental retardation), that individual may have a disability under the first prong of the statutory definition.²⁵ This determination alone, however, does not indicate that the individual is qualified to perform the job in question. Rather, the test focuses on whether the individual's access to the relevant labor market or job is limited due to the substantial nature of his impairment. If limited access to the relevant labor market is demonstrated, then the individual may be disabled for purposes of Title I analysis. A subsequent determination is required to determine whether the individual is qualified for the job and whether the employer discriminated against him because of his disability.²⁶

Unlike the first prong, the second and third prongs of the definition of disability (that is, "record of" and "regarded as" having an impairment) are meant to prevent employment discrimination on the basis of biased attitudes toward individuals with perceived, yet often presently asymptomatic, conditions (for example, persons with a history of cancer or mental illness).²⁷ As mentioned above, a worker's value in a discriminatory market is sometimes heavily contingent upon the worker's output and his employer's, relevant co-workers', or consumers' preferential or discriminatory attitudes about the worker.²⁸

24. 29 C.F.R. § 1630.2(j)(3)(ii).

25. See *Joslyn*, 5 Am. Disabilities Cas. (BNA) at 1226 (citing *Cook v. Rhode Island*, 10 F.3d 17, 25-26 (1st Cir. 1993)); *EEOC v. Chrysler Corp.*, 917 F. Supp. 1164, 1169 (E.D. Mich. 1996).

26. 42 U.S.C. § 12112 (1994).

27. An example of a case involving all three prongs is *Joslyn*, where the plaintiff contended he was qualified for the job, was regarded as a person with carpal tunnel syndrome, had a record of this impairment that substantially limited his major life activity of working, and was denied employment on that basis. *Joslyn*, 5 Am. Disabilities Cas. (BNA) at 1224.

28. See Donohue, *supra* note 5, at 2585 (defining this concept as "contingent equality"). Arguably, all labor markets are discriminatory in that they reflect, in part, preferences of the relevant employers. Discrimination in labor markets prohibited by Title I, however, is meant to prevent unjustified disfavor or prejudice toward the protected class of covered and qualified individuals with disabilities, for instance, to prevent employment decisions that are not related to worker qualifications and that are based on negative attitudes toward an individual's disability. See Marjorie L. Baldwin, *Can the ADA Achieve Its Employment Goals?*, 549 ANNALS AM. ACAD. POL. & SOC. SCI. 37, 43 (1997) (defining prejudice towards persons with disabilities); Johnson, *supra* note 8, at 161 (same).

In a situation where an employment action is made because of a worker's perceived disability and not on output, that is, not on the worker's actual qualifications, the value of the worker to the employer is distorted in a discriminatory manner.²⁹ This distortion and, in the aggregate, related market failure may be reflected in lower wages to the discriminated against employee or in loss of equal job opportunity. The goal of Title I is to enable qualified workers with perceived disabilities to receive the actual "value of their labor in a nondiscriminatory environment."³⁰

Analysis of issues associated with employers' attitudes about perceived and "hidden" disabilities (that is, conditions that are not immediately obvious, such as Tourette's Syndrome or epilepsy) serves several purposes related to the analysis of the statutory definition of disability and its relation to the assessment of the value of labor in the work force. First, studies suggest that increasing numbers of individuals with perceived disabilities are entering the work force and are denied equal employment opportunity on the basis of biased attitudes and prejudice about their impairments.³¹ Some studies find that the most common health impairments associated with disability are "hidden" conditions.³²

Second, the study of attitudes toward persons with hidden or perceived disabilities is illustrative of underlying biases and discrimination unrelated to actual worker value in the relevant labor market.³³ Thus, diminished worker value reflected in lower wages for comparable work is not related to actual output or to customers' preferences because of unfounded attitudinal discrimination (for example, biased attitudes toward individuals with physical disfigurements).³⁴ Unlike

29. Title I imposes liability for discrimination whenever the prohibited motivation based on disability affects the employer's decision, that is, "when it is a 'but-for' cause." See *McNely v. Ocala Star Banner Corp.*, 99 F.3d 1068, 1073-75 (11th Cir. 1996) (concluding that a literal reliance on the phrase "solely" by reason of disability leads to results inconsistent with congressional intent).

30. Donohue, *supra* note 5, at 2586 (defining this concept under a Title VII analysis as "intrinsic equality").

31. See, e.g., *DISABILITY WATCH*, *supra* note 19, at 3-4 (finding that the most common health impairments associated with disability are "hidden" conditions, and persons with "hidden disabilities," such as those with mental impairments, encounter severe attitudinal bias in the workplace).

32. See, e.g., *id.* at 3.

33. See *Blanck & Marti*, *supra* note 1 (reviewing research on attitudes about disability).

34. See Harlan Hahn, *Antidiscrimination Laws and Social Research on Disability: The Minority Group Perspective*, 14 *BEHAV. SCI. & L.* 41 (1996); Linda H. Krieger, *The Content of Our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 *STAN. L. REV.* 1161 (1995); Charles R. Lawrence III, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 *STAN. L. REV.* 317 (1987).

race or gender employment discrimination, the protected characteristics associated with hidden or perceived disabilities may not be immediately obvious to the employer, either at the time of hiring or during employment (for example, if the worker is injured on the job).³⁵ Attitudinal bias may be reflected in unconscious or unstated negative views of a worker's ability to perform a job, even though the individual with a perceived disability may be presently asymptomatic and qualified to perform the job in question.³⁶ Resultant discrimination by an employer based on animus toward a qualified individual with a perceived disability may result in a loss of productivity or economic value to the employer.³⁷

A hypothetical case involving the "regarded as" prong of the definition of disability might involve a qualified asymptomatic individual being denied an employment opportunity because of the employer's negative attitudes toward that individual's predisposition for cancer, genetic illness, HIV, psychiatric illness, or any other recognized impairment. In these situations, discriminatory and biased attitudes would impact employment decisions rather than an obvious impairment affecting the actual market value of the individual's labor.³⁸ From an economic standpoint, an employer would not be allowed under Title I to consider a presently qualified worker's future lost value or decreased output from actual, yet asymptomatic or perceived,

35. See *Hedberg v. Indiana Bell Tel. Co.*, 47 F.3d 928, 933 (7th Cir. 1995) (discussing similarity between nonobvious nature of religious discrimination and disability discrimination in cases involving hidden disabilities).

36. See, e.g., *Fink v. Kitzman*, 881 F. Supp. 1347, 1369-70 (N.D. Iowa 1995) (describing pervasive discrimination persons with disabilities have experienced on the purported ground that "others would feel uncomfortable around them"); U.S. GENERAL ACCOUNTING OFFICE, PEOPLE WITH DISABILITIES: FEDERAL PROGRAMS COULD WORK TOGETHER MORE EFFICIENTLY TO PROMOTE EMPLOYMENT, GAO/HEHS-96-126, at 4 (1996) [hereinafter GAO REPORT] (noting attitudinal bias toward people with psychiatric disabilities includes labeling as unemployable).

37. See John J. Donohue III, *Advocacy Versus Analysis in Assessing Employment Discrimination Law*, 44 STAN. L. REV. 1583, 1601-02 (1992) (arguing that productivity gains or economic value to employers may be enhanced if antidiscrimination employment laws succeed in reducing such attitudinal discrimination and suggesting that the economic benefits of even small gains in worker productivity may largely offset the direct or indirect costs associated with implementation of the particular antidiscrimination law).

38. See *Runnebaum v. NationsBank*, 95 F.3d 1285, 1295-96 (4th Cir. 1996) (noting that plaintiff believed he was discriminated against when his boss terminated him because she panicked upon learning he was HIV positive and not because of poor performance). According to EEOC regulatory guidance, in certain situations, the access to labor market test may not apply to analysis of the second and third prong definition of disability; that is, an individual could be covered under these parts of the definition regardless of whether the employer's attitudes "were shared by others in the field" See 29 C.F.R. § 1630.2(l) app. at 341-42 (1996) (protecting those discriminated against on the basis of attitudes about disability).

impairments, such as genetic illness or HIV, in making hiring- or employment-related decisions.³⁹

Title I's three-prong definition of disability is consistent with prior conceptions of employment equality that aim to ensure that "a worker's wage should equal the market-determined value of the individual's labor."⁴⁰ The access to labor market test, increasingly adopted by courts, reflects a high standard to be met by plaintiffs in Title I employment discrimination cases brought under the first prong of the definition of disability. It is arguable that plaintiffs must meet this high standard because the test is meant to ensure that Title I's definition of disability does not distort the value of labor to employers or alter their rational labor market behavior. Likewise, an employer's negative attitudes about people with actual or perceived disabilities do not alone constitute unjustified discrimination under Title I unless these attitudes form the basis for subsequent discriminatory behavior toward "qualified" individuals.⁴¹ Proof of the link between discriminatory attitudes and behavior, or "discriminatory animus," toward a qualified individual with a covered disability is an essential element of a Title I case.⁴²

Employment decisions based on perceptions of an employee's personality problems, such as a short temper or poor judgment in the workplace, are not prohibited by Title I if the underlying impairment is not "regarded as" a covered disability.⁴³ For instance, an employee

39. See *infra* notes 161-64 and accompanying text (noting approach also consistent with thrust of Health Insurance Reform Act of 1996).

40. Donohue, *supra* note 5, at 2585.

41. See, e.g., *Gordon v. E.L. Hamm & Assoc., Inc.*, 100 F.3d 907, 912-13 (11th Cir. 1996) (stating that as with actual impairments, a perceived impairment must be substantially limiting and significant, presumably perceived to substantially limit an individual to work in a class of jobs).

42. See *Johnson v. Boardman Petroleum, Inc.*, 923 F. Supp. 1563, 1569 (S.D. Ga. 1996) (noting that to establish a *prima facie* case of discrimination under Title I, a plaintiff must show that the decision to terminate was causally connected to the employer's discrimination against a disability). There are several forms of employment discrimination under Title I. See 42 U.S.C. § 12112 (1994) (defining the term "discriminate"). Discrimination against a qualified individual with a covered disability because of that disability may result in a claim for "disparate treatment" (that is, other similarly situated nondisabled employees are treated more favorably). *Id.* In some cases, where there is no direct proof of such discrimination, employees may use a burden-shifting method (that is, the McDonnell-Douglas burden-shifting test) to prove indirectly that an employer fired a qualified employee because of his disability. See, e.g., *Bultemeyer v. Fort Wayne Community Sch.*, 100 F.3d 1281, 1286 (7th Cir. 1996) (discussing the burden-shifting test in Title I context using direct or indirect evidence of discrimination). In addition, Title I discrimination may be based independently on an employer's failure to make reasonable accommodations for a qualified job applicant or employee with a covered disability. 42 U.S.C. § 12112(b)(5)(A)-(B).

43. See, e.g., *Fenton v. Pritchard*, 926 F. Supp. 1437, 1444-45 (D. Kan. 1996) (holding that the plaintiff's violent nature and short temper were not impairments under Title I); *Pouncy v. Vulcan Materials Co.*, 920 F. Supp. 1566, 1580 n.8 (N.D. Ala. 1996) (commenting that character flaws,

may allege employment discrimination in circumstances where the appropriateness of that employee's workplace behavior is at issue.⁴⁴ In one such case, an employee who was terminated for inappropriate and threatening behavior toward a fellow employee was deemed not qualified and thereby not entitled to Title I protections.⁴⁵ The employee contended unsuccessfully that his behavior toward co-workers led his employer to perceive him as a covered person with a mental disability.⁴⁶ Cases of this type suggest that an employer's negative attitudes toward an employee resulting in an adverse employment decision still must be based on defined disabilities that fall under the purview of the law.

In addition, employment discrimination under Title I will not be found where the employer does not "know" of, perceive, or treat an employee's impairment as a substantial limitation on the employee's present ability to work.⁴⁷ Thus, an employer's economic or humanitarian decision to grant a leave, educational or vocational training, or other workplace accommodations to a worker are not indicative of that employer's perceptions of a defined disability.⁴⁸ Likewise, an employer's decision not to hire an individual with an impairment for a position does not demonstrate that it perceives the employee as dis-

poor judgment, irresponsible behavior, and lack of impulse control are not necessarily impairments under Title I); *Greenberg v. New York*, 919 F. Supp. 637, 642 (E.D.N.Y. 1996) (same).

44. See *Blanck & Marti*, *supra* note 1.

45. *Fenton*, 926 F. Supp. at 1445-46. Negative case examples such as *Fenton* have been used by critics to suggest inefficiencies in Title I implementation. See *Blanck & Marti*, *supra* note 1 (noting other negative case examples). The representativeness of such cases to Title I implementation in practice is open to debate and study.

46. *Fenton*, 926 F. Supp. at 1445-46.

47. *Johnson*, 923 F. Supp. at 1569; see also *Holihan v. Lucky Stores*, 87 F.3d 362, 366 (9th Cir. 1996) (finding that an issue of material fact existed as to perceived disability claim where employer called employee into two meetings to discuss his "aberrational behavior," asked him if he had problems, and encouraged him to seek counseling); *Stewart v. County of Brown*, 86 F.3d 107, 111 (7th Cir. 1996) (noting employee did not make valid perceived disability claim even though employer thought he was excitable, ordered numerous psychological evaluations for him, and stated to third persons that he considered the employee to be emotionally and psychologically imbalanced because the employer repeatedly was advised that the employee was mentally fit for his job); *EEOC v. Joslyn Mfg. Co.*, 5 Am. Disabilities Cas. (BNA) 1220 (N.D. Ill. 1996) (finding a genuine issue of fact existed where employer contended it did not treat plaintiff's carpal tunnel syndrome as an impairment that substantially limited his ability to work at one job in the plant and that plaintiff was not disqualified from a class of other jobs).

48. See *Johnson*, 923 F. Supp. at 1569. A related question involves the extent to which Title I lawsuits on the basis of perceived disability conflict with other policy concerns underlying the law, such as the goal to encourage employers to humanize their relationships with their employees. *Id.*; see *infra* notes 177-85 and accompanying text (noting that businesses are increasingly investing in accommodations for workers with and without disabilities).

abled for purposes of Title I analysis, regardless of whether an accommodation is required.⁴⁹

B. Qualified Individual with a Disability

Proponents and critics of Title I argue that the law affects employers' ability to hire and retain "qualified" employees and thereby distorts labor market efficiencies. Some critics of the law contend that Title I implementation has resulted in economic waste and inefficiency, declines in productivity, and reverse discrimination toward qualified individuals without disabilities.⁵⁰ These arguments often are made by analogy to alleged market inefficiencies associated with Title VII of the Civil Rights Act of 1964 implementation involving issues of race and gender.⁵¹

An individual with a disability is "qualified" for purposes of Title I if he satisfies the prerequisites for the job, such as educational background or employment experience, and can perform essential job functions.⁵² The concept of a "qualified individual" with a disability is central to the analysis of the link between improper discriminatory attitudes and behavior, as well as to the portrayal of the economic implications of Title I.⁵³

49. See *Joslyn*, 5 Am. Disabilities Cas. (BNA) at 1225 ("[The] test for whether a perceived impairment substantially limits a major life activity is not whether the employer's rejection of the applicant was due to a good faith, narrowly-based decision that the applicant's characteristics did not match specific job requirements. Rather, the proper test is whether the impairment, as perceived, would affect the individual's ability to find work across a class of jobs or a broad range of jobs in various classes."); *Barnes v. Cochran*, 944 F. Supp. 897, 901 (S.D. Fla. 1996) (noting that the fact that an employer finds an applicant unqualified does not mean that it did not perceive applicant as disabled).

50. See, e.g., Walter Y. Oi, *Employment and Benefits for People with Diverse Disabilities*, in *DISABILITY, WORK AND CASH BENEFITS* 103 (Jerry L. Mashaw et al. eds., 1996) (noting that the ADA has not produced anticipated growth in employment).

51. See, e.g., John J. Donohue III, *Is Title VII Efficient?*, in *EQUAL EMPLOYMENT OPPORTUNITY: LABOR MARKET DISCRIMINATION AND PUBLIC POLICY* 137, 143 (Paul Burstein ed., 1994) (concluding that the theoretical attack on the efficiency of Title VII of the Civil Rights Act of 1964 is incomplete); Paula England, *Neoclassical Economists' Theories of Discrimination*, in *EQUAL EMPLOYMENT OPPORTUNITY: LABOR MARKET DISCRIMINATION AND PUBLIC POLICY* 59, 67 (Paul Burstein ed., 1994) (examining theory that most employment discrimination will disappear in competitive labor markets); Richard A. Posner, *The Efficiency and Efficacy of Title VII*, in *EQUAL EMPLOYMENT OPPORTUNITY: LABOR MARKET DISCRIMINATION AND PUBLIC POLICY* 147, 148 (Paul Burstein ed., 1994) (concluding that Title VII is not efficient or economically justified).

52. 29 C.F.R. § 1630.2(m), (n) (1996); cf. *Hegwer v. Board of Civil Serv. Comm'rs of City of Los Angeles*, 7 Cal. Rptr. 2d 389, 396 (Cl. App. 1992) (finding that a paramedic whose thyroid condition caused excessive weight gain was not a qualified employee because she exceeded the body-fat-based weight standards for fire fighters and emergency medical technicians which were reasonable means of insuring the health and safety of both employees and the public).

53. Blanck, *supra* note 4, at 864-65.

Title I does not require an employer to hire or retain individuals with covered disabilities who are not qualified or to hire or retain individuals with covered disabilities over equally or more qualified individuals without disabilities.⁵⁴ Employers are not discouraged from searching for the most qualified individuals with or without disabilities.⁵⁵ Nor are employers required to incur burdensome efficiency or productivity losses or opportunity costs, whether defined in terms of economic value in the relevant labor market or in retaining unqualified workers with or without covered disabilities.⁵⁶

Title I's "qualified individual" requirement is meant to ensure that the value of a worker's labor or productivity should equal or exceed the worker's wage in a given labor market.⁵⁷ Workers with covered disabilities are not deemed "equal" by their Title I status to workers without disabilities, nor are they provided preferential treatment in any aspect of employment. The goal of the qualified individual provision is to ensure that a worker with a disability who can perform legitimate essential job functions, with or without a reasonable accommodation, receives wages or other compensation that are comparable to his labor market value.

Critics of Title I argue that the definition of employee qualifications artificially constrains employers' ability to define employees' job functions and production requirements, thereby producing economic inefficiencies.⁵⁸ Yet in establishing employment qualifications (that is, educational background requirements or essential job functions), Title I only requires that the applicant's or employee's skills are to be considered independent of the purported disability, in other words, independent of unfounded attitudes about the relation of a disability to current job qualifications or of views about the efficacy or cost of an accommodation for a qualified individual with a disability. Employers are free to determine legitimate essential job functions or production requirements as they see fit.⁵⁹

54. 42 U.S.C. § 12111(8) (1994).

55. Cf. *Oi*, *supra* note 50, at 112.

56. The relation among job qualifications, essential job functions and Title I's requirement that employers provide reasonable accommodations to qualified individuals is discussed below. See *infra* notes 78-82 and accompanying text.

57. See *Donohue*, *supra* note 5, at 2584-85.

58. See, e.g., Mark A. Schuman, *The Wheelchair Ramp to Serfdom: The Americans with Disabilities Act, Liberty, and Markets*, 10 ST. JOHN'S J. LEGAL COMMENT 495, 496 (1995) ("[T]he ADA denies an employer the right to determine the qualifications and abilities relevant to a job.").

59. See *infra* notes 130-45 and accompanying text (discussing the costs and benefits to employers associated with the provision of reasonable accommodations).

Several trends in Title I case law support the view that the qualified individual provision of Title I has served to ensure that a worker with a covered disability who can perform essential or fundamental job functions receives a wage that is comparable to his labor market value. First, as mentioned, employers are not required to alter production standards or to shape a job for an individual with a disability.⁶⁰ Employers must maintain legitimate job requirements, however, as compared to those that are a "subterfuge" or pretext to exclude people with disabilities from equal employment.

As Professor Burgdorf has noted, "[e]mployers retain the prerogative . . . to determine what particular jobs need to be performed in their businesses and to establish the functions of those jobs."⁶¹ Thus, Congress did not intend for Title I to interfere with employers' non-discriminatory, rational economic decision making.⁶² Nevertheless, businesses of different sizes or with varying degrees of specialization have different needs with regard to the range of essential functions required of a particular worker. Such economies-of-scale questions are examined under the law on a case-by-case basis, which may have led to initial uncertainty by the small business community about implementation of Title I.⁶³

Second, as discussed below in the context of Title I's "undue hardship" provision, restructuring job functions as an accommodation to a covered individual with a disability may or may not cause an employer an economic undue hardship (that is, inefficiencies due to a fundamental alteration of the required job), depending upon relative costs and benefits associated with the specialization of the task, the size and nature of the business, the availability of worker substitutes in the relevant labor market, or cyclical changes in the market or economy that

60. See *supra* notes 58-59 and accompanying text.

61. Burgdorf, *supra* note 15, at 192. Title I distinguishes between essential and marginal job functions. Marginal functions are those incidental job requirements that are not necessary to the central performance of the job in question. *Id.* Employers may not exclude a qualified individual with a covered disability from employment on the basis of inability to perform marginal job functions. Many Title I cases involve the extent to which a particular job function is essential or marginal. Written job descriptions typically are used as evidence of essential functions. 42 U.S.C. § 12111(8) (1994).

62. *Weiler v. Household Fin. Corp.*, 101 F.3d 519, 526 (7th Cir. 1996) ("Congress intended simply that disabled persons have the same opportunities available to them as are available to nondisabled persons.").

63. The requirements of Title I affect businesses with 15 or more employees. See Peter D. Blanck, *The Emerging Work Force: Empirical Study of the Americans with Disabilities Act*, 16 J. CORP. L. 693, 772 n.330, 778-79 (1991) (finding little difference in attitudes of small and large businesses toward the employment of persons with disabilities, including views of low costs of workplace accommodations).

affect labor and production requirements.⁶⁴ The determination of the essential or nonessential nature of job functions also is made on a case-by-case basis.

Third, persons with actual, hidden, or perceived disabilities may be deemed "unqualified" for a job in circumstances in which they are shown to pose a direct safety or health threat to themselves or others in the workplace, regardless of their ability to perform essential job functions.⁶⁵ Factors considered in determining whether a direct threat exists include the duration of the risk, the nature of potential harm, and the likelihood that the harm will occur.⁶⁶ Employers are required to make an individualized and objective determination of direct threat based on the employee's present ability to perform safely essential job functions. This determination must be made on the basis of tests of current medical judgment⁶⁷ and not on anticipated lost productivity or predictions about the future impact of a disabling condition.

Fourth, pre- and post-employment inquiries regarding medical history or disability have been the subject of controversy in employment discrimination lawsuits involving the assessment of the qualifications of persons with different disabilities.⁶⁸ Title I prohibits disability-related pre-employment inquiries and medical tests, but such examina-

64. Burgdorf, *supra* note 15, at 210; see also 29 C.F.R. § 1630.2(p)(2) (listing factors relevant to undue hardship determination).

65. 42 U.S.C. § 12113(b) (1994); 29 C.F.R. § 1630.2(r) (1996) (defining direct threat as a "significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation"); see also 28 C.F.R. § 36.208 (1996) (noting that Title I may require accommodations that eliminate or sufficiently reduce a direct threat); 29 C.F.R. § 1630.2(r) (noting that where a disability is involved, the employer must identify the specific behavior on the part of the individual that would pose a direct threat, considering the duration, nature and severity, likelihood of harm and imminence of harm of the disability).

66. 29 C.F.R. § 1630.2(r).

67. *Id.*; see also Jean Campbell & Caroline L. Kaufmann, *Equality and Difference in the ADA: Unintended Consequences for Employment of People with Mental Health Disabilities*, in MENTAL DISORDER, WORK DISABILITY, AND THE LAW 221, 225-26 (Richard J. Bonnie & John Monahan eds., 1997) (stating that the direct threat standard balances rights of persons with disabilities against the needs of society to prevent harm); cf. Oi, *supra* note 50, at 107-08, 112-13 (discussing the impact of a disability on worker productivity and noting that "disability steals time").

68. See, e.g., Grenier v. Cyanamid Plastics, Inc., 70 F.3d 667, 675 (1st Cir. 1995) (holding that the employer did not violate the ADA where it inquired into ability of job applicant, former employee, with known psychological disability, to function effectively in the workplace and to get along with co-workers and supervisor, or where employer required applicant to provide medical information as to the ability to return to work with or without an accommodation and type of accommodation necessary); see Knapp v. Northwestern Univ., 101 F.3d 473, 484 (7th Cir. 1996) (holding that a university's—analogueous to an employer's—medical determination of whether an individual is medically qualified, if reasonable, must be given deference by the court).

tions are permitted after a conditional job offer has been made.⁶⁹ Medically related employment tests, if used by an employer, must be administered to all employees regardless of disability and, with limited exceptions, the information obtained must be treated as confidential.⁷⁰

Medical test results from a post-conditional offer of employment, or medical test results obtained during employment, may not be used to exclude a qualified individual with a covered disability from the job unless the exclusion is job-related, consistent with business necessity, and not amenable to reasonable accommodation.⁷¹ If an employee alleges discrimination based on an employer's medical test that purports to screen out qualified individuals with disabilities, the employer may rebut the claim by showing that the test accurately measures job skills that are consistent with business necessity, such as workplace safety or security requirements.⁷²

D. Reasonable Accommodations

The economic implication that has received the most attention involves Title I's effect on employers' ability to provide workplace accommodations for qualified job applicants and employees with disabilities. As discussed above, an employer may legitimately shape an employee's work or production requirements as long as those requirements are job-related and not a pretext for discrimination against covered persons with disabilities.⁷³ The employer's right to structure jobs, however, may not violate Title I's requirement that the employer

69. 42 U.S.C. § 12112(d)(3); EQUAL EMPLOYMENT OPPORTUNITY COMM'N, No. 915.002, ENFORCEMENT GUIDANCE: PREEMPLOYMENT DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS UNDER THE AMERICANS WITH DISABILITIES ACT OF 1990 36 (1994) [hereinafter EEOC ENFORCEMENT GUIDANCE]; see also Susan Alexander, *Preemployment Inquiries and Examination: What Employers Need To Know About the New EEOC Guidelines*, 45 LAB. L.J. 667, 678 (1994); Robert B. Fitzpatrick, *Employer Screening Procedures Under the Americans with Disabilities Act: What's Legal? What's Debatable?*, in CIVIL PRACTICE AND LITIGATION TECHNIQUES IN THE FEDERAL COURTS, 285, 290 (ALI-ABA Course of Study, Mar. 2, 1996), available in Westlaw, C106 ALI-ABA 285; David M. Katz, *Disability Queries Okay After Offering Job*, 16 NAT'L UNDERWRITER (PROP. & CASUALTY/RISK BENEFITS MGMT. ED.), JUNE 17, 1996, at 31 (discussing the window of opportunity for employers to ask about job applicants' disabilities after offers are made).

70. 42 U.S.C. § 12112(d)(3)(A)(B).

71. *Id.* § 12112(c)(4)(A); 29 C.F.R. § 1630.14(b)(3) (1996).

72. See 42 U.S.C. § 12113(a); *Murphy v. United Parcel Serv., Inc.*, 946 F. Supp. 872, 883 (D. Kan. 1996) (finding Department of Transportation driving qualification standards a complete defense to plaintiff's Title I claim); see also Kimberli R. Black, *Personality Screening in Employment*, 32 AM. BUS. L.J. 69, 113-15 (1994) (discussing methods to satisfy job-relatedness requirement that screening test validly relates to the job at issue).

73. Black, *supra* note 72, at 113-15.

provide "reasonable accommodations" for a qualified employee with a covered disability.⁷⁴

An accommodation is a modification or adjustment to a workplace process or environment that makes it possible for a qualified person with a disability to perform essential job functions, such as physical modifications to a work space, flexible scheduling of duties, or provision of assistive technologies to aid in job performance.⁷⁵ To be eligible for an accommodation, an employee must make his disability "known"⁷⁶ to the employer and request an accommodation. This requirement places a particular burden on an individual with a hidden and nonobvious disability to disclose in a timely manner the claimed disability and request the employer to provide an accommodation.⁷⁷ Once the request is made, the employer retains the right to choose the accommodation, as long as it is effective and the employee has a good faith opportunity to participate in the process.⁷⁸ An employee is not

74. See 29 C.F.R. § 1630.2(o); Barbara A. Lee, *Reasonable Accommodation Under the Americans with Disabilities Act: The Limitations of Rehabilitation Act Precedent*, 14 BERKELEY J. EMP. & LAB. LAW 201, 219-23 (1993).

75. See, e.g., 42 U.S.C. § 12111(9)(B) (providing that a qualified employee may request reasonable accommodation such as being transferred to a vacant and similar position with the employer). Compare *Overton v. Reilly*, 977 F.2d 1190, 1195 (7th Cir. 1992) (approving accommodation for chemist with depression of restricting job to decrease contact with public where contact with public occupied 5% of employees time), *Arneson v. Sullivan*, 946 F.2d 90, 92 (8th Cir. 1991) (finding when employee with apraxia, a neurological disorder characterized by disruptions in concentration, performs satisfactorily when placed in a semi-private work space, the employer must take reasonable efforts to provide a "distraction-free environment"), and *Kent v. Derwinski*, 790 F. Supp. 1032, 1040 (E.D. Wash. 1991) (requiring reasonable accommodation for employee with mental retardation of sensitivity training of co-workers and use of care by supervisor in disciplining to avoid criticism or undue stress), with *Hudson v. MCI Telecommunications Corp.*, 87 F.3d 1167, 1169 (10th Cir. 1996) (finding request by employee with carpal tunnel syndrome for unpaid leave for an indefinite amount of time not reasonable), *Pesterfield v. Tennessee Valley Auth.*, 941 F.2d 437, 441 (6th Cir. 1991) (finding plaintiff's inability to handle criticism made it impossible to perform functions of job and it was not reasonable to require employer to provide a stress-free environment to accommodate disability), and *Kuehl v. Wal-Mart Stores, Inc.*, 909 F. Supp. 794, 803 (D. Colo. 1995) (holding that an individual who rejected a reasonable accommodation was not a qualified individual with a disability).

76. Exactly how a "known" disability is defined for purposes of Title I has been the subject of some debate. See, e.g., *Hutchinson v. United Parcel Serv., Inc.*, 883 F. Supp. 379, 394 (N.D. Iowa 1995) (noting that the "ADA does not require clairvoyance") (quoting *Hedberg v. Indiana Bell Tel. Co.*, 47 F.3d 928, 933 (7th Cir. 1995), which stated that the employer cannot be liable without knowledge of the disability); *Morisky v. Broward County*, 80 F.3d 445, 448 (11th Cir. 1996) (same); see also *Burgdorf*, *supra* note 15, at 129-54.

77. See *Fussell v. Georgia Ports Auth.*, 906 F. Supp. 1561, 1569 (S.D. Ga. 1995); see also 29 C.F.R. § 1630.9 app. at 351 (noting that it is the responsibility of employee to inform employer of need for accommodation).

78. See, e.g., *Bultemeyer v. Fort Wayne Community Sch.*, 100 F.3d 1281, 1285 (7th Cir. 1996) (noting that the reasonable accommodation process requires good faith communication between employer and employee, and in a case involving an employee with mental illness, communication process is even more critical); *Taylor v. Principal Fin. Group*, 93 F.3d 155, 164 (5th Cir. 1996)

"qualified" if he cannot perform the job with or without an accommodation.⁷⁹

Critics of Title I have characterized an employer's obligation to provide accommodations to qualified persons as a form of market distortion leading to economic inefficiencies.⁸⁰ They claim that the duty of reasonable accommodation creates for persons with disabilities an employment privilege or subsidy, in that it attempts to provide covered workers the wages they would receive in a nondiscriminatory free market.⁸¹ The duty of accommodation is cast as compromising the ideal of free market efficiency by imposing upon employers an affirmative duty to retain less economically efficient workers.⁸²

There are at least three simplified hypothetical situations which illustrate the distribution of possible economic implications of the required provision of accommodations for qualified job applicants or employees covered by the law.⁸³ A first example involves two equally qualified workers, that is, workers who are equally productive and of equal economic value to the employer. Professor Donohue has set forth such a hypothetical: "[G]iven the choice between two equally productive workers, one requiring the expenditure of significant sums in order to accommodate him, one requiring no such expenditures, the

(noting responsibility for fashioning accommodation shared between employer and employee); *Beck v. University of Wis. Bd. of Regents*, 75 F.3d 1130, 1135 (7th Cir. 1996) (holding university not liable under the ADA where the plaintiff was responsible for breakdown in the accommodation process); see also 29 C.F.R. § 1630.2(o)(3) (setting forth accommodation process regulations).

79. 42 U.S.C. § 12112(8).

80. See, e.g., Donohue, *supra* note 5, at 2608.

81. Donahue, *supra* note 5, at 2609; cf. *Weiler v. Household Fin. Corp.*, 101 F.3d 519, 526 (7th Cir. 1996) (noting that the reasonable accommodation process does not require employer to "bump" other employees to reassign disabled employee, nor does it require an employer to create a new position for disabled employee); *Gile v. United Airlines*, 95 F.3d 492, 499 (7th Cir. 1996) (same).

82. See Pamela S. Karlan & George Rutherglen, *Disabilities, Discrimination, and Reasonable Accommodation*, 46 DUKE L.J. 1, 14 (1996) ("Reasonable accommodation is affirmative action, in the sense that it requires an employer to take account of an individual's disabilities and to provide special treatment to him for that reason."); Editorial, *Disabling Consequences*, RICHMOND TIMES DISPATCH, Jan. 13, 1997, at A-10 (noting that Title I reflects "an infringement of liberty for government to dictate whom employers must 'accommodate'").

83. Cf. *Vande Zande v. State of Wis. Dept. of Admin.*, 44 F.3d 538, 542-43 (7th Cir. 1995) (concluding that the term "reasonable" is intended to qualify the term "accommodation" so that the cost of any accommodation is not disproportionate to the benefit to the employer and the accommodation itself is efficacious, regardless of an undue hardship defense subsequently put forth by an employer); see also Carolyn L. Weaver, *Incentives Versus Controls in Federal Disability Policy*, in *DISABILITY AND WORK: INCENTIVES, RIGHTS, AND OPPORTUNITIES* 3, 14 (Carolyn L. Weaver ed., 1991) (discussing economic impact of accommodation provision).

profit-maximizing firm would prefer the worker who is less costly to hire."⁸⁴

Donohue's hypothetical is not problematic for Title I economic impact analysis. Title I does not require the employer to hire or retain a qualified individual with a covered disability, regardless of the need for accommodation, over an equally or more qualified individual without a disability. There is no resultant distortion of labor market or economic efficiencies by Title I's antidiscrimination provisions, nor is there a requirement "to make the disabled equal."⁸⁵ Employer prerogative and economic need is not disturbed and the employer is not discouraged from searching for the most qualified worker.⁸⁶ Moreover, as discussed in Part II, to the extent that many accommodation costs for workers with disabilities are fixed or sunk, the market incentive would be to retain the qualified disabled worker over an equally or less qualified nondisabled worker requiring no accommodation.⁸⁷

A similarly simple hypothetical involves two workers whose productivity varies. In this case, one individual with a covered disability is more "qualified" than an individual without a disability, say by three units of value to the employer. It requires a certain amount of unit value to accommodate this qualified worker with a disability, say three units of value. In this case, the net cost to the employer of employing the individual with a disability is comparable to employing the individual without the disability and their "value" is identical.⁸⁸ Title I would require the employer to hire the legitimately more qualified worker, regardless of disability, and would require the provision of an

84. Donohue, *supra* note 5, at 2608.

85. *See id.* at 2611; *see also* Johnson, *supra* note 8, at 164 (arguing that Title I "goes beyond the concept of equal opportunities for equally productive workers by requiring employers to modify job requirements or work environments to compensate for impairment-related limits on productivity").

86. *Cf.* Oi, *supra* note 50, at 112 (arguing that Title I creates efficiency losses by forcing employers to enact a *satisfying* employment policy); Weaver, *supra* note 83, at 6 (arguing that Title I forces employers to hire less productive workers). *But see, e.g.,* Martin v. General Mills, Inc., No. 95 C 2846, 1996 U.S. Dist. LEXIS 16436, at *21 (N.D. Ill., Nov. 4, 1996) (holding that Title I does not require employers to retain less productive employees).

87. Donohue, *supra* note 5, at 2610 n.72.

88. There are many direct and indirect costs and benefits associated with the provision of accommodations, including staff time spent on planning of an accommodation, enhanced productivity of the particular workers, and even tax benefits to employers for expenses incurred in the provision of reasonable accommodations. *See* Burgdorf, *supra* note 15, at 325-27 (describing tax benefits and that employees may contribute to the cost of an accommodation, particularly when aspects of the accommodation are personal in nature); SEARS II, *supra* note 10, at 56-61, app. D. (listing costs and benefits of particular accommodations).

accommodation.⁸⁹ A decision by the employer in this scenario to refuse the provision of accommodation to this qualified individual with a covered disability may constitute discrimination under Title I, assuming no undue hardship is associated with the provision of the accommodation.⁹⁰

The more controversial third hypothetical also involves two workers whose productivity varies. In this case, one individual with a covered disability is more "qualified" than an individual without a disability by three units of value to the employer. However, it requires thirty units of employer value to accommodate the qualified worker with a disability, or ten times the direct cost of the accommodation. In this case, the net cost to the employer of employing the qualified individual with a disability is considerably more than is the cost of employing the less qualified individual without the disability.⁹¹

In this third scenario, a decision by the employer to refuse to provide an accommodation to the qualified individual with a covered disability may or may not constitute discrimination under Title I. This may be true, even though provision of the accommodation may be economically inefficient to the employer, assuming actual direct and indirect costs and benefits of the decision could be calculated. Discrimination may be found if no undue hardship is associated with the provision of an effective accommodation. Alternatively, discrimination may not be found if the element of cost or efficiency is interpreted to be implicit in the concept of a "reasonable"

89. The requirement to hire a worker with a disability requiring accommodation is capped, however, by the employer's safe harbor provision of "undue hardship" examined below. See *infra* notes 100-04 and accompanying text.

90. See Pub. L. No. 100-430, 102 Stat. 1619 (1988) (codified at 28 U.S.C. §§ 2341, 2342, and scattered sections of 42 U.S.C.); see also *infra* notes 92-94 and accompanying text (noting that Title I discrimination may be based on an employer's failure to make reasonable accommodations for a qualified job applicant or employee with a covered disability).

91. With regard to this third hypothetical, Professor Feldblum has suggested that although the "failure to provide a reasonable accommodation is a form of *discrimination* [as it may be in the hypothetical immediately above]; it is not a remedy for discrimination in the way that various forms of affirmative action might serve as remedies." Chai R. Feldblum, *The (R)evolution of Physical Disability Anti-Discrimination Law: 1976-1996*, 20 MENTAL & PHYSICAL DISABILITY L. REP. 613, 618 (1996). In contrast to this view, in the Seventh Circuit case, *Vande Zande v. State of Wisconsin Department of Administration*, Judge Posner writes: "[W]e do not think an employer has a duty to expend even modest amount of money to bring about an absolute identity in working conditions between disabled and nondisabled workers." 44 F.3d 538, 546 (7th Cir. 1995). Judge Posner continues: "The duty of reasonable accommodation is satisfied when the employer does what is necessary to enable the disabled worker to work in reasonable comfort." *Id.*; cf. Feldblum, *supra* note 101, at 619 ("The 'reasonable' part of 'reasonable accommodation' refers to whether a requested accommodation is *effective* in ensuring the person with a disability can perform the job up to the standards required by the employer.").

accommodation.⁹² Under this latter view, an employer has no duty to incur even a modest loss in value because it would not be "reasonable" (that is, economically rational) to accommodate the disabled employee.⁹³

It is this third scenario that critics of Title I use to suggest that the accommodation provision, absent the high evidentiary burden on employers of showing undue hardship discussed below, in effect, is an affirmative subsidy to employees with disabilities.⁹⁴ Critics argue that the accommodation provision reflects a cost to employers incurred for employees with disabilities that is not spent on other employees without disabilities, who arguably are more economically efficient but possibly less qualified or productive to perform the job in question.⁹⁵ Others argue that Title I provisions reflect a judgment by society that qualified persons with disabilities should be able to work, even when "the value of their output does not equal the cost necessary to accommodate them in the work force."⁹⁶

Part II of this Article examines in greater detail findings from studies addressing the economic effect on employers of the provision of accommodations. Additional study is required, however, of the costs and benefits associated with accommodations in different businesses, jobs, labor markets, and involving persons with varying disabilities.⁹⁷ Study is needed also of the frequency of occurrence of the three hypothetical cases highlighted above. This analysis may show that, in practice, accommodating qualified workers with and without disabilities

92. See *Vande Zande*, 44 F.3d at 542-45.

93. See Feldblum, *supra* note 91, at 619-21 n.6 (discussing Judge Posner's reasoning in *Vande Zande* decision by claiming that Posner unfortunately interpreted the word "reasonable" to include a form of "cost-benefit" analysis).

94. See Sherwin Rosen, *Disability Accommodation and the Labor Market*, in *DISABILITY AND WORK: INCENTIVES, RIGHTS, AND OPPORTUNITIES* 18, 29 (Carolyn L. Weaver ed., 1991).

95. See, e.g., Schuman, *supra* note 58, at 504-05 ("This is an affirmative obligation to offer those employees with disabilities better terms and conditions than those offered other employees, at greater cost to the employer than that spent on other employees.").

96. Richard V. Burkhauser, *Post-ADA: Are People with Disabilities Expected To Work?*, 549 *ANNALS AM. ACAD. POL. & SOC. SCI.* 71, 80-81 (1997) (arguing that Title I provisions force taxpayers to bear part of the cost of accommodations, either through higher costs or tax credits).

97. Many qualified individuals with perceived disabilities or with a record of impairment covered under the second and third prong of the definition of disability may not need an accommodation, even though they are denied employment opportunity on the basis that their employer believes an accommodation may be required in the future. In this case, the Title I antidiscrimination provisions are implicated and should impose no economic inefficiencies on employers. See Weaver, *supra* note 83, at 14 (discussing the probable impact of the legislation and the courts having the capacity to alter the costs of legislation by deciding what is reasonable and what is covered). Empirical study is needed on employers' attitudes about the need for accommodations for employees with actual and perceived disabilities. See *supra* notes 31-37 and accompanying text.

leads to efficient and cost-effective workplace operation.⁹⁸ In the absence of accurate and reliable measures of worker "value," however, economic efficiency arguments, pro and con, of accommodation implementation may need to be reevaluated.

E. Undue Hardship

A final economic implication involves Title I's economic effect on employers of different sizes and in different labor markets, particularly with regard to the provision of reasonable accommodations. Title I does not require an accommodation if it would impose an "undue hardship" on the employer. An undue hardship requires significant difficulty or expense in relation to the accommodation or the resources of the company.⁹⁹ A common critique is that accommodations for qualified individuals create hardships that are costly and burdensome for employers. Attitudes about the cost-effectiveness of accommodations by employers, however, often have more to do with unfounded beliefs than with the actual qualifications of persons with disabilities or their ability to add to employers' economic value.¹⁰⁰

Title I identifies a number of economically based factors to be considered in determining undue hardship, including the nature and net cost of the accommodation, the financial resources of the business, the number of persons employed at the business, the impact of the accommodation on the operation of the business, the geographic separateness of the business facilities affected, and the composition and

98. See *infra* notes 130-43 and accompanying text (noting atypical cases whose frequency in practice may be too small to rely upon for policy making purposes, and as in critiques by economists that Title I is inefficient and made without reliance on empirical study).

99. Decisions about undue hardship are made on a case-by-case basis. 42 U.S.C. § 12111(10) (1994); see also *Borkowski v. Valley Cent. Sch. Dist.*, 63 F.3d 131, 138-40 (2d Cir. 1995) (discussing employer's cost-benefit analysis); *Gardner v. Morris*, 752 F.2d 1271, 2182-84 (8th Cir. 1985) (providing physician and laboratory facilities in remote location for monitoring appropriate medication level of employee with bipolar condition constituted undue hardship); *Hill v. Florida Dept. of Pub. Health*, 2 Am. Disabilities Cas. (BNA) 177, 182-83 (M.D. Fla. 1992) (holding that an employer did not have to eliminate public-contact function of position to accommodate employee with depressive disorder because accommodation would impose undue hardship by requiring co-worker to perform employee's job).

100. Cf. Philip S. Lewis, *Attitudes and Behavior of Employers Toward Persons with Disabilities in a Post-ADA Labor Market* (1994) (unpublished Ph.D. dissertation, The Union Institute), abstracted in 55 DISSERTATIONS ABSTRACT INT'L No. 10, at 4593 (1994) (finding minimal difference in attitudes and behavior of employers of different sizes or type of business, but substantial differences regarding provision of accommodations with larger firms more likely to provide accommodations); Lisa M. Ehrhart, *A National Study of Employer Attitudes Toward Persons with Disabilities* (1994) (unpublished Ph.D. dissertation, Virginia Commonwealth University), abstracted in 55 DISSERTATIONS ABSTRACTS INT'L No. 7, at 1082 (1994) (finding no difference between assessed attitudes toward person with disabilities and size of business).

functions of the work force of the business.¹⁰¹ This list of economic impact factors is meant to ensure that the business' size, type, sales, and relevant labor markets are not affected by accommodations that pose a financial hardship to the operation of the business or that fundamentally alter the nature of the business.¹⁰² Although the employer's undue hardship defense is assessed on a case-by-case basis, relevant economic, incremental, and opportunity costs claimed (for example, measured in terms of lost profits or market value) may vary by industry and will need to be assessed.¹⁰³

The next Part examines empirical study on the economics of the provision of workplace accommodations. Regardless of such analysis, proponents of Title I suggest that cost-benefit analysis is a secondary justification to the antidiscrimination purposes of the law. Yet, if it is the case that on average, the benefits and value to employers of effective accommodations implemented exceed the costs, then the accommodation provision is not only consistent with the antidiscrimination purposes of the law, but also reflects economically efficient and rational workplace practices that have applications to qualified persons with *and* without disabilities.

II. THE ECONOMICS OF WORKPLACE ACCOMMODATIONS

It is apparent that answers to questions related to Title I implementation and interpretation must be guided increasingly by systematic empirical study.¹⁰⁴ Professor Collignon has argued that it is crucial to establish baseline data and models of empirical study to help foster an informed dialogue about Title I implementation and effectiveness.¹⁰⁵ One area that has received the most study, given the ability to quantify associated costs and benefits, has been the analysis of the eco-

101. 42 U.S.C. §12111(10)(B).

102. See Feldblum, *supra* note 91, at 619 (discussing legislative history of undue hardship provision and that Congress rejected a bright-line amendment to Title I that would have tied the determination of undue hardship to a percentage of an employee's salary).

103. See Ralph R. Frasca & Bernard J. Winger, *The Americans with Disabilities Act of 1990: New Opportunities for Forensic Economists*, 6 J. FORENSIC ECON. 81, 86-90 (1993) (providing examples of incremental and net costs associated with provision of accommodations for different businesses).

104. Cf. GAO REPORT, *supra* note 36, at 3-4, 22 (finding absence of data collection efforts by agencies regarding ADA implementation).

105. Frederick C. Collignon, *Is the ADA Successful? Indicators for Tracking Gains*, 549 ANNALS AM. ACAD. POL. & SOC. SCI. 129, 130-32 (1997) (discussing various indicators of Title I implementation, including unemployment, poverty, and legal compliance rates); see also Corinne Kirchner, *Looking Under the Street Lamp: Inappropriate Uses of Measures Because They Are There*, 7 J. DISABILITY POL. STUD. 77, 82-86 (1996) (critiquing prior researchers overreliance on labor force participation measures as indicator of effective Title I implementation).

nomic implications to employers of workplace accommodations under Title I.¹⁰⁶ This Part examines the ongoing debate regarding the economics of accommodations in light of emerging study of the area.¹⁰⁷

As mentioned above, one common criticism is that the costs of accommodations outweigh the benefits provided to employers and persons with disabilities.¹⁰⁸ Critics contend that the required provision of reasonable accommodations places financial burdens and administrative costs on the operation of businesses.¹⁰⁹ Some argue that the costs of accommodations are especially high for large employers, who may be held accountable for extensive modifications due to their greater financial resources.¹¹⁰

A common thread in these critiques is that they are made without reliance on data. In the absence of empirical information, it is no surprise that the attitudes and behavior of many employers reflect the view that the costs of accommodations outweigh the benefits.¹¹¹ It is

106. See, e.g., Rosen, *supra* note 94, at 22 (finding previous research has been devoted to the connection between labor supply and disability); Weaver, *supra* note 83, at 5 (noting that "[t]he central flaw of the ADA . . . is in the imposition on employers of a duty to 'accommodate' the mental or physical limitations of the disabled worker or applicant without weighing the expected benefits of such accommodation"); see also *Employing People with Disabilities Makes Good Business Sense*, REGION V NEWS, (Great Lakes Disability & Bus. Tech. Assistance Ctr.), Fall 1995, at 4 [hereinafter GREAT LAKES] (finding that 28% of approximately 73,000 Title I charges through September 30, 1996, allege failure to provide reasonable accommodations, and that another 52% involve discharge).

107. The economic relationship among required public accommodations under Title III of the ADA (for example, accessible public transportation), Title I workplace accommodations, and employment opportunity for qualified persons with disabilities requires detailed analysis beyond the scope of this Article. See Karlan & Rutherglen, *supra* note 82, at 41 n.81 (noting the cost efficiencies theory regarding Titles I, II, and III of the ADA).

108. See, e.g., James Bovard, *Disability Intentions Astray*, WASH. TIMES, May 20, 1996, at A16 (concluding that the ADA is costly and economically inefficient); Richard A. Epstein, *The Legal Regulation of Genetic Discrimination: Old Responses to New Technology*, 74 B.U. L. REV. 1, 23 (1994) (discussing when the absolute right to refuse employment or insurance is denied, without exception, the employer or insurer is forced into a losing economic position); Christopher J. Willis, Comment, *Title I of the Americans with Disabilities Act: Disabling the Disabled*, 25 CUMB. L. REV. 715, 725-30 (1995) (finding that the costs which the ADA will likely impose on employers will ultimately be borne by consumers which will decrease the net wealth of American society).

109. See generally IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT (Lawrence O. Gostin & Henry A. Beyer eds., 1993) (reviewing Title I provisions). Title I also does not require that employers alter their insurance benefit plans to employees working part-time as an accommodation to their disability. See *Tenbrink v. Federal Home Loan Bank*, 920 F. Supp. 1156, 1162-64 (D. Kan. 1996) (holding that under Title I, an employer may provide health benefits only to full-time workers, even if this requirement results in reduction in benefits for workers with disabilities who are accommodated with part-time schedules).

110. Thomas H. Barnard, *The Americans with Disabilities Act: Nightmare for Employers and Dream for Lawyers?*, 64 ST. JOHN'S L. REV. 229, 251-52 (1990); Willis, *supra* note 108, at 726-27.

111. See Collignon, *supra* note 6, at 231-38 (arguing that economists' negative theorizing about the costly effects of accommodation often do not consider the actual experiences of busi-

helpful to reiterate that Title I does not require employers to hire individuals with disabilities who are not qualified or to hire qualified individuals with disabilities over equally or more qualified individuals without disabilities.¹¹² More than three quarters of all Title I charges filed with the EEOC have been dismissed¹¹³ because, among other reasons, the plaintiff alleging discrimination failed to show that he was qualified for the position.¹¹⁴

Many individuals with disabilities currently in the work force have appropriate job skills, that is, they are "qualified" for purposes of the law and have their accommodation needs met in reasonable and effective ways.¹¹⁵ Findings from the 1989 National Health Interview Survey show that roughly 60 percent of working age adults with disabilities rate their health as good to excellent.¹¹⁶ Nevertheless,

nesses); Baldwin, *supra* note 28, at 49 (suggesting that the most frequent employer concerns about Title I include costs of accommodations).

112. 29 C.F.R. § 1630.2(m), (n) (1991); SEARS I, *supra* note 10, at 30-40; SEARS II, *supra* note 10, at 42; *see also* Helen L. v. DiDario, 46 F.3d 325, 334 (3d Cir. 1995) (stating that the ADA ensures that qualified individuals be treated in "a manner consistent with basic human dignity, rather than a manner which shunts them aside, hides, and ignores them"). Nevertheless, some scholars cast Title I's reasonable accommodation provision as "contrary to our understanding of equal treatment developed under other anti-discrimination statutes." Deborah A. Calloway, *Dealing with Diversity: Changing Theories of Discrimination*, 10 ST. JOHN'S J. LEG. COMMENT. 481, 492 (1995) (interpreting Title I to judge individuals on the basis of their group status and not on their individual merits).

113. Lisa J. Stansky, *Opening Doors: Five Years After Its Passage, the Americans with Disabilities Act Has Not Fulfilled the Greatest Fears of Its Critics—or the Greatest Hopes of Its Supporters*, A.B.A. J., Mar. 1996, at 66 (1996) (noting that 40% of claims were dismissed for having "no reasonable cause" and another 43% were closed for administrative reasons).

114. GREAT LAKES, *supra* note 106, at 5 (finding as of September 30, 1996, 46% of Title I charges filed with the EEOC were dismissed for having no reasonable cause, another 40% were closed for administrative reasons, including claims that they were withdrawn or were closed because the complaining parties failed to cooperate with the agency); *see also* Ellison v. Software Spectrum, Inc., 85 F.3d 187, 190-91 (5th Cir. 1996) (holding that woman treated for breast cancer with daily radiation therapy did not have a disability under the ADA).

115. A study by the National Academy of Social Insurance found that many qualified persons with disabilities prefer to work and only use disability benefits as a last resort. 2 SUCCESSFUL JOB ACCOMMODATIONS STRATEGIES (June 1996); *see also* Executive Summary of "Balancing Security and Opportunity: The Challenge of Disability Income Policy", 59 SOCIAL SECURITY BULLETIN 79, 79 (Spring 1996) (showing about half of the 34 million working-age adults who experience mental illness over the course of a year are employed; about one-third of the 16.8 million persons with work disabilities are in the labor force, either working or looking for work); DISABILITY WATCH, *supra* note 19, at 16 (citing DISABLED AMERICANS' SELF-PERCEPTIONS: BRINGING DISABLED AMERICANS INTO THE MAINSTREAM (Louis Harris & Assocs., Inc., ed., 1986)) (showing that 79% of persons with disabilities below the age of 65 who do not work report that they want to work).

116. *See* Kaye, *supra* note 19, at 12 (noting that in many cases, disability is the result of a past health problem or injury that does not presently require medical attention). For an extensive analysis of factors related to the self-reported health status of persons with disabilities, *see* Mitchell P. LaPlante, DISABILITY, HEALTH INSURANCE COVERAGE, AND UTILIZATION OF

some courts presume that most impairments by definition impact an individual's ability to perform up to the standards of the workplace and increase the relative costs to employers of hiring the individual.¹¹⁷

In contrast to this view, surveys show that executives have favorable attitudes toward the employment and accommodation of qualified employees with disabilities. A 1995 Harris Poll of business executives found that 79 percent of those surveyed believe that the employment of qualified people with disabilities is a boost to the economy, while only 2 percent believe it poses a "threat to take jobs" from people without disabilities.¹¹⁸

The developing empirical evidence also does not reflect the view that Title I's accommodation provision is a preferential treatment initiative that forces employers to ignore employee qualifications and economic efficiency.¹¹⁹ To the contrary, studies of accommodations suggest that companies that are effectively implementing the law demonstrate the ability or "corporate culture" to look beyond minimal compliance of the law in ways that enhance economic value. The low direct costs of accommodations for employees with disabilities has been shown to produce substantial economic benefits to companies, in terms of increased work productivity, injury prevention, reduced workers' compensation costs, and workplace effectiveness and efficiency.¹²⁰

ACUTE HEALTH SERVICES IN THE UNITED STATES (Disability Statistics Report No. 4: U.S. Dept. Ed., Nat'l Institute Disability Research 1993).

117. See, e.g., *Vande Zande v. State of Wis. Dept. of Admin.*, 44 F.3d 538, 543 (7th Cir. 1995) (claiming that if the employers have potentially unlimited financial obligations to 43 million disabled people, there will be an indirect tax greater than the national debt).

118. SEARS II, *supra* note 10, at 43 (citing 1995 SURVEY OF CORPORATE EXECUTIVES OF THE ADA (Louis Harris & Assocs., Inc. ed., 1995) [hereinafter LOUIS HARRIS SURVEY]); PRESIDENT'S COMMITTEE ON PEOPLE WITH DISABILITIES, ABILITY FOR HIRE 1 (Washington, D.C., 1996) (citing MASON-DIXON POLL, Florida Chamber of Commerce Foundation's Disability Awareness Project (Jan. 1995) (on file with the *DePaul Law Review*)) (noting that 72% of businesses that hired persons with disabilities reported that the employment of people with disabilities had a favorable effect on their business and 87% said they would encourage other employers to hire persons with disabilities); OSHA Rules 'By Far' Most Burdensome for Employer Chamber Survey Finds, Daily Lab. Rep. (BNA) 124 A17, A18 (June 27, 1996) (rating the relative burden of requirements issued under various labor and employment laws on a scale of 1 (least) to 10 (most burdensome), small employers rated ADA requirements at 4.8 compared to a 6.2 for OSHA, and a 4.4 for the Fair Labor Standards Act).

119. See, e.g., SEARS II, *supra* note 10, at 42 (finding that the costs of accommodating qualified workers are relatively low and the economic and productivity benefits are relatively high).

120. See SEARS II, *supra* note 10, at 42-43; see also Francine S. Hall & Elizabeth L. Hall, *The ADA: Going Beyond the Law*, 8 ACAD. MGMT. EXECUTIVES 17, 17-26 (1994) (noting that one of the indirect benefits of following the ADA occurs when a corporation acknowledges reality and supports people with special needs, thereby gaining a strategic and competitive advantage).

In a series of studies conducted at Sears, Roebuck and Co. from 1978 to 1996,¹²¹ a time period before and after Title I's July 26, 1992 effective date, nearly all of the 500 accommodations sampled required little or no cost.¹²² During the years 1993 to 1996, the average direct cost for accommodations was \$45, and from 1978 to 1992, the average direct cost was \$121.¹²³ The Sears studies also show that the direct costs of accommodating employees with hidden disabilities (for example, emotional and neurological impairments comprising roughly 15 percent of the cases studied) are even lower than the overall average of \$45.¹²⁴

Other studies show that accommodations for employees with disabilities lead to direct and indirect benefits and cost-effective applications that increase the productivity of employees without disabilities. Studies by the Job Accommodation Network ("JAN") demonstrate the benefits to employers of accommodations for qualified employees. More than two-thirds of effective accommodations implemented as a result of a JAN consultation cost less than \$500.¹²⁵ In addition, almost two-thirds of the accommodations studied result in savings to the company in excess of \$5,000.¹²⁶ The savings associated with accommodations include lower job training costs and insurance claims, increased worker productivity, and reduced rehabilitation costs after injury on the job.¹²⁷ JAN reports that for every dollar invested in an effective accommodation, companies sampled realized an average of \$50 in benefits.¹²⁸ Likewise, the results of a 1995 Harris Poll of more than 400 executives show that more than three-quarters of those surveyed report minimal increases in costs associated with the provision of accommodations (for example, median direct cost for accommodations was \$233 per covered employee), and from 1986 to 1995, the

121. See, e.g., SEARS II, *supra* note 10, at 16 (stating that "Sears employs among its 300,000 person work force an estimated 20,000 persons with physical or mental disabilities").

122. *Id.* at 17 (noting "72% required no cost, 17% cost less than \$100, 10% cost less than \$500, and only 1% cost more than \$500, but not more than \$1,000"). Effective accommodations include assistive technology, physical access, changed schedules, assistance by others, and changed job duties. See Mary C. Daly & John Bound, *Worker Adaptation and Employer Accommodation Following the Onset of a Health Impairment*, 51 J. GERONTOLOGY S53 (1996).

123. SEARS II, *supra* note 10, at 18.

124. *Id.* at 20 (finding that from 1993 to 1996, the average cost for behavioral impairments was \$0 and the average cost for neurological impairments was \$13).

125. *Id.* at 26 (citing PRESIDENT'S COMMITTEE ON EMPLOYMENT OF PEOPLE WITH DISABILITIES, JOB ACCOMMODATION NETWORK (JAN) REPORTS (Oct.-Dec. 1994) (Washington, D.C., 1994)).

126. *Id.* (providing information on accommodations for employees with disabilities).

127. *Id.*

128. *Id.*; see also *infra* notes 146-49 and accompanying text (discussing a study of Canadian work force showing return on accommodation investment).

proportion of companies providing accommodations rose from 51 percent to 81 percent.¹²⁹

Several general implications may be drawn from the existing findings. First, the degree to which many companies comply with the accommodation provisions of Title I appears to have more to do with their corporate cultures, attitudes, and business strategies than with the actual demands of the law. For many companies with a culture of work force diversity and inclusion, implementation has resulted in economically effective business strategies that transcend minimal compliance with the law and produce economic value.¹³⁰ In this regard, studies of accommodation costs at Sears showed that the indirect cost of not retaining qualified workers is high, with the average administrative cost per employee replacement of \$1,800 to \$2,400¹³¹—roughly forty times the average of the direct costs of workplace accommodations.

Second, in terms of relative cost, although the direct costs of the accommodations for any particular disability tend to be low,¹³² many companies regularly make informal and undocumented accommodations that require minor and cost-free workplace adjustments that are implemented directly by an employee and his supervisor.¹³³ The trend toward the provision of accommodation in the workplace may suggest

129. SEARS II, *supra* note 10, at 24 (citing LOUIS HARRIS SURVEY, *supra* note 128).

130. See *id.* (finding neither cost alone nor severity of disability determined Sears strategy toward the provision of accommodations); Collignon, *supra* note 6, at 208 (stating “firms saw accommodation as good business practice”); PETER D. BLANCK & CRAIG L. LAMAY, TRANSCENDING THE AMERICANS WITH DISABILITIES ACT: RESEARCH, POLICY, AND EMPLOYMENT STRATEGIES FOR THE 21ST CENTURY (forthcoming 1997) (manuscript on file with author) (discussing when employers hire, work with, and accommodate qualified employees with disabilities, they enhance their customer bases, employee morale, and business goals); see also Lauren B. Edelman, *Legal Ambiguity and Symbolic Structures: Organizational Mediation of Civil Rights Laws, in EQUAL EMPLOYMENT OPPORTUNITY: LABOR MARKET DISCRIMINATION AND PUBLIC POLICY* 247, 247-48 (Paul Burstein ed., 1994) (finding that organizations are motivated by legal process to construct law in ways consistent with societal norms and culture); David A. Thomas & Robin J. Ely, *Making Differences Matter: A New Paradigm for Managing Diversity*, HARV. BUS. REV., Sept./Oct., 1996, at 79-80 (explaining that fundamental changes in an organization’s hierarchy adopting a diverse workplace increases profitability, creativity, and flexibility of the workplace).

131. SEARS II, *supra* note 10, at 42.

132. Although many of the accommodations studied at Sears involve simple and common sense strategies, these same accommodation requests in other settings have been the subject of litigation. See, e.g., *Kuehl v. Wal-Mart Stores, Inc.*, 909 F. Supp. 794, 798 (D. Colo. 1995) (discussing a Title I claim involving a requested accommodation of periodic sitting on stool while on work duty).

133. SEARS II, *supra* note 10, at 19-24; SEARS I, *supra* note 10, at 12 (noting that since 1972, fewer than 10% of Sears employees who were self-identified as disabled through the company’s Selective Placement Program required any kind of accommodation at the time of self-identification); cf. Karlan & Rutherglen, *supra* note 82, at 23 (arguing, without support of data, that an

that employers are realizing positive economic returns on the accommodation investment, for instance, by enabling qualified workers with covered disabilities to return to or stay in the work force and by reducing worker absenteeism.¹³⁴

Professor Rosen points out, however, that where the benefits of accommodations exceed the costs "there is no inherent reason to expect that labor markets free of government intervention will fail to provide job accommodations in normal job situations."¹³⁵ Yet, as discussed above, absent a truly competitive labor market, attitudinal discrimination against qualified individuals with disabilities alone may necessitate the required provision of accommodations under Title I, at least for a large segment of the labor force affected by this market failure.¹³⁶ This is true given that the value of a worker with a disability often is contingent upon his output and his employers' and others' attitudes about the worker.¹³⁷ Over time,¹³⁸ with the lessening of prejudicial attitudes resulting from effective Title I implementation,

accommodation in any form requires an employer to incur cost, and sometimes the "subsidy turns out to be a good investment" in terms of worker productivity or in attracting customers).

134. See Collignon, *supra* note 6, at 209 (stating that businesses are more likely to provide lower cost accommodations, particularly when a current employee becomes disabled); Weaver, *supra* note 83, at 9, 11-12 (noting that Title I provides economic incentives to businesses to hire individuals requiring accommodations that have indirect benefits to the firm or to customers); Deborah S. Cowans, *Employers Bear Millions in Elder Caregiving Costs*, BUS. INS., June 24, 1995, at 2 (discussing a study of a large manufacturer with about 87,000 employees who estimates \$5.5 million in lost productivity and time associated with employees providing personal care for elderly relatives, and accommodations such as flexible work schedules mitigate these costs); Heidi Berven & Peter D. Blanck, *Economic Returns on the Employment Provisions of the Americans with Disabilities Act: Empirical Study of Disability-Related Patents from 1970 to 1997* (forthcoming 1997) (manuscript on file with author) (providing an analysis of positive economic projections associated with disability-related patents filed).

135. Rosen, *supra* note 94, at 26.

136. See *Bultemeyer v. Fort Wayne Community Sch.*, 100 F.3d 1281, 1286-87 (finding bad faith in reasonable accommodation implementation process often reflective of irrational attitudinal bias by employer). Thus, independent of the effects of the civil rights guaranteed by the law, the crux of the normative question is whether Title I is economically rational.

137. See Donohue, *supra* note 5, at 2585 (discussing concept of "contingent equality"). Research is needed also on the extent to which contingent worker value varies across industries or with different labor markets. *Id.*

138. Long-term empirical assessment of Title I is necessary as has been discussed and conducted, for instance, on the Civil Rights Act of 1964. See, e.g., John J. Donohue III & James Heckman, *Continuous Versus Episodic Change: The Impact of Civil Rights Policy on the Economic Status of Blacks*, in EQUAL EMPLOYMENT OPPORTUNITY: LABOR MARKET DISCRIMINATION AND PUBLIC POLICY 183 (Paul Burstein ed., 1994) (examining the available evidence on the causes of African-American economic advances to access the contribution of federal policy); David L. Rose, *Twenty-Five Years Later: Where Do We Stand on Equal Employment Opportunity Law Enforcement*, in EQUAL EMPLOYMENT OPPORTUNITY: LABOR MARKET DISCRIMINATION AND PUBLIC POLICY 39 (Paul Burstein ed., 1994) (reviewing the accomplishments and shortcomings of federal opportunity law over the last 25 years).

and with increased knowledge from empirical study, employers who were formerly "economic discriminators" against qualified persons with disabilities may be less willing or less able to incur lost profits to satisfy their discriminatory tastes or preferences.¹³⁹

Third, accommodations involving universally designed and advanced technology have been shown to enable groups of employees with and without disabilities to perform jobs productively, cost-effectively, and safely.¹⁴⁰ The studies at Sears suggest that the direct costs associated with many technologically based accommodations (for example, computer voice synthesizers) enabled qualified employees with disabilities to perform essential job functions and that these strategies create an economic "ripple effect" throughout the company, as related applications are developed subsequently that increased the productivity of Sears employees without disabilities.¹⁴¹ These findings suggest that the direct costs attributed to universally designed accommodations may be lower than predicted, particularly when their fixed or sunk costs are amortized over time.¹⁴² In addition, the Sears findings support those of organizational researchers showing that many traditional blue-collar jobs increasingly require workers to use or monitor computers that control equipment performing work tasks and that workers with disabilities may increasingly and efficiently perform such essential job functions.¹⁴³

139. See Weaver, *supra* note 83, at 6 (noting that "[l]ost profits are the price an 'economic discriminator' pays to indulge his preferences"). Study is needed of the impact of the emerging consumer market comprised of people with disabilities and the affect that this market will have on employers' preferences and economic ability to hire and retain qualified workers with disabilities. See SEARS I, *supra* note 10, at 8-9.

140. See SEARS II, *supra* note 10, at 35-36; SEARS I, *supra* note 10, at 16-17, 26-29; S.F. Wilson et al., A TECHNICAL ASSISTANCE REPORT ON CONSUMER AND EX-PATIENT ROLES IN SUPPORTED HOUSING SERVICES (Burlington, Vt.: The Center for Community Change Through Housing and Support 1991) (concluding that the effect of hiring people with psychiatric disabilities was to improve the level of individual attention and accommodation to all employees, thus creating a more positive working environment); see also Peter D. Blanck, Communications Technology for Everyone: Implications for the Classroom and Beyond, Annenberg Washington Program Report (1994); Deborah Kaplan et al., *Telecommunications for Persons with Disabilities: Laying the Foundation*, WORLD INST. ON DISABILITY REP. (Oakland, California, 1992).

141. See SEARS I, *supra* note 10, at 16-17.

142. See Collignon, *supra* note 6, at 205-06 (noting that universally designed accommodations may reflect more efficient way to undertake production and improve productivity of co-workers); Donohue, *supra* note 5, at 2612 n.72 (suggesting that if accommodation costs for workers with disabilities are sunk, then the market incentive would be to retain the qualified disabled worker over an equally or less qualified nondisabled worker requiring no accommodation); Karlan & Rutherglen, *supra* note 82, at 23 (same).

143. SEARS II, *supra* note 10, at 22; see SHOSHANA ZUBOFF, IN THE AGE OF THE SMART MACHINE: THE FUTURE OF WORK AND POWER (1988); Edward H. Yelin, *The Employment of People With and Without Disabilities in an Age of Insecurity*, 549 ANNALS AM. ACAD. POL. & SOC. SCI. 117, 128 (1997).

Future examination is needed of the type, effectiveness, and cost of accommodations at large and small organizations, using standardized means for gathering and analyzing information.¹⁴⁴ Study must be conducted on the fears and stigmas associated with disclosure of actual and hidden disabilities and the resulting employment consequences, for instance, the extent to which qualified job applicants and employees with hidden disabilities forgo the benefits of accommodations due to fear of disclosure, thereby potentially depriving the labor market and employers of a source of value.¹⁴⁵

Close examination is needed of direct and indirect costs and benefits of Title I implementation and who bears the costs and receives the benefits associated with workplace accommodations for qualified persons with covered disabilities.¹⁴⁶ A recent empirical study based on over 1,000 observations in the Canadian work force examined the extent to which the costs of workplace accommodations are shifted by employers to injured workers through wage adjustments upon the injured worker's return to work after a workplace injury.¹⁴⁷ The researchers found that injured workers did not incur the cost of workplace accommodations when they returned to their time-of-accident employer. Presumably, these workers were "qualified" to resume their essential or comparable job duties in ways that added economic value to the employer.¹⁴⁸ Injured workers who returned to the work force but to a different employer did "pay" for a portion of workplace accommodations by accepting substantially lower wages.¹⁴⁹

Additional study is required of the extent to which accommodations for workplace injury enable qualified workers with covered disabilities to stay or return to work at their time-of-accident employer or to a

144. See Mary T. Giliberti, *Implementation of the Reasonable Accommodation Provisions of the ADA by the EEOC and the Courts*, 6 J. CAL. ALLIANCE FOR THE MENTALLY ILL 19, 19-20 (1995); Diane Sands, *Reasonable Accommodation or Improbable Emancipation?*, 6 J. CAL. ALLIANCE FOR THE MENTALLY ILL 19, 21-22 (1995).

145. See, e.g., Collignon, *supra* note 6, at 231 (noting a need for studies on those accommodations requested by job applicants who subsequently are not hired).

146. See Morley Gunderson & Douglas Hyatt, *Do Injured Workers Pay for Reasonable Accommodation?*, 50 INDUS. & LAB. REL. REV. 92, 101 (1996) (indicating that "injured workers did not pay for workplace accommodations or reduced physical demands if they returned to their time-of-accident employer," but that "injured workers who . . . took jobs with an employer other than the time-of-accident employer did pay at least a portion of the cost of the accommodations by accepting lower wages in exchange for workplace modifications").

147. *Id.*

148. *Id.*

149. *Id.*; see also Karlan & Rutherglen, *supra* note 4, at 23 (suggesting, without support of data, that persons with disabilities face higher costs of searching for a job than do persons without disabilities and that if costs to employer of accommodation by job transfer are greater than costs of worker job search, then worker should bear that cost).

different employer, who bears the associated costs, and how the costs vary with job type and other factors such as insurance coverage rates. Some researchers have suggested that, over time, the provision of Title I accommodations may increase or at least help maintain employment rates by enabling newly disabled workers to retain employment.¹⁵⁰ Other studies show that accommodations for workers' health conditions extend their work life by an average of five years.¹⁵¹

Indirect costs associated with Title I implementation include related expenses for administrative, compliance, or legal actions.¹⁵² The Sears study examined all 138 Title I charges filed with the EEOC against Sears from 1990 to mid-1995.¹⁵³ The findings showed that almost all of the EEOC charges (98 percent) were resolved without resort to trial litigation, and many through informal dispute processes that enabled qualified employees with disabilities to return to productive work.¹⁵⁴ Consistent with the Sears findings, a 1997 study of nationwide trends in Title I charges filed with the EEOC showed that 94 percent of beneficial outcomes were obtained by the charging parties before full EEOC investigations and formal litigation were initiated.¹⁵⁵

150. See Nancy R. Mudrick, *Employment Discrimination Laws for Disability: Utilization and Outcome*, 549 ANNALS AM. ACAD. POL. & SOC. SCI. 53, 68-70 (1997) (citing studies showing that a majority of persons injured in the workplace maintain their labor force attachment).

151. Burkhauser, *supra* note 96, at 80 (showing that the range of work life extension from accommodations was found to be from 2.6 to 7.5 years, but authors suggest that range is affected by severity of condition and expected prognosis rates).

152. Peter D. Blanck, *Transcending Title I of the Americans with Disabilities Act: A Case Report on Sears, Roebuck and Co.*, 20 MENTAL & PHYSICAL DISABILITY L. REP. 278, 283-84 (1996) (discussing the direct and indirect costs associated with Title I implementation); see also Rosen, *supra* note 94, at 22-27 (same). Some studies also suggest that the administrative, compliance, and legal costs associated with Title I implementation are not as great as some predicted. See SEARS II, *supra* note 10, at 43. Research is needed, however, on employers' costs associated with the threat of Title I sanctions or litigation, for instance, the legal costs incurred when an employee with a disability is terminated even for valid reasons. Research is needed on the costs (for example, inefficiencies and uncertainty) or benefits (for example, limited scope of inquiries) related to the case-by-case analytical approach required by Title I. *Id.* at 12-15 (discussing EEOC's 1995 modifications to Title I charge processing and prioritization process, designed to reduce charge backlog). Other costs and benefits related to potential Title I charges and capable of study relate to the planning of an accommodation or the impact of an accommodation on training and safe workplace practices for fellow employees without disabilities.

153. SEARS II, *supra* note 10, at 33-34.

154. *Id.* at 35-37 (finding in addition, of the cases studied, the average settlement cost to Sears, exclusive of attorney fees, was \$6,193); see also Karlan & Rutherglen, *supra* note 82, at 23 (arguing, without support of data, that there is an advantage of settlement over litigation in Title I context for persons with disabilities compared to other protected groups, due to factors such as hypothesized limitations in job search ability of persons with disabilities).

155. See Kathryn Moss et al., *Assessing Employment Discrimination Charges Filed Under the Americans with Disabilities Act*, J. DISABILITY POL'Y STUD. (forthcoming 1997) (suggesting that

Additional analysis is needed on a national scale of the patterns and magnitude of the costs and benefits associated with Title I implementation, compliance, and related litigation.¹⁵⁶ Professors Karlan and Rutherglen have suggested a variety of factors involving Title I implementation and compliance that may help guide future study.¹⁵⁷ They hypothesize that, given the low cost of many accommodations and high costs attendant to litigation, employers and applicants or employees with disabilities create a "bargaining range" within which they negotiate the costs and benefits associated with minimum accommodation the employee or applicant may accept and the costs and benefits associated with the maximum accommodation the employer may undertake.¹⁵⁸ Analysis of the relative magnitude of direct and indirect costs and benefits associated with the accommodation process for different employers and for workers with and without disabilities in similar jobs may enable a more accurate assessment over time of the economic impact of Title I.¹⁵⁹ Moreover, broadly defined, indirect costs and benefits may include the impact of effective accommodations on employee morale, perceptions of the business and its reputa-

the presence of Title I motivates parties to resolve disputes informally without resort to costly trial litigation and finding that variation in a charging party's likelihood of receiving a benefit based on the party's type of disability, race, and gender).

156. See, e.g., DISABILITY WATCH, *supra* note 19, at 22 (citing N.O.D./HARRIS SURVEY OF AMERICANS WITH DISABILITIES (Louis Harris & Assocs., Inc., ed., 1995)) (finding from survey of employers that 66% report that litigation has not increased as a result of the ADA, 82% report that the ADA is worth the cost of implementation, 27% report that it costs more to employ a person with a disability than a person without a disability); *ADA Changes Decline But Monetary Awards Increase*, WASHINGTON FAX (President's Comm. on Employment of People with Disabilities, Washington, D.C.), Nov.-Dec. 1996, at 1 (on file with the *DePaul Law Review*) (citing EEOC records showing that Title I charge filings decreased by 10% during 1996 year as compared to 1995).

157. See Karlan & Rutherglen, *supra* note 82, at 30.

158. *Id.* at 30-31; see also Peter D. Blanck, *On Integrating Persons with Mental Retardation: The ADA and ADR*, 22 N.M. L. REV. 259, 263-64, 270-71 (1992) (discussing the benefits of alternative dispute resolution practices in cases involving persons with disabilities, including the development of a "settlement framework" and "dynamic" working relationships among the parties).

159. See, e.g., Calloway, *supra* note 112, at 494 (suggesting that in absence of study, reasonable accommodation requirement may foster backlash against Title I); Collignon, *supra* note 6, at 208 (discussing the economic benefits of accommodation and reviewing study of accommodation costs and benefits under Rehabilitation Act of 1973); Donohue, *supra* note 37, at 1603 (suggesting need to study relative magnitude of costs to benefits in antidiscrimination employment laws); Oi, *supra* note 50, at 39 (suggesting the need for study comparing the average productivity and the costs and benefits of accommodations for a random sample of persons with and without disabilities, in and out of the work force). Future studies may examine the economic relationship among Title I implementation, Title VII of the Civil Rights Act of 1964 implementation, and laws such as workers' compensation laws, health insurance laws, the Family Medical Leave Act, and OSHA regulations, given that employment discrimination lawsuits increasingly allege multiple claims of discrimination under various laws. See Blanck & Marti, *supra* note 1.

tion by customers and the community, or relationship to effective implementation of other laws such as the Family Medical Leave Act or workers' compensation laws.¹⁶⁰

III. CONCLUSION

Systematic evaluation of the economic implications associated with the emerging and existing work force of qualified persons with disabilities is needed for several reasons. First, study of the labor force of qualified persons with disabilities may aid in long-term Title I implementation, as well as interpretation of related initiatives such as welfare, health care, and health insurance reform.¹⁶¹ The Health Insurance Reform Act of 1996, for instance, is written to ensure access to portable health insurance for employees with chronic illness or disabilities who lose or change their jobs.¹⁶² Under the law, group health plan premium charges may not be based solely on disability status or the severity of an individual's chronic illness.¹⁶³ The combined economic impact of the Health Insurance Reform Act and Title I on reducing employment discrimination facing qualified persons with covered disabilities is a promising area for study.¹⁶⁴

Second, study limited to the analysis of litigation and the EEOC charges associated with Title I implementation, while necessary, tends to focus discussion on the "failures" of the system, as opposed to economically efficient strategies designed to enhance a productive work force and identify potential disputes before they arise.¹⁶⁵ Independent

160. See Peter D. Blanck, *Communicating the Americans with Disabilities Act, Transcending Compliance: 1997 Report on Direct and Indirect Costs and Benefits of Workplace Accommodations at Sears, Roebuck & Co.* (forthcoming 1997) (manuscript on file with author).

161. Johnson, *supra* note 8, at 160-62 (arguing that the ADA must be evaluated in context of other social welfare programs, for instance, with regard to economic incentives to work or return to work).

162. Health Insurance Reform Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

163. *Id.* (discussing how this antidiscrimination provision does not apply to individual insurance plans); cf. EEOC v. CNA Ins. Co., Daily Lab. Rep. (BNA) 195, at D-89 (7th Cir. 1996) (rejecting the view that ADA Title I requires parity among physical and mental health benefits provided by employers). A similar study is required of the impact of the Mental Health Parity Act of 1996, Pub. L. No. 104-204, Title VII, 110 Stat. 2944, on employment opportunity for qualified persons with mental disabilities.

164. For instance, if a particular job-related medical intervention, such as gene therapy for chemical sensitivity to workplace air contaminants, would enable a qualified worker with a disability to perform his job (that is, work in the particular workplace), could this be considered a form of reasonable accommodation either required by Title I, assuming no undue hardship, and to what extent could the procedure then be covered by the employee's health insurance group plan? Discussions with Robert Olick aided in the development of this hypothetical.

165. See Karlan & Rutherglen, *supra* note 82, at 30-31 (arguing that reported Title I cases present a skewed picture of accommodation costs and benefits, for instance, when they involve situations where accommodation costs are high and job availability is limited).

of study of the enforcement of the civil rights guaranteed by Title I, the long-term promise of the law to raise awareness of the promise of equal employment opportunity for qualified persons requires the collection of information on attitudes, behavior, and the related economic implications of the law.¹⁶⁶

Third, some evidence suggests that Title I implementation has coincided with larger numbers of qualified persons with severe disabilities entering the labor force. In 1996, the U.S. Census Bureau released data showing that the employment-to-population ratio for persons with severe disabilities has increased from roughly 23 percent in 1991 to 26 percent in 1994, reflecting an increase of approximately 800,000 people with severe disabilities in the work force.¹⁶⁷ Examination is required of the economic impact of Title I on workplace accommodation costs and benefits against this backdrop of increased labor force participation of qualified workers with disabilities, particularly in the context of the recent reforms to welfare policy.¹⁶⁸

Despite the encouraging trends, estimates of unemployment levels for persons with disabilities range as high as 50 percent.¹⁶⁹ Some stud-

166. See, e.g., Blanck & Marti, *supra* note 1.

167. *Id.* (describing a longitudinal study from 1990 to 1995 tracking employment trends for several thousand persons with mental retardation finding that during this initial Title I implementation time period, 43% of the participants attained integrated employment and relative unemployment levels decreased from 39% to 12% and that in 1995 participants' job skills related to their earned income levels); "Six Years After Signing of Law, ADA Has Been Cited in More Than 1,000 Suits," *DISABILITY COMPLIANCE BULLETIN*, LRP Publications, Aug. 15, 1996 (showing that data reflects a 27% increase of persons with severe disabilities in the work force from 1991 to 1994). *Bur cf.* Rosen, *supra* note 94, at 18, 22 (suggesting that an increase in disability benefits may discourage disabled persons from working).

168. Study is needed of the interaction of Title I to the 1996 Welfare Reform Law, for instance, study of the impact on persons with disabilities of the requirement under welfare reform that the head of families on welfare must work within two years or lose benefits. See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. Law 104-193, 110 Stat. 2105; Collignon, *supra* note 6, at 137-38 (suggesting reduction in welfare dependency as indicator of Title I implementation); *cf.* Rosen, *supra* note 94, at 28-29 (arguing that decreased labor force participation and increasing insurance benefits of persons with disabilities is inconsistent with Title I accommodation policies); Murray Weidenbaum, *Why the Disabilities Act Is Missing its Mark*, *CHRISTIAN SCI. MONITOR*, Jan. 16, 1997, at 19 (arguing that negative trends in labor force participation of people with disabilities are not related to Title I, but to other federal entitlement programs, such as Supplemental Security Income, that provide monetary incentives for persons with disabilities not to work). Further analysis is needed of the relation among changes in the labor force participation of persons with different disabilities, Title I implementation, federal work-related entitlement programs, and changes in general population and employment rates.

169. See Paul Wehman, *Employment Opportunities and Career Development*, in *THE ADA MANDATE FOR SOCIAL CHANGE* 45, 54 (Paul Wehman ed., 1993) (citing a poll which indicated that two-thirds of the people with disabilities are unemployed); see also JOHN McNEIL, U.S. BUREAU OF THE CENSUS, *SURVEY OF INCOME AND PROGRAM PARTICIPATION* (1994) (reporting that in 1994, for persons with disabilities between the ages of 21 to 64 years, roughly 14 million of 29 million individuals (48%) were unemployed; the mean monthly income for workers with disa-

ies suggest that from the years 1970 to 1992, there has been no significant net change in the labor force participation rate among persons with disabilities.¹⁷⁰ As a result, the continued reality of economic, structural, attitudinal, and behavioral discrimination¹⁷¹ increasingly may lead qualified individuals to assert their Title I rights in the future.¹⁷² Analysis of job retention, assessment, advancement, disclosure, and accommodation strategies are needed to help qualified individuals keep their jobs and achieve their potential. This analysis is particularly important for those qualified individuals with severe disabilities, who may be most susceptible to unfounded negative attitudes about their labor force potential and value.¹⁷³

Study must address the social and cultural factors, and the structural and cyclical changes in the labor market and the economy, that influence employment opportunity for persons with and without different disabilities.¹⁷⁴ This study may include factors such as the types of jobs attained (for example, entry level, service-related, or production),

bilities was \$1,713 compared to \$2,160 for workers without disabilities). Additional study is needed of this population, for instance, with regard to the nature of disability and the types of jobs held by persons with and without disabilities. See *DISABILITY WATCH*, *supra* note 19, at 17 (summarizing national survey results regarding the employment status of people with disabilities and suggesting that studies show no significant increases in their labor force participation since 1991); H. Stephen Kaye et al., *Trends in Disability Rates in the United States, 1970-1994*, 17 *DISABILITY STATISTICS ABSTRACT* 1, 1-6 (Nov. 1996) (analyzing labor force rates and their relation to work limitations and disability).

170. See Yelin, *supra* note 143, at 124-25 (finding a disproportionate increase in persons with disabilities working part-time).

171. See *SUPPORTED EMPLOYMENT: STRATEGIES FOR INTEGRATION OF WORKERS WITH DISABILITIES* 54-58 (Paul Wehman et al. eds., 1992).

172. See Blanck & Marti, *supra* note 1 (detailing a longitudinal study from 1990 to 1995 tracking employment trends for several thousand persons with mental retardation finding that participants engaged in "self-advocacy" more likely to attain competitive employment and have higher earned incomes); David Pfeiffer, 'We Won't Go Back': *The ADA on the Grass Roots Level*, 11 *DISABILITY & Soc'y* 271, 282-83 (1996) (finding members of the disability community reporting empowerment and cynicism resulting from Title I implementation); William J. Hanna & Elizabeth Rogovsky, *On the Situation of African-American Women with Physical Disabilities*, 23 *J. APPLIED REHABILITATION COUNSELING* 39, 39-45 (1992) (finding 25% of African-American women with disabilities are employed full time, as compared to 77% of Caucasian men, 57% of African-American men, and 44% of Caucasian women with disabilities); *DISABILITY WATCH*, *supra* note 19, at 20 (citing N.O.D./HARRIS SURVEY OF AMERICANS WITH DISABILITIES (Louis Harris & Assocs., Inc., ed., 1994)) (finding 30% of working-age adults with disabilities reported experiencing job discrimination based on their disability).

173. See Baldwin, *supra* note 28, at 52 (suggesting that Title I may have little impact on equal employment for persons with severe disabilities who are subject to the greatest discrimination in the labor market); Marta W. Casper, *Seasons of Change—The Americans with Disabilities Act: Implementation in the Work Place*, 17 *J. REHABILITATION ADMIN.* 129, 131-32 (1993) (describing a qualitative study of employer attitudes about disability).

174. This study is needed given that many nondisabled individuals or members of their family will experience a disabling condition during the course of their lifetime that affects their employment activities. See Blanck, *supra* note 4, at 918-19; Tom Harkin, *The Americans with Disabili-*

amount of hours worked (for example, full time and temporary positions), geographic differences in labor markets and hiring patterns, turnover, productivity, retention, wage, and promotion rates, availability of transportation to work, and provision of accommodations.¹⁷⁵ It may also include analysis of persons with disabilities who are particularly vulnerable to changes in economic conditions, such as those in poverty, or those with minimal education or job skills.¹⁷⁶

Similar analysis is needed of cost-effective workplace accommodation strategies affecting qualified job applicants and employees without disabilities, such as those geared toward employee wellness programs, flexible hours for workers with young children, employer-sponsored child care centers, job-sharing strategies for workers with limited time availability, or employee assistance programs ("EAPs").¹⁷⁷ As Martin Gerry has suggested, many companies already expend large sums of money accommodating the needs of workers without disabilities, which in the aggregate may be substantially greater than the costs associated with accommodations for qualified workers with covered disabilities.¹⁷⁸ Analysis of these innovative

ties Act: Four Years Later—Commentary on Blanck, 79 IOWA L. REV. 935, 936 (1994) (noting that disability is a natural part of the human experience).

175. See Jerry L. Mashaw & Virginia P. Reno, *Overview*, in *DISABILITY, WORK AND CASH BENEFITS* 22 (Jerry L. Mashaw et al. eds., 1996) (finding that structural changes in economy affect job opportunities for workers with different disabilities); McNeil, *supra* note 169 (finding wage disparities among workers with and without disabilities).

176. See Mary C. Daly, *Who Is Protected by the ADA? Experience from the German Experience*, 549 ANNALS AM. ACAD. POL. & SOC. SCI. 101, 102 (1997) (arguing that many individuals with disabilities are "doubly disadvantaged" by having a poor education or job skills).

177. See Tyler D. Hartwell et al., *Aiding Troubled Employees: The Prevalence, Cost, and Characteristics of Employee Assistance Programs in the United States*, 86 AM. J. PUB. HEALTH 804, 804-08 (1996) (detailing a survey of 3,200 work sites finding 33% of employers with 50 or more employees offer EAPs with median cost per eligible employee of \$20, most commonly addressing worker substance abuse, family problems, and emotional problems); cf. Karlan & Rutherglen, *supra* note 82, at 39-40 (casting accommodation as "an individualized form of affirmative action" that may have applications for deterring employment discrimination based on gender and race); Joan C. Williams, *Restructuring Work and Family Entitlements Around Family Values*, 19 HARV. J.L. & PUB. POL'Y 753, 756 (1996) (suggesting that flexible work hours may accommodate needs of workers with children in child care).

178. See Martin H. Gerry, *Disability and Self-Sufficiency*, in *DISABILITY AND WORK: INCENTIVES, RIGHTS, AND OPPORTUNITIES* 89, 92 (Carolyn L. Weaver ed., 1991) (suggesting that large businesses are increasingly investing in attracting and retaining qualified employees "in a more holistic way" with disability as only one component of the measure of potential productivity and value); U.S. Dept. of Health & Human Services, *1992 National Survey of Worksite Health Promotion Activities: Summary*, 7 AM. J. HEALTH PROMOTION 452, 452-64 (1993) (detailing a 1992 survey of 1,507 work sites which found that 81% of companies offered employee health promotion activity). Likewise, many large companies are employing universal workplace and job site design and access to include qualified individuals with and without disabilities into productive work force participation in ways that add economic value to the company. See Daniel Stokols et al., *Integration of Medical Care and Worksite Health Promotion*, 273 J. AM. MED. ASSOC. 1136

strategies may show that they effectively and efficiently complement accommodations required by many qualified workers with disabilities.

For instance, studies show that workplace accommodation strategies enhance the productivity and job tenure of those large numbers of qualified workers without disabilities who are injured on the job or who may become impaired in the future.¹⁷⁹ In an eight-year study of Coors Brewing Company's health screening program covering almost 4,000 employees, the company realized net and direct savings of roughly \$2.5 million, in terms of saved payments in short-term disability, temporary worker replacement, and direct medical costs.¹⁸⁰ Given a conservative estimate of \$100 average direct cost per employee for workplace accommodations based on the Sears findings described earlier, the savings generated by the Coors study could fund accommodations for 25,000 qualified workers.¹⁸¹

Another study of Coors Brewing Company's wellness initiatives (for example, health screening and education, exercise, stress, and smoking cessation programs) found that the company saves up to eight dollars for every dollar invested in these programs.¹⁸² Likewise, a nine-year study of 28,000 Union Pacific Railroad employees found that their wellness program resulted in net savings of \$1.3 million to the company.¹⁸³ These findings suggest the huge economic implications associated with the development of cost-effective accommodations strategies designed to prevent workplace injury and to help retain the increasing numbers of qualified employees with and without disabilities. Considering that by the year 2000, the costs to employers

(1995) (finding that new technologies relate to cost-effective worksite wellness and health care programs); SEARS II, *supra* note 10, at 6.

179. See, e.g., Hal Clifford, *The Perfect Chemistry: DuPont's Work-Life Program*, HEMISPHERES 33, 34 (1996) (claiming a 637% return on expenditures for its LifeWorks program, a program designed to help employees deal with job and life pressures, based on estimated value of resulting increased performance, employee retention, stress reduction, and reduced absenteeism).

180. Mary Greenwood & Joanne Henritze, *Coorscreen: A Low Cost, On-Site Mammography Screening Program*, 10 AM. J. HEALTH PROMOTION 364, 368 (1996) (noting that breast cancer screening was provided for roughly 4,000 employees, cost savings of program was \$3,110,080, and procedural costs for the program were \$668,690, with net savings of \$2,441,190).

181. In 1995, it is estimated that companies spent over \$100 billion rehabilitating 3.5 million employees with work-related injuries. Shelly Reese, *Building an Express Lane Back to Work*, 14 BUS. & HEALTH 24, 24 (1996) (arguing that return-to-work programs and accommodation strategies may ease worker rehabilitation costs).

182. See Martha McDonald, *Valuing Experience: How To Keep Older Workers Healthy*, 8 BUS. & HEALTH 35-38 (1990) (estimating that for older workers, stress control program could save company \$100,000 over a five-year period).

183. See Catherine Carythers, *Will Wellness Ever Really Catch On?*, BUS. & HEALTH: STATE OF HEALTH CARE IN AMERICA SUPPLEMENT 55-58 (1996) (describing wellness programs on stress, exercise, and eating habits).

associated with back injury alone in the workplace are estimated to approach \$40 billion, examination of the economic savings related to accommodation strategies, injury prevention, and wellness programs is warranted.¹⁸⁴ Moreover, the educational side-effects associated with Title I implementation and comprehensive accommodation strategies may enhance general employee morale, as well as positive attitudes about qualified co-workers with different disabilities or those who are members of other protected groups.¹⁸⁵

In conclusion, this Article has explored the economics of Title I implementation. Clearly, further empirical study of Title I is needed to address the law's economic, cultural, and symbolic impact on employers and others in society. The economic model has yet to demonstrate empirically the hypothesized labor market inefficiencies associated with the operation of the law, particularly those claimed to be linked to the provision of workplace accommodations. Yet independent of economic analysis and related disciplinary study of Title I, definition is necessary of the social and moral policies underlying the equal employment of qualified persons with covered disabilities.¹⁸⁶

184. See Peter D. Blanck, *The Americans with Disabilities Act: Issues for Back and Spine-Related Disability*, 19 SPINE 103, 103 (1994) (citing studies estimating that in 1990, the cost to society of back-related disability included an estimated \$16 billion in workers' compensation costs, lost productivity, and other intangible costs).

185. Andrew I. Batavia, *Ideology and Independent Living: Will Conservatism Harm People with Disabilities?*, 549 ANNALS AM. ACAD. POL. & SOC. SCI. 10, 20 (1997) (arguing that Title I may be interpreted to require employers to accommodate the needs of employees with and without disabilities, rather than an infringement on business objectives).

186. See Peter D. Blanck, *Conceptions of Equality, Economic Efficiency and Affirmative Action under ADA Title I* (forthcoming 1997) (manuscript on file with author) (examining differing views of Title I's reasonable accommodation provision); Karlan & Rutherglen, *supra* note 82, at 25 (concluding that "[t]he prohibitions against discrimination and the requirements of accommodation . . . require more than efficiency and less than charity"); Gregory S. Kavka, *Disability and the Right to Work*, 9 SOC. PHIL. & POL. 262, 288 (1992) (concluding that economic analysis should not be sole criterion for defining social policy toward employment for qualified persons with disabilities); Richard K. Scotch & Kay Schrimmer, *Disability as Human Variation: Implications for Policy*, 549 ANNALS AM. ACAD. POL. & SOC. SCI. 148, 157 (1997) (arguing that disability implicates social issues beyond those associated with discrimination and stigma).

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Divider Title: _____

1:30-3:00 Friday
Concurrent Session

***Overcoming Obstacles in Public Sector
Decentralized Disability Management Programs***

Helping an employee return to work as quickly and as safely as possible is always the goal. But politically complex, decentralized public employers present challenging problems that require innovative approaches – especially when the administration of benefit plans cannot be fully integrated. Meet representatives from two large organizations that have met this challenge and who will share their “Top Ten” list of key strategies. Case studies will be featured.

Moderator: Kathryn Mulholland, PhD
Director, Off-Campus Programs, Department of Rehabilitation Counseling
Virginia Commonwealth University

Speakers: Martha M. Eichstadt
Interim Executive Director, Human Resources & Affirmative Action
University of Michigan

Bruce Y. Goya, MEd, CRC, CEAP
Manager, Faculty & Staff Support Systems
University of California/Office of the President

Beth J. King, RN, BSN, MA
MWorks Manager, Disability Management
MWorks Occupational Health & Disability Management, University of Michigan

Kathleen M. McLean, MS
Co-Manager, Vocational Rehabilitation Program
University of California, Davis

Barry J. Niman, MA, CRC, CDMS, CEAP, CCM
Employee Rehabilitation Program Manager
University of California, San Diego

LaVaughn Palma-Davis, MA
Administrator, Occupational Health
University of Michigan Hospitals & Health Centers

Martha M. Eichstadt is the Interim Executive Director of Human Resources & Affirmative Action at the University of Michigan. Previously, she was Director of the Benefits Office and has over 30 years of experience in the administration of benefits at the University of Michigan.

Bruce Y. Goya, MEd, CRC, CEAP is Manager, Faculty & Staff Support Programs at the University of California Office of the President. As such, he provides system-wide direction and support for the development of Work/Life and Disability Management programs at the University of California campuses, medical centers, and national laboratories. He also manages implementation of the insured disability income program, life insurance program, and behavioral

health care insurance programs. Mr. Goya holds a BA in Psychology and a Master's of Education in Rehabilitation Counseling from the University of Hawaii.

Beth King, RN, BSN, MA is Manager, Disability Management at MWorks Occupational Health Services in Ann Arbor, Michigan. She holds an MA in Health Education from Central Michigan University.

Kathleen M. McLean, MS is a vocational rehabilitation counselor who joined the University of California, Davis in 1992. She is currently co-manager of the Preventative Rehabilitation Program, a unit of Human Resources and Risk Management, which provides disability management services to faculty and staff. She is also Co-Chair of the Integrated Disability Management Committee at the University. Ms. McLean received her BA in Sociology and her MS in Counseling, Vocational Rehabilitation from California State University, Sacramento.

Kathryn Mulholland, PhD is Director of Off-Campus Programs in the Department of Rehabilitation Counseling at Virginia Commonwealth University. Previously, she has worked with integrated benefits, human resources, and vocational rehabilitation. Dr. Mulholland holds a BA in Psychology from San Francisco State University, an MS in Rehabilitation Counseling from California State University and a PhD from the United States International University.

Barry J. Niman, MA, CRC, CDMS, CEAP, CCM is Employee Rehabilitation Program Manager at the University of California, San Diego campus; he facilitates accommodation and retention of faculty and staff members with a wide variety of disabling medical conditions. As a Principal in his firm called Niman Consulting Services, Barry provides training, expert testimony, Americans with Disabilities Act Regulation Compliance Evaluations and Reviews, mediation services, and development of Disability Cost Management Systems. Mr. Niman holds a BA in Psychology from Northern Illinois University and an MA in Educational Leadership from San Diego State University.

LaVaughn M. Palma-Davis is an Administrator with MWorks in Ann Arbor, Michigan. As such, she is responsible for directing the development and service operations of all MWorks business units, including disability management, occupational health clinical services, health promotion, safety, and employee assistance programs. Ms. Palma-Davis holds a BS in Health Education from the University of Dayton and an MA in Public Health Education from Central Michigan University.

Overcoming Obstacles in Public Sector Decentralized Disability Management Programs

University of California

*20 Years of DM and Still
Learning*

Bruce Goya
Kathleen McLean
Barry Niman

Slide 4



**Introduction to the
University of
California**

Slide 5

Faculty and Staff Support Programs



- **Employee Assistance**
- **Work/Life**
- **Rehabilitation**

Slide 6

Presentation Topics



- **Overview**
- **Strategies that
Work**
- **Lessons Learned**

Slide 7

Overview of Services

- **Environmental Influences**
- **Activities**
- **Outcome Trends**

Slide 8

Kathleen McLean

Slide 9

Strategies that Work

- **Lead DM**
- **Communicate with Dr.**
- **Negotiate Accommodations**

Slide 10

Strategies that Work



- **Case Coordination**
- **Written Policies and Procedures**
- **Transitional Employment**

Slide 11

Strategies that Work



- **Separation if no Reasonable Accommodation**
- **UCD Docs Provide Care**
- **Fitness for Duty Evaluations**

Slide 12

Strategies that Work



- **Voluntary Wellness Program**
- **Systemwide Coordination and Data Collection**
- **Violence Prevention Committee**

Slide 13

Barry Niman



Slide 14

Lessons Learned



- Supervisors Hold the Keys to Success
- **Survivors Learn from Mistakes**
- Integrate Big and Little DM

Slide 15

Lessons Learned



- **Adapt to Each Culture**
- **Champions Aren't Essential**
- **Measure What You Manage**

Slide 16

Lessons Learned



- **Being Right Isn't Enough**
- **Money May Not Motivate**
- ***Occasionally*, a Cigar is Just a Cigar**

Slide 17

Conclusion



- **Focus on People to Avoid Burnout**
- **Focus on Systems and Politics to Achieve Long-term Change**

University of California Systemwide Data

This chart shows the number of cases at each UC location that met the eligibility requirements for UC Retirement Program , Workers' Compensation, and Prudential benefit income and identifies the dollar amount saved in each respective area. The data represents fiscal year 1994-1995.

	UCRP		WC		PRU		TOTAL \$ SAVED
	# CASES	\$ SAVED	# CASES	\$ SAVED	#CASEs	\$ SAVED	
UCB	12	\$318,549	47	\$752,000	8	\$120,000	\$1,190,549
UCD	64	\$1,248,052	30	\$480,000	51	\$765,000	\$2,493,052
UCI	-0-	-0-	-0-	-0-	11	\$165,000	\$165,000
UCLA	4	\$119,808	8	\$128,000	4	\$60,000	\$307,808
UCR	3	\$81,980	5	\$80,000	4	\$60,000	\$221,980
UCSB	1	\$71,200	27	\$432,000	14	\$210,000	\$713,200
UCSC	12	\$360,288	36	\$576,000	6	\$90,000	\$1,026,288
UCSD	19	\$349,103	15	\$240,000	53	\$795,000	\$1,384,103
UCSF	2	\$81,756	38	\$608,000	13	\$195,000	\$884,756
UCIMC	-0-	-0-	16	\$256,000	21	\$315,000	\$571,000
UCDMC	14	\$383,440	9	\$144,400	11	\$165,000	\$692,840
UCLAMC	5	\$128,000	1	\$16,000	-0-	-0-	\$144,000
UCSDMC	11	\$282,161	6	\$96,000	63	\$945,000	\$1,323,161
TOTAL	147	\$3,424,337	238	\$3,808,400	259	\$3,885,000	\$11,117,737
OP	5	\$120,000	9	\$144,000	3	\$45,000	\$309,000
TOTAL	152	\$3,544,337	247	\$3,952,400	262	\$3,930,000	\$11,426,737
LLNL*	15	\$360,000	22	\$352,000	26	\$390,000	\$1,102,000
TOTAL	167	\$3,904,337	269	\$4,304,400	288	\$4,320,000	\$12,528,737

*LLNL does not receive funding from University of California Retirement System

UC DAVIS COST of DISABILITY MANAGEMENT REPORT

FY 93-94

Revised 4/29/96

What is the Full Cost of Disability at Your Location?

Total Payroll: \$567,214,000. **Total Employees:** 14,460 (5,463 students)

Direct Costs of Disability

NonWorkers' Compensation Costs

Salary continuation/sick pay based on 70% use of sick time	<u>\$ 18,393,120.</u>
Employer paid short term disability	<u>\$ 1,060,475.</u>
Employer paid short term/long term disability settlements (Short term disability/long term disability -- Employee Paid) (Disability retirement - Systemwide)	<u>\$ 0.</u>

Workers' Compensation (WC) Costs

WC medical costs	<u>\$ 855,297.</u>
WC temporary disability	<u>\$ 154,853.</u>
WC permanent total/partial/awards	<u>\$ 391,736.</u>
Allocated Expenses	<u>\$ 145,567.</u>
WC Rehab	<u>\$ 39,487.</u>

Taxes and contributions for other government programs

Social Security taxes (employer share) .6% of FICA payroll	<u>\$ 3,403,284.</u>
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Administrative costs

Cost of administering non-Workers' Compensation claims	<u>\$ unknown</u>
Cost of administering Workers' Compensation claims A.R.M.	<u>\$ 775,780.</u>

Total Direct Costs	<u>\$ 25,219,599.</u>
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Covered Payroll =	<u>\$ 567,214,000.</u>
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Total Direct Costs ÷ Covered Payroll = .044 =	<u>4%</u>
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How Does This Compare with .04 or 4%, the Full Cost Study Average?

Hidden Costs of Disability

Total Direct Costs \$ 25,219,599.

Total Hidden Costs = (Total Direct Costs \$ 25,219,599 X .75) \$ 18,914,699.

Covered Payroll \$567,214,000.

Total Hidden Costs ÷ Covered Payroll = .033 = 3%

How Does This Compare with .03 or 3%, the Full Cost Study Average?

Disability Management Costs

Wellness programs \$ 70,000.

Employee assistance plans - ASAP \$ 171,831.

Medical clinics geared toward reducing disability - Employee Health \$ 197,782.

Employee safety program EH & S \$ 145,940.

Activities of claims management (Supervisors & Managers) \$ 1,725,200.

Workers' Compensation Unit \$ 284,703.

(Other Programs - Vocational Rehabilitation - funded by OP)

Benefits Counseling \$ 25,000.

Total Disability Management Costs \$ 2,620,456.

Total Disability Management Costs ÷ Covered Payroll =
.0046 or .46 %

How Does This Compare with .01 or 1%, the Full Cost Study Average?

Full Cost of Disability at Your Company

Total direct costs \$ 25,219,599.

Total hidden costs \$ 18,914,699.

Total disability management costs \$ 2,620,456.

Full Cost of Disability \$ 46,754,754.

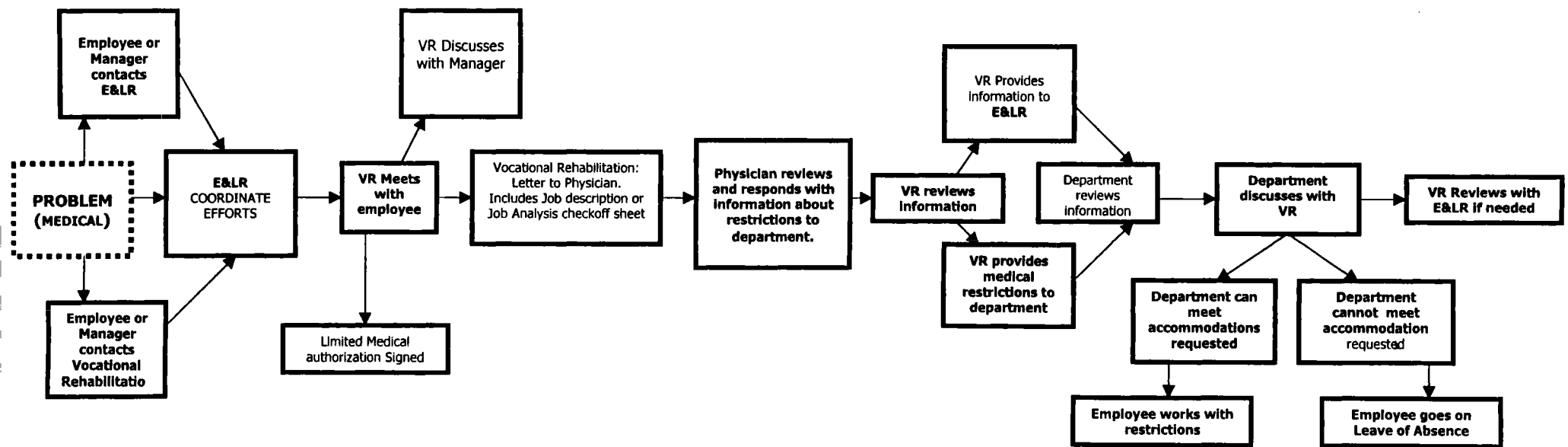
Covered Payroll \$567,214,000.

Full Cost of Disability ÷ Covered Payroll = .082 or 8.2%

How Does This Compare with .08 or 8%, the Full Cost Study Average?

PROCESS MAP

NON-INDUSTRIAL MEDICAL CLARIFICATION



UNIVERSITY OF CALIFORNIA PREVENTIVE REHABILITATION PROGRAM ANNUAL REPORT FORMAT

University Location: SANTA BARBARA
Fiscal Year: 98-99

I. CAMPUS POPULATION

A. Head count of academic employees: **1401** academic employees (includes faculty) in addition to **1390** student academic employees (e.g., Teaching Assistants, Graduate Student Researchers)¹

B. Head count of staff employees: **2929** staff employees in addition to **3534** student employees²

UCSB has approximately 4400 regular employees (academic and staff). In addition, there are 1390 graduate students who are considered academic employees and 3534 mostly undergraduate students who are considered non-academic employees.

II. CASELOAD

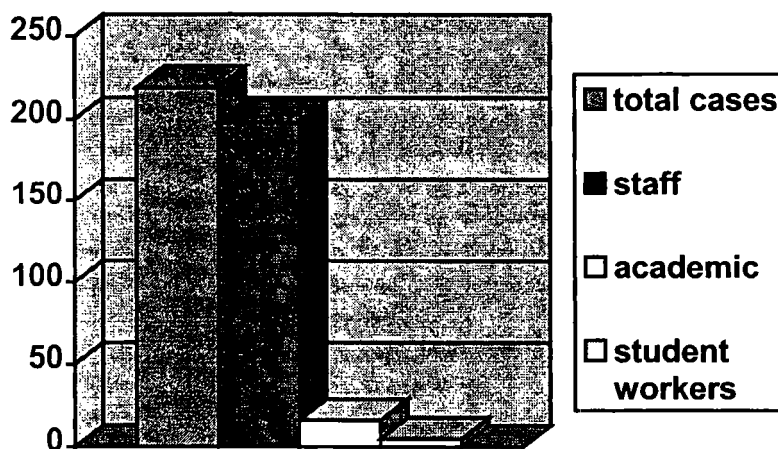
A. Total number of rehabilitation cases: **219** specific individual rehabilitation services provided to **185** employees

B. Academic: **16** (7 ladder faculty, 5 lecturers, 4 Graduate Student Researchers)

C. Staff: **198** (career and casual); **5** non-academic student workers

D. New cases: **210**

E. Continued from prior FY: **9**

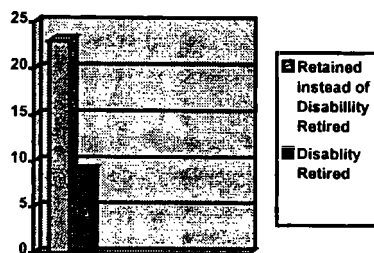


¹ Statistics obtained from Academic Personnel, UCSB, 2/25/99

² Statistics obtained from Human Resources Information Systems, UCSB Human Resources, 6/25/98

III. UC RETIREMENT PROGRAM

- A. Number of UCRP Disability Income applicants receiving rehabilitation services: **32** eligible employees³
- B. Number meeting all three conditions in footnote 3: **32**
- C. Number of faculty and staff meeting all three conditions provided with rehabilitation services and retained in employment: **23**
(9 applied for and were accepted for disability retirement)



RETAINED IN EMPLOYMENT

Academic/staff	Monthly Salary	Services Provided
Academic	\$5700	Accommodations
Academic	\$6167	Modified Job
Academic	\$3000	Accommodations
Academic	\$9600	Modified Job
Staff	\$2192	Alternate Work
Staff	\$2249	Modified Job
Staff	\$2338	Accommodations
Staff	\$2324	Modified Job
Staff	\$1850	Alternate Work
Staff	\$5450	Modified Work
Staff	\$2424	Modified Job
Staff	\$2024	Modified Job
Staff	\$2136	Accommodations
Staff	\$3431	Modified Job
Staff	\$2024	Modified Job
Staff	\$2668	Modified Job
Staff	\$2926	Modified Job
Staff	\$2324	Modified Job
Staff	\$2024	Modified Job
Staff	\$3014	Accommodations
Staff	\$3252	Modified Job
Staff	\$4844	Accommodations
Staff	\$3610	Modified Job
4 Academic; 19 Staff	\$77, 571/month total	

Note: Modified Job pertains to a work-related injury. Accommodations pertain to a non-work injury or medical condition. Alternate Work pertains to either a work-related or non-work injury or medical condition.

³ Employees with five or more years of service, potentially medically precluded from earning 50% of current salary, and with a disability expected to continue for more than one year.

IV. WORKERS COMPENSATION

- A. Number of PRM referrals to external rehabilitation services: **8** (approximation)
- B. Number of PRM referrals to internal rehabilitation program: **85**
- C. % of Workers Compensation cases referred by PRM to total caseload: **39%**⁴
- D. Number of employees with a claim successfully retained or returned to employment:
 - Those with a pre-QIW status: **42**
 - Those with determined QIW status: **15**

The occupations of the fifteen QIW's retained or returned to employment:

- 2 Groundskeepers
- Cook
- Salad Bar Coordinator
- Associate Director
- Small Engine Mechanic
- Professor
- Assistant Professor
- Lecturer
- Lab Assistant
- Manager
- Custodian
- Programming Assistant
- Carpenter
- Electronics Technician

- E. Number of referrals for Job Analysis only: **15**

V. EMPLOYEE AND EMPLOYER PAID DISABILITY PROGRAMS

- A. Number of cases receiving Liberty Mutual benefits: **10**
 - Those receiving UPD/EPD benefits (less than 6 months): **9**
 - Those receiving EPD benefits only (after 6 months): **1**
- B. Number of referrals from Liberty Mutual: **1**
- C. Number receiving benefits successfully retained or returned to employment: **1**
- D. Average total time off work: **10.2 weeks**

In spite of receiving only one formal referral from Liberty Mutual, the PRP program has been very proactive and has provided early return-to-work services to 6 employees who had been receiving disability benefits. In addition the PRP program was instrumental in obtaining alternate or modified work for 3 employees who had been receiving disability benefits.

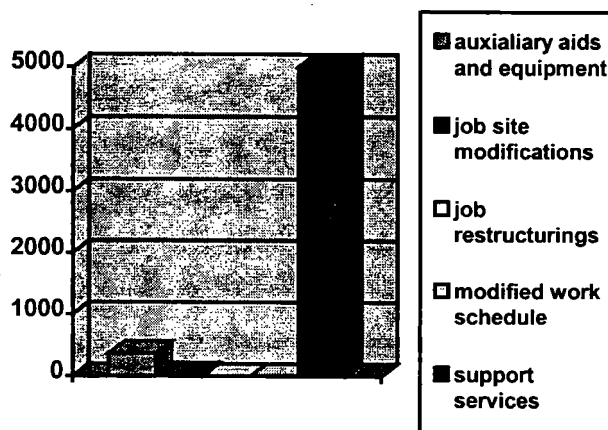
⁴ Referrals from PRM divided by total number of cases

VI. DISABILITY SERVICES PROVIDED

- A. Number of accommodations implemented: **34**
- B. Number of each type of accommodation implemented:
1. Auxiliary Aids and Equipment: **8**
 2. Job Site Modifications: **9**
 3. Job Restructurings: **11**
 4. Modified Work Schedules: **5**
 5. support services (readers, interpreters)⁵ : **1**
- C. Average cost of all accommodations: **\$279.00**

Note: *1 academic accommodation cost a total of \$5,000; if this one accommodation was factored out, the average cost of accommodations was \$132.00. The median cost of all accommodations was \$0.00.*

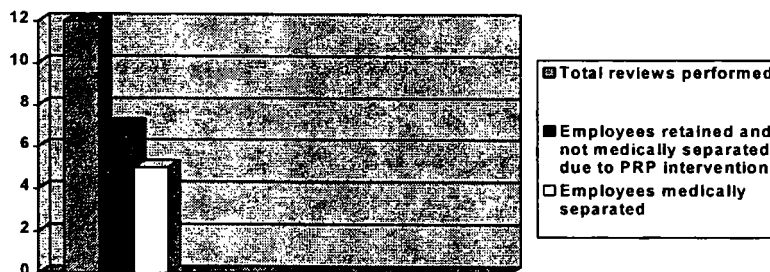
Average Cost



VII. MEDICAL SEPARATION

- A. Number of reviews performed : **12**
- B. Number medically separated: **5**
- C. Number of separations unnecessary due to an accommodation: **7**

Note: *The philosophy and practice of the PRP program is to become involved early in a situation where a department is considering requesting a medical separation. We then work with the employee and the department to develop accommodations or modifications to allow the employee to continue working. We were successful in this way seven times during this last year.*



⁵ Three employees had multiple accommodations provided

The job titles of the five employees medically separated were

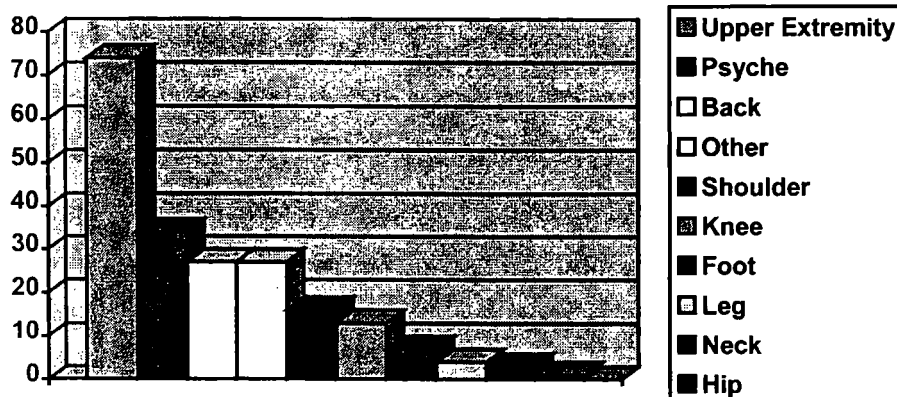
Automotive Mechanic
 Administrative Assistant II
 HVAC Welder
 Department Manager
 Biosafety Officer

The job titles of those who were retained as employees and not medically separated due to the intervention of the PRP program

2 Custodians
 Salad Bar Coordinator
 Lead Food Worker
 Lecturer
 Registrar's Assistant
 Electronics Technician

VIII. PRIMARY DISABLING CONDITION OF NEW AND CONTINUING CLIENTS (listed in order of prevalence):⁶

74 upper extremity
 34 psyche
 27 back
 27 other
 16 shoulder
 13 knee
 7 foot
 4 leg
 3 neck
 1 hip



⁶ Several employees had more than one primary disabling condition.

X. PROGRAM ACTIVITIES (NARRATIVE DESCRIPTIONS)

A. Prevention/Early Intervention

- The emphasis of the PRP at UCSB is prevention of injuries. The PRP works closely with Environmental Health and Safety to prevent injury and promote safety. During this past year, 64 workstation evaluations were performed by the PRP vocational rehabilitation counselor to prevent injury or further injury. Ongoing training in the Americans with Disabilities Act, ergonomics, and workplace safety is provided both formally and informally by the PRP.
- The administration of the Employer Paid Disability, Employee Paid Disability, Disability Retirement, Family Medical Leave and related laws support the PRP. Communication with the administration of these programs has resulted in early return to work and providing accommodations instead of Disability Retirement.
- The campus mediation program is presently administered through the PRP and two members of the PRP are trained mediators. Approximately 10 mediations per year are performed by the UCSB group of trained mediators.
- In conjunction with Risk Management and other interested campus parties, the PRP is involved in revamping the current Workers Compensation system at UCSB to make it more productive, more user friendly, provide more and better services as well as lower the costs of Workers Compensation at UCSB. As part of the Workers Compensation Work Group, the PRP has been involved in several meetings per month since February, 1999, to bring about process and correspondence improvement, forms review, and the development of a tracking system for Workers Compensation. The PRP is involved in developing methods to lower medical costs by partnering with local medical providers and providing training to high risk campus groups to reduce injuries.
- In cooperation with this revamping of Workers Compensation at UCSB, a more formal Transitional Return to Work Program was implemented by the PRP. This formal program (and computer tracking of this program) was begun during the last three months of the fiscal year. Thirty-three employees took part in this Transitional Return to Work Program at a cost savings of \$68,342.00 in Temporary Disability payments. This savings was achieved by early return to work of employees in a modified or alternate capacity. In addition to cost savings, it is our belief that this program has increased morale, maintained or improved productivity for campus departments, and kept injured workers part of the UCSB community, although these are not yet quantifiable. The PRP is also formalizing a process for temporary modified duty for non-industrially injured workers.
- A philosophy of the PRP is to develop relationships throughout the campus community and to work together with departments and other interested parties to retain our valued workers as employees of the University. This is accomplished by participation in cross-functional committees, providing training and input to campus employees and departments, and a redesign of correspondence sent to employees.

- Early intervention is provided to individuals in the Employer Paid Disability, Employee Paid Disability, and Disability Retirement programs, to provide return to modified or alternate work instead of medical separations and disability retirements. When employees at UCSB are medically separated or apply for disability retirement, every effort has been made to search for modified or alternate work by referrals to UCSB employment counselors, the Special Selection process, review and assessment of work skills and referral to the campus EAP program.
- The PRP has frequent consultations with the campus EAP program, benefits counselors, business services analysts, EH&S, the campus ADA coordinator, Labor Relations representatives and other parties.

B. Disability Services

- The PRP is establishing written guidelines, procedures and materials for employees with ADD or ADHD and Learning Disabilities.

C. Medical Separations

- The philosophy and practice of the PRP program is to become involved early in a situation where a department is considering requesting a medical separation. We then work with the employee and the department to develop accommodations or modifications to allow the employee to continue working. We were successful in this way seven times during this last year.

X. PROGRAM SHARED FUNDING

- A. Total Program Budget for fiscal year:
 - 1. Amount of Total Program Budget: **\$ 145,767**
 - 2. Cost Centers: UCRP, Campus Funds, PRP billing
 - 3. Total FTE: **1.5**
- B. Total recharged to PRM: **\$22,212**
- C. Total support from UCRP: **\$58,555**

UNIVERSITY OF CALIFORNIA
PREVENTIVE REHABILITATION PROGRAM
ANNUAL REPORT

UNIVERSITY LOCATION: San Diego

FISCAL YEAR: 1998-1999

I. CAMPUS POPULATION

- A. Head count of academic employees: **5,152**
- B. Head count of staff employees: **10,882**

II. CASELOAD

- A. Total number of rehabilitation cases: **206**
- B. Academic: **8**
- C. Staff: **198**
- D. New cases: **121**
- E. Continued from prior FY: **85**

III. UC RETIREMENT PROGRAM

Number of UCRP Disability Income applicants receiving rehabilitation services: **9**

- C. Number meeting all three of the following conditions: **9**
 - 1. Five or more years of service;
 - 2. Potentially medically precluded from earning 50% of current salary;

3. Disability expected to continue for more than one year.

D. Number of faculty and staff meeting all three above conditions provided with rehabilitation services and retained in employment. **2**

IV. WORKERS' COMPENSATION

Number of Professional Risk Management referrals for rehabilitation services: **109**

Number of Professional Risk Management referrals to internal rehabilitation program: **100**

Percent of Workers' Compensation Cases to total caseload: **48%**

Number of QIWs successfully retained or returned to employment: Information is not available.

V. EMPLOYEE AND EMPLOYER PAID DISABILITY PROGRAMS

Number of referrals from Liberty Mutual: **0**

Number receiving benefits successfully retained in or returned to employment: **39**

C. Average total time off work: **Data not Available**

VI. DISABILITY SERVICES PROVIDED

Number of accommodations implemented: **41**

Number of each type of accommodation implemented:

1. Auxiliary Aids and Equipment: **30**

2. Job Site Modifications: **5**

3. Job Restructuring: **10**

4. Modified Work Schedules: **9**

5. Support Services (readers, interpreters): **5**

C. Average cost of accommodation per case: **\$595.00**

VII. MEDICAL SEPARATION

Number of reviews performed: 16

Number medically separated: 16

Number of separations unnecessary due to an accommodation: 0

PRIMARY DISABLING CONDITION OF NEW AND CONTINUING CLIENTS (LIST IN ORDER OF PREVALENCE)

<i># of Clients</i>	<i>Primary Disability Type</i>
47	Orthopedic: Upper Extremity
32	Orthopedic: Lower Extremity
25	None: Preventive Workstation Evaluation
18	Psychological
17	Orthopedic: Back
13	Cumulative Trauma: Carpal Tunnel Syndrome
10	Cumulative Trauma: Tendonitis
5	Orthopedic: Cervical
4	Cancer
3	Cumulative Trauma: Dequervain Syndrome
2	Chemical Dependency
2	Visual Deficit
2	Respiratory Disorder
1	Acquired Immune Deficiency Syndrome
1	Arthritis
1	Asthma
1	Colitis
1	Cumulative Trauma: Epicondylitis
1	Cumulative Trauma: Thoracic Outlet Syndrome
1	Endometriosis
1	Gaucher's Disease
1	Migraine Headaches
1	Neurological Deficit
1	Pregnancy
1	Rheumatological Condition

1	Seizure Disorder
1	Stroke
1	Traumatic Brain Injury

IX. PROGRAM ACTIVITIES (NARRATIVE DESCRIPTIONS)

During Fiscal Year '98-'99 the staff of the Employee Rehabilitation Program have been involved in a wide range of activities designed to prevent impairment, facilitate return-to-work and retention, and to manage activities to ensure compliance with pertinent regulatory requirements. As part of a strategic planning process, we developed several goals. We targeted activities to enable us to progress in achieving our vision. The vision is to be a model disability prevention and management program that progressively develops and effectively provides exemplary services that demonstrate our commitment to:

- Valuing The Skills And Abilities Of People
- Preserving Expertise
- Enhancing Productivity

This Fiscal Year we progressed in our attainment of the following identified strategic goals:

- Simplify accommodation and medical separation processes;
- Enhance printed and web-based information resources to enable clients to independently learn about our services;
- Educate managers about proven methods to create and maintain healthful work environments;
- Respond to the recommendations of the UCSD Disability Management Process Review Team;
- Create simpler procedures for coordination of services to manage ergonomic risk factors;
- Increase the number of successful accommodations to retain qualified employees with disabilities.

Below I have listed activities that have contributed toward attainment of these goals.

A. Prevention/Early Intervention

In situations in which a case was not opened, we assisted 129 employees through individual resource consultations and recommendations to supervisors regarding reasonable accommodation alternatives, compliance with pertinent legislation and policy issues, and a variety of job retention and transfer efforts.

Trained 721 supervisors and staff members regarding the following:

- Americans with Disabilities Act
- Building Productivity
- Career Counseling For People with Disabilities
- Career Development & Planning
- Disability Management
- Enhancing Productivity
- Ergonomics
- Service Coordination
- Speech Recognition
- Supervisory Training Laboratory - Accommodation Responsibilities, and Employee Rehabilitation Program Services

Promoted an environment that fostered provision of services to enhance the productivity of staff and academic employees through the implementation of disability management system components;

Promoted services designed to use proven business management strategies to enable employees and supervisors to work cooperatively and sensitively towards resolution of issues associated with medical impairments;

Managed services as Americans With Disabilities Act Advisory Committee Chair and Americans With Disabilities Act Coordinator to ensure programmatic and facility access for staff, faculty, students, and visitors with disabilities;

Participated in the development of our response to the Office of Civil Rights regarding a graduate student who alleged discrimination by faculty members of the Graduate School;

Contributed to the success of Career Connection by designing and delivering the Career Planning Introductory Module;

Expanded the scope of training presentations to attract more staff, faculty, and students to educational opportunities regarding people with disabilities and regarding disability management;

Educated Campus community members about Medical Leave of Absence, Medical Separation, Accommodation, and Disability Management Procedures;

Achieved excellent organizational climate assessment ratings;

Contributed to efforts to achieve a diverse workforce through consultations with the Director of Equal Opportunity, Staff and Affirmative Action;

Enhanced coordination of responsibilities to ensure facility, program, and activity access and equal employment opportunity for people with disabilities as UCSD Disabilities Act Coordinator;

Developed work accommodation and work injury prevention funding proposals in cooperation with ERGO Team and ADA Advisory Committee members;

Participated actively on the Disability Management Process Review Team, the Ergonomics Team, and the Business Affairs Diversity Committee to create novel approaches to improve existing processes;

Fostered partnerships with Employee Relations, Faculty Staff Assistance Program, Policy and Quality of Work Life, Community Advocates for Disability Rights and Education (CADRE), Career Services, and representatives from large departments to develop innovative methods to achieve increased emotional well being on the job for employees and supervisors

B. Disability Services

Performed 79 Job Analyses to contribute to determinations of job-related injuries and illnesses, accommodations, and placement in alternate or modified positions.

Completed 24 Workstation Evaluations and provided suggestions for work habit, task, and workstation modifications to enable employees to work productively.

Provided a range of disability management services to employees, supervisors, and managers, and achieved satisfactory or above ratings on point of service evaluations from 98.2% of responding clients.

In the annual UCSD Customer Satisfaction Survey process achieved overall satisfaction ratings of 4.1 on a five-point scale from Academician customers and a rating of 3.5 on the same scale from Administrative customers.

Focused service and educational efforts on results oriented approaches designed to save financial and human resources and to ensure informed decisions in compliance with pertinent regulations;

Worked diligently to develop collaborative agreements with Risk Management and Professional Risk Management;

Enhanced opportunities for coordination of case management and service delivery options with Claims Professionals of Liberty Mutual Insurance Company;

Achieved excellent return on investment of Program funding;

Enhanced access to accommodation and assistive technology for supervisors and employees;

Provided effective and supportive counseling to supervisors and employees;

Led efforts to evaluate the effect of medical impairment on the safety and welfare of employees as the designated UCSD Medical Review Officer;

C. Medical Separations

Consulted with supervisors, administrators, managers and employees regarding possible accommodation alternatives to determine if reasonable accommodations could be implemented as an alternative to reviewing a medical separation request. Upon receipt of medical separation review requests, provided final analysis of accommodation efforts to ensure compliance with pertinent policies and regulations.

Consulted with departments and Violence in the Work Place Intervention Team members to determine employees' fitness for duty.

Fostered successful placements and job accommodations to achieve retention;

Revised administrative procedures to meet changing legislative regulations and case law implications;

Presented information in the Supervisory Training Laboratory, Occupational Ergonomics, and the Americans with Disabilities Act courses offered through Staff Education and Development to foster effective decision-making;

Simplified accommodation and medical separation review process in collaboration with department MSO's.

Managed complex and controversial medical separations and accommodation issues and avoided potential adverse actions related to grievances, lawsuits, complaints, or illegal discrimination claims;

D. Conclusion

During this fiscal year, we have provided a range of services to internal and external customers in a variety of complex, and at times, difficult situations. We have demonstrated our commitment to provide client-centered services in an honest and ethical manner. These services have contributed to a limited number of grievances, administrative reviews, and other legal actions being filed due to perceived instances of illegal discrimination. Also, the provision of these services has contributed to the reduction of lost time, to retention of knowledgeable and well-skilled employees, and to productivity enhancements.

X. **PROGRAM SHARED FUNDING**

A. Total Program Budget for fiscal year:

1. Amount of Total Program Budget: \$ 292,590.52

2. Cost Center(s):

University of California Retirement Program - \$75,768.00

UCSD Campus Funding - \$167,187.52

Professional Risk Management - \$49,000

3. Total FTE: 4.0

B. Total Recharged to Professional Risk Management: \$49,000.00

C. *Total support from UCRP: \$75,768.00

*(Support from UCRP will fund no more than the salary and benefit costs for one counselor at each campus or medical center.)



Goals and Objectives of the Ergonomics Review Guidance and Options Team

1. Foster communication among different departmental experts.
2. Disseminate information among departments.
3. Integrate consistent information and coordinate procedures.
4. Evaluate new or existing ergonomic products and vendors.
5. Reduce number of work related repetitive stress injuries by educating employees and evaluating workstation designs.
6. Determine ways and methods of funding to accommodate employees.
7. Propose incentives for managers to utilize ergonomically appropriate equipment, workstation design, work practices and employee training.
8. Provide continual training for workstation evaluators.

UCSD Ergonomics Program

1. Ergonomics Review, Guidance, & Options Team
2. Identifying High Risk Individuals & Jobs
3. Ergonomics Evaluation
 - a. Job Task
 - b. Work Habit
 - c. Work Station Configuration
4. Training
 - a. Staff Education
 - b. Departmental Level
 - c. Job Classification
5. Ergonomic Showroom
6. Equipment Loaner Service
7. Matching Fund
8. Ergonomic Follow-up Questionnaire

13Th Annual National Disability Management Conference

**Overcoming Obstacles in Public Sector Decentralized
Disability Management Programs**

Friday, October 29, 1999

The University of Michigan Experience

Presenters: Marty Eichstadt, Executive Director of Human Resources and Affirmative Action, University of Michigan; Beth King, Manager of Disability Management, MWorks; LaVaughn Palma-Davis, Director, MWorks

- I. Background on the University of Michigan
- II. Existing Partnerships to Effectively Address Disability Management
- III. Results of Early Work (Workers Compensation and Non-Occupational Pilot Project)
- IV. How We Got Started Developing the Integrated Disability Management Program (IDMP)
- V. What We Did to Gain Buy-In
- VI. Obstacles and Barriers; How They Were Overcome
- VII. Description of the Work~Connections Program (IDMP)

Early Work Done in Workers Compensation, 1997

- Risk Management
- MWorks Employee Health Service
- MWorks Ann Arbor Clinic
- Pro-Active, Intensive Case Management

Results

- Indemnity (Lost Wages) Paid Decreased over 40%
- Medical Costs Decreased over 30%
- Legal Paid Decreased over 30%
- Ratio of Medical Only to Lost Time
 - Hospitals & Health Centers from 8:1 to 11:1
 - Ann Arbor Campus from 11.5:1 to 14.5:1

Plant Pilot '97-98

Integration began

- Coordination with other Benefits/Services
- Medical Case Management
- Return to Work for Work-Related and Non-Occupational
- Significant Savings

Return to Work Efforts

- Campus
- Housing
- Hospitals and Health Centers

Case Study



How We Got Started

*Marty Eichstadt, Director
Human Resources/Affirmative Action*



"The Form"
Benefits & Risk Management

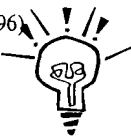




How We Got Started

Why We Thought We Needed "The Form"

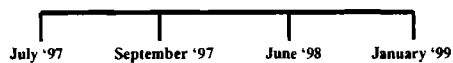
- ✓ Managed Care Programs ('90's)
- ✓ Workers' Compensation Focus Groups ('94-'95)
- ✓ M-Works ('96-'97)
- ✓ Medical Center "Cost of Care" Study ('96)
- ✓ Combined Time Off Plans ('96)





How We Got Started

- ✓ Concept Paper & Meeting (July '97)
- ✓ IDMP Work Group Formed (September '97)
- ✓ Business Plan (June '98)
- ✓ Implementation (January '99)





What We Did To Gain Buy-In

- ✓ Concept Paper
- ✓ Education of Leadership
- ✓ Cross Functional Work Team
- ✓ Surveys
- ✓ Focus Groups
- ✓ Business Plan Approved by CFO & Provost
- ✓ Plant Pilot Project Model
- ✓ Meetings With Unions
- ✓ Communications





Obstacles/Barriers

- Turf
- Data
- Benchmarking/Metrics
- Model
- Staffing
- Communications
- Systems Support
- Policies (lack of)
- Confidentiality Issue
- Change of Culture





Overcoming the Obstacles/Barriers?

- ✓ Committed Leadership
- ✓ Determination of the Work Group
- ✓ Willingness to Accept Change
- ✓ Understanding of Alternatives
- ✓ Keeping Issues in Front of Group
- ✓ Diversity of Work Group
- ✓ Communication to Constituents
- ✓ Good Program!





Work~Connections

(Established 1999)

✓ Mission Statement

To provide a faculty/staff-centered, best practice, occupational and non-occupational managed disability program.

"The Work~Connections team will assist you in a caring and supportive way when you experience an illness or injury, either work-related or non-work-related. Work~Connections assistance continues through your recovery and safe return-to-work."



Work~Connections

✓ Team Structure: Two teams with support specialists to provide services to the Campus & Medical Center



Each team consists of:

Intake Coordinator
Nurse Case Manager,
Claim Consultant;

Support consists of:

Workers' Compensation
Specialist,
Return-to-Work Coordinator,
Clerical Staff and Manager



Work~Connections

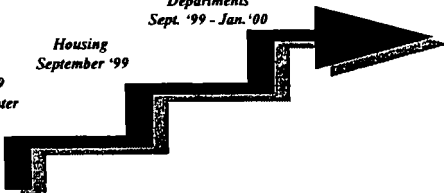
- ✓ Mission Statement
- ✓ Team Structure
- ✓ Nurse Case Manager
- ✓ Ramp - Up



Remaining
Departments
Sept. '99 - Jan. '00

Housing
September '99

January '99
Medical Center
& Plant





Work~Connections

- ✓ Mission Statement
- ✓ Team Structure
- ✓ Nurse Case Manager
- ✓ Ramp - Up
- ✓ Staffing
- ✓ Reporting

Work~Connections
is the joint responsibility
of Staff Benefits
and Risk Management



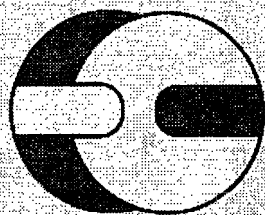


Work~Connections

- ✓ Mission Statement
- ✓ Team Structure
- ✓ Nurse Case Manager
- ✓ Ramp - Up
- ✓ Staffing
- ✓ Reporting
- ✓ **Budget**

Our "Business Plan" was approved at a funding level of \$750,000. More than half of the staff were already in the Workers' Compensation Unit





Work~Connections



UNIVERSITY OF MICHIGAN

team will assist you in a caring and supportive way when you experience an illness or injury, either work-related or non-work-related. Work-Connections assistance continues through your recovery and safe return to work.

Work-Connections
University of Michigan
2072 Administrative Services Building
1009 Greene Street
Ann Arbor, MI 48109-1432

ANN ARBOR
(734) 615-0643

TOLL-FREE
1-877-869-5266 (UMWKCON)

FAX
(734) 936-1913

EMAIL
Work.Connections@umich.edu

WEB SITE
<http://www.umich.edu/~connect>

Work~Connections Program

Faculty and Staff Centered Approach	2
Reporting an Illness or Injury	
Work-related illness or injury	2
Non-work-related illness or injury	2
Cost of the Program	3

Confidentiality 4

When and How to Report Your or Your Employee's Illness or Injury to Work~Connections 5

What Happens When You Call Work~Connections

Your Supervisor or You Report an Illness or Injury	6
During Recovery	6
Return-to-Work Plan	6

Glossary 7

*Dear Faculty, Staff
and Supervisors
at the University of Michigan:*

We are pleased to announce Work-Connections, an integrated disability services program designed to assist and support you when you experience an illness or injury, either work-related or non-work-related. Work-Connections offers you "one-stop" access to University services that continues through your recovery and safe return to work.

Work-Connections is jointly sponsored by Risk Management and Human Resources & Affirmative Action, and is provided at no cost to all University of Michigan faculty and non-student staff members. This booklet contains information to help you access its services.

Work-Connections will be implemented in phases. Phase I begins December 1, 1998, and includes the Plant Department and the UMHS. Phase II begins in early 1999, and involves the Housing Division. The rest of the University will implement the program over the coming year.

There are two important changes to remember. All work-related illnesses and injuries must be reported to Work-Connections beginning December 1, 1998. All non-work-related illnesses and injuries must be reported to Work-Connections beginning on the date when your department phases in the Work-Connections program.

We invite you to call or email the Work-Connections staff with any questions you may have on accessing its services, what to expect when you do so, and how the program can assist you. We look forward to providing this confidential, comprehensive service to the University community.

Norman G. Herbert
Associate Vice President and Treasurer, Office of
the Executive Vice President and Chief Financial Officer

Jackie R. McClain, B.S., J.D.
Executive Director, HR/AA

Work~Connections



Confidentiality

Health information you or your department provides to Work-Connections remains confidential. We follow appropriate medical ethics and all information is handled in accordance with the program.

Work-Connections is an integrated disability services program designed by the University of Michigan to assist and support you when you experience an illness or injury, during the subsequent recovery, and through your successful return to work. Work-Connections services are available to **all faculty and non-student staff** of the University of Michigan for work-related or non-work-related illness or injury.

The Work-Connections team cooperates with other programs and services within the University to help you and your supervisor receive needed or related services when you are ill or injured. Offices and services that coordinate with Work-Connections include your home department, Risk Management, Human Resources, the Benefits Office Long-Term Disability program, Employee Rehabilitation Program, MWorks, Employee Health Service, the HR/AA Faculty and Staff Assistance Program (FASAP) and the UMHS Employee Assistance Program, as well as Occupational Safety and Environmental Health (OEH).

Faculty and Staff Centered Approach

"Faculty and staff centered" means Work-Connections provides services that consider your needs as well as the University's need for a healthy and able workforce, and provides the necessary services to meet those needs in a consistent, customer service-based approach that is committed to your well-being and productivity.

To assist and support you during an illness or injury, Work-Connections provides:

- Confidentiality;
- Trained professionals who are available to help you, including registered nurses, occupational therapists, vocational rehabilitation counselors, consulting physicians, and others;
- A centralized support team — you can reach all the University services you need during your recovery and return to work through your Work-Connections team;
- Continuity and on-going contact — your team works with you and your supervisor through your recovery and return to work;
- Consistent services and results for you and all faculty and staff;
- Return-to-work support, such as accommodations, job analysis, and ergonomic consultation, if you need it;
- Equal access to services; and
- A qualified professional to coordinate all necessary and useful services you need, and ensure their delivery.

Reporting an Illness or Injury

Work-related illness or injury

Beginning December 1, 1998, all work-related illnesses and injuries in all departments at the University must be reported to Work-Connections.

Non-work-related illness or injury

When a department phases in the Work-Connections program, reporting of non-work-related illnesses and injuries to Work-Connections begins.

Sick Time

If you are a faculty or staff member eligible for standard sick time, you will be referred to Work-Connections after 10 consecutive days of absence from work as a consequence of a non-work-related illness or injury. The 10 days is defined as 80 hours, pro-rated for part-time, or a total of 10 days of intermittent absences in a three-month period due to a chronic condition. Your supervisor is responsible for reporting your illness or injury to Work-Connections.

Paid Time Off

If you are a faculty or staff member eligible for the UMHS Paid Time Off program or other paid time off programs implemented elsewhere in the University, you will be referred to Work-Connections after 10 consecutive days of absence from work (as defined above), as a result of a non-work-

related illness or injury. Your supervisor is responsible for reporting your illness or injury to Work-Connections.

Sick Time and Paid Time Off—Reporting Earlier

In certain circumstances, your supervisor or you may report your illness or injury to Work-Connections prior to 10 days. For example, reporting may be earlier (1) if it is known that you will be absent for 10 days or more, (2) if you might benefit from Work-Connections assistance during the first 10 days of absence, or (3) if you request that your illness or injury be reported immediately.

Cost of the Program

There is no cost to you when you use Work-Connections services. The University provides the program to all faculty and non-student staff.

Who Can

Access Help

from Work-

Connections?

All regular and
non-student
staff members
who work for the
University of
Michigan can

access assistance
and support
from the Work-
Connections team
when an illness
or injury occurs,
during the
recovery and
the return-to-
work period.

Work-Connections
is a free, confidential service
that provides support and
assistance to faculty and
non-student staff members
who are experiencing a
work-related illness or injury.

Work-Connections is a free, confidential service that provides support and assistance to faculty and non-student staff members who are experiencing a work-related illness or injury.

Work-Connections is a free, confidential service that provides support and assistance to faculty and non-student staff members who are experiencing a work-related illness or injury.

Confidentiality

Health information you or your treatment professionals provide to Work-Connections remains confidential. Maintaining appropriate confidentiality of health information is a fundamental principle within the program. Your health information will be released **only** in the following circumstances:

- With written authorization from you;
- When a strict need to know is established;
- When your or your co-workers' safety may be at risk; or
- To comply with the Worker's Compensation law.

The University recognizes that you may voluntarily choose at any time to discuss a medical situation with your supervisor or co-workers. This is a personal choice which, in many cases, may lead to a great deal of support and encouragement.

Your health information belongs to you, and the University will guard it appropriately. This means that:

- Medical information will be kept secure, private, and out of public view.
- Computer records will be protected.
- Work-Connections staff will not discuss any medical issues in public areas.

When and How to Report

Your or Your Employee's Illness or Injury to Work~Connections

Your supervisor is responsible for reporting your illness or injury to Work~Connections.

When to Report	Notify your supervisor on the first day of the illness or injury, or your first day of absence, according to your department's policy.	Report all work-related illnesses or injuries to Work~Connections within 24 hours.	Report the illness or injury to Work~Connections after 10 consecutive days of absence (80 hours, pro-rated for part-time, or a total of 10 days of intermittent absences in a three-month period due to a chronic condition).
When to Report Earlier than 10 Days	You may request assistance prior to the 10 th consecutive day of absence, if you wish.	Report all work-related illnesses or injuries to Work~Connections within 24 hours.	• If it is known that the employee will be absent at least 10 consecutive days; or • The employee could benefit from interaction with Work~Connections prior to the 10th consecutive day of absence; or • The employee requests assistance from Work~Connections prior to the 10th consecutive day of absence.
How to Report	Not applicable.	• Complete the Report Form and mail or fax it to Work~Connections; or • Call the Work~Connections program and provide the information by telephone; or • Email the information to Work~Connections; or • Complete and send the Report Form on the Work~Connections Web site.	• Complete the Report form and mail or fax it to Work~Connections; or • Call the Work~Connections program and provide the information by telephone; or • Email the information to Work~Connections; or • Complete and send the Report Form on the Work~Connections Web site.
If Medical Treatment is Needed	If desired, request assistance from Work~Connections.	Refer the employee for medical treatment to one of the University's designated treatment facilities for work-related illness or injury. See page 7.	Not applicable.

What Happens

When you call

Work~Connections

Each person's circumstances are different. The range of services below was designed to allow a caring and supportive response to each individual's needs. While all these services are offered and available to any participating faculty or staff person who needs or requests them, you may not need or want all of these services.

Your Supervisor or You Report an Illness or Injury

When you are ill or injured, your supervisor is responsible for reporting that to Work-Connections. However, if you feel that you could benefit from assistance from Work-Connections, you may call the program directly. When your illness or injury is reported, Work-Connections staff will:

- Take basic information regarding your illness or injury;
- Mail information to you regarding the program and how it can help you;
- Review your needs and requests;
- Review your supervisor's needs and requests; and
- Review your medical condition.

During Recovery

Work-Connections staff will assist and support you and your supervisor in the following ways during your recovery:

- Contact you and your supervisor on an "as needed" basis;
- Facilitate communication with your physician and other health care providers and assist you in understanding the options available to you;
- Respond to your department's concerns;
- Consult with your doctor and discuss your diagnosis;

- Help evaluate what is required for your job and whether you need assistance when you return to work; and
- Assist you with benefit and employment questions.

Return-to-Work Plan

When you are able to return to work, Work-Connections staff will assist in the following ways:

- Develop and discuss a return-to-work plan with you, your supervisor and your physician;
- Maintain regular contact with you to oversee the success or status of your return-to-work plan;
- Advocate on your behalf to help resolve any issues that arise when you return to work;
- Explore with you whether you need assistance to help facilitate your return-to-work plan from other University resources such as the Employee Rehabilitation Program, the HR/AA Faculty and Staff Assistance Program (FASAP), or the UMHS Employee Assistance Program;
- Provide appropriate updates to you, your supervisor and your physician, as needed;
- Provide health resources information to you, as needed;
- Follow up on your medical progress and assist you with any medical issues after you return to work.

Reporting
All non-work-
related illnesses
and injuries must
be reported to
Work-Connections
beginning on the
date when your
department
clears to the
Work-Connections
program



Below are definitions or descriptions for some terms that appear in this booklet.

Chronic Condition

A chronic health condition is one that continues for an extended period, such as three months or longer, or recurs often.

Designated Treatment Facilities for Work-Related Illness or Injury Only

If you become ill or are injured at work, the University of Michigan will refer you to one of the designated treatment facilities listed below. For a work-related illness or injury, you need to seek treatment at one of these facilities in order for the cost to be covered.

MWorks Ann Arbor Clinic

2098 South Main Street
Ann Arbor, MI 48109-5827
(734) 763-7758

MWorks Employee Health Service (UMHS employees only)

1500 East Medical Center Drive
Ann Arbor, MI 48109-0838
(734) 764-8020

UMHS Emergency Department

(after clinic hours or on weekends)
1500 East Medical Center Drive
Ann Arbor, MI 48109-0303
(734) 936-6666

Employee Rehabilitation Program

The program is open to all faculty and staff at the University. The rehabilitation program assists the faculty or staff member to remain on the job or return to employment when a physical or emotional condition has interfered with his or her ability to work. The program offers individual consultation on a

number of levels. It approaches each problem on a case-by-case basis. The counselors can help determine the appropriateness of vocational rehabilitation efforts, recommend and coordinate job accommodations, and coordinate strategies to help the staff member return to work. The program also refers individuals to other programs and resources, even to outside agencies when warranted.

Employee Assistance Programs

The HR/AA Faculty and Staff Assistance Program (FASAP) serves central campus, and the UMHS Employee Assistance Program serves UMHS faculty and staff members. Employee assistance programs provide counseling and other assistance to faculty and staff who have a need for confidential information when they experience persistent and potentially troublesome personal problems, such as alcohol, drugs, marital strife, financial and emotional difficulties. There is no cost for the services provided directly by either office.

Long-Term Disability (LTD)

Long-Term Disability is a benefit plan that provides continued salary and benefits to eligible regular faculty and staff who (1) are enrolled, and (2) are unable to perform work of any kind for a period of at least 12 months. This benefit is not automatic. Faculty and staff who are covered by this benefit must file a claim and be approved for the benefit on the basis of their medical condition.

Phase II

Antismoking

Work-Related Illness or Injury Only
The implementation of phases II and III begins December 1, 1995, and includes the Plant Department and the UMHS. Phase II begins in early 1996, and involves the Human Resources Division. The rest of the University will implement the program over the coming year.

Call for assistance
Supervisors are responsible for reporting faculty and staff illness and injuries to the UMHS. However, you may call the program directly for assistance.

Managed Care

In a managed care environment, your primary care physician is responsible for directing all your health care, including treatment and referrals to specialists.

MWorks

MWorks is the comprehensive occupational health and disability management program of the University of Michigan Health System (UMHS). MWorks provides services for health promotion, occupational medicine and disability management. Preventing illnesses and injuries and helping faculty and staff return to work and sustain successful employment are key features of the MWorks program.

Non-Work-Related or Non-Occupational Illness or Injury

A non-work-related, or non-occupational, illness or injury is one that is *not* related to, or caused by, the work you do.

Paid Time Off

Paid Time Off is a time off plan provided to many UMHS employees which combines short-term sick time, vacation time and season days in one bank of time. In July 1999, employees represented by AFSCME will be covered by a PTO plan which is slightly different than the UMHS plan.

Regular Faculty and Non-Student Staff

At the University of Michigan, you are considered to be on a "regular" appointment if you have at least a 20% appointment.

Risk Management

Risk Management, in cooperation with the total University community, works to minimize the adverse effects of losses due to accidents or other events that may be inflicted upon the people or physical assets of the

University. To protect against losses, Risk Management (1) identifies and analyzes risk; (2) develops and implements loss funding and risk financing mechanisms; (3) eliminates or minimizes risk; and (4) provides claims control and litigation management.

Sick Time

Short-term sick time

Non-bargained-for faculty and staff. Short-term sick time refers to the 15 days sick time for full-time employees allowed each year for each faculty or staff person at the University, except those who are in the Paid Time Off program.

Bargained-for staff. Your short-term sick time is defined in your contract.

Extended sick time

Non-bargained-for faculty and staff. Extended sick time refers to a University of Michigan program that provides for payment of 100% of your salary during the first six months of your recovery from an illness or injury, and 50% of your salary during the second six months of your recovery.

Bargained-for staff. Your extended sick time is defined in your contract.

UMHS

University of Michigan Health System.

Worker's Compensation

The State of Michigan Worker's Compensation Act prescribes benefits available to you if you experience a work-related illness or injury.

Work-Related or Occupational Illness or Injury

Work-related, or occupational, refers to an illness or injury that arises out of or during the course of your employment.

Accuracy of Information

Every effort has been made to ensure the accuracy of information in this booklet. If you have questions about current practices and procedures, consult the Director of Work-Connections.

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Work-Connections is jointly sponsored by Risk Management and Human Resources & Affirmative Action.

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Affirmative Action Statement

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16

Divider Title: _____

1:30-3:00 Friday
Concurrent Session

***Early Detection of Emergent Behavior: the
Implications for Mental Health at Home and Abroad***

Disorders such as situational or clinical depression cost companies billions of dollars each year in medical expenses, lost productivity, staff attrition, and workplace violence. Yet psychiatric claims are often inadequately documented, met with skepticism and limited in duration by policy. And the causes, symptoms, and coping mechanisms can vary culturally, along with the stigma attached to the disorder. Learn how new concepts of prevention and accommodation in the global workplace environment can positively affect outcomes.

Moderator: Veronica Vaccaro Goff, MS
Vice President
Washington Business Group on Health

Speakers: Janet Barbara Bein, MS, MFCC, CEAP
Regional EAP Manager
Levi Strauss & Co.

Thomas J. O'Connor
Director, Disability Management
PRS Disability Management

Darrel A. Regier, MD, MPH
Associate Director, Epidemiology & Health Policy Research
National Institute of Mental Health

Janet Barbara Bein, MS, MFCC, CEAP is a Regional Employee Assistance Program Manager for Levi Strauss & Co. in San Francisco, California. In this capacity, she provides comprehensive EAP, preventive care, mental health, and chemical dependency expertise through consultation to management and EAP clinicians throughout the U.S. She co-produced and directed an educational HIV/AIDS video entitled "The Changing Face of AIDS: A Global Epidemic" which was presented at the 1998 World AIDS Conference in Geneva, Switzerland. Ms. Bein holds a BA in Sociology from New York University and an MS in Clinical Counseling from California State University.

Veronica Vaccaro Goff, MS is Vice President of the Washington Business Group on Health, a non-profit policy research and education organization whose membership represents Fortune 500 companies and large public employers. She has lead the Health & Productivity Management Initiative and Workplace Depression Program and provided strategic leadership on mental health, consumer education, and information technology and health care delivery. Ms. Goff received her degrees from Southern Illinois University.

Thomas J. O'Connor is the Director of PRS Disability Management, a nationally recognized leader in psychiatric disability management which specializes in mental health-related disability, return to work, and cost containment. Mr. O'Connor holds a Master's degree in Psychiatric Rehabilitation from the University of Maryland.

Darrel A. Regier, MD, MPH is the Associate Director for Epidemiology & Health Policy Research at the National Institute of Mental Health. In this position, he is responsible for integrating research information to address major mental health policy issues facing the nation; he has been asked to lead a Workgroup of the National Advisory Mental Health Council to develop a Congressionally-mandated report on the effect of parity legislation and managed care on access, use, cost, and quality of mental health services. Dr. Regier is a psychiatrist who received his medical training from Indiana University School of Medicine.

Disability Orientation to Behavioral Risk Management

Thomas J. O'Connor, M Ed, CRC
PRS Disability Management
www.psychdismgmt.com

Washington Business Group on Health
October 29, 1999

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1

Necessity of Behavioral Risk Management

- ◆ **Depression Research (Greenburg, Kessler, UNUM/Salkever)**
- ◆ **Escalating Mental Health Related STD/LTD Claims**
- ◆ **Response-Oriented Managed MH System Does Not Address or Reduce Disability**
- ◆ **Escalating Lost Productivity, Employee Management, and Attrition costs**

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Devising a Disability Orientation to Behavioral Risk

- ◆ **When Does Emergent Behavior Require a Disability Intervention?**
- ◆ **What are the Disability Characteristics of a Clinical Behavioral Profile?**
- ◆ **What are the Risk Management Considerations for This Employee?**
- ◆ **What is a Disability Management Intervention for This Employee?**

When Does Emergent Behavior Require a Disability Intervention?

- ◆ **Persistent in Nature and Not Situational**
- ◆ **Employee Behaviors Impact Work Culture Dynamics (Morale, Productivity, etc....)**
- ◆ **Employee is Unaware or in Denial of its Impact and Features (Inappropriate, Not Reality-Based)**

Disability Characteristics of a Clinical Behavioral Profile

- ◆ **Diminished Role Functioning *and Ability to Maintain a Professional Identity***
- ◆ **Persistent Cognitive Impairment in Task Management and Completion**
- ◆ **Poor Responsiveness and Adaptive Coping to Diminished Capabilities**

Risk Management Considerations for This Employee

- ◆ ***Almost Never* Discloses Diminished Capacities or Disability Identity Prior to a 'Crisis' Point**
- ◆ **More Likely Than an Employee with a Physical Disability to File a Grievance to Counter Employer Unresponsiveness or Perceived Discrimination**
- ◆ **Linked Directly to Lost Productivity and Employee Management Costs**

Risk Management Considerations for This Employee (cont'd)

- ◆ **More Likely to Utilize STD and LTD**
- ◆ **More Likely to Have a Prolonged Absence Following an Occupational Injury (WC)**
- ◆ ***Most* Likely Not to Return-to-Work When Disability is Managed Passively**

Disability Management Intervention for This Employee

- ◆ **Step 1. Develop a *Disability* vs. Clinical Orientation to the Employee**
 - **The Employee's Ability to Perform a Work Role is Dependent on Learning/Practicing a Sophisticated Set of Adaptive, Cognitive, and Social Skills**
 - **This Functional Skill Set is Enhanced or Diminished as the Employee is Exposed to Various Stressors**
 - **Re-Define the Employee As Having a Measurable Skill Set vs. a Symptom Profile**

Disability Management Intervention for This Employee

- ◆ **Step 2. Develop and Implement a Rapid Response Plan**
 - Assess Occ. Health/Vendor/HRM Capabilities
 - Define Competency-Based Role Collaborations
 - Develop Skills-Oriented and Behavior-Based Employee Management Plans
 - Provide Behavioral Coaching Resources to Employees
 - Identify and Plan for “What if” STD/LTD Scenarios

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Disability Management Intervention for This Employee

- ◆ **Step 3. Develop a Risk Management Performance Assessment**
 - Employee and Staff Feedback to Interventions
 - Staff and Vendor Performance Audits
 - Benefit/Vendor Utilization Data Analysis

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10

Why Does It Matter?

- ◆ **All Mental Health-Related Risk Management Analysis Boils Down to Identifying, Interpreting and Addressing Employee and Management Behavior**

Current Orientation to Behavioral Risk Management

- ◆ **“Deal with behavioral risk when it happens”**
- ◆ **“We provide total health management to our employees--our wellness company provides disease management and our EAP manages mental health”**
- ◆ **“All we know is that the employee is depressed --we can’t get anyone to tell us why she can’t perform her job or how we can get her back to work”**

Why It Doesn't Work

- ◆ **Reactive, Costly Employee Management**
- ◆ **Isolates Mental Health from Total Functioning**
- ◆ **Diagnosis/Impairment Does *Not* Define Disability**
- ◆ **Medical/Clinical Providers are not Disability Experts, But are Expected To Be**

Follow Up Assessment for Self Insurers

- ◆ **If Your Behavioral Risk Management is Response-Oriented, Who is Performing Your Loss Control ?**
- ◆ **What is the Psychiatric *Disability* Expertise of Your Risk Management Consultants and Brokers?**

Follow Up Assessment for Disability Insurers

- ◆ **What is Your Current Investment in RTW for Psychiatric Disability Claimants?**
- ◆ **How Do You Provide a Behavioral Risk Management Customer Service That will Lower Your STD/LTD Claims?**

Follow Up Assessment for Human Resource Management

- ◆ **Do You Have a Pro-Active Response Plan to Address Disability-Related Behavior?**
- ◆ **How Do You Promote and Reinforce Effective Employee Management Skills Amongst Your Managers?**

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17

Divider Title: _____

1:30-3:00 Friday
Concurrent Session

Functional Outcomes and Productivity

Researchers from the New England Medical Center have developed a new tool for the measurement of functional outcomes in the disability management process called *The Work Limitations Questionnaire* (WLQ). In partnership with LL Bean, the WLQ has been shown to correlate closely with performance and productivity on the job. What has LL Bean found to be the link between employee disability and performance?

Speakers: Debra J. Lerner, MS, PhD
Research Scientist
New England Medical Center

Ted Rooney
Manager, Employee Health Management
L.L. Bean Inc.

Debra J. Lerner, MS, PhD is a Scientist with The Health Institute at the New England Medical Center in Boston, Massachusetts. Her research has included such topics as work loss and limitations, improving outcomes, and disability in the workplace. She holds a BA in American Studies from the State University of New York at Buffalo, an MS in Health Planning/Administration from the University of Cincinnati and a PhD in Sociology from Boston University.

Ted Rooney is Manager, Employee Health at L.L. Bean, Inc. He manages employee health, safety, ergonomics, fitness, EAP, and Workers' Compensation programs. He is responsible for improving employee health and productivity while reducing injuries/illnesses, disabilities and associated costs. Mr. Rooney holds degrees in Sociology, Nursing, and Health Administration and has published extensively in the field of ergonomics and total quality management.

DRAFT

The Work Limitations Questionnaire (WLQ)[®]

The WLQ is a 25-item, self-administered questionnaire measuring health-related decrements in ability to perform job roles. The WLQ generates two types of assessments: 1) the degree of health-related limitation in performing specific job demands; and 2) the productivity loss and costs associated with these limitations. The WLQ applies to a wide range of health problems and work situations. Initially developed as an outcomes assessment tool for clinical trials of pharmaceutical interventions, the WLQ was required to be brief while meeting accepted standards of validity, reliability and precision.

The WLQ was envisioned as supplementing conventional work disability indicators, job loss and work absence rates, which do not reflect on-the-job limitations, and health status scales, which frequently do not distinguish between disabilities in paid and unpaid work.

The WLQ's development was sponsored by GlaxoWellcome, Inc. It involved approximately 300 primary care and specialty clinic patients from the following groups: 1) respiratory disease (asthma, chronic obstructive pulmonary disease, chronic bronchitis and/or emphysema); 2) gastrointestinal disease (Crohn's Disease and liver disease); 3) mental illness (depression and/or generalized anxiety); 4) epilepsy; 5) chronic daily headache syndrome; and 6) rheumatoid arthritis. Parallel studies have included patients with heart disease, occupational injuries and more than 1,000 healthy worker controls.

The WLQ has four scales. Each one measures a specific category of work limitations. The Time Management scale (Question 1) contains five items addressing time and scheduling demands. The six-item Physical Demands scale (Question 2) covers job tasks that involve bodily strength, movement, endurance, coordination and flexibility. The Mental/Interpersonal Demands Scale (Questions 3 and 4) has nine items. Six items pertain to cognitively demanding tasks and/or tasks involving processing of sensory information. Three items address interactions with people. The fourth scale is the Output Demands scale (Question 5). It contains five items concerning work quantity and work quality.

To generate work limitation scores, each WLQ scale is scored separately. The scales are scored from 0 (limited none of the time) to 100 (limited all of the time). Scores represent the reported amount of time in the past two weeks, the respondent was limited in their ability to perform the particular category of job demands. Because there is variability in job demands, each WLQ scale includes a "Does Not Apply to My Job" option. Scale scores are produced by averaging an individual's non-missing responses (scale range = 1-4).

A scoring algorithm is available to translate WLQ scale scores into a summary of biweekly output and health-related productivity costs. One algorithm has been developed for sedentary occupations and another for manual occupations. The algorithms were developed in a study involving more than 2,000 observations of workers within a large company. This study

quantified the association between WLQ scores and objectively-measured work productivity. The algorithms are available by request from the WLQ's developers.

The following sections describe the initial steps in the WLQ's development, results of psychometric tests and considerations for users.

Item Pool. The WLQ items ask respondents to rate their level of difficulty or level of ability to perform 25 different job demands. These demands have four defining features: 1) a wide range of jobs in the US include these demands; 2) a wide variety of physical and emotional health problems make it difficult to perform these demands effectively; 3) the demands are considered important to the job from the perspective of job incumbents; and 4) losses in individual work productivity are frequently related to the degree to which these demands are performed.

The item pool was developed according to a multi-step process. The aim was to generate items that had a high degree of face and content validity. Early steps in the process involved a review of the work classification literature, which identified categories of job and occupational demands, and a series of condition-specific focus groups. A pool of 70 candidate items was developed and evaluated using intensive interview methods (e.g., item paraphrasing and think-aloud responses). Approximately 40 employed, chronically ill patients participated. Items were rated for comprehensibility, ease of recalling information necessary to respond and ease of formulating a response. The item pool was narrowed to 38 items and reviewed by a multidisciplinary physician panel. Items were evaluated for "clinical sensibility" and "clinical importance". "Clinical sensibility" means the degree to which performance of the demands could be regarded as an outcome of a wide range of chronic, disabling illnesses. "Clinical importance" refers to the degree to which the limitations captured by the questionnaire would be considered "red flags" for work disability.

The final step in this process was an assessment conducted at two different employers. Approximately 15 pairs of coworkers participated. Pairs were matched on type of job but one coworker had at least one chronic condition and the other didn't. Each pair was blinded to the fact that health status was an eligibility criterion. This evaluation determined whether the job demands mentioned in the WLQ were present in a variety of jobs, the degree to which the demands were accurately rated as present or absent, and the degree to which chronic illness biased perceptions of demands (e.g., sensitized workers to their presence). Participants completed the job demand survey. During the period addressed in the survey, a trained observer assessed the job demands for each type of job represented in the study. Item sensitivity and specificity were rated.

Response Scale Development. A scaling evaluation was conducted to identify the scale or scales that elicited the most consistent and accurate responses. Approximately 40 employed, chronically ill patients participated. Nine job demands were embedded in three different question stem/response scale formats: 1) an intensity of difficulty scale; 2) an "amount of time able to" scale ("none of the time" through "all of the time"); and 3) a scale similar to #2 with responses stated in numbers of days categories. If the scales were equal in terms of their ability to elicit correct information from respondents, then responses should have been the same across scales. If the scales were not equally as effective in eliciting correct information, responses to

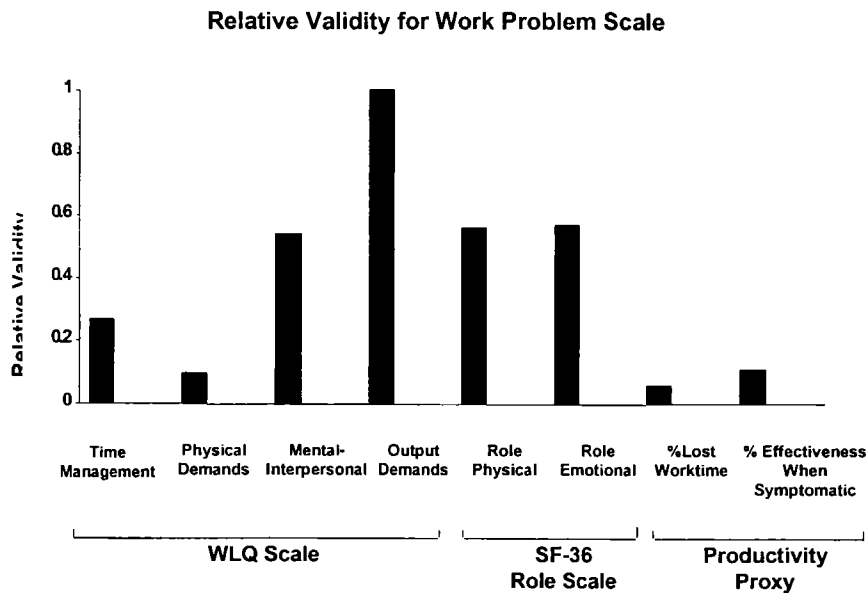
some items would differ. Scales # 1 and #2 had the lowest rate of mismatched responses. A research assistant probed each participant about mismatched responses and determined which of the mismatched responses, if any, were likely to be accurate. The “difficulty” scale performed best in this test.

Scaling Properties of the 25-item WLQ. The WLQ was assessed in a mail-out/mail-back survey involving 121 employed patients within three illness groups: RA, chronic daily headache and epilepsy. Cronbach’s α statistics were between the recommended levels of .70 and .90 for all items or slightly higher. Item-to-total scale score correlation coefficients, corrected for overlap, were greater than the minimum acceptable .20 level and exceeded the more stringent .40 level. Items within each scale were more highly correlated with their assigned scale’s score than with the other scales’ scores (scaling success rate = 100% for each scale). With 25 items, scores tend to be skewed slightly to the floor (no limitations); the degree of skewness is reduced with a larger number of items. The percentage of “does not apply to my job” responses was small (less than 5% for three scales and 12% for the Physical Demands scale).

Scale	Items n	Mean Raw Score	(SD)	Range	Floor %	Ceiling %	Scaling Success	Cronbach’s Alpha	Alpha Range	Item-to- Total Range	Does Not Apply %
Time Management	5	10.6	(5.3)	5-25	13.9	.9	100	.89	.84-.89	.61-.82	3
Physical	6	11.8	(6.0)	6-30	20.9	1.7	100	.89	.85-.88	.63-.79	12
Mental- Interpersonal	9	16.8	(6.9)	9-40	14.8	0	100	.91	.90-.91	.57-.83	1
Output	5	8.9	(3.9)	5-21	16.5	0	100	.88	.83-.89	.53-.82	2

The WLQ’s scale structure has been replicated in several other samples, and most recently in a randomized control trial of 227 primary care patients with major depressive disorder, dysthymia or subthreshold depression. Item-to-total scale correlation coefficients, corrected for overlap, were between .58 and .92. Scaling success rates were 100% for all scales. Internal reliabilities were .89, .94, .94 and .94 for the four respective scales.

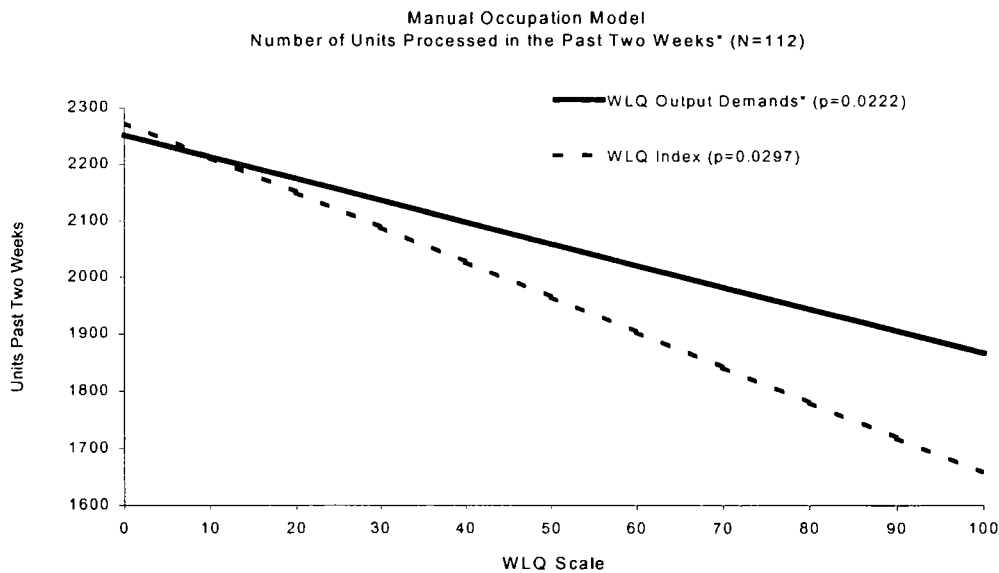
Convergent Validity. To establish the relationship of WLQ scores to parallel measures of functioning, the WLQ was compared to the SF-36 role limitation scales (role/physical and role/emotional). In 7 out of 8 multiple linear regressions (adjusted for age and gender), the WLQ scales were related significantly to the scales (n=121). We also assessed the relative validity of the WLQ vs. the SF-36 role scales for predicting productivity loss. The dependent variable was a summated two-item index of self-reported work problems (failure to meet work quantity and/or quality requirements based on “yes” or “no” responses to the relevant items). In separate regression models, in which the index was regressed on each scale, the WLQ Output Demand scale had the best relative validity.



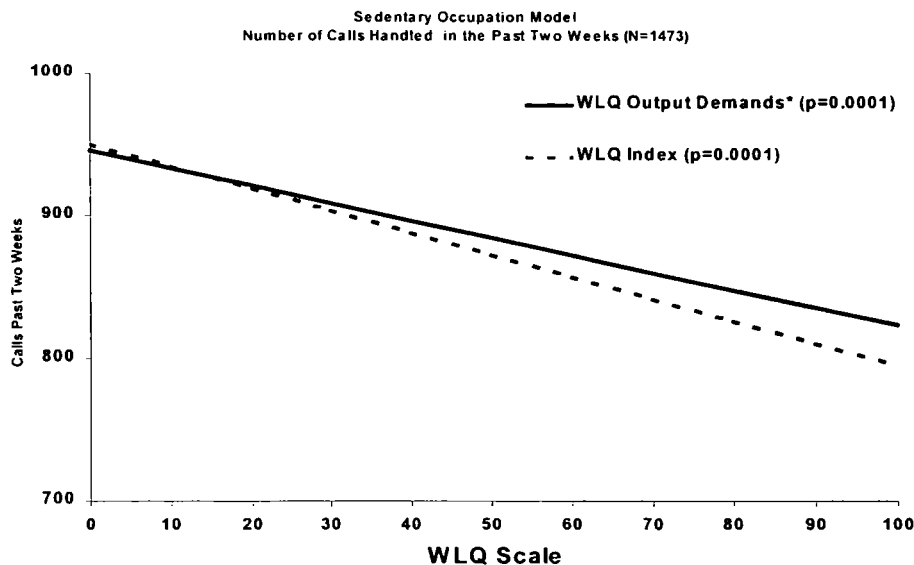
NOTE: F-values from regressions adjusted for age and gender (N=121)

WLQ Recall Reliability. A sample of employed chronically ill workers and healthy coworkers (n=65) participated in a reliability test, which compared retrospectively-reported questionnaire to weekly diary data. Half of the WLQ items were included in a weekly diaries (asking about work in the past week) and half, equivalent to the first in terms of content, were embedded in the questionnaires. Each subject completed four weekly diaries and either two, 2-week questionnaire or one 4-week form. Multiple regression models regressed each subject's questionnaire and diary data (for a specific scale) on a "subject" and a "method" variable. In most models the variation in responses was due to inter-subject variation vs. method (diary or questionnaire). The reliabilities of the retrospective scales, according to Shrout-Fleiss statistic, ranged from .76 to .90, thus, surpassing the recommended minimum .70 level.

WLQ Construct Validity. The relationship of WLQ scores to productivity was tested in a sample of approximately 919 employees of a large New England firm that monitors employee productivity electronically. The WLQ was administered (on-site) during three months to non-absent employees assigned to eligible jobs (n= 2,185). Survey responses were compared to work productivity data obtained for the same period. The sample consisted of workers in sedentary and manual jobs. **Sedentary Models.** In 16 multiple regression models adjusted for correlated errors (4 scales x 4 criteria), WLQ scores predicted productivity in 9 models. The Output Demands scale predicted productivity, which is conceptually-related to productivity, in all 4 of its tests. **Manual Models.** In 4 adjusted models (4 scales x 1 criterion), scores on the Time Management and Output Demands Scales explained a significant portion of the variation in productivity. **WLQ Index.** Results from the prior regressions confirmed that the Output Demands scale was a valid indicator of work productivity. To further explore the construct validity of the three other scales (Time Management, Physical and Mental/Interpersonal), we sought to identify the best combination of items for predicting productivity. In stepwise regressions, 8 items drawn from the scales were highly predictive of productivity in either sedentary or manual jobs.

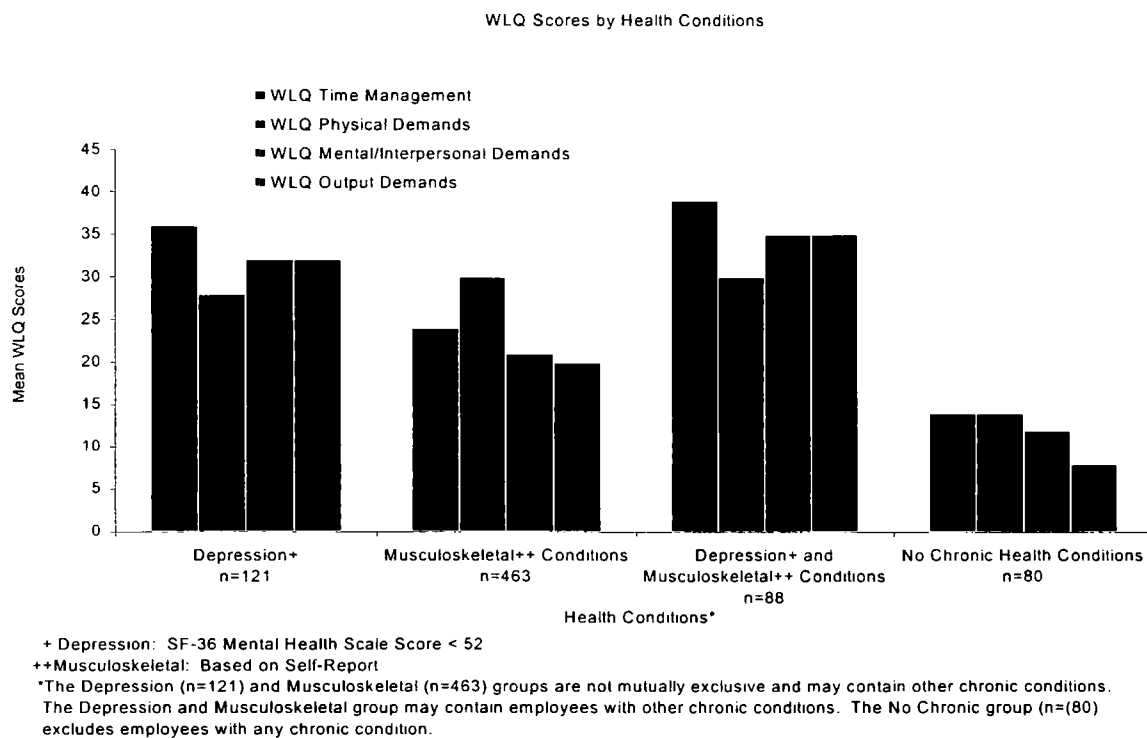


*Assumes 80 hours worked

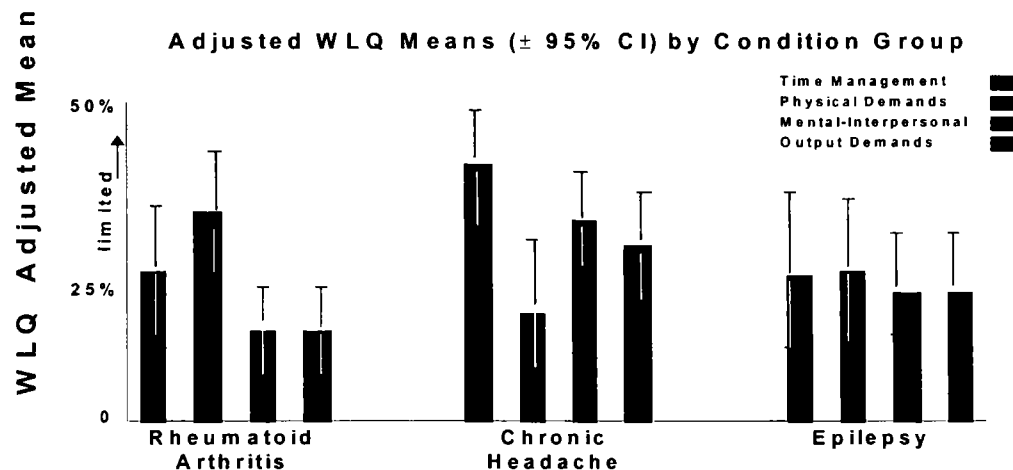


Impact of Depression on Self-Report. The potential for depression to bias WLQ responses was evaluated in the productivity study. The available depression indicator was the SF-36 MHI score. Research indicates that scores of 52 or lower is a reliable cutpoint for depression screening. In each of the productivity models described previously, each productivity criterion was regressed on a WLQ scale, age group, gender, education group, survey administration and depression. Depression was not significant in any of the models and the interaction of depression and WLQ scale scores was not significant. This analysis suggested that the WLQ is not substantially biased by depression.

Discrimination of Known Group Differences. In several studies, the WLQ has demonstrated its ability to detect clinically-relevant differences between groups. In the productivity study, WLQ scores of four employee groups were compared: depression based on the indicator SF-36 mental health index (MHI) score ≤ 52 ; musculoskeletal conditions (arthritis or back pain); depression plus musculoskeletal; and no chronic impairing conditions. The illness-free group had a fraction of the depressed group's limitation rate. The depressed group was more limited than the musculoskeletal group on all scales except for the Physical Demands scale; the latter group was more limited in its ability to handle their jobs' physical demands. The group with both conditions, was the most limited.



In the sample of 121 chronically ill patients, the WLQ detected differences between patient groups.



Note: Adjusted for age and gender (n=121)

The WLQ has also detected differences between patients who were defined as depressed according to a reliable depression screening instrument; the Inventory to Diagnose Depression (IDD) or not depressed.

Work Limitation Questionnaire (WLQ)

Criterion Groups	N	Time Management		Physical		Mental/Interpersonal		Output	
		mean	SE	mean	SE	mean	SE	mean	SE
IDD Depression									
Yes (5+ symptoms)	84	45.1	3.0	30.4	3.4	37.4	2.5	34.1	3.2
No (<5 symptoms)	164	34.4	2.5	21.1	2.3	27.8	1.9	26.3	2.3
T-test		2.6**		2.3*		2.9**		2.0*	

** p<.01

Considerations for Users. The WLQ is available royalty-free for non-commercial applications. If you would like to obtain a copy of the WLQ, please contact us and ask for a user form. Complete and return the form and we will send you the WLQ. We ask that users consider sharing WLQ data they have collected so that we may continue to test the instrument and build a data base for users.

The user form can be obtained by contacting Dr. Debra Lerner's office at:
617-636-8636, The Health Institute, New England Medical Center Box 345, 750 Washington Street, Boston, MA 02111. Email: debra.lerner@es.nemc.org or benjamin.amick@es.nemc.org.

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18

Divider Title: _____

**3:00-4:30 Friday
Concurrent Session**

***The Measurement of
Return to Work Performance***

What are the common denominators that successful return to work programs share – and which should be a part of your program? Speakers will present specific processes and interventions that reduce risk and assist employees return to work, with or without accommodation. This session will advance the notion of the development of benchmark standards for return to work program performance.

Moderator: Roxanne Newland, BSN, MSPH, JD
Managing Director
CQS Consulting Group, LLC

Speakers: Susan J. Olson, MSPH
Second Vice President, Integrated Health, Safety, & Disability Management
UnumProvident

Edwin W. Quick
Director, Disability Management
Union Pacific Railroad Company

Peter F. Rousmaniere
President
Rousmaniere Designs

Roxanne Newland, BSN, MSPH, JD is Managing Director of the CQS Consulting Group, LLC, a management consulting firm. Through her consulting, she assists organizations in the strategic planning, design, implementation, and evaluation of various products and programs, including disability, total absence management, Workers' Compensation, and return to work. Ms. Newland received her BS in Nursing from Kansas University, her MS in Public Health from the University of Minnesota and her JD from IIT Chicago-Kent College of Law.

Susan J. Olson, MSPH is Second Vice President of UNUM Enterprise Human Resources – Integrated Health, Safety and Disability Management. She is responsible for development of UNUM's strategy, business, and financial plans for the employee health, safety, and disability management programs for all U.S.-based employees. She also manages the employee disability plan design for short-term and long-term disability and directs the stay at work and return to work programs. Ms. Olson received her BA in Sociology and Criminal Justice from the University of Southern Maine and her MS in Public Health from the University of Massachusetts.

Edwin W. Quick is Director of Disability Management for Union Pacific Railroad, based in Omaha, Nebraska. He holds an MA in Vocational Rehabilitation Counseling from the University of Cincinnati and an MBA in Human Resource Management from the American University.

Peter F. Rousmaniere is President of Rousmaniere Designs, a Cambridge, Massachusetts-based consulting firm. His work focuses on the design and implementation of disability programs. Mr. Rousmaniere holds a BA and an MBA from Harvard University.

First Annual Managed Care Survey

Peter Rousmaniere
Rousmaniere Designs
Cambridge, MA
pfr@rousmaniere.com

Rousmaniere Designs

1

Growth of Managed Care in Workers Compensation

- 1991 - 1 state
- 1996 - 26 states

Rousmaniere Designs

2

Maturation Milestones

- Focus on performance measurement
- Consolidation of vendors
- Renewal of service contracts
- Penetration of all states

Rousmaniere Designs

3

Overview of Survey

- Journal of Workers Compensation
- Peter Rousmaniere and Maddy Bowling
- Conducted in 1999
- 241 usable responses

Rousmaniere Designs

4

Response breakdown

- 29% Employers
- 22% Payers
- 20% Managed care providers
- 8% Brokers
- 12% Consultants
- 9% Others

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Questions Asked

- What are five important goals?
- What is the most important goal?
- Do you measure (today, tom'w)?
- Common/external data source?

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Ranking of Important Goals - All Respondents

	important	most important
■ Reduce claims costs	75%	22%
■ Return worker to pre-injury function	60%	22%
■ Reduce # lost workdays	55%	8%
■ Reduce Freq.LT claims	43%	5%

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Ranking by Segment

	Emp	Payers	MCPs
■ Reduce claims costs	77%	90%	62%
■ Preinjury Function	58%	57%	67%
■ Reduce lost days	47%	60%	56%
■ Reduce frequency	44%	45%	22%
■ Comply with regs	53%	36%	47%

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Other Selected Responses

	Emp	Payers	MCPs
■ Reduce med'l costs	25%	36%	40%
■ Claimant satisfaction	46%	40%	53%
■ Emp'ler satisfaction	na	47%	62%
■ Comply w/ guide'ns	25%	9%	16%
■ Integrated Dis Mgt	19%	12%	24%

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Most Important Goal

	Emp	Payers	MCPs
■ Return Wkr Pre-Inj	19%	16%	35%
■ Reduce claims costs	16%	35%	21%
■ Comply w/ regs	18%	15%	12%
■ Reduce lost days	11%	7%	2%

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Current Perf. Reporting

	Emp	Payers	MCPs
■ Claims costs	82%	96%	50%
■ Medical cost svngs	68%	84%	67%
■ Freq. Of LT Claims	73%	89%	48%
■ Lost Workday red	63%	75%	57%
■ Employer satisfaction	na	79%	76%
■ Claimant satisfaction	28%	57%	63%

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Future Reports - Greatest Gains

- Frequency of recurrences
- Return to pre-injury functioning
- Integration of disability management

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12

Impact of Mgd Care on Costs

	25% - 100%
■ All	50%
■ Employers	42%
■ Claims payers	46%
■ MCPs	62%

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13

Common Outcomes Reptg Service?

Agree/strongly agree	
■ All	90%
■ Employers	89%
■ Claims payers	88%
■ MCPs	96%

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14

External Data Source?

Agree/strongly agree	
■ All	91%
■ Employers	89%
■ Claims payers	91%
■ MCPs	96%

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15

Summary

- Cost savings
- Pre-injury functioning
- Reduce lost work days
- Compliance with regulations

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National Disability Management Conference



**Edwin W. Quick
UPRR**

**The Measurement of
RTW Performance**

Introduction:

- Overview of FELA vs. Workers' Comp
- Common Denominators of RTW Success
- Union Pacific Program Overview
- Quantifiable Success at Union Pacific

Workers' Comp vs. FELA

- | | |
|---------------------------------------|--|
| ■ Law Varies by State | ■ One Law |
| ■ State by State Administration | ■ Case by Case Administration |
| ■ All Covered Workers | ■ Railroad Workers Only |
| ■ No Fault System | ■ Fault System |
| ■ Limits on Awards | ■ No Limits on Awards |
| ■ Various Levels of Union Involvement | ■ Significant Level of Union Involvement |

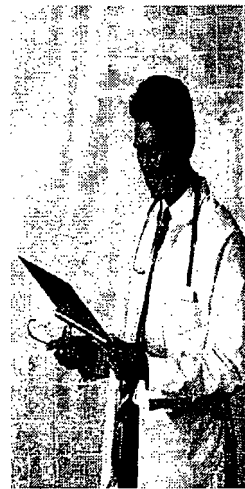
Common Denominators of RTW Success:

- Prevention
- Early Intervention
- Work Environment
- Quality Medical Care
- Education & Training
- Support Network & Programs
- Attitude



Union Pacific Program Overview:

- Safety and Prevention
- Medical Quality Assurance
- Vocational Stability Point
- Fitness for Duty
- RTW/Vocational Rehabilitation



Medical Quality Assurance

...this process assures that injured employees receive the highest value of medical care which has been designed to result in the maximum level of functioning. The process is designed to assure employees have the opportunity to RTW as soon as it is safe to do so...this process also assures that employees who are not working have medically justifiable reasons.

Two Components of MQA:

■ Injury Management:

* Driven by medical events/factors only

■ Disability Management

* Driven by factors other than medical events which impact the employees ability to RTW

How MQA Works:



Vocational Stability Point (VSP)

...the point at which, in consideration of restrictions, if any, or craft variability, the individual can RTW or it has been determined that the employee can not return to work.

Fitness for Duty Decision (FFD)

- ...is performed immediately after it is determined an employee has reached VSP. It is a determination process which establishes the employee's capabilities based on functional medical information of both the employee and their job.

RTW/ Vocational Rehabilitation

- Parallel Process
- Assessment and Evaluation
- Network VRCs
- Internal Placement
- RTW
- External Placement
- Oversight



Network VRCs What Does it Require?

- Masters Degree in Vocation Rehabilitation
- Certified Rehabilitation Counselor (CRC)
- A Minimum of 2 Years of Work Experience
With Industrially Injured Clients
- Railroad Case Management Experience
Preferred

Key Factors Impacting Placement

- Litigation
- Physically Demanding Work Environment
- 20 + Years of Service
- 240 Months of RR Service



Key Factors Impacting Placement (cont'd)

- Eligibility for RRB Disability Annuity
- Aging Work Force (46 yrs)
- Less Than 2 Years of Service
- Minimal Transferable Skills

Examples of Internal Placements:

- Train Dispatcher
- Admin Asst.
- Yard Clerk
- Claims Representative
- Locomotive Engineer
- EAP Manager
- Supervisor Train Ops
- Crew Dispatcher
- Supervisor Yard Ops
- Security Officer
- Transportation Supervisor
- LAN Administrator

RTW Quantifiable Successes:

- 229 Internal Placements (since '89)
- 183 still actively employed (20%)
- Average starting salary \$39,000/yr.
- At least 50% have been advanced into positions earning \$50,000/yr.

Additional Statistics:

Oversight Activities

- RTW
- Accommodations



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Divider Title: _____

3:00-4:30 Friday
Concurrent Session

***Contrasting Approaches to the Development of
Performance Indicators and Accreditation Standards***

What are the process or outcome performance indicators which payers, employers, referrers, consumers, and families can use to compare and evaluate disability/rehabilitation-related providers? Accrediting bodies can add value for purchasers by demonstrating how high-performing providers achieve better results by focusing on functional outcomes. Employer and service provider stakeholders share the ways in which disability management providers can and should be held accountable for service outcomes.

Moderator: Claire Sharda, RN, MBA, MHSA
Director
Washington Business Group on Health

Speakers: Liza Greenberg, RN, MPH
Vice President, Research & Quality
American Accreditation Healthcare Commission/URAC

Deborah L. Wilkerson, MA
Vice President, Research & Quality Improvement
CARF...The Rehabilitation Accreditation Commission

Liza Greenberg, RN, MPH is Vice President of Research and Quality Initiatives at the American Accreditation HealthCare Commission/URAC, a national organization which promotes continuous improvement of health care quality by establishing health care standards, conducting educational programs, and accrediting managed care programs. Her responsibilities include development of new research initiatives on performance measurement and health outcomes for managed care plans. She is project director on a project funded by the Robert Wood Johnson Foundation titled *Development of Standard Performance Measures for Workers' Compensation Managed Care Organizations*.

Claire Sharda, RN, MBA, MHSA is a Director at the Washington Business Group on Health (WBGH), a non-profit policy research and education organization whose membership represents Fortune 500 companies and large public employers. As such, she leads projects within WBGH's Health and Productivity Management Initiative that identify how health care delivery systems can work with employers to optimize workforce health. She also staffs the WBGH Board of Director's Organized Systems of Care committee to further develop WBGH's stated expectations of the health care delivery system to provide organized, effective health care to its members' employee. Ms. Sharda received her BS in Nursing, her MBA and her Master's of Health Services Administration from the University of Michigan.

Deborah L. Wilkerson, MA is Vice President, Research and Quality Improvement for CARF...The Rehabilitation Accreditation Commission in Tucson, Arizona. In this capacity, she spearheads CARF's Quality and Accountability Initiative projects. Ms. Wilkerson earned a Master's degree in anthropology from Wake Forest University and is currently pursuing her doctorate in medical anthropology at the University of Arizona.

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Contrasting Approaches to The Development of Performance Indicators and Accreditation Standards

WBGH National Disability Management Conference

October 29, 1999

E. Liza Greenberg, RN, MPH

Vice President, Research and Quality Initiatives

American Accreditation HealthCare Commission/URAC



1

Who is URAC?

Founded in 1990 as the "Utilization Review
Accreditation Commission"

501c3 non-profit organization

Mission: develop and apply standards for
utilization review, managed care and workers'
comp organizations

web: www.urac.org phone: 202 216-9010

American Accreditation HealthCare Commission/URAC



2

URAC Member Organizations

- Managed Care Industry
- Public Interest
- Health Care Provider

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3

What Does URAC Offer Employers?

Accreditation Programs: national standards
for structure and operations

Performance Measures: Under development
for workers' compensation

Publications: cutting edge information on
regulation and industry trends in managed
care.

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4

Difference Between Accreditation Standards and Performance Measures

Accreditation examines structure and capabilities compared to standards

Performance measures assess process and outcome information

Accreditation and performance measures complement each other and increase accountability



Accreditation Programs

- Health Utilization Management
- Workers' Compensation Utilization Management
- Health Network and Health Plan (PPO and HMO)
- Workers' Compensation Network
- Practitioner Credentialing
- 24-Hour Telephone Triage and Health Information
- CVO
- Case Management Organizations



Implications of Accreditation for Disability Management

- Accreditation standards are developed by panels of experts
- Standards set national operational benchmarks
- Standards are a “bar” that vendors seek to achieve
- Can be used to develop new programs



Standards for Workers' Comp UM

Standards for:

- Staff qualifications
- Clinical review process
- Clinical review criteria
- Appeals mechanisms
- Oversight of delegated functions
- Staff credentialing



Standards for Workers' Comp Networks

Network Management

- Provider availability and accessibility
- Provider contracting
- Grievances and appeals
- Marketing

Quality Assurance

- Program organization and staffing
- QA planning

Credentialing of Providers

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9

Example: URAC Case Management Standards

First national standards for case management organizations (CMO)

Reality: there is a lot of diversity in CMOs

Committee debate: where to set the bar - at best practice or current practice?

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10

Issues in Developing CMO Standards

- Professional qualifications of staff
- Confidentiality/sources of data
- Performance and outcomes reporting
- Professional ethics



Uses of Performance Measures

- External accountability
- Meet purchaser demand
- Regulatory compliance
- Quality improvement



Considerations for Performance Measures in Disability Management

- Underuse
- Overuse/Misuse
- Satisfaction
- Efficiency
- Outcomes



Tools for Measuring Health Care Quality

Performance reports

- HEDIS, FACCT, ORYX, QISMC

Report cards

- Ohio, New York, Pennsylvania

Provider Profiles

National Surveys

- CAHPS, BRFSS, NHIS



Underuse

Importance: prolongs disability

What is it?

- Underuse of preventive services or appropriate therapy
- Underuse of health services in general

Potential causes?

- Patient factors (not seeking care)
- MCO/Provider factors (access barriers, denials)

Performance Measures:

- rates of services, access questions

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Overuse

Importance: increases level of disability

How is it defined?

- Unnecessary care
- Inappropriate care e.g. emergency room use

Causes?

- Patient factors (inappropriate demand)
- MCO/Provider factors (standards of care)

Performance Measures:

- rates of service, geographic comparisons

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Satisfaction (outcome measure)

Importance: may affect RTW and functioning

- Issues:
 - Whose satisfaction is important - patient, employer, provider, or insurer?
 - What does satisfaction tell you about quality?
 - Measuring satisfaction - survey design and implementation issues
- National efforts
 - Consumer Assessment of Health Plans Survey (CAHPS)

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Efficiency

Importance: related to cost of disability management and satisfaction

Types of Administrative Quality Measures:

- Claims processing
- Customer service
- Cost

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18

Outcomes

Functional Status

Return to Work

Cost

Satisfaction



Provider Profiles

Importance: Providers strongly influence all aspects of care.

- Issues:

- The profile may be the most relevant unit of analysis
- Provider feedback as internal QI approach
- Provider utilization data: risk adjustment
- Disability management is multidisciplinary



URAC Project with the RWJ Foundation

Create a national set of performance measures, using standard specifications, to assist work comp MCOs in voluntary reporting of data

Test the measures to ensure that data reports are useful in comparing and improving work comp MCO performance



URAC Goals for Standard Performance Measures

- Increase comparable data for purchasing, QI, and outcomes research efforts
- Increase MCO incentives to measure quality in order to improve care
- Provide information to customers and consumers on health care quality



Characteristics of Performance Measures

Information on specific areas of performance is collected and reported using standard criteria.

Good Performance Measures:

- are valid and reliable
- are feasible to produce
- measure organizational/provider characteristics that can be improved



MCO Survey Priority Measures

Return to Work

Cost and Savings

Utilization

Network Usage

Lost Time



Advisory Committee Performance Measure Categories

Access

Prevention/ Disability Management

Appropriateness of Clinical Care

Coordination and Communication

Cost/Utilization

Patient/Payer Satisfaction

Outcomes

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Challenges to Measuring Outcomes in WC

- Employer role
- Age, sex, marital status
- Job functions
- Inconsistent RTW
- Data problems

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Definitions Developed to Ensure Consistent Reporting

Define MCO functions of interest

Define categories of performance

Define time frame

Define cases:

LBP, Knee, Shoulder, Arm complaints



Example, “What is an MCO?”

Accurate comparisons depend on
examination of similar organizations

Premise: a work comp MCO can influence care.

- Provider network
- utilization review
- medical bill review
- case or disability management



URAC Recommended Sources for WC Performance Measures

Patient Survey

Claims / Bill Data

Medical Records

MCO Report

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Advisory Committee Performance Measure Categories

Access

Prevention/ Disability Management

Appropriateness of Clinical Care

Coordination and Communication

Cost/Utilization

Patient/Payer Satisfaction

Outcomes

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Assumptions for Work Comp Performance Measures

Activities being measured are important
indicators of quality of care and organizational
performance

Purchasers of comp services will value the ability
to compare data and will demand reporting

Data collection methods can be specified with
enough precision to allow for comparisons
across organizations and across states

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Conclusion

Performance measures and accreditation
standards are designed to improve quality of
disability management services

phone 515 248-4736

More research is needed on links between
performance and disability outcomes

For more information:

www.urac.org

Lgreenberg@urac.org

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Performance Indicators for Rehabilitation Programs: CARF's Approach

WBGH Disability Management Conference
October 29, 1999

Deborah Wilkerson
CARF...The Rehabilitation Accreditation
Commission

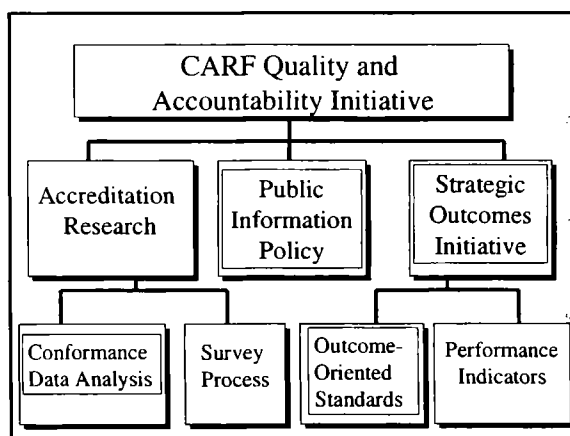
For this Session...

- Update on the project
- Key concepts
- Update on 1999 advisory meetings
- Questions for the group

2

THE PROJECT

3



CARF...Indicators in

- Behavioral Health
- Medical Rehabilitation
- Employment and Community Services
- Adult Day Services

5

ACMHA & Behavioral Health Indicators

- American College of Mental Health Administration
 - WBGH's Dr. England in key role!!
- Santa Fe Summit
- 5-accrediting body work group
- Draft of about 15 concerns/ 30 indicators
- All are looking at in conjunction with our own indicators efforts in some way...

6

New since last year...

- 5000 copies of CARF Performance Indicators Version 1.1
- American College of Mental Health Administration accreditor work group
- CARF Consumer Forum
- Performance Indicators Advisory Council
- Don Galvin's Switzer paper
- Marsha Wise's search for rehab/ *US News*

BASIC CONCEPTS

Performance Indicators Project

- Identify and communicate key indicators of performance important to
 - persons served
 - payers
 - managed care organizations
 - other accrediting bodies
 - e.g., NCQA
 - policy makers

Performance Indicators Project

- Provide a template for reporting performance to stakeholders
 - Consumers, families, payers, employers...
- Guide providers in developing outcome information systems
- Enable "apple-to-apple" comparisons of performance

Taxonomy and Terms

Coming to terms with the concepts

Coming to Terms with the Concepts

- | | |
|-------------|------------------|
| • Domain | • Data Element |
| • Concern | • Specifications |
| • Indicator | • Performance |
| • Measure | • Benchmark |

Performance Indicators Project

- **Domain**

- General category of interest
 - Donabedian
 - Structure
 - Process
 - Outcome
 - Add Access

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Performance Indicators Project

- **Concern**

- Value statement reflecting a stakeholder's perception of quality

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Performance Indicators Project

- **Indicator**

- Quantitative expression used to point to program performance; quantity, ratio, rate, etc.

15

Performance Indicators Project

- **Measure**

- Specific tool or data element used to quantify the indicator

16

Performance Indicators Project

- **Data Element**

- Single-variable measure OR
- One part of a multi-item scale measure

17

Performance Indicators Project

- **Performance**

- Achievement of certain level on the indicator

18

Performance Indicators Project

- **Indicator Specifications**

- Formulae and data collection details

19

Performance Indicators Project

- **Benchmark**

- Target level of performance
- Externally- or internally-determined

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CLARIFIED CONCEPTS

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Clarified Concepts

- Standards vs. Indicators
- Purposes of performance indicators
- Research needs... "below-the-line" work

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Standards vs. Indicators

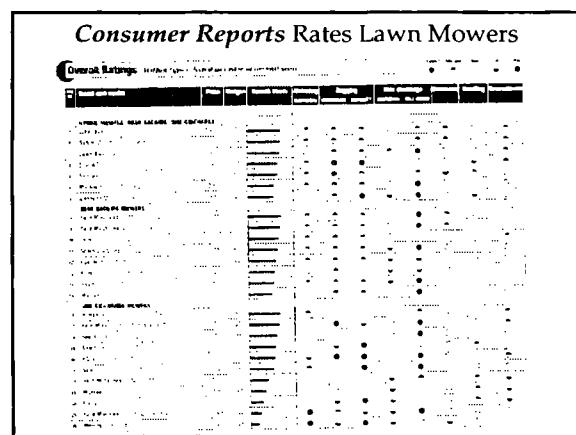
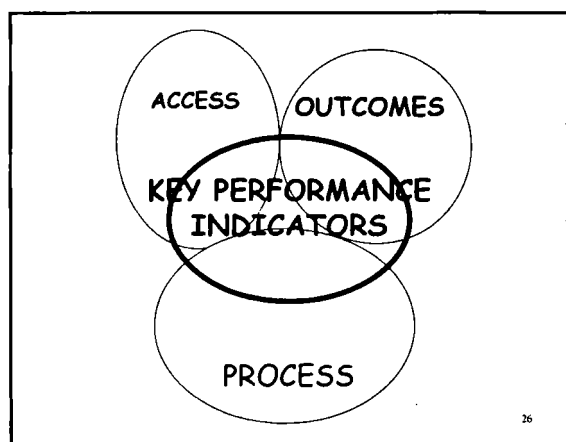
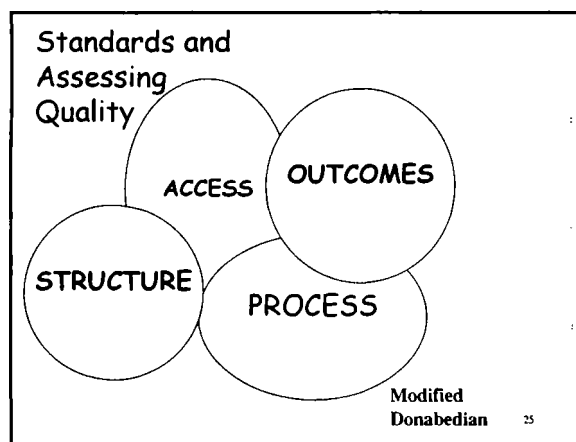
- | | |
|---|---|
| <ul style="list-style-type: none"> • Standards for accreditation <ul style="list-style-type: none"> – Structure – Process – How the organization should be structured and run – What is likely to lead to quality performance | <ul style="list-style-type: none"> • Performance indicators <ul style="list-style-type: none"> – Access – Process – Outcome – Quantitative expressions of quality performance |
|---|---|

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Standards vs. Indicators

- | | |
|--|---|
| <ul style="list-style-type: none"> • Standard • The organization has an outcome management system • The organization uses outcome data to improve service quality | <ul style="list-style-type: none"> • Indicator • Percent of persons served who obtain jobs • Decreased time from intake to job placement |
|--|---|

24



How do you choose the rehabilitation programs and services you use or purchase?

How is the information you get developed and reported?
(How are the dots defined?)

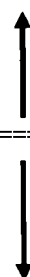
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The *Consumer Reports* Analogy

- Identify those key 8 factors (P.I.'s)
- Describe specifications
 - How to evaluate the product to fill in the dots
- Preferences of person served can be met by scanning the array of products
 - You don't care about seat comfort if you don't want a riding mower
 - Look at key traits (descriptive) before rating
- No plans for CARF to produce the *Report!!* 29

The Goplerud Line (from ACMHA Work Group)

- Domain
- Concern
- Indicator
- Measure
- Data elements
- Specifications



Conceptual

Technical

30

Purposes of Performance Indicators and Measures

- Consumer Information & Choice
- Payer Information & Choice

Uniformity

- Provider Quality Improvement
- Oversight

Individuality

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FIELD INPUT 1999

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CARF Consumer Forum on Performance Information

Washington, DC
June 21-22, 1999



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Who was there...

- Recipients of services
- Consumer advocates
- Family members
- Links to CARF
- Any combination of the above...

Project Questions

- What does a stakeholder want to know about a program's performance in order to know about its quality and choose a program?
- What should programs count?
- How should they count the same things, the same way?

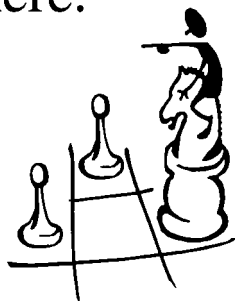
35

CARF Consumer Forum

- Your review of our work so far
 - How important are these items to you?
 - What did we miss?
- Your ideas on information you want, and where it should come from
 - Organizations, CARF, other consumers
- What we should ask other consumers

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Start here.



What they said...

- Clean up your language
- We want to know what the provider can do for a person like me
- Give lots of descriptive, process information
- Guide us in what we should ask providers
- We want uniformity of reporting
- We want it understandable
- Identify cross-cutting indicators

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What they said...

- “Don’t talk to me about outcomes data...just tell me if people improve.”
- Consumer guide to selecting services:
 - What to ask the provider

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Some cross-cutting themes

- Satisfaction
- Education
- Employment / productivity / financial
- Quality of relationships / support / inclusion
- Health Status
- Psychiatric well-being / self-advocacy
- Substance misuse
- Safety
- Provider / payer relationship

40

Performance Indicators Advisory Council (PIAC)

35 participants
 All 4 divisions
 Cross-over with Consumer Forum
 Loews Ventana Canyon
 August 6-7, 1999

41

The meeting was about...

- Getting to version 2.0
- Incorporating a year’s input
- Clarifying some concepts
- Getting more refined information to the field
- Coming closer to an “implementable” set
- Being very, very focused
 - Ruthless taskmasters

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What we've learned

- Enthusiasm over version 1.1
- Work with ACMHA and more enthusiasm
- On language
- On gibberish
- A few consumer priorities
- A few provider priorities

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Where we are now

- Replicate consumer input sessions
- Balancing interests of various audiences
 - Consumer
 - Payer
 - Provider
- Identifying uses of different indicators
- Confronting "the line"-- defining measures and specs
- Refining the set(s) further

44

Where we are NOT...

- CARF collecting data
- CARF reporting performance data
- Dictating to NACs whether and how to refer to indicators

45

Tasks for the PIAC

- Absorb input on version 1.1
 - Feedback from monograph
 - Feedback on feedback from PIAC
 - Consumer Forum ratings & comments
 - PIAC survey re: criteria for indicators
- Whittle, reword, clarify, specify, translate
- Consider purpose
- Essentially...produce version 2.0

46

Refinement Actions

- A Keep/edit level A
 - Ready or not...
- B Keep/edit level B
 - Not ready for prime time
- C Back burner
 - Still cooking
- D Drop from indicators
 - Toast
 - Suggest other ways to address

47

Below-the-line Measure Actions

- 1 Multiple measures exist
 - review 1.1 list & expand
 - tips for our research (\$\$ would help too)
- 2 One measure exists
 - reference and rationale if possible
- 3 No measure exists
 - suggest steps
- 4 Simple data element suffices
 - suggest categories if possible

48

Purposes

- CC Consumer information and/or choice
 - Uniformity
- PC Purchaser information and/or choice
 - Uniformity
- QI Provider quality improvement
 - Individuality

49

Key Recommendations of PIAC

- More consumer input before Version 2.0
- Say where we're going with this. Options:
 - FYI only for the field--take it or leave it
 - Specify concerns in standards
 - Specify indicators in outcome management standards
 - Surveyors look at data on site
 - Organization report to their stakeholders on data in key areas

50

Parity between consumers and others.

51

Consumer information the primary project goal

What about payer information?
Internal quality improvement?

52

Identify core indicators uniform across CARF "divisions"

...to be supplemented by more specific indicators

53

Some Possible Core Concerns

- Community living status
- Employment
- Health and benefits
- Respect and dignity
- Participation in service process

54

Move from Muddle to Huddle

Define our mission for PIs and tell
the field...
In progress.

55

Next Steps

- Time out...digest and document
- More consumer input
- Payer input
- Monograph 2.0 first half of 2000

56

QUESTIONS

57

How could disability research be involved?

- Point to acceptable risk-adjustment data
- Develop needed risk-adjustment methods
- Identify best measure(s)
- Conduct trials using indicators
- Help get consumer input

58

More Questions...

- What is the reception of consumers, payers, and providers to the idea of PI's?
- Would payers use PI information?
- What are the implementation challenges?
- How should we deal with gaming issues?
- What are the benefits and costs of having uniform key indicators specifications?

59

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Research and Quality Improvement
CARF...The Rehabilitation
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dwilkerson@carf.org

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20

Divider Title: _____

3:00-4:30 Friday
Concurrent Session

***Disease Management: A Unified Approach to
Managing Disability and Medical Costs***

Where do you start in the management of chronic disability? Depression awareness and intervention programs? Diabetes management self care programs? Cancer support groups? By “drilling down” in health and disability databases provided by CORE, INC., Analysis Group/Economics has developed a prioritized illness prevention/disease management protocol which can assist employers in allocating limited resources to where they will have the most impact. Representatives of two Fortune 50 companies will share their strategies for targeting disease management interventions.

Moderator: Paul E. Greenberg
Principle & Director, Health Care Economics
Analysis Group/Economics

Speakers: Rebecca Auerbach
Vice President
CORE, INC.

Howard G. Birnbaum, PhD
Vice President
Analysis Group/Economics

Daniel J. Conti, PhD
Vice President/EAP Director
Bank One

Victor L. Paganucci
Director, Integrated Disability Systems
Champion International Corporation

Rebecca Auerbach is Vice President of the Analytic Services Business at CORE, INC., a national provider of managed disability and health care benefits management services. At CORE, she has designed and developed many of the company's innovative analytic products in managed health and disability program evaluation, disease specific and outcomes research, and benchmarking programs. Ms. Auerbach holds an MS in Economics from the University of Maryland.

Howard G. Birnbaum, PhD is a Vice President in the medical economics practice of Analysis Group/Economics. An applied microeconomist who has specialized in the health care sector for over 20 years, his areas of expertise include pharmacoeconomics, employee and retiree benefits, reimbursement and capitation modeling, and the costs of illness. Dr. Birnbaum has managed engagements involving the design of effective health financing strategies and tools to optimize the process and outcomes of care, as well as the development of software applications that model the cost effectiveness of specific managed care technologies. He holds a PhD in economics from Harvard University.

Daniel J. Conti, PhD serves as Vice President and Manager of the Employee Assistance Program of the Bank One Corporation, the parent company of the fifth largest bank in the United States. He has developed and implemented innovative programs that address the link between behavioral health status and corporate costs and has published significant research on this subject. Dr. Conti received his BA from John Carroll University and his MA and PhD in Clinical Psychology from DePaul University.

Paul E. Greenberg, a Principal of Analysis Group, specializes in the application of industrial organization economics to problems in complex business litigation, as well as applications of microeconomics to health care issues. He has consulted in a variety of cases involving claims of anti-competitive behavior, and has developed damage assessments and valuation analyses and intellectual property cases. Mr. Greenberg holds an AB in Economics from Vassar College, an MS in Management from the Sloan School of Management at the Massachusetts Institute of Technology and an MA in Economics from the University of Western Ontario.

Victor L. Paganucci is Director, Integrated Disability Systems for Champion International Corporation, a Connecticut-based diversified forest products company. Previously, he held a number of positions in brokerage and risk management assisting various companies in their Workers' Compensation and casualty insurance programs. Mr. Paganucci holds a BA from St. Francis College.



ANALYSIS GROUP/*Economics*

An Analysis Group Company

*Disease Management: A Unified Approach
to Managing Disability and Medical Costs*

Presentation to:

Washington Business Group on Health

October 29, 1999

Cost of Illness to an Employer: Traditional Perspective

- ◆ Direct costs
 - Inpatient care
 - > Short-term (e.g., hospital)
 - > Long-term (e.g., nursing home)
 - Outpatient care
 - > Doctor visits
 - > Home care
 - Pharmaceutical therapy
 - Other (e.g., out-of-pocket expenditures on dependent care)

- ◆ Indirect costs
 - *Morbidity (e.g., in the workplace, home or school)*
 - Mortality (e.g., premature death or suicide due to illness)
 - Quality of life (e.g., ability to perform usual activities of daily living)
 - Other (e.g., dependent care provided by family or friends)

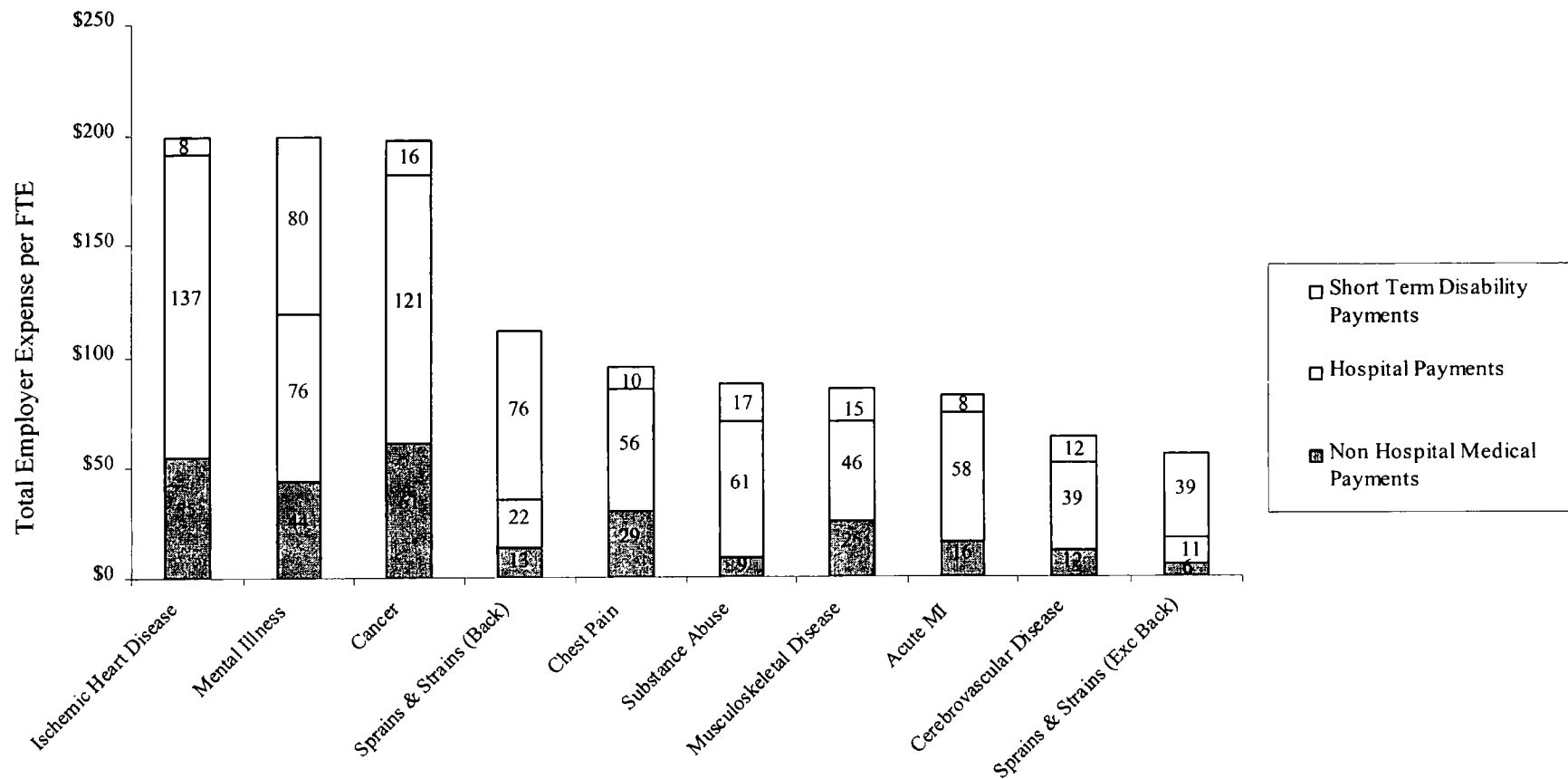
Conceptual Framework

- ◆ Traditional focus on one health-related cost category at a time results in a “silo” mentality,” which reinforces cost containment objectives at the company.
 - Existing paradigm: Health care and disability payments are costs to be minimized.
- ◆ Integrated approach to corporate benefits management, in which direct and indirect costs categories are evaluated simultaneously, highlights strategic opportunities in health care.
 - New paradigm: Health care and disability are investments to be optimized.

Data Analytic Framework

- ◆ What is the comprehensive economic cost of a specific disease to an employer?
 - Medical costs directly related to the disease
 - Medical costs indirectly related to the disease
 - Short and long term disability costs
 - Worker's compensation costs
 - Absenteeism costs and lost productivity
 - Turnover costs
- ◆ Develop comprehensive benefit database (e.g., data warehouse) to analyze employee specific costs *across benefit programs*.

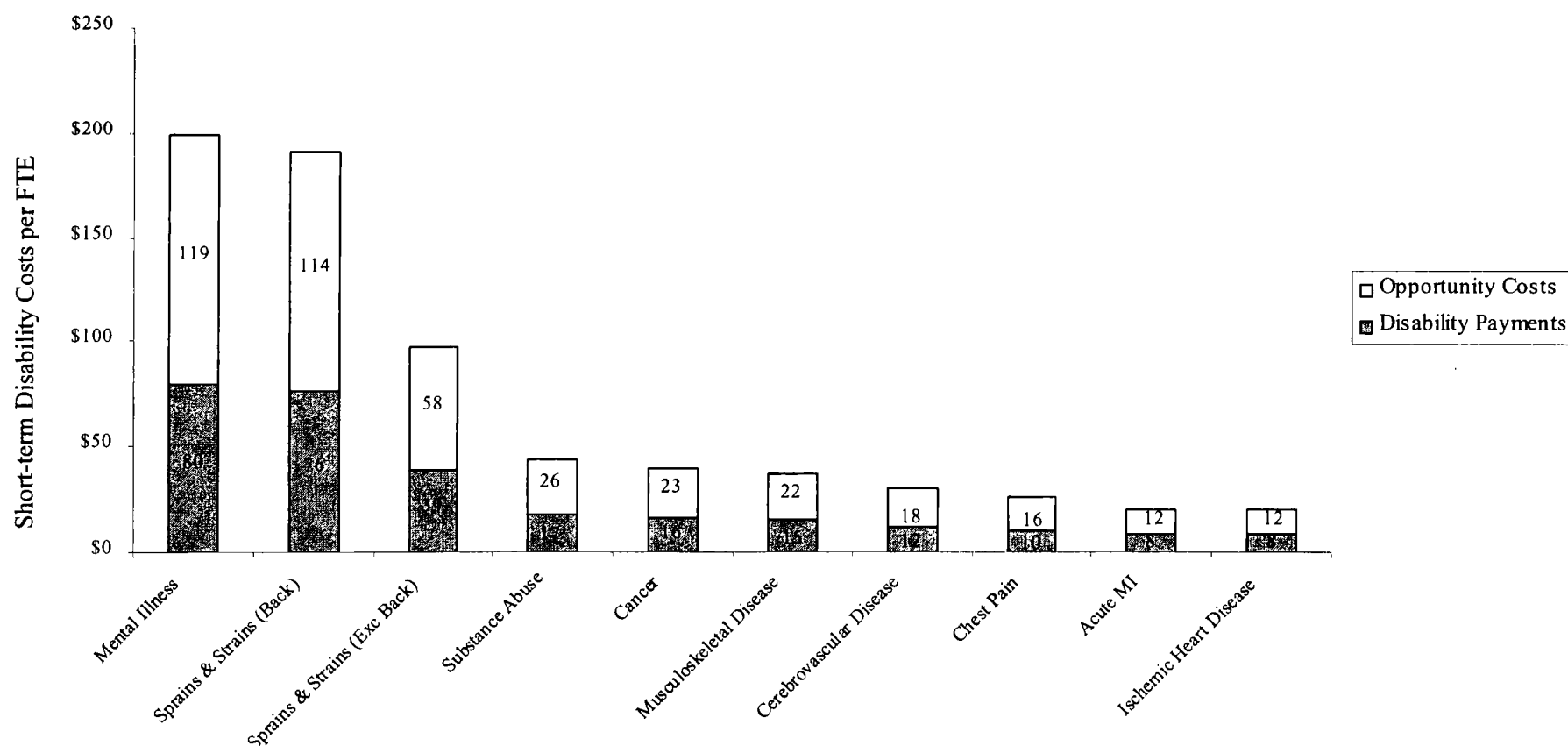
Top Ten Diseases by Total Employer Expense: 1995-1997



Note: Disease groupings are based on ICD-9 codes and do not reflect additional disability payments classified by CPT medical procedures. Further refinements to this analysis would involve mapping CPT codes to ICD9 codes for a more comprehensive analysis.

Source: *Business & Health*, May 1999

Burden of Short-Term Disability Costs for Most Costly Diseases: 1995-1997



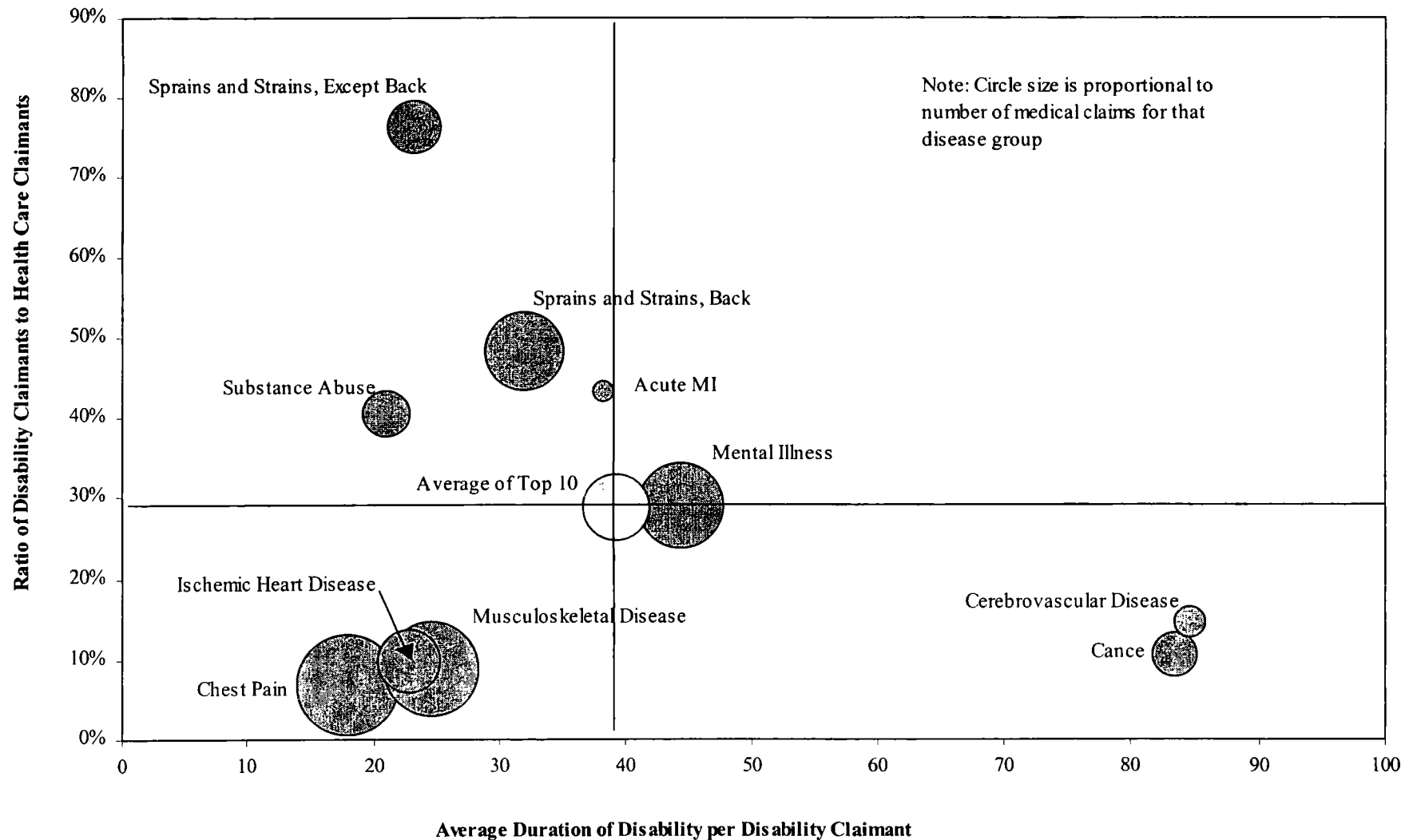
Note:

1. The employer's opportunity cost for work loss days due to short-term disability is estimated at 2.5 times employer short term disability payments to employees. The 2.5 multiplier is an industry standard estimate to reflect the value to the employer of administrative and training costs for replacement workers.
2. Disease groupings are based on ICD-9 codes and do not reflect additional disability payments classified by CPT medical procedures. Further refinements to this analysis would involve mapping CPT codes to ICD9 codes for a more comprehensive analysis.

Source: *Business & Health*, May 1999

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Short Term Disability Cost Components to an Employer For Most Costly Diseases: 1995-1997



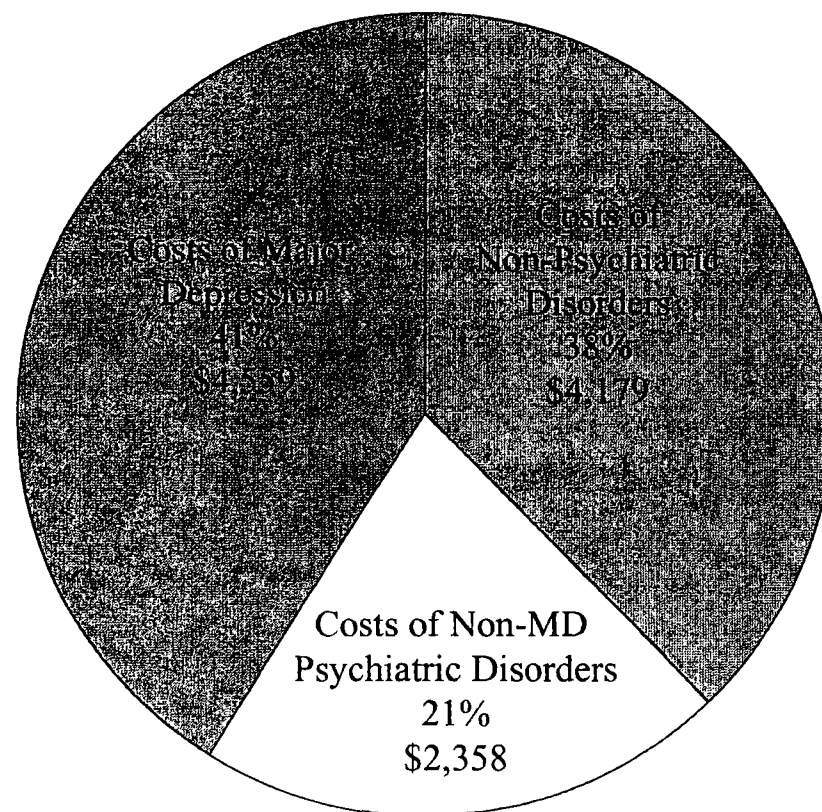
Source: *Business & Health*, May 1999

Possible Approaches to Disability Management

- ◆ Broad programs at the level of all employees, e.g., educational, lifestyle changes;
- ◆ Targeted programs at the level of employees who are treated for certain illnesses which are associated with a high incidence of disability among patients with this illness, e.g., sprains and strains; and
- ◆ Targeted programs at the level of persons with disability claims, for certain illnesses with long durations of disability, e.g., cancer.

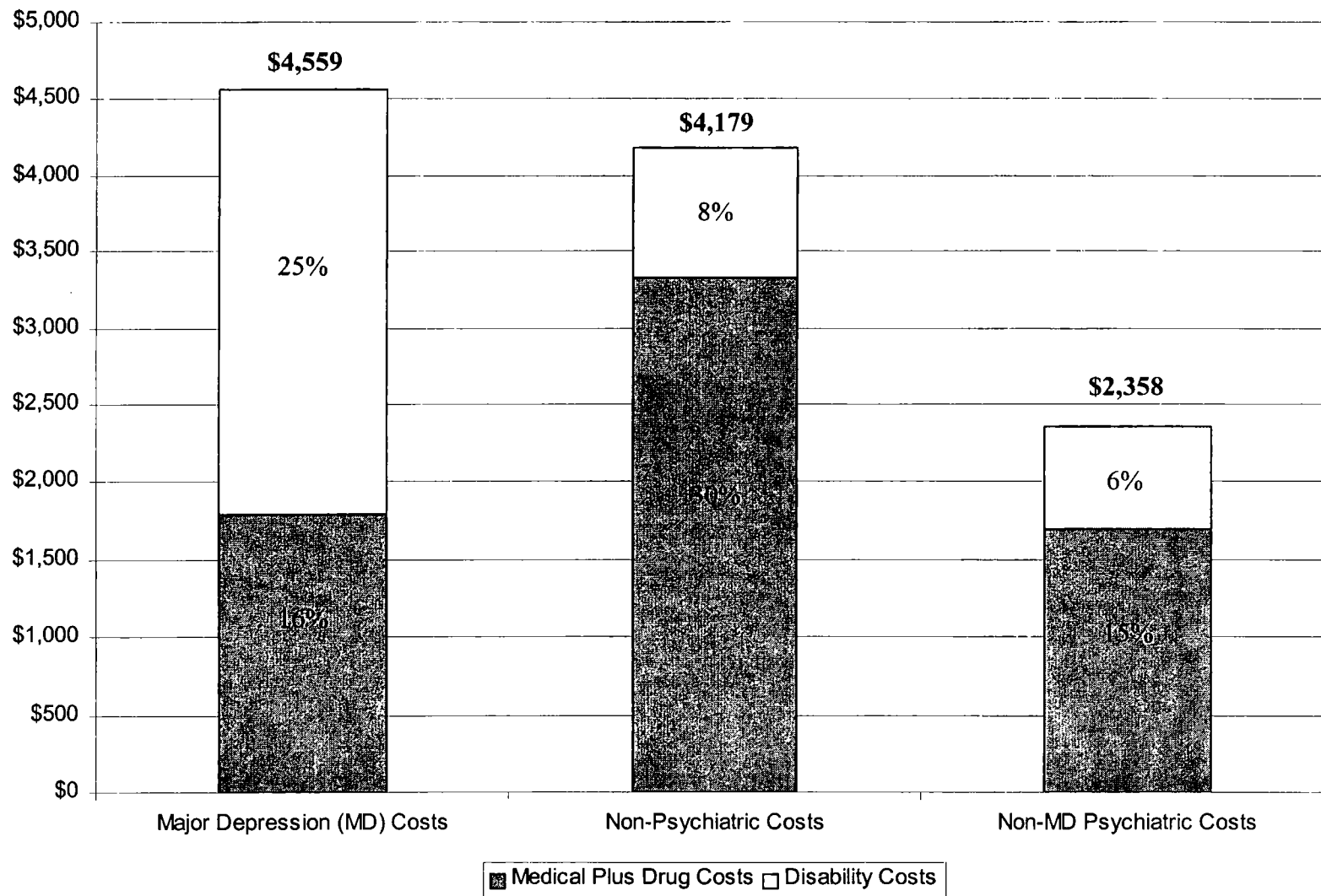
Confidential

Components of Annual Employer Payments for Employees Treated for Major Depression

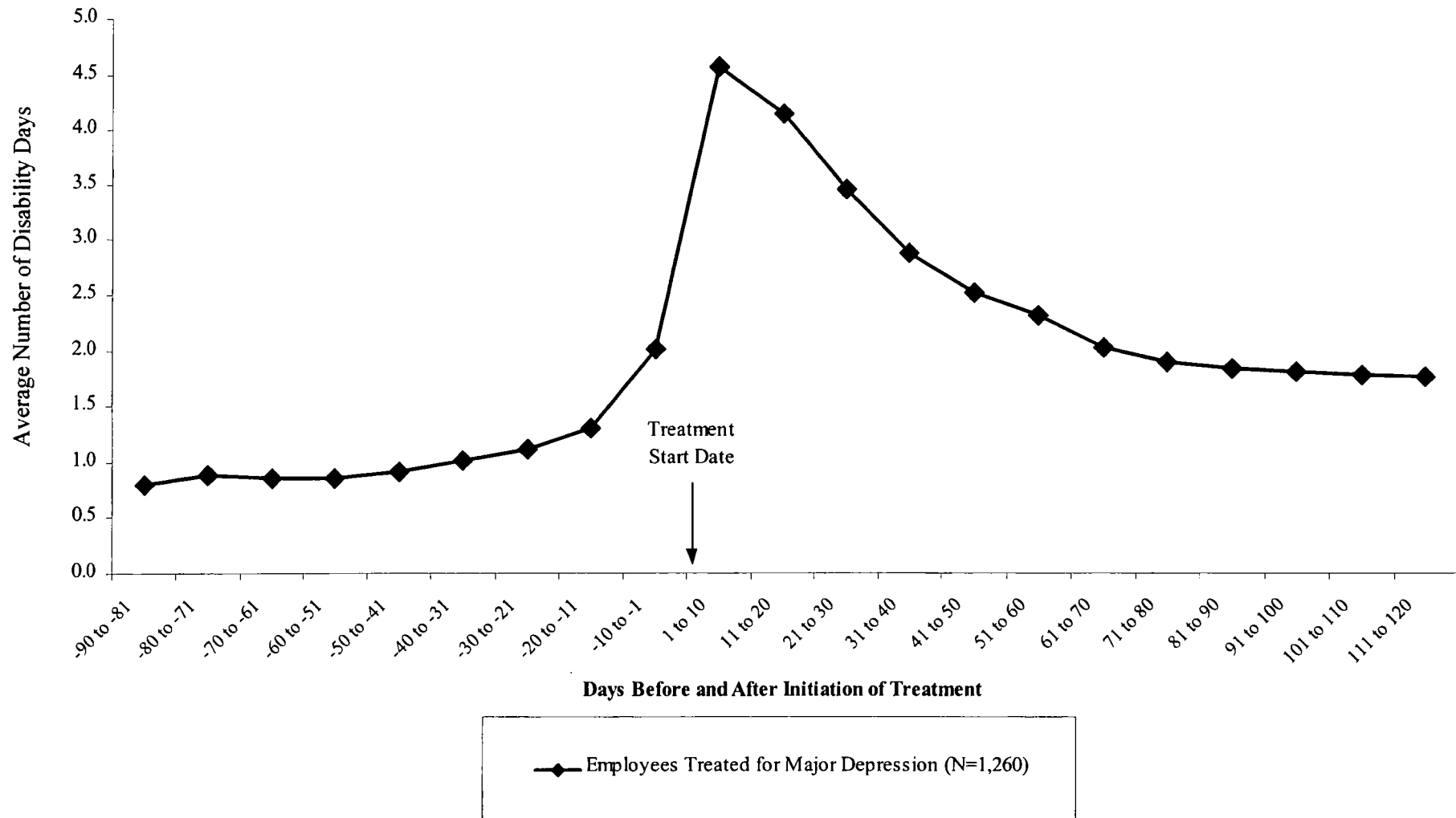


Note: 1997 employer payments for medical, prescription drug, and disability claims totaled \$11,096 for the average MD patient. This compares with \$3,127 for the average employee, based on 10% random sample, including persons with MD.

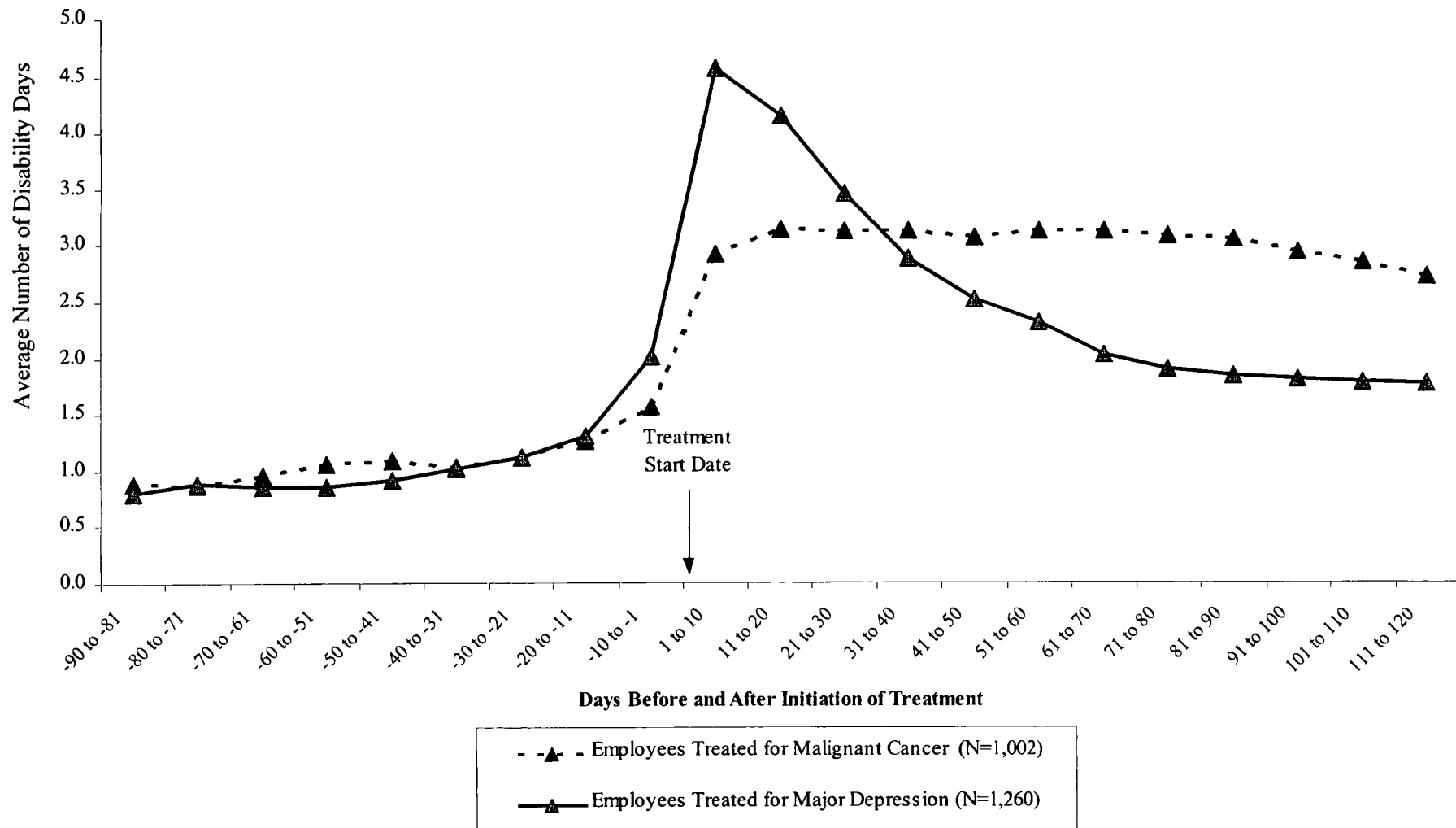
“Count”: Components of Annual Employer Payments for Employees Treated for Major Depression (1997 Average Cost = \$11,096)



Patterns of Work Disability Relative to Treatment Onset: Major Depression



Patterns of Work Disability Relative to Treatment Onset: Major Depression v. Cancer



Goal for Employers

- ◆ Characterize the overall burden of illness and its components.
- ◆ Investigate the relationship between medical, pharmaceutical, disability and other expenditures to identify possible offset opportunities in terms of both medical and workplace costs.
- ◆ Describe the process leading to a disability from work, and the role of illness and its treatment in driving this adverse outcome.
- ◆ Match strategies to each condition's patterns and outcomes rather than identifying a single overall cost driver.

Analysis Group/Economics Health Care Consulting Senior Staff

- ◆ **Howard G. Birnbaum, Vice President:** *Ph.D. and M.A. in Economics, Harvard University*

Dr. Birnbaum is an applied microeconomist who has specialized in the health care sector for over 20 years. He has consulted to health care payers, government organizations, manufacturers and providers, and has served as an expert witness in litigation. Dr. Birnbaum's work in health economics has been published in leading medical and health economics journals.

- ◆ **Paul E. Greenberg, Principal and Director, Medical Economics Practice;** *M.S. in Applied Microeconomics and Finance, Sloan School of Management, Massachusetts Institute of Technology; M.A. in Economics, University of Western Ontario*

Mr. Greenberg has directed numerous health care related projects involving pharmaceutical industry pricing analysis, cost-of-illness analysis and investigation of the economic impact of public policy proposals. His work in health economics has been published in leading medical, economics and management journals.

Analysis Group/Economics Health Economics Practice

- ◆ Analysis Group/Economics helps health care clients achieve long-term competitive advantage through research-based solutions to complex business problems.
- ◆ Our services include health outcomes research, such as cost-of-illness and pharmacoeconomic cost-effectiveness studies, as well as statistical and econometric analysis of clinical trials and administrative claims data, simulation modeling, productivity studies and public policy assessments.
- ◆ The firm also performs economic and financial analyses to assist law firms in all phases of litigation, and advises corporate and government clients on issues such as financial planning, market analysis, and mergers and acquisitions.

For more information, visit our web site at www.ag-inc.com or contact us by telephone at 617-349-2100.

The Rising Cost of Psychiatric Disability

Daniel J. Conti, Ph.D.
Bank One

Bank One

- 5th largest U.S. banking corporation
 - World's largest *Visa* card issuer (First Card, First USA)
 - Over 1,900 banking centers
 - Result of 10/2/98 merger
 - Bank One + First Chicago NBD
 - 93,000 employees
-

Bank One

- 10 Corporate Medical Departments
 - Blended EAP
 - Internal staff at medical units
 - Affiliates & vendors serve widespread branch network
-

Bank One

- EAP Services
 - Short-term counseling and/or referral
 - Managerial training & consultation
 - Critical incident stress debriefing
 - Major psych case management for Med Plan
 - Psych STD case management
-

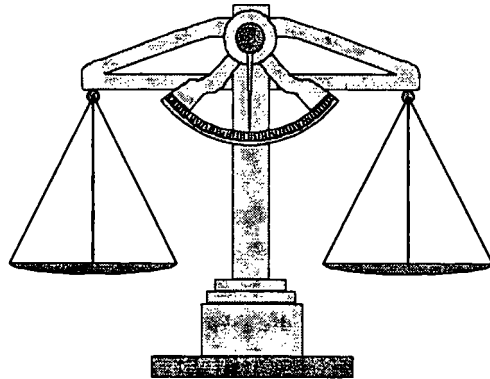
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- Short-Term Disability
 - “Self-insured” salary continuation benefit
 - Begins on 6th consecutive day of absence
 - Lasts up to 6 months
 - Managed by EAP
-

EAP Management of Psych STD

- Goals
 - Ensure appropriate care
 - Manage return to work
 - Provide follow-up support
-

Total Cost of Illness...



A Balance of Direct & Indirect Costs

Psychiatric Disability Costs Rising...

- UNUM Life Insurance Corp. (1996)
 - 1982 to 1994: *national* M&N disability claims nearly double (to 23% of all claims)
 - 1989 to 1995: UNUM experiences growth rate of 335% in M&N disability claims
 - Currently account for 11% of all new claims
-

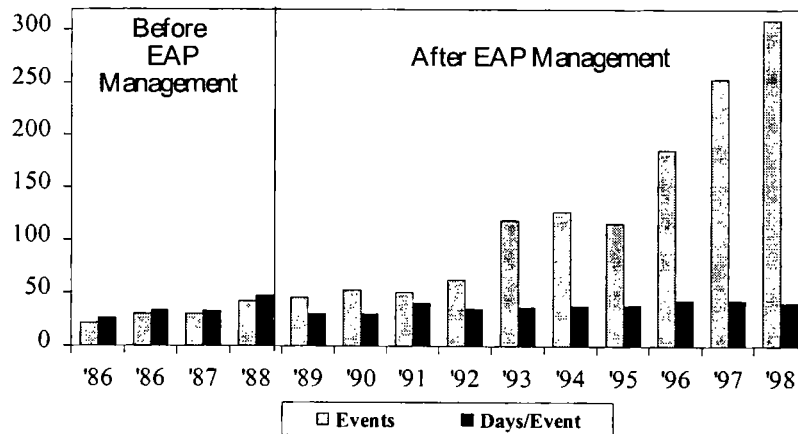
Psychiatric Disability Costs Rising...

- *Global Burden of Disease* (1996)
 - 1990: Depression is 4th leading cause of disability
 - By 2020: Depression will rank 1st
-

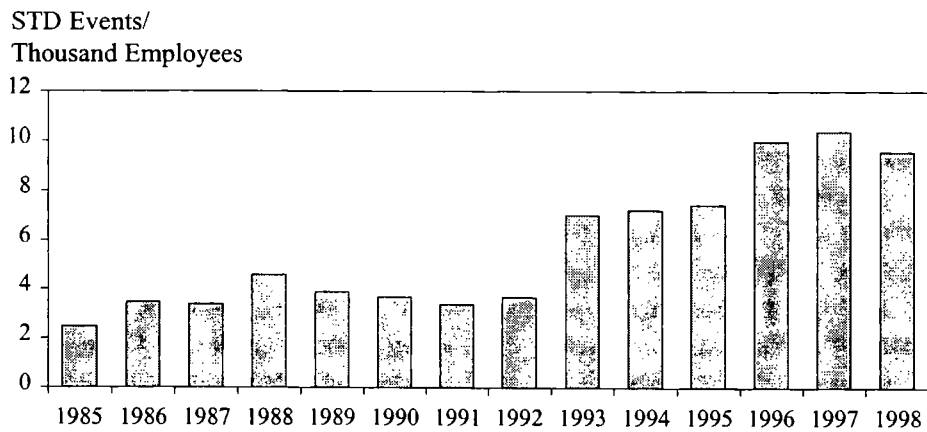
First Chicago NBD: Psych STD

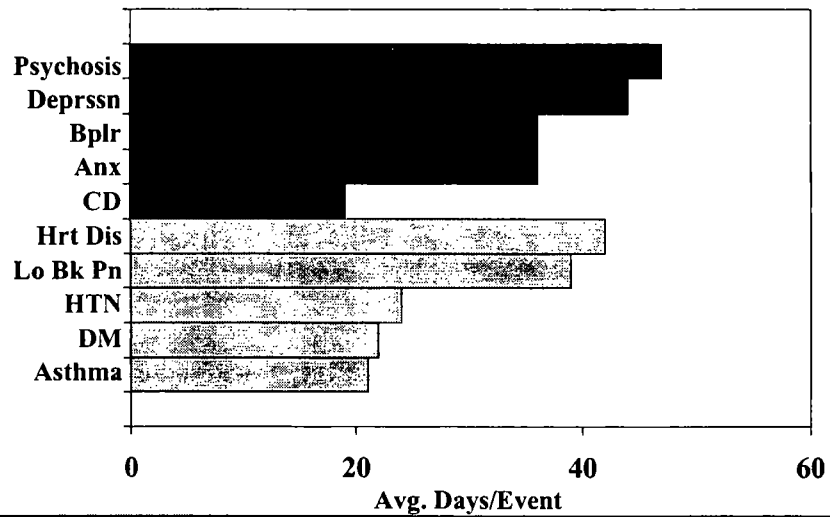
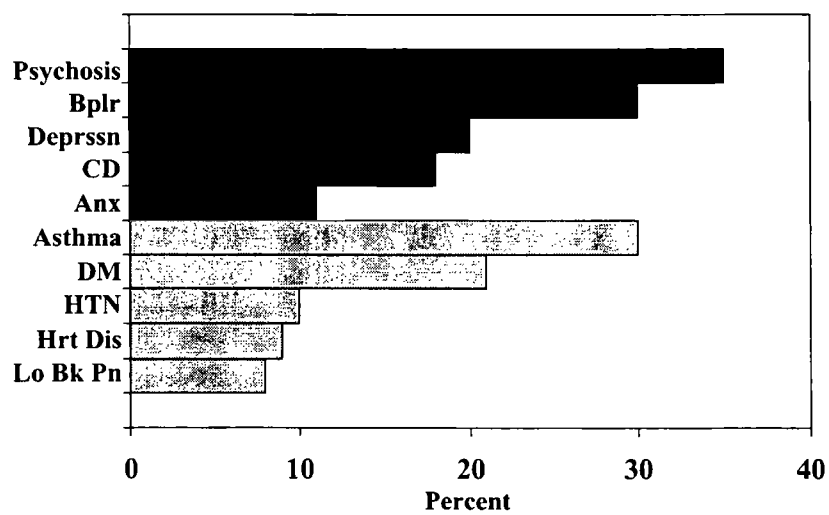
- | | |
|-------------------------------------|-------------------------------------|
| • 1989 | • 1997 |
| – 6th leading cause of an STD event | – 2nd leading cause of an STD event |
| – 4th in total STD days | – 2nd in total STD days |
-

FCNBD: Psych STD, 1986-98



FCNBD: Psych STD Events per Thousand Employees, 1985-1997



FCNBD STD: Average Days per Event, 1989-1996**FCNBD STD: 12-Month Recidivism, 1989-1996**

Multiple Factors Influence Psych Disability Increase

- Increased physician awareness & diagnoses as a result of M.D.-ed. programs
 - Public awareness campaigns (e.g., D/ART) increase self-referrals
 - Demographics: Increase of women in workforce
 - Organization of work factors
 - Current corporate climate
 - Changing nature of work in U.S.A.
-

Current Corporate Climate Fuels Psych Disability Increase

- UNUM & Johns Hopkins (preliminary study, 1997)
 - Companies with recent mergers that led to layoffs reported 33% higher M&N claims incidence
 - AMA & Cigna (1996)
 - Companies that eliminated jobs experienced largest increase in M&N and CD claims
 - Survivors also show effect
-

Responses to Increasing Psych. Disability

- Managed disability programs
 - Increased use of psych forensic examiners
 - Challenge to managed care
 - Examination of OoW variables
-

Issues in Psych Disability Management

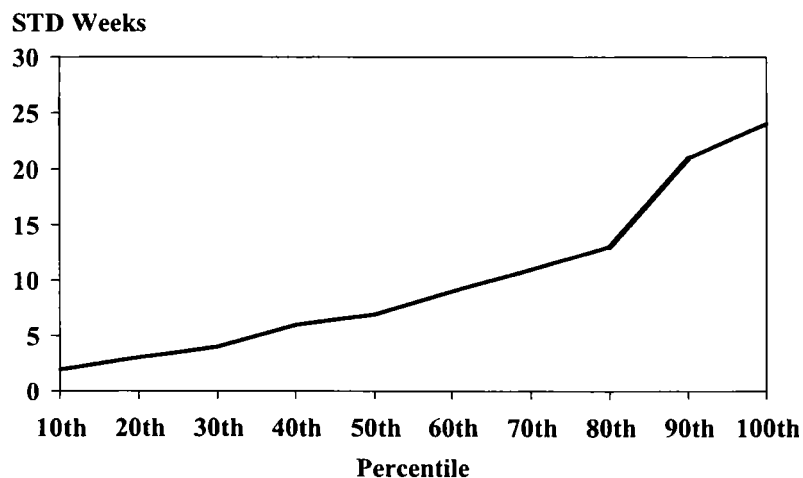
Issues in Psych Disability Management

- Providers
 - Length of event
 - Elements of Tx
 - Requests for accommodation
-

Issues in Psych Disability Management

- Length of Event
 - Observed:
 - Great variance within Dx
 - Contributing factors:
 - Little published data
 - Few corporations collect disability data
 - FCNBD response:
 - Provide reference points
-

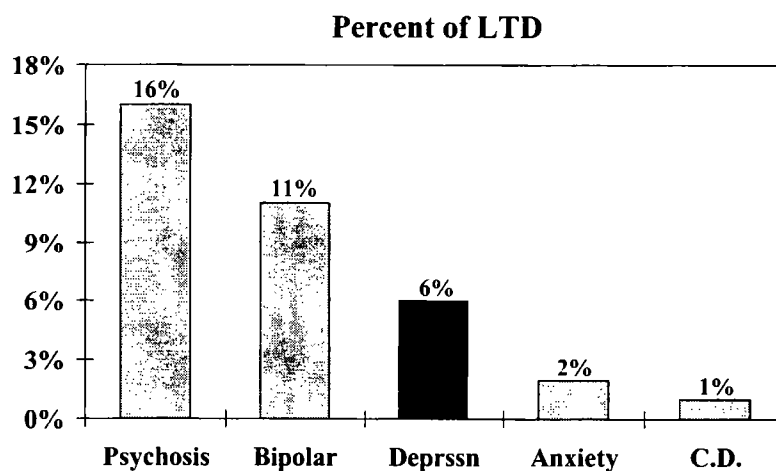
Percentile Rank of Depression STD Length, 1989-1996



Issues in Psych Disability Management

- Length of Event
 - Observed:
 - Great variance within Dx
 - Contributing factor:
 - Diagnostic issues: somatozation, malingering, personality disorders
 - FCNBD response
 - Use of IME's
 - Provide reference points

Psych STD, 1989-1995



Issues in Psych Disability Management

- Length of Event
 - Observed:
 - Great variance within Dx
 - Contributing factor:
 - Nature of behavioral health Tx
 - Question:
 - Can therapist play a more directive role?

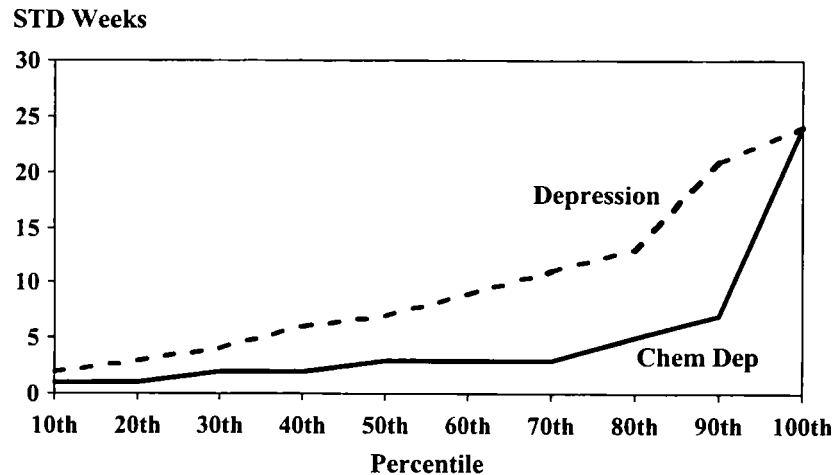
Issues in Psych Disability Management

- Elements of Tx
 - Observation:
 - Inadequate/insufficient Tx
 - Issues:
 - Access to behavioral healthcare providers
 - Inclusion of meds or psychotherapy
 - Step-up to higher intensity Tx
 - FCNBD Response:
 - Establish official liaison with MCO
 - Use of MCO “report cards”
 - A challenge to managed care . . .

“Report Card”: MCO’s & Psych STD, 1995

HMO	Avg STD Length	12-Mo. Rcdvsm.	Days/ 1000 Ee’s
HMO “A”	40	10%	236
HMO “B”	34	15%	346
HMO “C”	32	30%	404

Percentile Rank of Depression & CD STD Length, 1989-1996



Issues in Psych Disability Management

- Requests for Accommodation
 - Observation:
 - Vague, unreasonable requests
 - FCNBD response
 - Dialogue between provider & EAP Disability Coordinator

Issues in Psych Disability Management

- The Perception of Conflicting EAP Roles
 - Question:
 - Whom does EAP serve?
 - FCNBD Response:
 - Centralize STD management
 - Ensure EAP management adds value
-

“Generations” of STD Management

- 1st Generation
 - Comparable to U.R. Function
 - Anybody can “count days”
 - 2nd Generation
 - Comparable to Case Management
 - Ensure that treatment is being delivered
 - 3rd Generation
 - Comparable to Disease State Management
-

3rd Generation STD Management

- Best Performed by a Behavioral Health Professional
 - Strong knowledge of diagnostics & treatment
 - Strong knowledge of relationship of work to recovery
 - Follow-Up -- Key to Reduction of Recidivism
 - Monitor & support Tx compliance
 - Assist in relapse prevention
-

Summary

- Psych STD is a Growing, Major, Indirect Corporate Health Cost
 - Behavioral Health Care Must Respond
 - To avoid direction from Non-BHC forces
 - To further establish our value in decreasing corporate health care costs
 - To prevent the erosion of a significant worker benefit
-

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Fixating on fraud—which is widely believed to be responsible for just 1 to 3 percent of cases—is not an effective way to manage disability. But with annual disability costs estimated at 10 to 15 percent of total payroll, neither is passive acceptance that a newly disabled employee needs to be out of work indefinitely.

That's why astute employers are taking a broader view. They're on top of the tangled web of state and federal regulations, and they do what's necessary to guard against rip-offs. More importantly, they operate under the assumption that the vast majority of claimants want to work, and they devote the bulk of their energy to getting them off the disability rolls and back into the workplace.

In this new bimonthly series, we'll discuss the components of an effective corporate policy, including ways to establish mutual goals with disabled workers while enlisting the support of local physicians. We'll also report and analyze instances of admirable success and abject failure.

To begin, a veteran benefits consultant who has personally battled disability offers advice on developing a humane and cost-effective program.

The new di DISABILITY M

B Y J U D Y R . L E R N E R

The push for ERISA reform may have been triggered by the managed care backlash, but it is spilling over into the realm of disability management. In June, a federal district court in Virginia awarded a plaintiff—a former K-Mart employee unable to work because of severe depression—not just back payments but future benefits as well, continuing until he turns 65 if need be.

That decision was significant for several reasons: It narrowed the protective umbrella of the Employee Retirement Income Security Act, under which employers and insurance carriers have been held accountable only for the amount of past benefits denied. It was also a victory for advocates of mental health parity because the court found no compelling reason for coverage of mental disabilities to be different from (and less than) medical disabilities. Finally, it paved the way for increasing efforts to launch suits alleging discrimination against specific categories of illnesses, gathering force under the aegis of the Americans with Disabilities Act.

It all points to a need for a new direction in disability management: away from deeply rooted suspicions toward claimants that many disability specialists view as the biggest obstacles to humane employment policies and toward the widespread recognition that no one *wants* to be disabled. Given the choice, the vast majority of people would rather spend their days working than trudging from one doctor to another, undergoing rounds of tests, and all too often, devoting scarce energy to fighting the system. Obvious as that sounds, it can easily be forgotten amid the piles of disability claims, charts and medical bills.

The author, a freelance writer and former principal at a major benefits consulting firm, was disabled following a severe accident and chronic illness.

rection in ANAGEMENT

The best disability professionals are aware of legal ramifications and human considerations. They have processes in place to evaluate cases appropriately, and they forge relationships with claimants that head off costly and embarrassing litigation. Above all, they help employees return to work, even if that means in a different capacity or at a different company.

The problem's magnitude

Their management challenge has been growing steadily. There has been a 30 to 40 percent increase in long-term disability cases since the late 1980s, says Dick Lewis, a senior partner with LewisCo, a disability consulting and case management firm in Deerfield, Ill. Some insurance companies, Lewis adds, are experiencing rates as high as five per 1,000 covered employees, up from three per 1,000 a decade ago.

Federal disability rolls have swelled by more than 40 percent since 1987. This Social Security program is reserved for people unable to do any work at all, a much stricter standard than that of many employer-based plans. Nevertheless, 30 to 40 percent of applications get approved, and another 17 percent are approved at the first level of appeal. John Verlinden, disability program administrator at Social Security's Boston office, says the federal program processes some 2.5 million new applications each year. Nearly 5.5 million Americans received monthly disability checks in July of this year.

That's not to suggest that it's easy to join the ranks of those on Social Security. Proving you're disabled is a rigorous, drawn-out process, detailed in a recent *Los Angeles Times* article titled "Disability claims often face devastating wait." In three years, the average time it takes to process an appeal has stretched from

150 days to 340, the *Times* reports, leaving many claimants impoverished.

The real reason for the surge, Verlinden says, is demographic: "Claims are increasing as the baby boomers are reaching the age where the incidence of disability increases."

Couple the volume with the high cost of ongoing disability payments and the high risk-reward ratio for denial, and it should be no surprise that many employers and insurers do their best to deny claims. The downside of unwarranted denials has been minimal because ERISA prohibits claimants from suing for compensatory or punitive damages.

Pressure to revise ERISA, however, is escalating on both the legislative and judicial fronts. Although other federal courts have ruled differently than the judge in the K-Mart case and the retailer is likely to appeal, the recent U.S. District Court ruling gives plan sponsors reason to be wary.

Challenging assumptions

The real point, though, is not how much an employer can get away with but how to manage disability in a way that makes economic sense while protecting the interests of workers with legitimate claims. Experts I've interviewed, including disability consultants, attorneys,



JAMES ENDICOTT

physicians and health care executives, generally agree that no more than 2 percent of claimants are out to beat the system.

Yet the myth of widespread abuse continues. In the process, too many people with legitimate claims and desperate need of economic support are worn down by a system that repeatedly attacks their integrity and questions the validity of their suffering.

When I became disabled, for example, Social Security approved my application for benefits while my company denied my claims, citing reasons that were not listed in the plan document or summary plan description. And my story is far from unique.

Take the case of Kathy, a patient relations representative with a major health plan when multiple conditions, including rheumatoid arthritis and Crohn's disease, left her disabled. After six months of employer-paid short-term disability, she was denied benefits by the LTD carrier. She returned to work, missed 10 out of the next 30 days due to her ill health and left work again. More than a year later, her LTD claim still on appeal, the financial strain forced her into bankruptcy.

Gary, an HR director at a large insurance company, faced a similar conundrum after developing chronic fatigue syndrome: His employer allowed him to work on a half-time basis, but "expected me to get full-time results." After months of delays and denials, he settled his case for a fraction of the benefits he was due—a deal that required him to sign a statement promising he would not tell his story.

Reality calls for a different approach

Most people define themselves by their work, not by their marital status, their education or their hobbies, points out Steve Schrenzel, managing director of The Governance Group in Summit, N.J. He elaborates: "They say, 'I'm a nurse.' 'I'm a consultant.' 'I'm a construction worker.' Virtually every person I've met who has had to leave the workforce due to an injury or illness has had a terrible problem with personal identity. When asked what they do, they fall back on, 'I used to be ...' Our society links occupation and personal identity."

*"The government
isn't going to
solve this one
for us.
It's costing
us money,
and it's our
problem to fix."*

Getting back on the job before a "disabled mindset" becomes entrenched has major implications for an individual's sense of self worth, not to mention a company's financial liability. Still, Lewis regrets, "for many companies—even the large ones—this is more talk than action." Many people who go on disability can return to some form of work, whether part time or full time and whether in the same or a different position, he adds. "But we have to challenge our assumptions" and, in some cases, find creative ways to slightly bend the rules.

That's precisely what's going on at Metro-Goldwyn-Mayer Studios Inc., in Los Angeles. Sandy Sexton, executive director of employee benefits, says, "We're

not only here to protect the company (and its money) but also to help employees."

For example, when an in-house attorney got shot during a carjacking—she has undergone eight reconstructive surgeries thus far—the firm structured her first period out of work to combine STD benefits and salary continuation, allowing the staffer to do some work from home so the entire absence wouldn't count against her entitlement. Now she's on LTD, which will continue for two years as long as she remains unable to return to her own job. After that, MGM's plan calls for a reassessment, with benefits to continue as long as the claimant can't do *any* work for which she's reasonably qualified. The firm, like other employers with progressive disability programs, recognizes that a flexible benefits policy has intangible rewards (in addition to any monetary gains) in terms of employee loyalty and morale.

"We do our best to accommodate people's needs," Sexton adds, adjusting work locations and schedules as much as possible. "We even have a number of employees who work at night when there aren't other people around because they can't take the stress of interruptions during the daytime. You just have to use a little creativity."

Innovative thinking

That's where Workers Transition Network in Lancaster, Pa., comes in. The organization, says CEO Steve

second in a series

THE NEW DIRECTION IN DISABILITY MANAGEMENT

Tactical teamwork

Savvy employers know that PCPs play a key role in disability management and that the best results occur when there's plenty of interaction, not just between doctor and patient but between physician and employer as well.

BY KIRK STROSAHL, PhD, AND PAUL JOHNSON, MD



Disability costs the average business an estimated 8 percent of total payroll. Direct costs, such as short- and long-term disability premiums and workers' compensation, account for anywhere from 4 to 6 percent. Indirect costs, including absenteeism, lost productivity, hiring and training replacement workers and low employee morale, can push that tab to 10 percent of payroll.

The challenge, both in human and monetary terms, is enormous. But in our experience, disability remains poorly understood. In fact, it involves not only physical illness and injury but also personality characteristics, workplace stress and interpersonal dynamics as well as family, financial and nonwork role influences. What's more, many work absences stem from stress-related disorders or factors that interfere with physical rehabilitation after injury or disease.

Take pain, for example: In 1995, one study found, it accounted for nearly one in four sick days, or 50 million lost workdays nationwide. Add to that the evidence showing that pain-related disabilities cost the business community nearly \$3 billion a year. Then there's depression, found by one major study to be the second leading cause of missed workdays, surpassed only by end-stage coronary artery disease.

Little wonder, then, that companies have identified the need to actively manage disability as a cost of

doing business and that astute employers have begun to recognize the key role primary care physicians play. In addition to assessing physical needs and psychosocial factors that may escalate an employee's risk of remaining disabled, a doctor can be most effective by learning as much as possible about the patient's work environment—and forging a solid partnership with the employer.

A partnership philosophy

Companies vary widely in their approach to disability. Some manage cases aggressively while others adopt a hands-off approach. Some manage disability internally, and others rely almost entirely on third-party administrators. The broad set of options on the employer side is matched by differences among clinicians. Some see themselves not just as providers of health care but also as advocates for the patient in discussions with the employer, supervisor or disability case manager. Others believe their job is solely to provide care and steer clear of time-loss and return-to-work issues.

Regardless of the management context, the employer's representative in the disability process—the employee's supervisor, an internal disability case manager, an employee assistance program specialist or a third-party case manager—would do well to team up with the patient's physician. Effective management

Dr. Strosahl, a health psychologist practicing in primary care centers within Kaiser/Group Health Northwest, a regional HMO with 460,000 members, frequently addresses disability issues. Dr. Johnson, corporate medical director of U.S. West in Denver, oversees some 10,000 short-term disability cases annually.

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occurs when the doctor understands how the disability system works and adopts a philosophy geared to addressing the patient's health care needs and work realities as well as the employer's priorities. Without such physician participation and intervention, we've found, the patient's transition back to work is likely to be slower than need be.

What's more, meetings between benefits managers or HR professionals and physicians can go a long way toward delineating roles. Done properly, the interaction leads to a three-way tactical partnership of physician, patient and employer. In that climate, the patient receives effective medical care without the pressure of a poorly managed or vague disability claim, and employer and employee benefit from a speedy and successful return to work. And the physician experiences the satisfaction of not only successfully treating a medical or behavioral health problem but also of helping the patient return to a healthy level of functioning.

In forging this type of partnership, benefits managers need to keep three principles in mind:

Too much time off is unhealthy. Work is a major source of physical and psychological well-being. Conversely, evidence links being unemployed, disabled or retired with increased risk of psychological dysfunction. While a patient may convincingly argue that time off from work will help, the fact remains that anything more than a temporary respite may lead to depression or other psychological ills. A core management goal is to limit the length of disability, which helps keep the patient from developing a "disability lifestyle" that could result in long-term disability.

Disability is a mind-body process. While disability often emanates from a physical problem, the longer-term course usually is governed jointly by health and behavioral health processes. The extent of each varies from case to case. Disability stemming from major depression involves a hefty behavioral health component, for example, but frequently there are direct medical concerns, such as severe headaches, as well. Many common disability complaints, particular of pain and stress-related conditions like irritable bowel syndrome and migraine, involve physical and mental health.

The point is that effective disability management always involves a conscious assessment of medical and behavioral health factors. Part of this assessment should address the question, "What about this condition is consistent with an inability to perform the job?" This will help distinguish pain and other troubling symptoms from true disability.

As a rule, it is useful to involve an on-site behavioral health specialist in the management of cases that present with even modest psychosocial complications. If one is not available, the benefits manager or HR staffer should collaborate with an outside behavioral health provider who specializes in disability.

Pain and disability are not the same. The word "pain" is generally associated with serious physical illness or injury as well as distressing emotional symptoms. "Disability," on the other hand, refers to the functional impact of those symptoms, which can vary widely from patient to patient. Some people have a high tolerance for pain or discomfort and can function at close to normal levels in spite of it. For others, functioning deteriorates more than objective measures of the symptoms would suggest. Prior learning and current social context have a great deal to do with this variability, we believe. But the main point for employers is that objective symptoms and disability behaviors should always be managed as separate issues.

"Without physician participation and intervention, the patient's transition back to work is likely to be slower than need be."

Sizing up a disability case

Assessing, managing and in some cases, preventing work disability calls for the simultaneous application of two seemingly divergent approaches: Treat the patient as an individual *and* use population management principles to develop the best interventions. For the sake of simplicity, it helps to think of three distinct types of disability populations that require varying levels of management:

The first group encompasses patients with well-defined acute or progressive diseases or injuries, such as a heart attack or broken arm. For them, physical health care or occupational medicine is the primary intervention and the individual response to treatment is the primary determinant of the return-to-work time line and new work capacities.

In the second group are patients with acute or progressive diseases or injuries where behavioral health factors play a prominent role. For this population, health outcomes and the return-to-work time line are jointly determined by physical and behavioral health factors. Examples of patients in this group: a depressed worker with a back injury and an employee who suffers from migraine headaches and an anxiety disorder.

The third group consists of patients with behavioral health problems for which mental health or chemical dependency treatment is the primary intervention. Response to behavioral health services is the major determinant of the return-to-work time line and capacity. Examples include depression, alcoholism or loss of function due to marital separation or divorce.

Experience suggests that while the first group accounts for a significant portion of work disability, the vast majority of poor health and poor return-to-work outcomes occur in populations two and three. In many health care settings, the primary care physician will be responsible for the management of all three groups, even in cases where other clinicians, such as occupational health or behavioral health providers, are involved.

Strategies for success

In today's fast-paced primary care environment, the goal is to respond to immediate health concerns while maintaining some semblance of an on-time schedule. While that system works well with many of the patients who visit PCPs, we believe it is prone to failure when disability management or prevention is involved. The reason? Seemingly common-sense palliative strategies, like bed rest for a back injury, can actually induce functional disability. What's more, effective disability management calls for doctors and case managers who pay close attention to the patient's psychosocial context and are aware that conventional healing strategies can sometimes have unintended negative effects.

What does work? Benefits managers, case managers and anyone involved in disability management would be wise to keep the following strategies in mind:

- Look to the health care expert. The physician is a conduit for expert information about the patient's expected and real response to treatment, prognosis and functional capacity. But the doctor doesn't decide whether disability is warranted. That decision is made on the basis of a broader range of information, which includes a variety of workplace issues.
- Focus on functioning, not cure. If disability represents the functional impact of an illness, injury or set

of symptoms, then effective management should center on restoring the patient's functioning rather than eliminating symptoms. For patients with chronic pain or a progressive disease—conditions that may never be “cured”—the emphasis is on preventing unnecessary functional decline. The goal is to maximize functioning, including on-the-job function, in the presence of distressing symptoms.

Practically speaking, this means it is not just permissible but important to return a patient to work even if uncomfortable residual symptoms remain, especially if those symptoms do not directly interfere with the patient's capacity to perform functions intrinsic to the job. Savvy companies support light or modified duties to facilitate a return to work in such circumstances.

- Be compassionate but firm. While it is important to work collaboratively with the patient, managing disability requires a blend of empathy and determination. A conflicting array of financial and social reinforcements may encourage the employee to make demands that are unhealthy, unjustified or unethical.

For example, a patient with chronic back pain might request modified job duties that involve no physical exertion whatsoever. Yet honoring that request could exacerbate the chronic pain problem, since some form of regular physical activity is a basic chronic pain management strategy. Similarly, a depressed employee may want to be removed from major decision-making duties because he's afraid of making a serious mistake. Agreeing to such a request, however, could end up lowering his self-esteem over the long term, making a relapse more likely.

Still, it's important not to be rigid if an approach is clearly not working or if new evidence suggests a different course of action. As a rule, it is important for both employer and physician to explain guidelines and rationales in plain terms and for all parties to discuss and work toward a “win-win” solution or compromise. Giving the worker with a back injury brief intermittent periods of physical activity is likely to slowly increase his tolerance, for example.

- Be clear about what's disabling. Most employers have a specific definition of what constitutes “work disability,” a term that generally applies to the loss of capacity to perform tasks intrinsic to the job. By that definition, though, a worker can have many distressing physical or psychological symptoms and still not be disabled. For example, a depressed patient may suffer from fatigue and sleep disturbance but not be impaired in the concentration, decision making or short-term memory the position requires. Under cer-

tain disability plans, this employee would not be eligible for work disability.

- **Make return to work the goal.** From the very first employer-physician interaction, it is important to stress that any treatment or protocol needs to focus on getting the employee back to work in the shortest possible time. Encourage the physician to set a tentative return-to-work date at the time the initial disability leave is granted. For a patient with low back pain, for instance, it's a good idea to discuss accepted treatment guidelines—a few days' bed rest followed by rapid reactivation and return to normal activity level.

Many occupational health programs offer return-to-work classes that teach practical coping skills and address the psychological barriers employees may encounter after being off work for a while. If one is available, consider making immediate enrollment part of the required treatment plan. And whenever possible, involve the patient in helping to set a return-to-work time frame.

- **Set functional return-to-work criteria.** From the start, be clear about what functional criteria will be used to determine return-to-work readiness, and make it clear that these measures are achievable. Functional capacity, not the elimination of distressing physical or mental symptoms, should be the benchmark for return to work.

Telling a back injury patient that she can return to work when she has no more back pain, for example, could easily prolong, not shorten, a disability leave. Paradoxically, allowing a patient to remain off work and physically inactive is the surest way to create further chronic pain problems. A better approach is for the doctor to tell the patient she can return to work when her back pain subsides a bit and to reassure her some residual pain is normal for this type of injury.

- **Counter secondary reinforcers.** The concept of secondary gain is often applied to situations where a medical or behavioral problem persists at least partly because of social or financial reinforcements. For example, the patient who is eligible to receive full salary replacement for 90 days of short-term disability might view that as a three-month vacation from a stressful job. The frustrated spouse who becomes the center of a partner's attention because of a stress-relat-

ed leave of absence may not be fully motivated to aggressively work on her coping skills. There is no way to avoid secondary reinforcements, nor is it responsible to blame the patient for responding to them. A better approach: Giving an employee an aggressive, clear return-to-work message, coupled with a short disability time frame, tends to forestall the insidious impact of secondary gain.

- **Build reasonable job accommodations.** Frequently, an effective return-to-work plan involves a phase-in process in which the worker comes back on the job for specified periods, and relies on time or environ-

mental accommodations. Indeed, many attempts fail, either because the employer uses the accommodations in an adversarial way or because they are too extreme, unnecessarily requiring a worker to be reassigned to a new position altogether.

In short, accommodations should not be used to permanently redesign a patient's job unless it is unequivocally clear that the job setting or design is the primary cause of the patient's disability. Instead, employers and case managers should be as creative and flexible as possible, allowing an employee to temporarily switch to

a night shift job to reduce stress, for example, or to engage in modest physical activity for brief but increasing blocks of time.

The combination of employer and clinician perspectives we've suggested can easily be used to create an integrated approach to disability management and prevention. To accomplish it calls for a working partnership between patient, physician, and employer, however—not an adversarial relationship. Ironically, it also calls for including the patient in disability and return-to-work treatment planning *and* for doctors and employers to maintain a compassionate yet firm stance.

This approach also recognizes that while disability protection is a basic and valued employee benefit, it is one that is laden with destructive potential as well. Our hope is that our management philosophies and assessment and intervention strategies help benefits managers work with disabled employees in a way that allows the workers to heal and the employers to retain valuable staff members. □

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THE NEW DIRECTION IN DISABILITY MANAGEMENT

When it works

Disabled employees who are off the job longer than necessary often attract lots of attention, while those who return rapidly are overlooked. Here are three success stories—with an analysis of what went right.

BY JAN ZIEGLER, CONTRIBUTING EDITOR

Companies that manage disability can be assumed to have one goal in mind, and that is to manage it well. That's a challenging task, complicated by the fact that the definition of "managing well" has changed, as has the corporate culture.

A reflection of the change is the sharp rise in the number of employers with integrated disability management (IDM) programs: from 17 percent in 1996 to 42 percent last year. The reason, of course, is IDM's success. The figures come from Bruce Flynn, director of disability management at the Washington Business Group on Health, which surveys between 200 and 400 employers each year.

Integrated disability is not a complicated concept. It simply means employee benefit programs that have been around for a long time—health care, sick leave, short- and long-term disability and workers' compensation, all previously compartmentalized—work with each other and with the company. The common goal is to resolve whatever problem an employee is having and to get him or her back to the job, or to a job, as quickly as possible. Which makes a big difference to the employee who's disabled, says Steve Palermo, a former major league umpire who learned to walk with a cane after being paralyzed from gunshot wounds he incurred when he helped a woman during a robbery. Palermo now heads the WillReturn Council, a non-profit group formed by

Fortis Insurance Benefits Co. of Kansas City to research rehab successes and find out what made them work.

"With compartmentalization, it was as if you were being passed through the system like a baton," he says. Integrated programs, on the other hand, return the disabled employee to duty and eliminate managerial, administrative and medical duplication of effort. They also boost productivity by reducing absenteeism. And they do it all, Palermo asserts, without increasing premiums.

The integrated approach, whether it comes from inside a company or an outside vendor, requires a good deal of teamwork, yet in essence it boils down to two key parts. One is the components in place to help the employee through the disability, from medical care to occupational therapy. The other part, says Flynn, is the corporate culture.

Without supervisors who are willing or trained to help disabled employees come back on terms they can handle, without the provision of flex time or flexible duties, without help from the employees' individual work groups, the concept of integrated disability management can't live up to its promise. "I've seen cases where an employer buys the best disability management product, but the first time the case manager calls and says this guy can return to work if he can have a 15-minute break in the morning to do his back exercises, the



supervisor says, 'You've got to be kidding. That guy's not coming back until he's ready to do the job,' Flynn says.

Inside the company

Along with the integrated approach, more and more firms have changed their attitude concerning disability management, seeing it now as a point along a continuum. "The way most companies are looking at their health benefits is that they're an investment in people, in keeping people healthy and productive," says Ted Rooney, employee health manager at L.L. Bean in Freeport, Maine.

Bean has a number of plans and providers for disability care and coverage, but to this citadel of snowshoes and summer shorts, disability management begins with the promotion of wellness. "We recognize the potential for disability early. If you really want to go upstream, you could say smoking education is prevention for disability from heart attack," he says. The same goes for back injuries. Encouraging employees to get fit reduces the chance of injury and the need for surgery and disability leave.

When someone does become sick or disabled, the Bean approach follows athletic theory: If you get sore, what can you do to stay in the game? And what can your employer do to help you? "If you look at our products, it's important to go out and to be healthy to do that," Rooney says. "That underlies the whole philosophy."

At PepsiCo, whose product line includes Fritos and other snack foods as well as the ubiquitous soft drink, "business is predicated on millions of transactions that go on every day around the

world," says Dawn Werle, manager of health and welfare planning. "And many of those are particular transactions involving knowledge of product placement in a store, the local market, the store managers. Anytime a worker who knows those market factors is disabled, there's a chance for sales to suffer." PepsiCo's aim is to do whatever it can to help employees with conditions that affect job performance and return them to full speed, she says.

For example, PepsiCo's program tapped into community-based resources to find a church group to bring food to—and access to an illness support group for—a disabled employee who couldn't get out to shop. It also provided basic education to help an employee with diabetes learn how to better self-manage the disease, for instance, and linked him to a local endocrinologist for a more effective assessment of his condition.

The company supplements its local HR and line managers by partnering with vendors who are experts in helping people with these conditions, and in identifying and helping to solve employees' specific needs. These "partners" work with managers individually, where appropriate, to help them understand restrictions and required accommodations, Werle says. "We've improved the system, and managers appreciate getting employees back to functionality sooner to help them meet their business objectives," she adds.

When and why it works

Disability often arrives unexpectedly and when it does, it takes stamina and even enthusiasm for an employee to get back to speed for a return to the job. And that stamina, employers and disability management firms find, can sometimes use a boost. Depending on the situation, Fortis Benefits uses a variety of techniques, including site visits, to determine how to handle a case. Fortis may simply stay in touch with the employer, or may call the employee regularly to cheer him or her on. Case managers working with disabled employees use a questionnaire to help divine each patient's resiliency, "pro-activity," conscientiousness and will power. "It's a quick get-to-know you," says John Althoff, a rehabilitation officer. "As we interact with disabled employees over time, we adjust and try to help them capitalize on the strengths they have."

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Success Stories

In the White Mountains

Joan Jones, 60, is one who benefited from a more personal touch. Jones is a full-time graphic designer in the marketing department of Elan Publishing Co., an educational materials publisher in Moultonboro, N.H., whose staff of 35 turns out an array of products, including such things as teachers' plans and record books. "It's a very interesting job," she says. "I've been there the second longest of anyone there."

But following knee and hip replacement surgery in May 1997, Jones developed a knee infection and ended up spending more than 175 days flat on her back. For most of this time, she was at home. Every day, her husband administered an antibiotic drip through a chest tube. "I was so frustrated," she recalls. "It is no joke that I had Dr. K's phone number right on the bed rail" (Dr. K being the famous Jack Kevorkian, of course).

But then the light went on. Lynn Meyers, a rehab specialist with Fortis in Kansas City, recalls that when her office started talking with Jones about rehabilita-

tion, the patient got excited and "took charge of everything." When she was able to start moving around, Meyers says, Jones found her own wheelchair. Jones recalls the case reps at Fortis calling every three or four weeks, at one point asking her specifically if they could buy her a chair—and whether she needed a foot rest. They even said they'd try to find her one, but she did that herself.

Sue Brockman, a rehab specialist in Fortis' Minneapolis office, says her group also checks in regularly with its patients. Simply asking, "How are you?" often yields valuable feedback, they've found. "It's more than just calling and sharing the interest. We do something with the information we get back," Brockman says.

"We compare a lot what various parties are saying," she explains, so if healing doesn't go by the book, appropriate adjustments can be made. "It would be nice if we all healed the way we're supposed to heal, but we don't," Brockman adds.

Wyoming lineman

Flexibility with job assignments is also important. But the Powder River Energy Co. already knew that.

PRE is a customer-owned electric cooperative run by a board of directors that serves 9,300 people in northern and northeastern Wyoming. Its crews operate from offices sometimes more than 100 miles from headquarters in Sundance, and they're composed of people who are used to being jacks-of-all-trades. "The co-op is very pro-employee, so they work with us in every way they can. One of the things they do is provide short-term and long-term disability coverage," says personnel administrator Larry Kreuter.

The organization also tries to accommodate age: The older you

get, the less you have to climb—poles, that is.

Charles Atkinson, 62, was a PRE lineman for many years when he noticed funny things going on with his back. When the ache got worse and his right leg started to go numb, he decided he'd better get down from his poles and see a doctor. On September 29, 1997, he underwent surgery for three ruptured discs. He was up and walking the second day after surgery, but the medical orders were clear: No lifting. No driving. And that meant no work for four months. But he kept PRE and Brockman, the DM case manager, informed "all the way down the line," says Kreuter.

When he did go back to work—and he says he was really ready—

PRE assigned light duties: reading meters, inspecting jobs for the foreman and then replacing fuses on transformers, a job that requires the use of long, extendable sticks rather than climbing. Now, Atkinson goes out with line crews to replace hardware on poles. "The two guys I work with won't let me lift anything over 25 pounds," he says. "They take care of me like I'm my mother."

Kreuter explains: "We move people around anyway," so during Atkinson's absence if someone was needed for an emergency, an employee was moved in from another crew. Certain routine duties were short-staffed. "It's proved to be best for us to bring the employee back as soon as possible," Kreuter says.

Juggling at Silicon Graphics

Sometimes a disability is not just a single hit-and-run but a series of them. Over about eight years, James Sarauer, 37, experienced exactly that. Already asthmatic, in 1991 he was diagnosed with idiopathic cardiomyopathy, a condition that had left his heart able to function at only 16 percent of its normal capacity. A year later, he was diagnosed with testicular cancer. Nearly two years after that, Sarauer had a cancer recurrence in which two inoperable tumors were found affecting an artery of the leg. The first cancer was treated with surgery, the second with chemotherapy.

Now, although Sarauer twice became a candidate for a heart transplant, he's off the waiting list, thanks to a drug that has helped his heart return to over 50 percent of normal function. After each incident, Sarauer fought back and returned to work for as many hours as he could. Now he works full time, even overtime if he feels like it. He goes ice fishing, camping, on walks, on motorcycle trips and sometimes can even shovel the driveway. "My life is good," he says.

But in between medical crises, he was out for months at a time. When he returned to work, sometimes he couldn't even put in the full four hours agreed to. The company dealt with this by being flexible with assignments. "My bosses were really good about it," Sarauer says. "If I had to go to the doctor, I could. If I couldn't work the full four hours, I did what I could. They bent over backwards and so did everybody else."

"We worked together very closely for a long time," says Kit Duplessie, a nurse and the company's environmental health and safety specialist. Duplessie stayed in touch with the firm's managers and Sarauer's providers to help keep everything on track. During Sarauer's convalescences, he was assigned less urgent projects. However, during one phase, the firm was working on a more pressing assignment: helping to develop two supercomputers and a related data storage device. Though they were all related to each other, they had different electrical controls, and Sarauer was documenting the differences. His supervisor at the time, Steve Lasure, says the firm saved the parts only Sarauer could work on for when he was able to take up his duties again. The projects required a lot of synergy anyway, Lasure says. And he notes: "We had our parts of the projects done on time."



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All is well, usually

Disability experts generally agree that most employees are willing to get back to work. There are the occasional few, however, who are content to draw disability compensation even though they're capable of employment. In those cases, says Fortis' Meyers, the case manager may talk to the physician to see if a solution can be arranged, urge the employee to seek counseling or try some other route. Fortis offers a plan whereby it begins to reduce benefits when the employee returns to the job—any job. In a couple of cases, it has reduced benefits as if the employee had returned to work, even though that was not the case. This move usually has the desired result, however: "Sure enough, soon they have another job," Meyers says. □

last in a series

THE NEW DIRECTION IN DISABILITY MANAGEMENT

Curbing workers' comp claims and costs

Companies that address each component of workers' compensation individually—and coordinate the activities of them all—are virtually guaranteed substantial savings.

BY WILLIAM ATKINSON

Watching a company struggle with workers' comp brings to mind the story of the blind men and the elephant: Each "sees" only the part of the pachyderm directly in front of him but believes his vantage point reflects the entirety of what an elephant is.

HR managers, for instance, tend to view workers' comp as a hiring issue and zero in on their responsibility for compiling a staff committed to health and safety. Risk managers may see it as an insurance issue and education managers as a worker training issue, while operations managers are likely to consider it solely from a first-line supervisor's perspective. But the only way for an employer to have a successful workers' comp cost-reduction program is to look at the whole picture. Workers' comp, like the other components of a comprehensive health benefits program, thus becomes an organization-wide effort involving all functions, departments and levels of the company.

The workers' compensation program at St. Anne's Hospital, an 800-employee facility in Fall River, Mass., is a model of this broad approach. "We focus attention and resources on all the issues related to occupational illness and injury," says Sheila L. Wallace, director of security and safety and workers' comp coordinator. She's got the stats to show that the strategy works.

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In 1994, Wallace recalls, the hospital's workers' comp premiums more than doubled, going from \$200,000 to over \$500,000 in just one year. The drastic leap stemmed from a peak in job-related illness and injury two years earlier, when St. Anne's employees lost a total of 415 workdays related to workers' comp claims.

In the years since, St. Anne's has seen a dramatic turnaround. In September 1998, "we received a surplus distribution check from our insurance carrier in excess of \$225,000," boasts Wallace, who helped launch the coordinated workers' comp initiative four years earlier. This year's premium is \$112,000, down from \$609,000 for '98.

Julie Strickland, director of workers' comp for Houston-based Continental Airlines, echoes St. Anne's comprehensive approach. Rather than measure the results of a single component of corporate efforts to curtail job-related illness and injury, "we measure the results of the overall program, which we consider to be in line with a change in culture," she says.

Like St. Anne's, Continental has the numbers to substantiate the value of its multidisciplinary approach. Since '95, the airline's goal has been to reduce both lost time and claims costs by at least 10 percent per year, but, Strickland says, Continental has repeatedly surpassed it. Between 1995 and 1997, for instance, workers' comp costs fell 45 percent and the injury rate took a 55 percent nosedive. Impressive

JAMES ENDICOTT

as those numbers are, analysts agree that most any company, regardless of size, can do much the same. Here's how:

Don't hesitate to ask questions

While the bulk of the program relates to what happens when an injury is incurred and what steps are taken to reduce the severity, a comprehensive workers' comp program starts with prevention. And it begins in the prehiring phase.

Prior to the Americans with Disabilities Act (ADA), enacted in 1992, employers were relatively free to use health and fitness criteria, including knowledge of previous workers' comp claims, in making hiring decisions. That's not true anymore.

The ADA provides stringent guidelines designed to prevent discrimination against people with disabilities. Despite tales of woe and fear-mongering, though, the federal law does not leave employers twisting in the wind. While it is no longer legal to ask health-related questions in a job interview, it is permissible to do so after a conditional job offer has been made.

At that point, you can legitimately request information about past and present medical conditions and previous workers' compensation claims. A physical exam is also permissible, provided it relates to the work at hand and is paid for by the future employer.

What can you do with the results? Although court rulings on the ADA are split as to where the burden of proof lies, legal experts generally say it's permissible to withdraw the job offer at this point *if*:

- The applicant is found to have lied about his or her medical history or workers' compensation claims;
- a clinician certifies that the candidate has a disorder that would pose a health and safety threat to him- or herself or others even with the "reasonable accommodation" the ADA requires; or
- the medical professional declares the applicant unable to perform the essential functions of the job even if the requisite accommodation were made.

At St. Anne's, for example, occupational health specialists receive functional job descriptions for everyone with a conditional job offer, then review each candidate to ensure that he or she can handle all the elements of the particular position. A nurses' aide, for instance, would have to be capable of assisting in lifting and turning patients.

The message here: There is little reason for letting your fear of violating the ADA force you to abdicate your opportunity—even responsibility—to actively screen applicants for relevant health and safety concerns. "There is not as much risk on the front end as one might think," asserts Len Koch, vice president-

business development, for Avert Inc., a Fort Collins, Colo.-based pre-employment screening firm. His company has conducted "millions of screening initiatives" for employers, Koch says, "and only three job applicants have taken issue with our processes." None made it as far as a courtroom. "The real risk," he says, "is on the back end if you end up hiring the wrong people."

Focus on safety and supervision

Keeping job-related illness and injury to the bare minimum requires an environment with a heavy emphasis on safety. Savvy employers like St. Anne's set the tone right from the start, with a comprehensive safety orientation for all new employees. To maintain a commitment to workplace safety, however, efforts must be ongoing. St. Anne's follows up with a variety of education programs, ranging from monthly safety meetings to classes in safe lifting techniques to occasional incentive-based games devised when a particular safety problem threatens to turn into a trend. When the number of puncture wounds escalated, for instance, the hospital adopted a three-pronged approach. Its components: a "safety bingo" game, devoted solely to the prevention of accidental needlesticks; flyers focusing on accident prevention; and, perhaps most important, new and innovative recapping devices and needle systems designed with worker safety in mind.

Although accident prevention is an organization-wide effort, much of the real work falls to first-line managers. Indeed, incident rates vary considerably by department, fluctuating according to how well the supervisor orients new employees, stresses safe work techniques and keeps safety in the forefront. Those with the best safety records also maintain close enough employee contact to recognize and act on the need for intervention from the employee assistance program or referral for wellness or disease management, for instance—conditions that could rapidly escalate if allowed to progress unabated.

Ironically, studies suggest that the most important thing a supervisor can do to cut workers' compensation claims and costs is simply to be a good supervisor. Employees who dislike their jobs or are angry at or resentful of their superiors have been found to file many more claims than their more contented colleagues. Sometimes the claims are seen as a way to get revenge. In other cases, a workplace incident may be a conscious (or not-so-conscious) way to escape for a while. "Whenever we find a large number of claims, we look for poor attitudes on the part of employees," says Jeffrey W. Pettegrew, vice president, insurance and risk management for the Walnut Creek, Calif.-

based Western Staff Services. Poor supervision may be underneath it all, he says.

Build a solid team

Selecting a workers' compensation insurance broker who can meet your needs for ongoing help with loss prevention and control is vital, too. Because workers' comp is state-based, however, program provisions and the services required to help you comply depend in large part on the state in which your company is headquartered. Before you sign on with a vendor, verify that it can provide the needed support and ask other clients how cooperative the broker has been.

St. Anne's Wallace has worked closely with the hospital's workers' compensation carrier to develop what she calls re-education programs to combat encroaching trends. When she detected an increase in back strains among intensive care nurses, for example, the facility and the carrier joined forces to develop training in proper lifting techniques. Since the nursing staff began attending the lifting class, this type of injury has virtually disappeared.

St. Anne's also goes out of its way to forge cross-functional workers' compensation teams. Wallace acts as liaison with HR, risk management, occupational medicine and the employee health nurse, for instance, hosting a meeting with this interdisciplinary safety committee each month to discuss employee health and work-related illness and injury and address any trends that emerge. Wallace works closely with all department heads as well.

Respond immediately

No matter how tightly a firm focuses on prevention, on-the-job incidents can never be eliminated entirely. When accidents occur, the key is to remain in control. Action must be fast, deliberate and carried out in this order.

1. Assess the physical, mental and emotional condition of the injured employee, and provide immediate comfort and emergency treatment to the extent possible in the first few moments.

2. Arrange to transfer the employee to the appropriate medical provider, whether it's an in-house occupational health nurse, a doctor's office or a hospital emergency room, for follow-up treatment as quickly as possible.

3. Report the incident to the proper department or person, following a written protocol that every employer should have and every supervisor should be aware of.

4. Conduct a comprehensive accident investigation, complete with photos, interviews with witnesses and any other available evidence, to determine the cause of the accident. Document your findings.

5. Identify and implement strategies to prevent or reduce future occurrences.

This, of course, requires teamwork. "Any time an accident report is filed, the occupational health nurse and I conduct a follow-up investigation," says Wallace. If a hospital employee slipped and fell in a corridor, for instance, they would check for spills or foreign substances that may have made the floor especially slippery. And if a cleaning product or chemical agent were found, the protocol for its use and the seals on the containers it's stored in would be reviewed, with suggestions for avoiding future spills in mind.

Continental, too, emphasizes the importance of timely reporting. While supervisors once filed written accident reports weeks or even months after the fact, the airline's new system requires that someone—usually but not necessarily the worker's first-line manager—calls in or faxes the details of the incident to the airline's occupational nurses the same day. "Our goal is timely intervention," Strickland says.

Work closely with physicians

Many employers pass up an excellent opportunity to save money and ensure the best medical care for injured workers by paying little or no attention to the providers these employees see. While workers' comp laws vary from state to state on the rights and responsibilities of employees and employers regarding physician selection, companies almost always have some ability to steer injured workers to company-approved docs.

Ideally, these should be providers who specialize or are experienced in treating occupational illness and injury. It's particularly important for the physicians to be aware of the complex, and occasionally competing, considerations involved in treatment, recovery, the ability to function and rapid return to work.

"We have arrangements with occupational medicine clinics close to our airports," says Strickland. "We also have a list of specialists that we continue to update, and we provide these lists to the occupational clinics. We select all treating physicians on the basis of experience, reliability and timely availability."

St. Anne's has an easier time with physician selection, of course, because it is a medical facility. While injured employees are free to seek treatment from their private physicians, most feel comfortable being treated by the hospital's occupational specialist—the same doctor who conducts pre-employment physicals. Even when a worker opts to go elsewhere, the occupational doc gets involved. "If an employee wants to be treated by a family physician, we arrange for the two physicians to communicate with each other," Wallace says. In addition, all injured employees must be seen

by St. Anne's occupational doctor before they're allowed to return to work.

Stay in touch

It used to be common for recovering employees to remain at home for long periods, with no contact or communication with anyone from the company—with the possible exception of a case worker the insurer or third-party administrator might have contracted with. While the practice was never meant to be cruel or unusual punishment, it has been known to trigger a range of negative emotions on the part of the at-home worker, who may imagine that the company blames him for the accident or no longer considers her the right person for the position. The lack of contact has even been known to produce such anger and hurt feelings that the injured employee becomes increasingly more inclined to sue.

Fortunately, such problems have been recognized and, at least among savvy employers, the practice has been abandoned.

To be effective, the new thinking goes, contact needs to be in two forms: Regular visits or calls from first-line supervisors or managers to express personal care and concern, and ongoing case monitoring by a team often comprising the employer's workers' comp coordinator, the treating physician, the firm's TPA, the employee's manager and a nurse or other clinician specializing in occupational health. The idea is to make sure nothing falls between the cracks and that the employee is mending both physically and psychologically.

"We never allow a week to go by without some kind of contact with a worker who is recuperating," says St. Anne's Wallace. The employee health nurse usually makes the first contact, but Wallace often follows up.

Department supervisors maintain contact, too, except in situations where previous problems, such as disputes over the worker's performance, make such interaction too highly charged. "If there are performance issues, employees could construe a call from a department head as checking up on them" rather than as a show of support, explains Wallace.

Get 'em working

The latest workers' comp mantra, of course, is rapid return to work. In addition to being crucial to keeping workers' comp costs low, it's good for the psyche of the employees involved. Indeed, the old stay-at-home-til-you're-100-percent-recovered strategy has been found to be flawed in several key ways, from both an employer and employee perspective.

Lengthy time off incurs extra lost time costs, of course. On top of that, analysts say it gives workers

more time to get accustomed to not working—and to weigh the merits of an employment lawsuit. Then, too, research suggests that the shock of returning to work, purportedly 100 percent functional, after a long period of not working increases the risk of reinjury.

Prolonged absences are as bad for the worker as for the employer. Earlier return to work diminishes the isolation injured employees often feel and allows them to regain the companionship of coworkers. Not only does it allow the affected worker to return to a full wage but it facilitates speedier recovery. A gradual build-up of activity has been found to promote faster and safer physical recovery and return to overall well-being.

Successful organizations have return-to-work programs that offer opportunities for light-duty or transitional work, allowing employees a number of options:

- Return to their regular job full time, except for certain strenuous tasks;
- return to their regular job on a part-time basis; or
- return to a lighter duty job, either in their own department or elsewhere in the company.

"We work closely with department heads to get employees back to modified duty," states St. Anne's Wallace. "If the employee's department head is unable to find work, other department heads are usually able to find a budgeted position. If there are no budgeted positions, we can still find some unbudgeted work for the employee. This has helped reduce our lost time rates dramatically."

The hospital's time off policy is designed to encourage employees to return to work in a timely fashion, too. Officially known as CTO (for combined time off), it lumps vacation time, holidays and sick time together. "If an employee is injured and off work, the first five days come out of the CTO bank," says Wallace, so the worker can quickly lose the five sick days allotted each year. The insurance company kicks in on the sixth day but pays only 60 percent of salary. "So employees are usually very willing to come back to work in a modified duty capacity as soon as possible," she says.

"The only problem we have with our transitional duty program is that we occasionally have more employees than available jobs," notes Continental's Strickland. "One reason is that we have so many different work locations, and many employees don't live near where they work." To address this challenge, the airline is creating job banks where supervisors can go on record saying, "I will be able to take any employee you can send me at any time." Besides the obvious goal of getting workers back sooner, the new system is designed to help supervisors find people to perform tasks that have fallen by the wayside in the face of staffing shortages. □



Thinking Points

Perspectives on health care delivery and health reform

The Evolution of Workplace Disability Programs from Supported Absence to Productive Participation: Another Perspective

By Patricia M. Owens, Senior Disability Advisor, UNUM Life Insurance Company and
Bruce G. Flynn, Director of Disability Management, Washington Business Group on Health

People with disabilities in the workforce have been a major news topic in recent months, what with the President's Task Force on Employment of Adults with Disabilities' report, the Civil Rights Commission's hearings on the Americans with Disabilities Act (ADA), and the related ADA cases before the U.S. Supreme Court this term. As policymakers debate the funding of Social Security and Medicare in the next century, the costs of cash and medical benefits for persons with disabilities will become an increasingly hot topic. It's important that we not be distracted by the legal wrangling, some would say bickering, over the current ADA cases being heard by the U.S. Supreme Court. These cases, regardless of their legal merits, represent progress toward the broader, longer-term goal of full inclusion of people with disabilities in the workforce.

Being in the news is a sign of progress. It's about time that we have a broad, informed public discussion about workplace disability generally, and in particular, about how public and private employers can find ways to bring and to keep talented, experienced people in the workforce, by removing barriers to employment.

Disability benefit funding represents a significant portion of total health-related budget costs for large employers and for most employers generally. Social Security disability income replacement benefits amounted to \$78 billion in 1998, while their proportion of the over-all Social Security payout is increasing every year. Given today's tight job market, employers are highly motivated to rehabilitate and train capable employees. So it is clearly in employers, insurers, caregivers—and federal policymakers'—best interests to ensure that disabled employees achieve maximum recovery and return to work after illness or injury.

Large public and private employers have been in the forefront of addressing workplace disability issues for some time and have reaped positive results with initiatives that support productivity and full inclusion of people with disabilities. The Washington Business Group on Health (WBGH) represents primarily large private sector employers who have for several years pioneered development of workplace disability management (DM) programs designed to reduce the cost of disability for both employer and employee. Based on the results of a recent survey by Cornell University of ADA practices among WBGH members, these DM initiatives have also become the primary vehicle for the provision of reasonable accommodation for employees with disabilities following implementation of the ADA in 1992.

DM programs enable thousands of employees from WBGH member companies to continue working or return to work rather than becoming dependent on private or public disability payments. By meeting the accommodation needs of their own employees with disabilities, through eliminating physical, financial and attitudinal barriers, DM programs lay the groundwork for the hiring of job applicants with disabilities.

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The success of these efforts demonstrates that employers are willing to make accommodation to employ qualified persons with disabilities. A logical next step to move from absence support to productive participation is new public policies that promote return to work, ongoing support of working people with disabilities through continued health benefits, and legislation to encourage hiring or return to work for those with disabilities.

The \$2 billion budget endorsed by the President includes funding for provisions of the Work Incentive Improvement Act of 1999 which would extend Medicare coverage for people with disabilities who return to work, a Medicaid buy-in for those who remain disabled but lose eligibility for Medicaid due to medical improvement, tax credits for work-related expenses for the disabled, and the development of assistive technology to help employers better integrate people with disabilities into the workforce.

Employers know a good business deal when they see it and their investment in DM programs to retain and return employees with disabilities to work has paid dividends to both employers and employees over the past decade. Proposals to extend additional support (including health care) to disabled Social Security recipients who want to become self-supporting can also provide a long term payoff to all of us when increasing numbers of working age people with disabilities participate in the workforce.

The clock is running. The demographics of the 21st Century U.S. workforce suggest that there will not be a person to waste. Social Security and Medicare costs must be addressed before we enter a crisis mode. The President's Task Force and the Supreme Court ADA cases should serve as catalysts for increased public discussion and better understanding of the contribution of the working persons with disabilities. In this era of escalating health care costs and limited financial resources, paying for absence from work should be a last resort.



**Statement for the Record on the
Confidentiality of Health Information**

By

The Washington Business Group on Health

Submitted to the

**Committee on Health, Education, Labor and Pensions
United States Senate**

**April 27, 1999
Washington, DC**

I. Introduction

The Washington Business Group on Health (WBGH) has historically been a strong voice for the employer community on health care issues and remains so with a membership of 165 of the nation's largest and most innovative public and private sector employers. WBGH's members provide health care coverage for more than 39 million U.S. workers, retirees, and their families. WBGH's mission since 1974 has been to represent employers in promoting market-based, performance-driven health care delivery systems that improve the health and productivity of companies and communities.

Recognizing the seriousness of confidentiality issues and the enormous impact that legislation will have on employers, WBGH has formed a work group so that members can discuss their confidentiality concerns. This work group currently has 15 participants from 11 WBGH member companies. WBGH has asked both the work group and our Board of Directors to examine proposed confidentiality legislation for its impact on the day-to-day operations of their health-related programs and to provide feedback to inform the legislative process. We hope the information in this statement provides the basis for an ongoing dialogue between employers and lawmakers about this important issue.

II. Employer Stake in the Confidentiality Debate

WBGH is keenly aware that the Congressional debate over medical confidentiality issues will progress rapidly over the next few months and that employers have a key stake in the outcome of this debate. If authorization, record access, research, and state law preemption requirements do not recognize the complex, integrated environment in which employers' health-related plans currently operate, the effective functioning of these programs could be placed in serious jeopardy.

Passing confidentiality legislation that gives proper weight to the interests of consumers, employers, researchers, health plans, pharmaceutical companies, and others that utilize individually identifiable health information is a delicate balancing act. While employers understand and agree that any final confidentiality legislation must prevent identifiable data from being used improperly or shared inappropriately, we worry that regulations used to achieve this goal will be overly stringent and may hamper employer efforts to integrate different types of health care data, manage disability and chronic illnesses, and stimulate the development of organized systems of care.

Today's marketplace requires America's corporations to perform well and operate efficiently. At a time when very few workers are unemployed and the globalization of commerce requires companies to compete worldwide for market share, leading employers are seeking out ways to optimize the health and productivity of their employees. The cost of providing workplace health benefits (group health insurance, short and long-term disability benefits, and workers' compensation benefits) is of concern to employers, with these employee health benefits averaging 20%-25% of payroll for many companies and the price of providing health care rising an average of 7% annually.

aggregated and correlated predominately by external data management organizations. The use of individually identifiable information is typically limited to those situations where the identity of the individual is essential to carry out a function or intervention, such as in the case of disability management or the processing of workers' compensation claims.

IV. Employer Health-related Programs and Innovative Practices

Integrated Data Management. More employers are moving to integrate their health-related databases. These consolidated databases are used to identify both cost drivers and appropriate clinical interventions. Many employers have integrated their health data management systems to identify meaningful correlations and relationships among the variables in the databases.² For example, companies have used their integrated health data management systems to:

- identify specific problems (compare company data with other companies, units within a company, or normative data);
- determine the impact of one program on another (e.g., link data from health risk appraisals to health insurance claims);
- model the effect of proposed changes (real cost rather than cost based on actuarial estimates);
- identify potential areas for negotiations with providers (break out unit costs from utilization data).

By combining information from their health and disability programs, employers are able to achieve tangible and important results such as: creating a work environment that prevents employees from missing work, quickly returning sick or injured employees to health and to productive work, and keeping health benefits costs in check.³

Disease and Disability Management. Many employers and health plans have developed proactive, targeted disease and disability management programs. These programs focus on early identification and case management techniques to ensure these conditions are properly treated. In addition, employer-sponsored health promotion activities often focus on preventive services such as health screening and education to prevent illnesses and disabilities. Employers often use population health risk assessments (i.e., health risk appraisals and/or health screenings) to target health care resources to individuals who need them most. Today's health promotion initiatives increasingly incorporate primary intervention and the day-to-day management of chronic diseases, such as asthma and diabetes.⁴

² *Putting the Pieces Together: A Guide to the Implementation of Integrated Data Management Systems*, Prevention Leadership Forum, Washington Business Group on Health, 1992

³ *Creating a Line of Sight: From Benefits to Business Results*, Washington Business Group on Health-Watson Wyatt, 1999

⁴ *Diabetes Management: Making the Business Case*, Washington Business Group on Health, 1999

and provided by a multidisciplinary team of clinicians. The management and sharing of information is critical to achieving the OSC vision.⁶ Information systems and technologies enable OSCs to answer key questions about the appropriateness, cost, and outcomes of care provided to members. To do this, WBGH believes OSCs should have electronically linked clinical, financial, and administrative databases. This involves the transfer of individually identifiable information.

V. Administrative and Technical Safeguards

Trust is an essential element in the relationship between patients and health care providers and between workers and their employer. WBGH companies recognize that employers must ensure that strong safeguards are in place so that confidential medical information is not misused. These safeguards should enable employees to feel comfortable sharing sensitive medical information with appropriate providers and personnel in the doctor's office and at the worksite. Accordingly, employers use specific techniques such as encryption, organizational firewalls, and password technologies to prevent inappropriate access to individually identifiable health data. Well-defined penalties are in place to deal with any confidentiality violations.

VI. Specific Comments on Proposed Confidentiality Legislation

The three major confidentiality bills the Senate will debate this year – S. 578 sponsored by Sens. Jeffords (R-VT) and Dodd (D-CT), S. 573 sponsored by Sens. Leahy (D-VT) and Kennedy (D-MA), and Sen. Bennett's (R-UT) proposal – are comprehensive in scope and are indicative of the effort being put forth by this legislative body to meet the August 1999 HIPAA-imposed deadline to pass confidentiality legislation. Despite good intentions, there are requirements in each of these bills that would interfere with an employer's ability to accomplish both simple and more complex health-related functions. We are particularly concerned with how five issues have been dealt with in proposed confidentiality legislation: (1) how an authorization to use individually identifiable health information should be obtained; (2) narrow definitions of health care treatment, payment, and operations; (3) preemption of state confidentiality laws; (4) the time frames specified for amending individually identifiable information; and (5) new regulations for privately-funded health research.

Authorization

Employers may find that drafting a detailed authorization is both difficult and impractical. Senate confidentiality legislation requires that selected entities obtain an individual's one-time, written authorization to disclose individually identifiable health information for purposes of treatment, payment, and health care operations. This authorization must at a minimum: (1) describe the nature of identifiable information being used or disclosed; (2) identify the types of people to whom disclosures would be made; (3) describe the purpose of disclosures; and

⁶ *Health Care Delivery System Reform: Distinguishing Organized Systems of Care*, Washington Business Group on Health, 1995

employers and their employees is that these definitions cover a wide array of current health care practices. For instance, the term health care operations has been crafted to include many health-related functions employers and health plans currently perform such as: quality assurance and improvement activities; outcomes assessments; provider education; accreditation, licensing, or credentialing; analyzing health plan claims or health care records data; utilization review; recertification or preauthorization of services; and conducting or arranging for auditing services.

It is unclear, however, whether individually identifiable information can be used in executing sophisticated health education, disease management, or disability programs. This depends on whether such management and education activities fall under the bills' definitions of treatment, payment, or health care operations. If they do not, then employers would have to obtain additional authorizations from individuals to use their health information for these purposes, making it extremely difficult to carry out innovative health education and management programs. This is an undesirable outcome.

Another concern is that the term health care treatment, payment, and operations does not appear to include worker's compensation functions. Employers recognize that regulating workers' compensation benefits has been an area traditionally handled by states but it must be understood that the application of federal standards for all health programs but workers' compensation programs could be quite problematic. If workers' compensation activities are not included in the health care treatment, payment, and operations definition, then employers may be unable to pool health, disability, and workers' compensation data to coordinate care and benefits, facilitate payment, identify at-risk employees, recognize patterns of disability incidence, or target individuals or groups for health interventions.

Employers like WBGH member Owens Corning, for example, have experienced great success in terms of reducing both costs and lost work days when workers' compensation activities have been combined with short and long term disability functions into an integrated disability program. In 1993, Owens Corning initiated its integrated disability effort and assigned regional multidisciplinary teams to formulate and implement an individualized treatment plan for each injured or disabled employee. Since this time, the number of workers on long-term disability has decreased from 800 to 525 people and total disability costs have plummeted from \$25 million to \$10 million.⁷ If workers' compensation activities are not covered by the definition health care treatment, payment, and operations, benefit integration and the fiscal and functional improvements integration brings about, could be put at risk.

Preemption of State Confidentiality Laws

Employers need full preemption of state confidentiality laws for effective benefits administration and data collection. Not surprisingly, large, multi-state employers have generally been supportive of a uniform federal confidentiality law, instead of state-by-state regulation. Therefore the preemption provisions in some of the more stringent confidentiality

⁷ *Investing in People for Corporate Success*, Washington Business Group on Health, 1999

well-being of employed populations would be lost resulting in increased costs and disability and diminished productivity.

In her testimony to the Senate Labor and Human Resources Committee on September 12, 1997, Secretary of Health and Human Services Donna Shalala asked, "Will our health records to be used to heal or reveal us?" This question underscores the competing interests that Congress must weigh during the 1999 confidentiality debate. We hope that when legislators consider issues of confidentiality they will focus not only on protecting privacy, but also on understanding how employers and others use critical health information to heal individuals and maintain maximum functionality. WBGH stands ready to help Congress accomplish this task.

Commentary: A Business Perspective on Disability in the Workplace

Bruce G. Flynn

The cost of doing business in past years included paying many people to stay home and collect workers' compensation, short-term, long-term, and retirement disability benefits. As the cost of public and private-paid disability benefits soared, businesses realized that there had to be a better way. Organizations are now beginning to develop and integrate health and disability management programs with an eye toward health promotion, disease prevention, and reducing disability-related lost time. Business has recognized that "there is not a person to waste" when it comes to managing their human resources.

When I was a vocational rehabilitation counselor working for the state agency in Michigan in the mid-1970s, I couldn't figure out why employers in my area didn't hire more people with disabilities. My coworkers and I had followed all the prescribed steps for preparing clients for work: medical and vocational evaluations, retraining, job-seeking skills, adaptive equipment—the whole nine yards. Admittedly, there weren't very many jobs up for grabs then, because the automobile industry was in a slump and a lot of people were out of work. But it seemed that our state agency clientele had at least as good a shot at the few jobs that were open. Why did so few get jobs, I wondered?

Then, one day a machine shop human resources director and I were discussing this issue, and she said the answer was quite simple—most businesses already had all the employees with disabilities that they could handle. It took me another few years to figure out what she meant. At the time, I certainly didn't see very many people with obvious disabilities around that shop. Who were these employees with disabilities that she said every employer already employed?

As it turned out, she was referring to the huge number of workers' compensation and disability benefit recipients that most companies maintained on their payrolls (or at least on their inactive employee rolls) who

continued to draw benefits nearly indefinitely in those days. The cost of doing business in the 1970s included paying many people to stay home and collect workers' compensation and short-term, long-term, and retirement disability benefits. It was basically a tacit agreement—a benevolent conspiracy if you will—between employers and workers that employees who became disabled through work or nonwork-related injuries or illnesses while employed would collect disability benefits in some form until they either recovered, died, or became eligible for Social Security. That was the bargain: you get sick, we'll pay you to stay home. So employers had plenty of "disabled workers." They just weren't at work.

No one much questioned it—it was just the way things were. And it became entrenched during the recession of the late 1970s because, with few jobs available and more and more unskilled and semiskilled workers being laid off, who would be fool enough to trade a guaranteed monthly income for the rigors and uncertainty of a vocational retraining program? I was regularly greeted with puzzlement, skepticism, and outright disbelief when I would suggest to an unemployed factory worker with an eighth-grade education and a crushed left foot that he should consider getting his general education degree (GED) and then study electronics, drafting, or maybe even that new field, computer programming, at the local community college. "What? And risk giving up my union pension and Social Security checks? I'm clearing over \$1500 a month, tax free. Will I earn that if I go back to work as a computer programmer?" So, through the mostly well-intentioned complicity of employees and employers, the cost of disability was shifted onto private and public sources of disability benefit income. The image of the worker with a disability was that of a cost driver, so it was not surprising that most employers would not consider adding more employees with disabilities to their workforce. In their view, they already had as many employees with disabilities as they could afford.

A lot has changed in 25 years, however. I was employed by a large public employer during the 1980s and a multistate financial institution in the 1990s doing employee benefits, human resources, and, as it has become known, disability management work. What I and my colleagues in this fledgling field worked to achieve during those years was fuller appreciation of the real costs of poorly managed workplace disability. Ultimately, employers (and the federal government) learned that the paid furlough of employees with disabilities from the workplace had become expensive, costing hundreds of millions of dollars per year. Workers' compensation and private disability benefit costs soared, while the number of working age people drawing Social Security increased by 60% between the mid-1980s and the mid-1990s. The "tacit agreement" had turned into a financial disaster for organizations and for federal entitlement programs, not to mention the difficulties faced by

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individuals on fixed incomes during years of double-digit inflation. It was time to renegotiate.

Thus, disability management was born from the blending of vocational rehabilitation, human resources management, and benefits administration (along with contributions from claims and case management, safety and ergonomics, employee assistance, physical medicine, risk management, and a host of other specialty areas that touch on workplace disability issues). When the Washington Business Group on Health founded the Institute for Rehabilitation and Disability Management in 1982, the term *disability management* was barely known outside of a handful of businesses and a few consultant-researchers who had begun working in this hybrid field. Seventeen years later, disability management is the cornerstone of workplace-based disability programs within hundreds of progressive organizations that save companies millions of dollars in benefit outlays and lost work time every year.

For all the insurance and Social Security reforms enacted during the late 1980s and into the 1990s, the biggest gains for employers in controlling disability costs have been realized through the implementation of systematic medical treatment, case management, and return-to-work strategies. For those companies that recognized the potential savings and implemented programs years ago, the process has fundamentally changed the bargain struck during the 1970s with their employees with disabilities. Progressive and cost-conscious companies will now do anything reasonably possible to ensure that employees who become disabled while employed have a job to which they can return.

If "reasonably possible" sounds a lot like "reasonable accommodation," it is not coincidental. Beginning in 1992, the Americans With Disabilities Act (ADA) brought the weight of a new civil rights law to bear on the development of these programs. As human resources professionals came to understand the implications of the ADA, a dialog began to develop between those on the benefits and finance side of businesses and those on the employee-relations side of businesses (a new and, in many cases, unfamiliar dialog for many organizations). This dialog resulted in an alliance whose goal was not only to save benefit dollars but to protect the company from liability for potential discrimination charges, as well. Employers now understand reasonable accommodation as the means for achieving their lost-time management objectives and have melded the two in the creation of company policies that promote return to work through job modification.

As we prepare to enter the twenty-first century business environment—an environment that demands rapid adaptation to marketplace change, continuous innovation, and instant access to information—employers, insurers, and benefit consultants by the thousands attend conferences to hear the latest developments in integrated benefit strategies, time-loss

management, and return-to-work program design. Organizations are beginning to integrate health and disability programs with an eye toward health promotion, disease prevention, and improving health outcomes for all employees, disabled and nondisabled alike. Workers' compensation costs have stabilized (and, in many states, declined) and disability benefit cost increases have flattened. Legislation has been proposed that would allow the Social Security Administration to provide extended benefit and medical coverage to those recipients who embark on return-to-work rehabilitation plans.

But statistics from the Equal Employment Opportunity Commission indicate that unemployment rate among people with disabilities remains at 60 to 70%, despite a booming economy and miniscule unemployment among the majority of the nation's working age population. Clearly, this is a large and potentially productive labor pool that, in these times of a dwindling labor force, could assist employers in meeting their workforce needs. But a number of forces are at work that will affect whether or not this will happen.

Consider the following questions:

What is the real effect of workplace technology advances? The emergence of the personal computer as the omnipresent workplace tool has created more opportunities for technically competent employees. It has also created expanded options for telecommuting and long-distance communications. But software applications and the Internet are not universally accessible. Although schools now routinely expose children to computer use at an early age, many Baby Boomers in their 40s and 50s still lack basic computer knowledge. If job openings requiring computer expertise are to be filled from the current pool of disability benefit recipients, training resources must be made available for vocational rehabilitation on a massive scale.

How will employers cope with the aging workforce? As Baby Boomers push the average age of employed workers above 40 for the first time in history, the management of chronic disease and disability looms as a primary challenge for corporate health and disability programs. As employees age, their need for accommodation in the workplace will increase. To assist these employees in maintaining their productivity, employers will have to become even more creative about the way jobs are structured, work time is scheduled, and work tools are designed and used as part of corporate investment in its people assets. This could create even more opportunities for new employees with disabilities as these types of accommodations become more the rule than the exception in the workplace.

Will the managed care debate resolve the issues of what constitutes true healthcare quality? Health plans have already squeezed the last wasteful dollars out of the system, according to most experts. Many health care plans limit access to chronic care services (such as pain management, diabetes management, and low-vision services) and new "high tech" treatments to

save money. In addition, the cost-effectiveness of mental health care is still being debated (despite numerous studies showing that access to good mental health care actually drives down overall health costs). If business is committed to keeping employees healthy and employed, shortsighted cost cutting must give way to a broader view of the return on health investments in the form of employees who can continue working productively well into their 60s and 70s. To justify rising costs predicted for the next millennium, health care organizations must respond to the needs of their patients as well as the employer-purchasers of care for the improvement of overall organizational health and productivity.

Is there a connection between disability management and hiring employees with disabilities? Employers who have implemented disability management programs for their own workers understand how to coordinate health care services to optimize return-to-health outcomes; they have policies and programs that support reasonable accommodation; and they focus on the abilities, not the disabilities of their employees. However, few have applied the lessons learned in managing disability for their own workforce to the hiring process for new employees with disabilities to their workforce. Another internal business dialog will be necessary, prompted by those in those in the rehabilitation counseling and disability management field, to bring the message to the recruitment-employment side of the organization that this company has the policies and programs in place to promote the entry of new employees with disabilities—employees who can help the company meet its workforce needs without requiring new services or adaptations—into the workplace. Clearly, organizations that are committed to optimizing the health and well-being of their workers in the long run will be the most successful companies, able to sustain corporate growth while fostering creativity among employees. It remains for further research to demonstrate whether disability management programs can lay the groundwork for hiring new employees with disabilities.

I believe that in the next century, the link between health and productivity, both on an individual level and on an organizational level, will become much clearer than it is today. But the terms *health* and *productivity* have to be redefined. Health is not simply the absence of disease or disability—it is optimal functioning. A person with quadriplegia functions optimally not when he or she is free of decubita or breathes without assistance, but when his or her mind is engaged and he or she is capable of making her or his way back and forth to work. In the same way, productivity in organizations is not simply everyone working as hard and as long as possible but each person contributing in their own creative and unique way to the organization's long-term goal of continuous innovation and growth.

I am proud of the rehabilitation counseling profession for what it has contributed to the business world's understanding of the nature of dis-

ability in the workplace. The challenge for the next century is daunting but attainable in my view. Business, health care, rehabilitation, government—all parties must embrace a broader view of what it means to be healthy and what it means to be productive for the promise of the ADA to be truly fulfilled: "The nation's proper goals with regard to individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency" (Marshaw & Reno, 1996, p. 11).

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Job Retention Through Disability Management

Rochelle V. Habeck

Employer-based disability management is an important component in a comprehensive approach to improving employment for people with disabilities because of its impact on job retention and the quality of employment obtained. The article reviews the literature regarding the rationale for including this approach and available evidence about its importance for individuals with disabilities, for employers, and for the goals of public policy. The competencies required for this approach are presented and their implications for professional development and service delivery systems are discussed.

Practitioners and scholars alike have long recognized that the chances of obtaining new employment after disability are far riskier than staying with the job one has. On the theoretical side, this premise has been articulated by scholars in economics and labor-market theory (Levitan & Taggart, 1977); and on the practical side, it has been the rationale behind the "hierarchy" of job placement strategies in the workers' compensation arena (e.g., Matkin, 1985). In the current labor market, considerable evidence demonstrates that searching for new employment or for new employees is typically more costly and risky to all parties (Wegmann, Chapman, & Johnson, 1985). For the worker, this strategy is likely to result in a period of unemployment, possible retraining or work at a lower skill level, and lower relative compensation, in benefits and wages. For the employer, there are more costs and risks involved in paying for benefits and services to accomplish outplacement and in hiring a new employee, compared with those typically involved in accommodation and retention.

Both for workers who become disabled and their employers, the rational solution is job retention. This is generally intuitive and motivating when the parties have been satisfied with the payoffs of their past relationship and the disability situation is perceived by both parties as potentially manageable.

However, if job satisfaction or job satisfactoriness was not strongly present in the situation before disability, if attitudes toward the disabil-

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ity are negative, or if other factors enter the equation as barriers (e.g., downsizing, family needs), then accepting the more distant and uncertain costs and risks involved in new employment/replacement may seem easier than facing the known obstacles and compromises to accomplish successful retention. The human tendency to idealize a new, hypothetical solution and to avoid the anticipated struggles and dissatisfactions of working through the current employment situation and disability issues make job retention the more difficult path in some situations. This is especially true if the costs and consequences of avoidance can be passed along to a third party.

For example, suppose a very skilled and experienced worker has developed rather brittle diabetes, which has become challenging to manage. In addition, the worker's job has changed to a more demanding productivity schedule due to staff reductions, and a new supervisor has been assigned to achieve management's goal for this unit. Let's further suppose that the supervisor wants to please the unit manager by meeting the ambitious productivity and budget goals that have been set but has very limited technical knowledge of the work and feels insecure in interacting with workers who have been in the unit for a long time. Previously, the worker had enough personal control over the schedule and pace of the work to accommodate the ups and downs of the course of the diabetes. Now, the supervisor controls the work process and seems intent on bringing everyone into conformity with the new model. When the worker is absent, the supervisor has one less of the "old guard" to battle, and the worker can address personal health needs with less stress. Eventually, the worker has missed enough work to activate the long-term disability (LTD) benefit policy and the supervisor is able to replace the worker with a different worker. Although both parties are incurring significant long-term losses—for the worker the losses from withdrawing from this valued work role, including social isolation and income reduction and for the supervisor the unnecessary personnel and benefit costs, including the loss of skill and experience—they are both successfully avoiding short-term pain. Mitchell and Leclair (1995) described this state as "co-malingering," to explain how employer and employee inaction and failure to proactively manage and accommodate disability can perpetuate work disability.

HOW PRIVATE SECTOR ACTIONS LEAD TO PUBLIC SECTOR CONSEQUENCES

Following this negative scenario to its logical conclusion, one can see how failure to achieve job retention (after disability) through effective accommodation can result in greater human and economic costs for all of the parties, including the public at large. Two solutions that employ-

ers or their third party representatives may use in place of job retention or return to work (RTW) are (a) compromise and release settlements in the case of permanent, work-related disability; and (b) application for Social Security Disability Insurance (SSDI) benefits in the case of long-term, nonoccupational disability.

Many companies assist workers who have nonoccupational disabilities, as in the case above, to apply for SSDI benefits because their status as beneficiaries will reduce the burden of the wage replacement (and health care costs when they become entitled to Medicare coverage). Or suppose the above worker had a disability that resulted from work. In work-related cases, the employer and the employee can come to an agreement for a negotiated settlement (compromise and release), assuming that return to work is not possible. Then, the worker may be foreclosed from further benefits, including private VR and is dependent upon this settlement for future economic security. Should these resources become exhausted, then the person may apply for SSDI benefits. If so, there will be a subsequent referral for VR services. From what we know, this person is likely to be presumed eligible for VR services or to be eligible for SSDI and Medicaid. In both situations, responsibility for disability benefits and rehabilitation has been transferred from the private sector to public responsibility.

There are many instances where these outcomes are preferable or necessary solutions for the person with the disability and their family when disability cannot be accommodated and VR is not possible. But in many other instances, losing one's former employment can be an unnecessary path toward poverty, role loss, dependency and poor mental health. From the perspective of the consumer, the outcomes of new placement efforts are not likely to be as favorable in terms of the probability of obtaining an offer, the time involved in the process, and the quality of employment accessed (i.e., wages, benefits, career advancement potential; Wegmann et al., 1985). From an economic perspective, the costs of private sector failures at job retention after disability—including the employer, the insurer, and their contracted providers—create a significant burden in public benefit costs.

It is evident that a portion of our current crisis in Social Security stems from the escalating costs that result when job retention efforts fail following the onset of disability. In fact, the Government Accounting Office (GAO) has recognized the significance of RTW as a partial solution to the needs of participants in the public disability program (SSDI) and the applicability of solutions generated by the private sector to guide this effort (Ross, 1996). Yet, current public policy efforts to reform Social Security and address the unemployment status of people with disabilities have primarily focused on supply-side issues; namely, changes in services to the beneficiary population (alternate providers, choice) and ad-

dressings work disincentives and Social Security Administration (SSA) process redesign that may influence their participation in the labor market. Although there have been other policy efforts intended to influence behavior on the demand side of the equation—most notably the Americans With Disabilities Act, as well as Supported Employment and the Projects With Industry (PWI) program—these were geared primarily toward facilitating the hiring of persons with disabilities who are out of work and seeking employment. Although these are very important, similar efforts to motivate employers to retain workers who become disabled deserve further consideration.

UNDERSTANDING THE IMPORTANCE OF DEMAND-SIDE FACTORS

Labor market theory explains how employment is the result of an exchange between the needs of the employer and the needs of the worker. Although “the employer as customer” has had attention in VR (e.g., Corthell & Boone, 1982; Fry, 1997), there still seems to be a lack of recognition about the connection between helping employers successfully respond to and accommodate the needs of their own workers who develop disability and working with employers to hire and successfully integrate VR consumers in their workforce. It would be reasonable to argue that rehabilitation counselors and service systems would be more successful at the latter (job placement and employer development) as a result of learning how to do the former (job retention and return to work through disability management), given the human resource goals of employers to achieve productivity and control costs.

A fully developed and integrated approach toward the employment of people with disabilities needs to address the factors within the workplace that influence both of these processes (i.e., hiring and retention) as part of a complete set of strategies. There are developments in this direction as recounted by Gilbride and Stensrud (1999) in their work with Iowa and Georgia. In Michigan, the state vocational rehabilitation agency has established business services as a priority focus of their strategic plan (Michigan Jobs Commission, 1997), presuming that they must focus on the needs of both customers in an employment transaction—the consumer (the seller) and the employer (the buyer). In a full model of employment strategies, we must address the supply-side as well as the demand-side factors to achieve better outcomes (Gilbride, Stensrud, & Johnson, 1994; Vandergoot, 1994). Poor placement efforts on the part of VR (e.g., lack of job readiness as discussed by Strauser, Waldrop, & Ketz, 1999) and failure to accommodate workers who develop disability on the part of employer organizations, both lead to employment failure for people with disabilities. Adapting our service model to address this full range would better match the human resource function of employers to recruit, place

and retain productive and healthy workers (Washington Business Group on Health, 1998).

Nevertheless, historically most of the attention in VR has been focused on the supply side, relying too much on a medical model to explain disability and an individual approach to resolving it. When the focus is on the workplace, it has often been from a hollow sales perspective to artificially stimulate demand without an adequate approach for understanding and addressing factors within the workplace that may lead to success or failure in retaining the person with the disability in employment. If professionals in our field can better understand the phenomenon of successful retention as it relates to employees with disabilities, then we can see how to adapt our approach to address more successfully the broader set of factors that influence work disability, including both the person and the workplace. One could say that this calls for a merger of the individual and the systems perspective—an integrated approach.

EMPLOYER-BASED DISABILITY MANAGEMENT AS A COMPLEMENTARY EMPLOYMENT STRATEGY

The development of integrated employer programs for health and disability management over the past 15 years holds significance for the field of VR and for public disability policy. Research and case studies have demonstrated the significant influence of employer policies and practices for disability prevention and management on the incidence and outcomes of work-related disability and provided examples of service models from the private sector that have implications for public sector policy (e.g., Hunt, Habeck, Owens, & Vandergoot, 1996; Ross, 1996). The strategies and practices identified in successful employer RTW initiatives in the U.S. private sector and other industrialized countries (Ross, 1996) are those that are central to employer-based disability management (DM) for job retention. Akabas, Gates, and Galvin (1992) defined disability management as

a workplace prevention and remediation strategy that seeks to prevent disability from occurring or, lacking that, to intervene early following the onset of disability, using coordinated, cost-conscious, quality rehabilitation service that reflects an organizational commitment to continued employment of those experiencing functional work limitations. The remediation goal of disability management is successful job maintenance, or optimal timing for return-to-work. (p. 2)

In this, one can see how the goal of stemming the tide of people who lose employment unnecessarily after disability, through employer disability management efforts, is related to a coordinated public/private system of comprehensive strategies for successful employment and career advancement of people with disabilities. Employer disability man-

agement programs are an essential element for accomplishing job retention following disability onset, referred to as "job saves" in the state federal VR program. In addition, RTW is a critically important and underused policy approach to achieving fuller employment participation of people with disabilities. The provision of DM services that result in job retention should be given specific credit in the evaluation of outcomes as being at least equally as important to job entry for all parties. Therefore, the expertise that is required to help employers accomplish this goal should be reflected in the skills of VR practitioners and the services offered by VR programs and in the education and training of rehabilitation counselors (RCs).

SKILLS NEEDED TO FACILITATE JOB RETENTION WITHIN DISABILITY MANAGEMENT

There are some important distinctions in the levels of services that practitioners must be prepared to offer to support disability management efforts. The specialized competencies needed for practice in disability management vary, depending upon whether the RC is providing services within an organized disability management program or whether the RC is seeking to help an employer develop or improve their capacity to provide disability management.

When one's focus is primarily on the provision of clinical and direct service skills at the individual employee level, specific clinical skills and vocational expertise adapted to delivery in the workplace are the competencies most frequently used. In contrast, when one's focus is on assessment and intervention at the organizational level of the workplace as a whole, specific organization development expertise and analytical skills related to disability management at the systems level are the competencies required. Somewhere in between are the program development and management functions related to any organized return-to-work effort, which are critical to its effective and efficient coordination.

Disability management is clearly more than a set of specific services that can be purchased from a single provider. In addition, regardless of the specific role in the process or whether one is employed by the firm or contracted externally, Shrey and Olsheski (1992) argued very clearly that services should be delivered in the workplace to overcome environmental barriers and accomplish return to work.

The terms *organizational DM* and *individual DM* have been used (Habeck & Kirchner, 1999) to differentiate between the approach that is geared toward the organization as a whole and the range of specific services that are used to help achieve the goals of disability management but usually at the individual case level. Organizational DM includes the organizationally focused initiatives that are aimed at bringing about disability management at the employer level. Whereas individual DM refers to dis-

ability management services that are provided from within and from outside the workplace to help bring about disability management at the individual level (Habeck & Kirchner, 1999).

Correctly perceiving the level of intervention need—individual or organizational or both—is part of the task of the disability management provider, and having the requisite competencies to address the need is part of the professional's responsibility. These concepts can help providers and organizations understand their potential interface and the competencies required for interventions that must occur at each level of the process. Rehabilitation counselors in disability management typically begin at the clinical expert level (e.g., case management) and move toward organizational systems change (e.g., consultation in program design) as years of experience and specialized training increase.

Research and training efforts with practitioners in disability management have also helped clarify the distinction between the functions and competencies needed for practice at the organizational and individual levels of intervention. In her dissertation research, Scully (1996) attempted to further delineate the competencies needed for disability management, as perceived by a sample of rehabilitation counselors and others involved in disability management training conferences. Her findings confirmed the existence of the systems and individual levels of practice. She identified three factors, based on their ratings of importance. Factor 1, labeled Fundamentals of Disability Management, involves activities dealing with the organizational context, such as (a) using data for risk reduction, (b) coordinating a team approach for RTW, (c) facilitating labor management issues, (d) training internal parties for their roles in RTW, (e) managing the RTW program and interventions, (f) making job modifications and ergonomic changes, (g) providing consultation for disability-related legal compliance (e.g., ADA), and (h) developing a program evaluation system. Factor 2, labeled Elements of Vocational Rehabilitation, involves placement-related functions with individual clients that resemble the essential functions of job placement in private rehabilitation; and Factor 3, labeled Elements of Facilitative Counseling and Advocacy, involves the provision and facilitation of coordinated and constructive communication among the parties in the medical and vocational aspects of cases.

Although all the groups rated Factor 1, Fundamentals of Disability Management (organizational DM) as most important, the providers who function from outside the workplace perceived Factor 2, Elements of VR (individual DM), as being more important than providers whose roles are closer to the organization's disability management process. This suggests that when the focus and timing of service moves farther away from the workplace, the process begins to resemble the traditional model of private VR.

The preliminary findings of the research being conducted by the Certification of Disability Management Specialists Commission (Currier, Chan,

Taylor, & Wood, 1997) further substantiate a clear differentiation in the job functions and knowledge areas required by level of practice in disability management. Using the concepts described as "big DM" and "small dm," nominated experts in the practice of disability management were asked to define functions at each level of practice and to rate their importance. The 15 items rated at least very important to "big DM" practice are listed in Appendix A. These functions are generally managerial or administrative in nature, involve less direct contact with individual employees, and focus intervention at the level of the organization from a systems approach to activity. The 11 items rated at least very important to "small dm" (disability management services) practice are listed in Appendix B. These functions involve service delivery and direct contact with disabled workers in which activity is focused on the individual as the approach to intervention (Currier et al., 1997).

According to all these findings, participating at the organizational level of disability management requires professionals to be involved in policymaking and executive decision making, organizational and program development, service administration and direct service, in descending order. Participating at the individual service level of disability management requires professionals to provide direct services related to case management and RTW and, to a lesser extent, in program development, administration and organizational development (Currier et al., 1997; Habeck, Kress, Scully, & Kirchner, 1994; Habeck & Munrowd, 1987; Scully, 1996).

On the one hand, this research provides further confirmation for the centrality of highly developed expert knowledge and skills that have been reflected in our profession. That is, there is a definite need in the employment arena of job retention and disability management for the competencies of RCs who are experts in (a) understanding the specific impacts of disability, (b) analyzing the requirements of work, and (c) employing a wide array of interpersonal, remedial, developmental, and environmental accommodation strategies to optimize work opportunity and successful performance. On the other hand, new competencies must be acquired for the systems level roles involved in developing the capacity of employer organizations to provide effective and timely disability management for job retention. This systems role seems especially important for affecting demand-side factors that influence accommodation, job retention and career advancement of working age adults who develop disabilities.

In the significant public and private sector efforts currently underway to address problems of disability and work (Reno, Mashow, & Gradison, 1997) there is little emphasis (and perceptible skepticism) focused on the potential of VR to play a significant role in addressing these needs. Our field is perceived in some quarters as unable to see the larger picture that our work must serve.

In business, organizations and individuals have undergone profound change as a result of forces such as global competition and technological change that our field is now beginning to experience and grapple with in parallel ways (e.g., voucher systems and consumer choice to practitioners, distance education for educators). In these environments, individuals, teams, departments, processes, products, divisions, contractors have been profoundly changed as they have been forced out of traditional work boundaries (often referred to pejoratively as "functional silos") to make their work better serve the whole process.

It seems that our field has been slow to see the whole, to let go of our familiar understandings, models, and services despite very radical changes that have been occurring in the nature of employment, the nature of disability, the assumptions that now define consumer expectations and public disability policy, and the cultural move toward integrated systems. In an ironic way, the assumptions behind the advocacy approach that has been the hallmark of our field may constitute a limitation in understanding how our services must facilitate reciprocally beneficial employment relationships between the consumer and the employer.

IMPLICATIONS FOR REHABILITATION COUNSELING

The findings of disability management research and the disparity between the systems and the services level functions provide an opportunity to see the gap that may exist between our traditional individually-focused model of service and the organizational needs of the workplaces where the individuals we serve wish to work. It seems that to be part of the comprehensive system of policy and services that is developing to meet the employment needs of people with disabilities, our profession must understand and become competent to address both the individual (supply) and employer organizational (demand) factors involved. It is clear that the core functions of the highly skilled RC have tremendous relevance and potential value in a wider array of strategies than perhaps we thought possible. But unless we are able and willing to link them to the larger systems that can effect the environmental changes necessary for these skills and interventions to affect outcomes, we may be perceived as irrelevant to people outside our present sphere of interaction as they struggle to define the problems and determine the strategies to be used. To meet this need, we will need to learn to accomplish more and better outcomes in new ways that are simultaneously more efficient and more effective. This challenge faces all systems, organizations, and professions as we adapt to the assumptions of continuous change and performance improvement in place of institutional mores of tradition and endurance that once defined excellence.

Practitioners, educators, and researchers will need to discover ways to better facilitate the readiness of the profession to participate in integrated

systems (like employer-based disability management program) by developing a larger (systems) worldview in which to connect our work (individual DM). This may require a very different kind of learning model and service delivery approach than the one we currently follow in our linear sequence of services and courses, to the point where mere tinkering to accommodate new priorities is no longer an adequate strategy for change. Achieving the advanced systems competencies necessary to participate at the organizational level of employment strategies (e.g., as in organizational DM) may require us to offer an advanced professional development option perhaps even in an interdisciplinary venue. Perhaps we need to rethink the nature of doctoral training in our field to prepare graduates for a wider set of leadership roles in systems like disability management, in addition to traditional academic, clinical, and rehabilitation management roles. Restructuring our existing model may be a considerable challenge, but it also may create important opportunities for our profession to play a more significant role in improving the employment prospects of people with disabilities.

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APPENDIX A

Job Functions Rated Most Important in "Big DM"

1. Conduct analyses regarding corporate disability costs/performance within a business.
2. Design DM policies, programs, coordinating structures, and RTW plans.
3. Develop methodology to measure DM outcomes.
4. Establish DM goals related to corporate mission, strategies, and goals.
5. Monitor/evaluate DM impact on treatment, RTW, and program outcomes.
6. Motivate the organization and partners regarding DM.
7. Engage in professional development to keep abreast of state-of-the-art DM practices.
8. Collaborate/negotiate with labor and management.

9. Train labor and management regarding best practices in DM.
10. Conduct assessments of work-site factors related to DM.
11. Develop internal capacity to conduct early intervention functions for RTW.
12. Promote and market the DM program internally.
13. Perform administrative and coordinating functions related to operation of DM program.
14. Contract, purchase, monitor, and evaluate case management services with external vendors.
15. Promote and market the DM program among external providers.

APPENDIX B

Job Functions Rated Most Important in "small dm"

1. Perform case management functions.
2. Perform RTW functions.
3. Conduct job analyses and job accommodation activities to facilitate prevention.
4. Provide RTW coordination services.
5. Engage in professional development to keep abreast of state-of-the-art DM practices.
6. Perform individual assessments.
7. Evaluate, purchase, and coordinate acquisition of assistive technologies.
8. Conduct and perform medical case management functions.
9. Perform counseling interventions.
10. Perform job placement and outplacement activities.
11. Promote and market the DM program among external service providers.