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DEPARTMENT OF LABOR

[Agency Docket Number: DOL-2017-0003]

Request for Information on Potential Stay-at-Work/Return-to-Work Demonstration Projects

AGENCY: Office of Disability Employment Policy, DOL.

ACTION: Request for information.

SUMMARY: Washington State's workers' compensation system runs several promising early intervention programs including the Centers of Occupational Health and Education (COHE) and the Early Return to Work and the Stay at Work programs, which provide early intervention and return-to-work services for individuals with work-related health conditions and their employers. The President's FY2018 budget proposed that the Office of Disability Employment Policy (ODEP) at the U.S. Department of Labor (DOL) and the Social Security Administration (SSA) jointly conduct a demonstration testing the effects of implementing key features of these programs in other states and/or for a broader population beyond workers' compensation. To do that, we anticipate funding two to three states to operate projects with key elements drawn from the Washington State programs mentioned above, with an increased emphasis on access to employment-related supports, or fund the expansion of existing programs to include increased access to employment-related supports. The ultimate policy goal is to increase employment and labor force participation of individuals who have or are developing work disabilities. This request for information (RFI) seeks public input on how the proposed demonstration projects can best be designed to promote labor force attachment, coordinate employment and health services,

and support injured and ill workers in returning to and remaining at work. The input we receive will inform our deliberations about the possible design of a future demonstration project.

DATES: Comments must be received by [INSERT DATE THAT IS 30 DAYS FROM DATE OF PUBLICATION OF THIS NOTICE IN THE FEDERAL REGISTER]

ADDRESSES: You may submit comments by any one of three methods—Internet, fax, or mail. Do not submit the same comments multiple times or by more than one method. Regardless of which method you choose, please refer to Docket No. DOL-2017-0003in your comment pages so that we may associate your comments with the correct docket.

Caution: In your comments, you should be careful to include only the information that you wish to make publicly available. We strongly urge you not to include in your comments any personal information, such as Social Security numbers or medical information.

1. *Internet:* We strongly recommend that you submit your comments via the Internet. Please visit the Federal eRulemaking portal at *http://www.regulations.gov.* Use the ‘‘Search’’ function to find docket number DOL-2017-0003. The system will issue a tracking number to confirm your submission. You will not be able to view your comment immediately because we must post each comment manually. It may take up to a week for your comment to be viewable.

2. *Fax:* Fax comments to (202) 693-7888.

3. *Mail:* Mail your comments to the Office of Disability Employment Policy, U.S. Department of Labor, 200 Constitution Avenue NW, S-1303, Washington, DC 20210.

Comments are available for public viewing on the Federal eRulemaking portal at *http://www.regulations.gov* or in person, during regular business hours, by arranging with the contact person identified below.

FOR FURTHER INFORMATION CONTACT: Jennifer Sheehy, Deputy Assistant Secretary, Office of Disability Employment Policy, U.S. Department of Labor, 200 Constitution Avenue NW, S-1303, Washington, DC 20210, (202) 693–7880, or visit *https://www.dol.gov/dol/contact/contact-phonecallcenter.htm* (TTY), for information about this notice.

SUPPLEMENTARY INFORMATION:

Purpose

Millions of American workers leave the workforce each year after experiencing an injury or illness.[1] Hundreds of thousands of these workers go on to receive state or Federal disability benefits.[2] Many injured or ill workers could remain in their jobs or the workforce if they received timely, effective supports.

This request for information (RFI) offers interested parties — including but not limited to states, community-based and other non-profit organizations, philanthropic organizations, researchers, employers, health care providers with assorted training and specialties, private disability insurance providers, vocational rehabilitation specialists, and members of the public — the opportunity to provide information and recommendations to inform the development of a potential grant program aimed at reducing long-term disability and increasing labor force participation among workers who are injured or become ill while employed.

Background

[1] Bardos, Maura, Hannah Burak, and Yonatan Ben-Shalom. "Assessing the Costs and Benefits of Return-to-Work Programs." Final report submitted to the U.S. Department of Labor, Office of Disability Employment Policy. Washington, DC: Mathematica Policy Research, March 2015.

[2] Social Security Administration, "Annual Statistical Report on the Social Security Disability Insurance Program, 2015." SSA Publication No. 13-11826. Washington, DC: Social Security Administration, October 2016.

The President's 2018 budget supports a demonstration to test promising Stay-at-Work/Return-to-Work (SAW/RTW) strategies aimed at improving labor force participation, employment, and earnings outcomes for workers who are injured or become ill.

The proposed demonstration program is modeled after promising programs in Washington State including the Centers for Occupational Health and Education (COHE)[3] and the Early Return to Work[4] (ERTW) and Stay at Work programs.[5] Projects funded through the proposed demonstration project, however, would include additional connections to existing employment services and supports provided through the workforce development system.

COHE, which is funded by Washington's workers' compensation system, provides early intervention and RTW services for individuals with work-related health conditions. An evaluation of the COHE pilot in the early 2000s produced promising results: COHE participants were less likely to be off work and on disability benefits one year after the claim, and combined medical and disability costs were reduced by $510 per claim for COHE participants. The magnitude of these reductions was greater for back sprain cases (a common occupational injury): the relative risk of being off work and on disability at one year was 37 percent lower for back sprain COHE patients, and disability costs for back sprains were reduced by $542 per case.[6] Preliminary analysis indicated that at the eight-year mark, 26 percent fewer COHE claimants received Social Security Disability Insurance (SSDI) benefits.[7]

[3] http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/OHS/default.asp
[4] http://www.lni.wa.gov/ClaimsIns/Insurance/Injury/LightDuty/Ertw/Default.asp
[5] http://lni.wa.gov/Main/StayAtWork/
[6] Wickizer, T.M., Franklin, G., Fulton-Kehoe, D., Gluck, J., Mootz, R., Smith-Weller, T., and Plaeger-Brockway, R. (2011) "Improving Quality, Preventing Disability and Reducing Costs in Workers' Compensation Healthcare: A Population-based Intervention Study." *Medical Care*, Vol. 49, No. 12, pp. 1105-1111.
[7] Franklin, G.M., Wickizer, T.M., Coe, N.B, and Fulton-Kehoe, D. (2015) "Workers' Compensation: Poor Quality Health Care and the Growing Disability Problem in the United States." *American Journal of Industrial Medicine*, 58: 245-251.

The ERTW program and Stay at Work programs in Washington State provide related assistance. The ERTW program helps injured and ill workers RTW as soon as medically possible by providing access to a team of vocational services consultants, therapists, and nurse consultants to assist with developing and implementing medically appropriate RTW options. The Stay at Work program is a financial incentive program that reimburses employers for some of their costs when providing temporary, light-duty jobs for injured workers while they heal.

This demonstration will draw from and test key features of the Washington COHE model and ERTW and Stay at Work programs, in other states and/or for a population beyond workers' compensation (i.e., for non-occupational injuries and illnesses). To do that, we anticipate funding states to operate one or more COHE-style programs, or fund the expansion of existing programs, with an increased emphasis on access to employment-related supports. The ultimate policy goal is to increase employment and labor force participation of individuals with work disabilities, and to identify and/or confirm effective strategies for doing so. For the purposes of this RFI, the term "work disability" is defined as an illness, injury, or medical condition that is anticipated to inhibit or prevent continued employment or labor force participation.

This RFI offers interested parties the opportunity to provide recommendations on effective approaches for the design and implementation of the demonstration project. We expect that public input provided in response to this request will assist us in defining the scope and design of the demonstration project. For example, a demonstration project could test whether elements of the COHE workers' compensation model, which focus on immediate or early intervention, could be combined with re-employment services provided through the American Job Centers for the

subset of participants who do not return to work within 90 days so that they could obtain additional employment services and supports to maintain a workforce attachment. The RFI specifically seeks public input on how the proposed demonstration projects can best be designed to promote labor force attachment, coordinate employment and health services, and support injured and ill workers in returning to and remaining at work.

Background on the COHE model and Early Return to Work and Stay at Work programs:

As the proposed demonstration is based on elements from Washington State's COHE, ERTW, and Stay at Work programs, the following background material is provided about these programs. There are six COHE centers across the state of Washington, including some housed in large medical systems and others that are community-based. Each of these centers[8] recruits and trains health care providers in their area – often orthopedists or other doctors specializing in treating workers' compensation (WC) patients. COHE started as a small pilot in two regions and has grown to currently include about 3,500 health care providers who cover about 60 percent of all WC claims in the state. Injured workers retain health care provider choice. They receive COHE services if they choose a COHE-affiliated provider for their care.

Given that health care providers often see relatively few patients who are at risk of labor force separation due to their illness or injury, many may have limited knowledge and resources to address the employment-related needs of this population. Health care providers affiliated with COHE, however, receive training in occupational health best practices for these cases, including the following four best practices:

[8] Grantees will not be required to establish a "center" or new entity as part of the demonstration.

1. Submitting a complete Report of Accident (ROA) in two business days or less;
2. Developing an activity plan, which communicates the worker's ability to participate in work activities, activity restrictions, and the provider's treatment plans;
3. Communicating directly with employers when injured workers are absent or expected to be absent from work; and
4. Assessing the injured worker's barriers to return to work and developing a plan to overcome them.

Health service coordinators are integral to the success of the COHE model. The program is based on the MacColl chronic care model.[9] Successful health service coordinators are skilled in vocational rehabilitation and motivational interviewing and work directly with injured workers, employers, health care providers, and other stakeholders to coordinate care and RTW activities for injured workers. They also help stakeholders navigate the workers' compensation system by performing claim coordination functions, such as ensuring forms are received and complete and contacting stakeholders as needed for clarifications or follow-up. Health service coordinators frequently contact injured workers, employers, health care providers, state agency staff, and other stakeholders to help with the RTW process, and identify barriers to returning to work and resources to resolve them. The RTW activities they coordinate for the patient can include functional assessments, referrals to existing training and employment services, and setting appropriate RTW expectations. Health service coordinators also educate employers on the financial and other benefits of retaining injured workers and can refer employers to the ERTW and Stay at Work programs for resources and financial incentives to help them with job

[9] See http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.

accommodation. The health service coordinators monitor all cases, but focus on those at risk for long-term disability, typically less than a quarter of all cases. The health service coordinator role is critical and depends heavily on the neutrality of health service coordinators in helping the health care and RTW system work effectively for patients, employers, health care providers, and the insurer. This neutrality allows health service coordinators to be trusted by the various stakeholders, allowing health service coordinators to maximize the likelihood of the best-case recovery and employment outcome.

As a program based in the medical system, COHE depends heavily on project champions among sponsoring health care organizations' leadership to create organizational buy-in and support. Additionally, each COHE participates in a Regional Business-Labor Advisory Board that ensures community support and solicits input from local business and labor interests.

Key features of the COHE model of interest to the proposed demonstration include:

1. Coordination of services, including enhanced stakeholder communication, RTW planning, and identification of potential delays and solutions to keep treatment and RTW plans on track;
2. Physician training on occupational health best practices;
3. Incentives for physicians to utilize the best practices for participating patients;
4. A data management system allowing services coordinators real-time access to all relevant information on each case to support effective triage, population monitoring, and case management.

The ERTW program helps injured and ill workers RTW as soon as medically possible by providing access to a team of specialists including vocational services consultants, therapist consultants, and nurse consultants who assist health care providers and employers develop and implement medically appropriate RTW options. Resources available to employers include risk management specialists, safety consultants to provide on-site consultations, and job modification funds. By providing these resources, the ERTW program speeds the worker's recovery and reduces the financial impact of a workers' compensation claim on the worker, the employer, and the workers' compensation system.

The Stay at Work program incentivizes employers to offer temporary light-duty work to injured employees while they heal, by reimbursing the employers for some of the costs of providing such jobs. Eligible employers can be reimbursed for 50 percent of the base wages they pay the injured worker and some of the cost of training, tools, or clothing the worker needs to do the light-duty or transitional work.

The COHE model focuses services on the first 12 weeks after injury because this period is most critical in maximizing the likelihood of RTW. While the proposed demonstration builds upon the COHE model and the ERTW and Stay at Work programs, it differs from the original model by adding an extended focus on employment services and supports and a strong and purposeful involvement of the workforce development system.

Potential Project Scope

DOL and SSA anticipate three acquisitions for this project: implementation grants awarded via a cooperative agreement, a technical assistance contract to support grantees, and an evaluation

contract. The agencies anticipate implementing the demonstration in two to three states representing diverse programmatic contexts and with the ability to provide meaningful analyses and policy recommendations. There would be a separate technical assistance (TA) contract to assist states with implementation and a separate integrated evaluation contract to evaluate all of the sites and address specific research goals. For the purposes of this RFI, the implementation grantees are referred to as the "projects," the technical assistance contractor is referred to as the "TA provider," and the evaluation contractor is referred to as the "evaluator."

We anticipate designing this demonstration to solicit innovative projects that create systems changes by targeting individuals when they are in the early stages of developing a work disability, and assisting them in maintaining a connection to the labor force, preferably through their current or most recent employer. Projects will be encouraged to build upon existing programs or systems, such as state-based temporary disability insurance (TDI) programs, collaborative health care organizations, disability management insurance providers, or workers' compensation programs. We would also encourage projects to think broadly about new and effective ways to prevent the development of long-term work disability. The solicitation will leave flexibility for applicants to develop their own projects that adapt to the specific programmatic, demographic, and economic contexts of their state or region while also satisfying the project's requirements.

Preliminary required design elements of the demonstration are described below. We encourage public input and comment on these elements in response to the questions in the following section.

Overview: We anticipate funding implementation grants in two to three states to either operate one or more projects with key elements drawn from the COHE model and the ERTW and Stay at

Work programs, with an added emphasis on access to employment-related services and supports, or the expansion of similar existing programs to include increased access to employment-related supports and services. The ultimate policy goal is to increase employment and labor force participation of individuals with work disabilities through timely and effective coordination of health care and employment-related services. Each grantee would be responsible for identifying, recruiting, and training health care providers within their geographic area, and incentivizing their use of occupational health best practices for eligible workers. In addition, each grantee would be responsible for providing and supporting return to work service coordinators who will coordinate and facilitate the RTW process for eligible workers. Grantees would also be responsible for providing a centralized data collection and reporting system for the efficient management of the care and RTW coordination system, and to support the evaluation of the program.

We anticipate requiring funded projects to include the following treatment elements:

- Coordination of services, including enhanced stakeholder communication, RTW planning, and identification of potential delays and solutions to keep treatment and RTW plans on track;
- Health care provider training on occupational health best practices that COHE uses;
- Incentives for health care providers to utilize the specified best practices for participating patients;
- Possible incentives for employers to actively participate in worker retention and other RTW efforts through utilization of strategies such as temporary light-duty jobs, job modifications, and job-banking;

- Provision of, or facilitated access to, employment-related services and supports (such as needs assessments, skill assessments, accommodations, job coaching, job search assistance if not remaining with original employer) and training;
- Engaging key stakeholders (e.g., the business community, labor representatives) up front and on an ongoing basis; and
- A data management system that:
    - (1) allows service coordinators real-time access to all relevant information on each case for purposes of triage, individual case management, and population health monitoring, including on disability time loss duration; and
    - (2) supports the evaluation of the project.

Eligible grant applicants: We anticipate requiring each project and application to have a state agency designated as the lead coordinating entity. The lead agency would be required or encouraged to form partnerships with other public or private organizations, such as DOL-funded employment-service providers, state vocational rehabilitation agencies, private non-profit organizations, health care providers/organizations, other public or private organizations, state and local Workforce Investment Boards, and county or municipal-level governments as appropriate.

Population: Each project would be required to identify and clearly define its target population, including showing that the population has a substantial risk of developing a long-term work disability, and/or transitioning to Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI), such that the intervention could change their employment outcomes. Projects are encouraged to include workers with active state TDI or workers' compensation claims, or those using paid leave, as well as broader populations of workers experiencing the

onset of a medical condition that could result in a work disability. The target population must be clearly identifiable using existing administrative records, easily completed screening forms, or an information management system, and there must be a clear mechanism that triggers the start of services.

Participant Recruitment: Each grantee would propose a recruitment plan for outreach and enrollment of worker participants based on their target population and their project design. Grantees would be required to be able to recruit a sufficient number of worker participants to allow for a meaningful assessment of the impact of the intervention. Applicants would also be required to recruit and have signed MOUs or letters of intent with project partners, including partnering health care providers.

Evaluation Design: We anticipate carrying out an impact and implementation study to understand how the programs are implemented, service components, who is being served, the extent to which those served experience improved outcomes (including labor market outcomes, receipt of SSDI/SSI), and a cost-benefit analysis. The impact study would include a process evaluation and participation analysis in order to assess the implementation and fidelity of the program and general interest and take-up rates across the project sites. The evaluation design would be finalized once the evaluator is secured and would take into account the specifics of the funded projects. All projects would be required to fully cooperate with and participate in the evaluation.

Data collection: Projects would be required to provide for centralized data collection to capture care management, RTW coordination information, and measures and outcomes of interest to the evaluation. The evaluation contractor would be provided access to this data. A data management system would be required to allow the service coordinators and others in the intervention to have

real-time access to all relevant information on each case in order to effectively triage, monitor, and intervene as needed on a timely basis. Projects would be encouraged to use or adapt existing centralized data systems.

Evaluation: We anticipate evaluating projects on two primary research questions:

- Does the intervention improve employment outcomes compared to the control group?
- Does the intervention reduce application to Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI)?

Below are additional research questions of interest, which may not all be answered by the initial evaluation of the proposed demonstration:

- Does the intervention increase labor force participation of participating workers?
- Does the intervention increase labor force attachment of participating workers?
- Does the intervention reduce labor force exit of participating workers?
- Does the intervention maintain or result in increased wages of participating workers?
- Does the intervention improve the ability of participating workers to maintain hours of work?
- Does the intervention reduce medical, time lost, or litigation costs?
- What are optimal and efficient methods to identify target populations at risk of exiting the labor force that will benefits from the intervention?
- What is the best timing to engage a worker effectively while also minimizing cost?
- What recruitment methods are most effective to engage a target population?
- Does the intervention decrease SSDI or SSI allowance rates?
- What elements of the intervention are most influential in determining success (i.e., improved employment outcomes and reduced need for SSDI or SSI benefits)?

- What environmental factors are necessary for successful implementation of the intervention?
- What are the cost effective and efficient interventions that reduce workers exit from the labor force?
- What are the effective and efficient strategies to incentivize employers to actively retain workers with injuries and health conditions?
- What are effective and efficient strategies to create buy-in from health care providers that work is an important health care outcome?

Request for Information

This request for information (RFI) seeks public input on how the proposed demonstration projects can best be designed to promote labor force attachment, coordinate employment and health services, and support injured and ill workers in returning to and remaining at work. Through this notice, we are soliciting feedback from interested parties on the scope and design of a potential demonstration project related to providing coordinated occupational health and employment services to individuals who become injured or ill while employed in order to enable them to remain in the labor force, thereby improving their employment and earnings outcomes and maximizing their self-sufficiency. Responses to this request will inform decisions about the development, design, and evaluation of the potential demonstration project.

This notice is for internal planning purposes only and should not be construed as a solicitation or as an obligation on the part of the Department of Labor or any participating Federal agencies.

We ask respondents to address the following questions, where possible, in the context of the discussion in this document. You do not need to address every question and should focus on those that relate to your expertise or perspectives. To the extent possible, please clearly indicate

which question(s) you address in your response. We ask that each respondent include the name and address of his or her institution or affiliation, if any, and the name, title, mailing and email addresses, and telephone number of a contact person for his or her institution or affiliation, if any.

Questions

I. Intervention Elements

1. Are there potential issues with the treatment elements listed under "required treatment elements" on pages 6-7? Should any *not* be required? What other elements might be useful, and what is the evidence base for them? What additional optional services and supports could grantees choose to include in the model? What is the existing evidence documenting the effectiveness of these additional optional services and supports?

2. What should be the required and optional roles and responsibilities of the RTW service coordinator in implementing the treatment elements?

3. Where should the role of a RTW service coordinator be housed in order to most effectively accomplish its goals, including an ability to maintain neutrality? For example, should service coordinators be employed by health care provider networks, by the public workforce system, by private disability insurance providers, by employers, or by another entity?

4. Should there be educational and/or experience requirements for the RTW service coordinators, such as vocational counseling or public health backgrounds? How should these

educational and experience requirements parallel and differ from those of health navigators, community health workers, and vocational rehabilitation counselors?

5. What specific employment-related interventions should be required or allowed? What evidence supports these interventions as effective in early intervention for these populations? When referrals to existing employment-related service providers occur, will these providers have sufficient capacity and funding to provide services in a timely manner to referred individuals?

6. The COHE model focuses interventions primarily in the first 12 weeks after injury/illness (with occasional exceptions allowing up to 26 weeks). For a demonstration such as this requiring increased involvement of the workforce development system, what is the optimal timing and length of intervention? Why, or what is the evidence base?

7. Employment services (such as needs assessments, skill assessments, accommodations, job coaching, job search assistance if not remaining with original employer) and the public workforce system are important elements of the proposed demonstration program. What is the optimal time to provide employment services? For example, should employment services be provided during the same time window as the health care services/coordination, or afterwards? How can the RTW service coordinators best facilitate the effective use of employment services?
8. What role should employer incentives play in this intervention? Are there particular employer incentives that we should consider in projects where workers' compensation

insurance premiums play a limited role? Are there effective non-financial ways to engage and incentivize employers to support and implement SAW/RTW programs within their workplaces?

9. What is an appropriate health care provider payment or fee structure to incentivize the specific occupational health best practices and to encourage a focus on employment as a health outcome? Are there models other than fee-for-service that would be appropriate and feasible, such as basing payments on process and/or outcome metrics? How would these models operate in the context of managed-care organizations?
10. How can health systems and health care providers be better incentivized to consider employment a valid health outcome? What is the recent relevant evidence documenting the effectiveness of incentive models (including financial or other incentives) that include employment as an outcome?

II. Target Population and Sites

11. What is an appropriate age range of participants to target for this demonstration project? For example, should the demonstration projects target prime-age workers (25-54)? Why or why not?
12. What populations of RTW participants – such as those listed below – should be allowed, encouraged, or required in the demonstration? Why should the populations you recommend be included? Are there populations of RTW participants that you would not recommend?
    - Individuals with active state-based TDI claims?
    - Workers accessing FMLA benefits (except for pregnancy and caring for others)?
    - Individuals with active WC claims?

- Others (not participating in WC or TDI) experiencing the onset of a medical condition that could affect their connection to the workforce?

13. How should the target population described above be specifically defined and cleanly identified? We are particularly interested in how to define an appropriate population that is not limited to individuals with state-based TDI claims or WC. What are the most appropriate eligibility criteria (such as time off work, type of condition, type of employment) to identify such individuals? What kinds of "triggers" would work for the population as a mechanism for enrollment into the project?
14. Are there specific functional risk assessment instruments that you recommend using for this project? What are the benefits and limitations of those instruments? How might they be used to identify the target population here or form the basis for an RTW plan?
15. Are there aspects of your state's TDI, paid leave, FMLA, WC, or other state programs that would pose particular advantages or challenges for identifying workers who might benefit from an intervention like the one discussed above? Are there aspects of these programs that would pose particular advantages or challenges for collecting data on treatments, services, and outcomes for a project like this?
16. Should the target population be limited to individuals with certain types of medical conditions, such as musculoskeletal conditions and chronic health conditions? Why or why not?
17. How should project service areas be defined? For example, should demonstrations be carried out state-wide, in specific counties, regions, or local communities? Would these service areas have a large enough target population for evaluation purposes?

18. What types of entities would be the most beneficial to consider partnering with to provide the COHE-style services, and why? Examples could include large health-care systems, collections of small health care provider offices, private self-insured employers with in-house disability management, vocational rehabilitation providers, accountable or managed care organizations, federally qualified community health centers, community based organizations, and urgent care centers.

III. Eligible Applicants

19. What types of state government entities are the most logical or well-positioned to serve as the primary applicant and fiscal agent? What is the best way to organize the structure of a demonstration like the one described above in your state? What structure would best enable effective leadership, responsibility, and accountability for the project? Would a single agency be the natural lead for the project?
20. Similar state functions may be housed in different agencies, depending on the state. Should key functions be required, rather than specific agencies? If so, what functions should be required?
21. Should groups of states be allowed to jointly apply? Why or why not?
22. Could a non-state (i.e., county or local government) or non-governmental (i.e., non-profit or private organization) entity serve as the primary applicant and fiscal agent? If so, what characteristics should be required of such entities? Would this be preferable to a state governmental agency serving in this role? Why or why not?
23. The COHE model in Washington operates within a monopolistic WC system, which allows for centralized participant controls, service management, and data collection. Would states with other WC models, such as privately managed and competitive WC markets, be able to

feasibly implement a similar model, particularly with regard to data collection? If so, how? Would states with short-term or temporary disability insurance programs or states with mandatory paid sick leave be able to do so, and how? In other words, should grant applicants be limited to states with specific characteristics, and why or why not?

24. What partners, public or private, should be required or encouraged as part of the demonstration project? What other entities might be beneficial as collaborators? In what ways could they assist?

IV. Evaluation and Design Issues

25. Are there research questions, not specified above, that could be answered through the evaluation which would improve understanding of ways to better serve and increase employment and labor force participation of individuals with work disabilities?

26. What entity would be most successful in recruiting participants who have a qualifying injury or health condition (that makes them at risk for leaving the labor force)? Examples could include an insurance company, state TDI or WC insurance providers, an employer, or a health care provider.

27. Do health systems and/or health care providers utilize risk predictors to target specific types of services? If so, which predictors are used, and for which services? Are any employment- or SAW/RTW-related?

28. If a cluster-randomized design is used for an experimental impact evaluation, how could the unit of randomization be defined and operationalized within various types of grantee sites?

Are there other evaluation designs (randomized or not) that would be more feasible (e.g. quasi-experimental design)? If so, how could a potential comparison group be identified? If other randomized designs are recommended, what are potential units for random assignment and points at which assignment would occur?

Rights to Materials Submitted

By submitting material in response to this notice, you agree to grant us a worldwide, royalty-free, perpetual, irrevocable, nonexclusive license to use the material, and to post it publicly. Further, you agree that you own, have a valid license, or are otherwise authorized to provide the material to us. You should not provide any material you consider confidential or proprietary in response to this notice. We will not provide any compensation for material submitted in response to this notice.

Jennifer Sheehy,

Deputy Assistant Secretary for Disability Employment Policy.

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