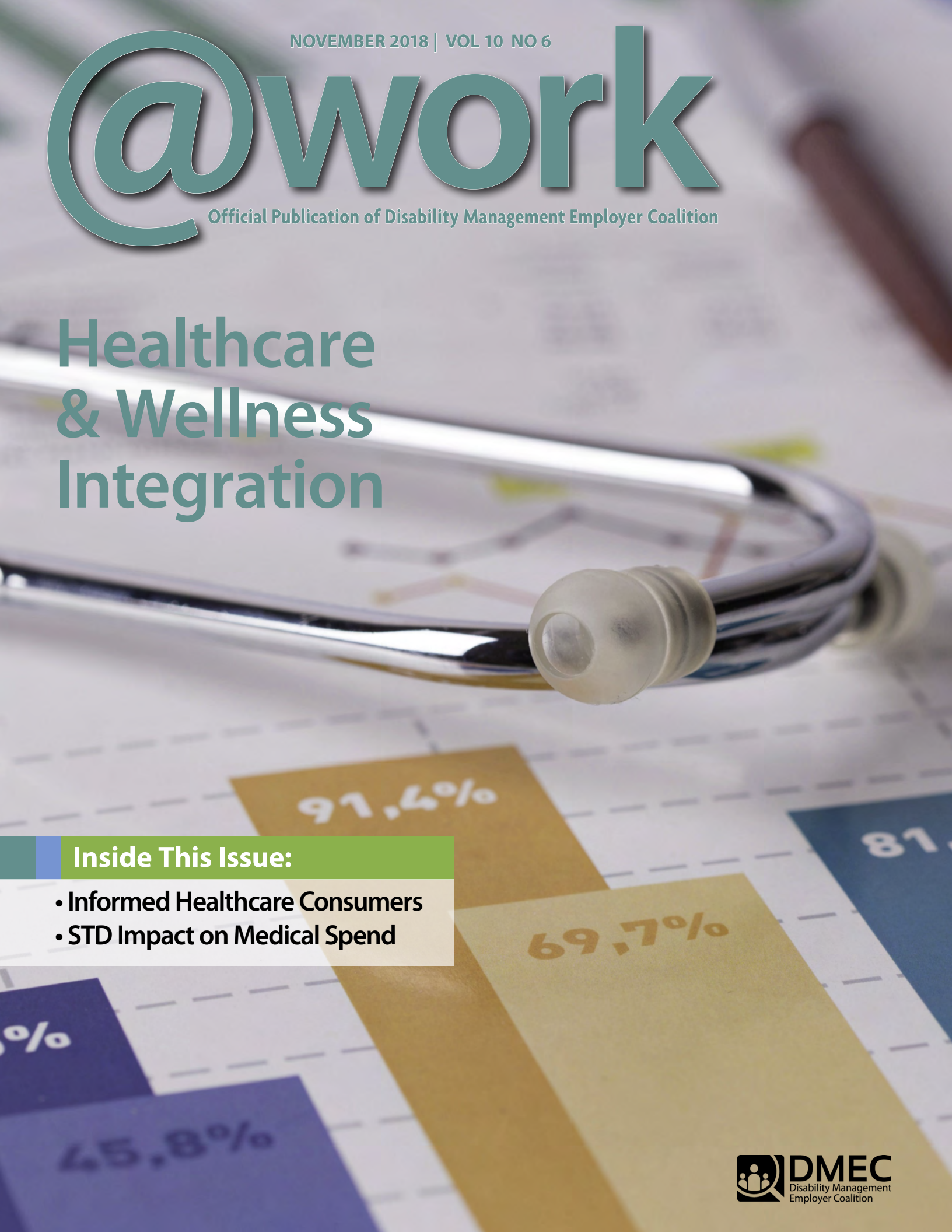
NOVEMBER 2018 | VOL 10 NO 6

@work

Official Publication of Disability Management Employer Coalition

Healthcare & Wellness Integration



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DMEC
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Behavioral Health White Paper: Managing Optimal Work Performance

Millions of Americans struggle with behavioral health conditions, and a predictable sequence of impacts and events occur as symptoms emerge. This sequence of impacts can be used to create a map for supervisors whose employees are experiencing behavioral health conditions. Download the white paper to learn more.

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Terri L. Rhodes
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Getting Real About Wellness Programs

About 75% of HR professionals said that their organizations offered some type of a wellness program according to the 2018 Employee Benefits Survey conducted by the Society for Human Resource Management (SHRM). In another SHRM survey, 72% of the respondents noted that wellness programs were "somewhat effective" or "very effective" in reducing the costs of healthcare.[1]

Corporate wellness programs are nearly an $8 billion industry in the U.S. and are expected to grow at a clip of nearly 7.8% through 2021.[2] The Global Wellness Institute puts that number at $43 billion worldwide, even though only roughly 9% of the three billion member global workforce has access to workplace wellness programs at their jobs.[3]

"Wellness programs are... a way to create a culture of health and caring that improves employee engagement..."

As the interest in employee wellness programs has grown, much focus has been placed on measuring the return on investment of these programs. But, let's get real, the most tangible cost of not implementing a program is loss of human capital.

When an employee is ill or doesn't feel well, productivity declines and absenteeism and presenteeism increases. Both of these can have an impact on or a reduction in your company's productivity. Ensuring that you have enough people to answer your customer calls, respond to client needs, care for patients, etc. is an important argument for wellness programs. If we invest in educating employees and providing tools and resources for employees to take better care of themselves, their overall health should improve.

In one study, health risk improved dramatically with exercise and diet change in as little as six weeks.[4] The study found that "despite remarkable pharmacological and technological advances, the greatest improvements in public health in the United States will be made by helping individuals adopt and maintain more healthful lifestyles."

Wellness programs have grown far beyond their original goal to reduce medical spending by reducing or eliminating tobacco use, obesity, or other health risks. Whether you believe wellness programs have achieved these goals, we all know that wellness today is much more than tobacco cessation, cholesterol metrics, and body mass index.

Health plans are the single largest benefit cost for many employers and often operate in a vacuum. The future of employee health and wellness lies in coordinating health plans, employee assistance programs, and wellness programs into broader initiatives focused on employee engagement. This does not require full integration; much can be accomplished through coordination and data integration.

Software platforms and wearable devices that monitor and measure health are important to employees and help to encourage activity. What we haven't yet been able to accomplish is getting to the heart of what motivates employees to get healthy and stay healthy. This will be the next challenge for wellness programs.

Although much research supports the importance of wellness programs, they are not the silver bullet we all had hoped for to reduce medical costs. They are, though, a way to create a culture of health and caring that improves employee engagement and, hopefully, improves their lives in a positive way.

Terri L. Rhodes,
DMEC CEO

CEO's Desk references provided on p. 35

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Compliance Memos

CM #18 FMLA Leave for Chronic Conditions Requires Ongoing Care

Employers often assume an employee is receiving medical care and seldom review the frequency of physician visits when granting Family and Medical Leave Act (FMLA) leave, but this issue was the crux of *Watkins v. Blind and Vision Rehabilitation Services of Pittsburgh*. In July, 2015, Karen Watkins was the victim of a random act of violence, exacerbating a formerly stable case of post-traumatic stress disorder (PTSD) from her military service. A downward spiral in her work performance occurred; only after termination for job abandonment did Watkins request FMLA leave or say she was denied her FMLA rights. Since Watkins was never hospitalized nor had inpatient treatment, the court held she had to show she received continuing treatment for PTSD: doctor's visits at least twice a year. She did not meet that burden so her case was dismissed. Attorney Katrin Schatz of Jackson Lewis raised key questions for employers. "When an employee requests FMLA leave for a chronic health condition, take a careful look at the certification form," she said. "Does the provider identify a period of hospitalization or identify recent dates of treatment? Does the provider confirm that the employee will need periodic visits at least twice a year? If the answer is negative, the employee may well not qualify for FMLA leave." To learn more, visit http://dmec.org/2018/10/09/fmla-leave-for-chronic-health-conditions/.

CM #19 U.S. Dept. of Labor Issues Updated FMLA Forms

Employers will need to download and use new FMLA notices and certification forms issued by the Department of Labor (DOL) on Sept. 4, 2018. The only change to these forms is the date of expiration, but older forms must be discontinued. The forms are approved for three years; the older forms expired on May 31, 2018, but were granted temporary extensions. To download the new forms, visit https://www.dol.gov/whd/fmla/forms.htm.

CM #20 New Overtime Rule Proposal Rescheduled for March 2019

The Trump administration is advancing work on a project begun in the Obama era to update regulations of the Fair Labor Standards Act (FLSA) affecting overtime pay. The U.S. Dept. of Labor (DOL) was scheduled to publish a Notice of Proposed Rulemaking in October 2018, then rescheduled for March 2019. The Obama regulation would have required employers to pay overtime to workers making less than the equivalent of $47,476 per year ($23,660 currently), regardless of whether they are eligible for other exemptions. Those regulations were halted by injunction of a federal District Court in Texas. When the DOL requested comments about the overtime regulations in July 2017, it asked stakeholders what the new threshold should be, or whether a threshold approach should be discontinued. If the DOL continues using a threshold, many expect it to be substantially lower than the Obama proposal, which would benefit employers. Democrats introduced House and Senate bills with a $48,412 threshold; the party that controls Congress will determine the outcome of this legislation. To learn more, visit https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201810&RIN=1235-AA20.

CM #21 Extended Leave May Not Be a Reasonable Accommodation

How much leave, if any, is required as an accommodation under the Americans with Disabilities Act (ADA)? Court decisions are beginning to provide more guidance for those decisions.

Compliance Memos continued on p. 22

YOUR EMPLOYEES HAVE PLENTY OF REASONS TO TAKE LEAVE.

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By
Judy Gordon
Wellness Director
The Hartford

Employer-Provided Resource Fosters Well-Informed Healthcare Consumers *For Better Outcomes, Lower Costs*

Some of the leading drivers of employee absenteeism and lost productivity are disability leaves due to employees' ongoing management of chronic medical conditions or recovery from procedures.

Unfortunately, the U.S. healthcare system is plagued with great variations in the quality and cost of medical care, with patients receiving incorrect diagnoses and inappropriate or unnecessary treatment.

"A review ... by USA Today *revealed that doctors performed thousands of unnecessary surgeries (especially) orthopedic surgeries such as back, knee, and hip surgeries, and hysterectomies."*

A 2017 study conducted by the Mayo Clinic, for example, found that among patients who came to the Mayo Clinic for a second opinion or diagnosis confirmation before treatment for a complex condition, an astounding 88% left with a new or refined diagnosis and a changed treatment plan.[1] Unfortunately, most Americans do not get second opinions when diagnosed with a serious condition. According to Gallup's 2010 Health and Healthcare Survey poll, 70% of Americans don't believe second opinions are needed.

Numerous studies have documented that some of the most expensive hospitals do not have better health outcomes for patients.[2] Medical errors and incorrect care are common. One study suggests that medical errors are now the third leading cause of death in the United States.[3] Low quality, inappropriate, or unsafe medical care not only results in lost worker productivity, but it also places patients at risk for physical and financial harm.

A review of government records and medical databases by *USA Today* revealed that doctors performed thousands of unnecessary surgeries, with the most common types being orthopedic surgeries such as back, knee, and hip surgeries, and hysterectomies.[4] Some of these surgeries, for example spinal fusion, cause patients to miss an average of eight weeks of work or more.[5] The average recovery time for a hysterectomy is six weeks.[6]

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with resources to become informed healthcare consumers and better able to advocate for themselves, they are more likely to receive high-quality healthcare and have better health outcomes, according to numerous studies.[7] Another well-regarded survey shows that patients who received an "enhanced" level of support when making healthcare decisions not only had better health outcomes, but lower healthcare costs as well, including 12.5% fewer hospital admissions.[8]

Our Experience

Based on anecdotal evidence from employees who were dissatisfied with care they received or surgeries they had undergone, we took a close look at our 2010 and 2011 medical claims data, specifically the high incidence of musculoskeletal related surgeries.

Our review of the data led us to the conclusion that our employees were undergoing a significant number of these types of surgeries. It was having an impact not only on worker productivity but also on our medical spend.

We decided to seek out a partner who could help our employees become better informed consumers of healthcare through several resources and services, including:

- arming them with up-to-date medical research related to their specific condition;
- providing them with questions to ask their physicians;
- facilitating virtual and in-person second opinions;
- evaluating the quality of providers and facilities; and
- reviewing treatment plans to ensure they were appropriate, reflected their desires, and were conducive to their lifestyles.

With this information, we were confident our employees would make the best medical decisions for themselves and their families.

In 2012, we selected Consumer-Medical as our partner in this effort. This service empowers consumers by focusing on five critical aspects affecting quality of care: diagnosis, physician quality, treatment, hospital quality, and coping support. They offer medical decision support, expert medical opinions, and ongoing support and concierge services. Using their "medical ally" model, they guide individuals through their healthcare journey with high-touch support, evidence-based information, and deep clinical expertise.

ConsumerMedical's program for surgical decision support focuses on preference-sensitive surgeries for which multiple treatment options may produce equal outcomes when low back, knee, hip, bariatric surgery, or hysterectomy has been recommended. Their own research demonstrates that 20% of these surgeries are performed unnecessarily. Their service

presents patients with all their treatment options, including the pros and cons of each, so patients can select the highest-value alternative that is right for them.

In 2015, we implemented a penalty strategy requiring all medical plan members who were planning, on an elective basis, to have one of the five targeted surgeries to participate in the surgical decision support program or pay a financial penalty when their claim is processed. Our goal was to increase engagement in the program which had already demonstrated positive outcomes and high participant satisfaction. Engagement in the program increased four-fold the year after we implemented the penalty.

Since launching ConsumerMedical in 2012, over 30% of our employee population, more than 5,000 employees, have engaged in the program by requesting an in-person or virtual second opinion, requesting educational information about a health topic, finding help locating a high-quality specialist or facility, or by participating in the surgery decision support program. Between 2013 and 2016, 676 individuals participated in the surgical decision support program resulting in a return on investment based on direct cost savings from avoided surgeries or election of less invasive options of $4.35 saved for every $1.00 spent. In addition, an estimated $500,000 in savings was achieved through avoided missed work days.[9]

Case History

Here's one example of how employees engage with the program and make more informed healthcare decisions. Jane discovered while she was pregnant with her first child that she had a large fibroid tumor. After having a healthy son, her physician recommended she have a hysterectomy due to the size of the fibroid. She sought a second opinion, hoping to find an option that would allow her to have more children. At this point, she engaged with the program and was provided with information about hysterectomies, alternative treatment options, high-quality specialists, and questions to ask her physician. As a result of the information, Jane decided not to have a hysterectomy. Instead she changed doctors and chose a less invasive surgical option — one that was far less expensive, allowed her to return to work much more quickly and, most importantly, did not prevent her from having additional children.

"Decision support programs help employees better understand their diagnoses and treatment options and make more informed healthcare decisions."

Conclusion

A key way to reduce the incidence and duration of disability leaves of absence is to provide resources to ensure employees receive high-quality healthcare, and have surgery and other procedures only when needed and only from high-quality providers. Decision support programs help employees better understand their diagnoses and treatment options and make more informed healthcare decisions.

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STD Plan Design Impacts on Health Plan Cost Trends

For many companies, benefit trends are viewed in isolation. Medical spend is commonly viewed with pharmacy expenditures over the same time periods, but other benefits such as short-term disability (STD), long-term disability (LTD), and workers' compensation (WC) are rarely presented in conjunction with health plan metrics. This detachment of information means that the health plan leaders in these companies are lacking what could be a key indicator of their future spend.

In reality it is highly logical that these benefits, in particular STD, impact the health plan costs for any company. After all, to be eligible for STD an employee will need to show evidence of a qualifying medical event or condition. Whatever event drives the need for an STD claim will also require medical and pharmacy care, and in many cases the reason for the claim is severe enough to warrant higher-cost interventions.

"The higher the STD wage replacement, the higher the medical spend... For every 5% increase in STD wage replacement, this population saw annual medical costs increase by nearly $170 per person. "

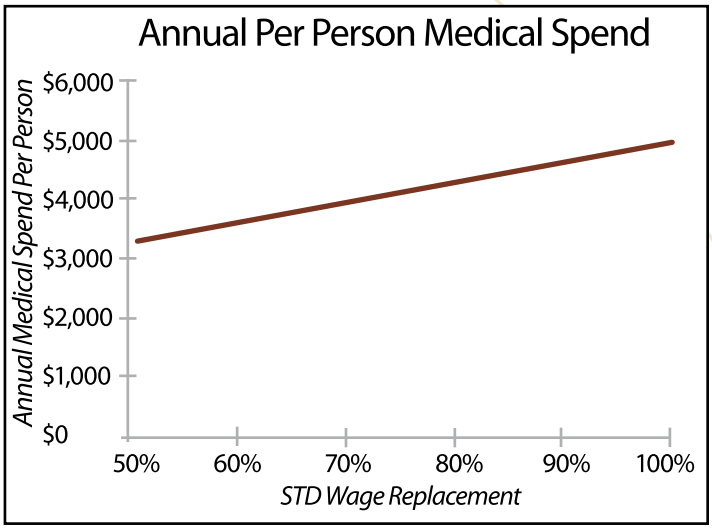
With this link in mind, it is not surprising that in a recent analysis of multiple companies in the HCMS Group's Research Reference Database we found that employees out on a non-maternity STD claim accounted for 30-40% of the company's annual total health plan spending. These employees also had per person health plan costs that were 10 times higher than employees without an STD claim. Combining these findings with the well-known relationships between levels of wage replacement and prevalence and length of STD claims provides a strong link between health plan trends and STD plan designs. STD plan design can drive higher medical spending; when STD benefits are more generous or less generous than an *optimal range*, medical spending is higher.

To further quantify how STD wage replacement levels impact health plan spending, 78,000 employees were analyzed from multiple companies with varying health plan and disability policies. Their industries were finance, technology, transportation, retail, energy, and environmental services. All employees were continuously enrolled in medical, drug, and STD benefits for three years from 2015 through 2017. For each company, the average *STD wage replacement and the percent of medical spend paid by the employee* (versus the employer) were derived from the

data. Total medical spend includes both plan-paid and member-paid dollars.

The relationship between the annual per person medical spend and the *STD wage replacement* percent is clear. The higher the STD wage replacement percent, the higher the medical spend (see Figure 1). In fact, for every 5% increase in *STD wage replacement*, this population saw annual medical costs increase by nearly $170 per person. In a company with 25,000 employees continuously enrolled in both a health plan and STD coverage, that would equate to $4.25 million in incremental spend for the year.

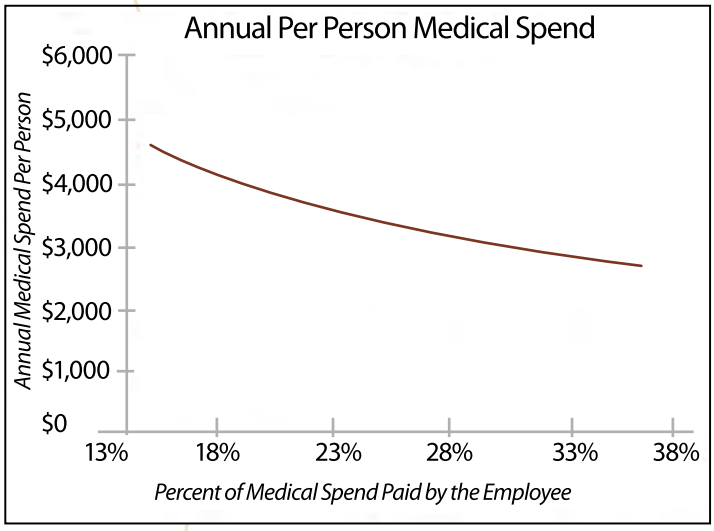
Figure 1: STD Wage Replacement vs. Annual Medical Spend



However, these companies do not have identical health plans and the richness of the health plan can obviously impact medical costs as well. The data on these companies suggest the impact of shifting more costs to the employee (measured by the *percent of medical spend paid by the employee*) can reduce total spend, likely through increased consumeristic behavior. But that impact diminishes at higher levels. A modestly high deductible is usually enough to encourage consumerism and continued escalation of deductibles and cost-shares have minimal return.

For example, companies that have a *percent of medical spend paid by the employee* in the high range of 30% to 35% will find that each 1% increase to the employee burden will only net ~$50 in health plan cost savings per person annually. To put that in perspective, this small increment of savings may lead to more costly negative impacts on hiring and retention. On the low end of the spectrum, companies in the 10% to 15% range can expect an average return of $260 lower health plan cost per person annually with each 1% increase in *percent of medical spend paid by the employee*. See Figure 2.

Figure 2: Percent of Medical Spend Paid by the Employee vs. Annual Total Medical Spend



We learned that a lower *percent of medical spend paid by the employee* will result in increased medical spend, and higher STD wage replacement percentages will also result in higher medical spend. We wanted to learn how these two factors worked in combination to impact total medical spend. We calculated a ratio of *STD wage replacement* percent to percent of

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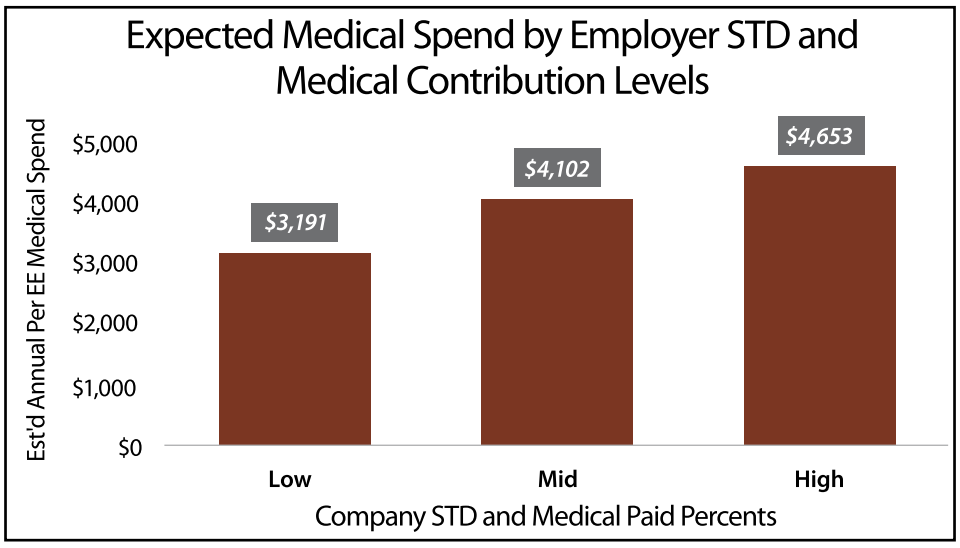
medical spend paid by the employee. With this ratio metric, if the employee is responsible for more out of pocket medical expenses, the ratio will decrease. Also, if the company has a lower STD replacement percent, this will also push the ratio down. However, the opposite is also true: lower cost burdens on the employee will result in a higher value for the ratio, as will higher STD replacement percentages. As the ratio decreases, the per-person health plan cost decreases.

This ratio allows us to consider both the level of the health plan offering and the level of wage replacement offered by the company. The relationship again was very strong for these companies. Companies with the lowest value for this ratio metric had total medical spending of $3,191 per person annually. This is in comparison to the companies with mid-level values of this metric at $4,102 annually, and companies with high values of this metric at $4,653 annually.

Figure 3: Expected Medical Spend



This analysis indicates that for every tenth of a point that this ratio goes up, medical spend will go up by ~ $39 per person per year. This metric is dependent both on a company's medical plan and its STD replacement percent.

The impacts of both are represented in Figure 4 (on page 37). For these companies, the average spend was ~$4,025 in annual total medical spend per person.

For a company that would like to keep its health plan costs at or below this average spend, the table gives insight into how this could be accomplished. Even more, the values that would keep this cost level are realistic for employees and employers alike. In the population studied, the optimal numbers to keep health plan costs at or below the average were an employee medical cost share of 20%, paired with an 80% STD wage replacement.

The key numbers to maximize medical cost reduction were a lower STD wage replacement level of 50%, coupled with 35% of medical spend paid by the employee. Basing a program on those maximized numbers may be unsustainable, however, as it may increase recruiting and retention cost, and may cause negative employee health outcomes by reducing preventive care. We advise our clients to target "average" health plan expenses as a lower-risk approach.

If your medical costs are growing significantly, it may not feel intuitive to review your STD plan parameters. However, as shown with these companies, finding an optimal level of STD wage replacement makes a big impact on medical spend. If this replacement level is coupled with data about percent of medical spend paid by the employee, a more comprehensive view of your current and future spend is available.

Note that we are not suggesting that the overall cost to employees is shrinking. On the contrary, their total dollar costs are increasing year-over-year as well. However, due to higher cost treatments, fragmented care and other

STD Impacts, continued on p. 36

Introducing FINEOS Absence

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Absence from work costs employers around **22% of total payroll**, but with **over 100 reasons to be absent from work** and an ever-changing regulatory landscape (federal, state, municipal regulations, including FMLA, Paid Family Leave, and Disability Benefits Law) managing absence can be a very complex problem to solve.

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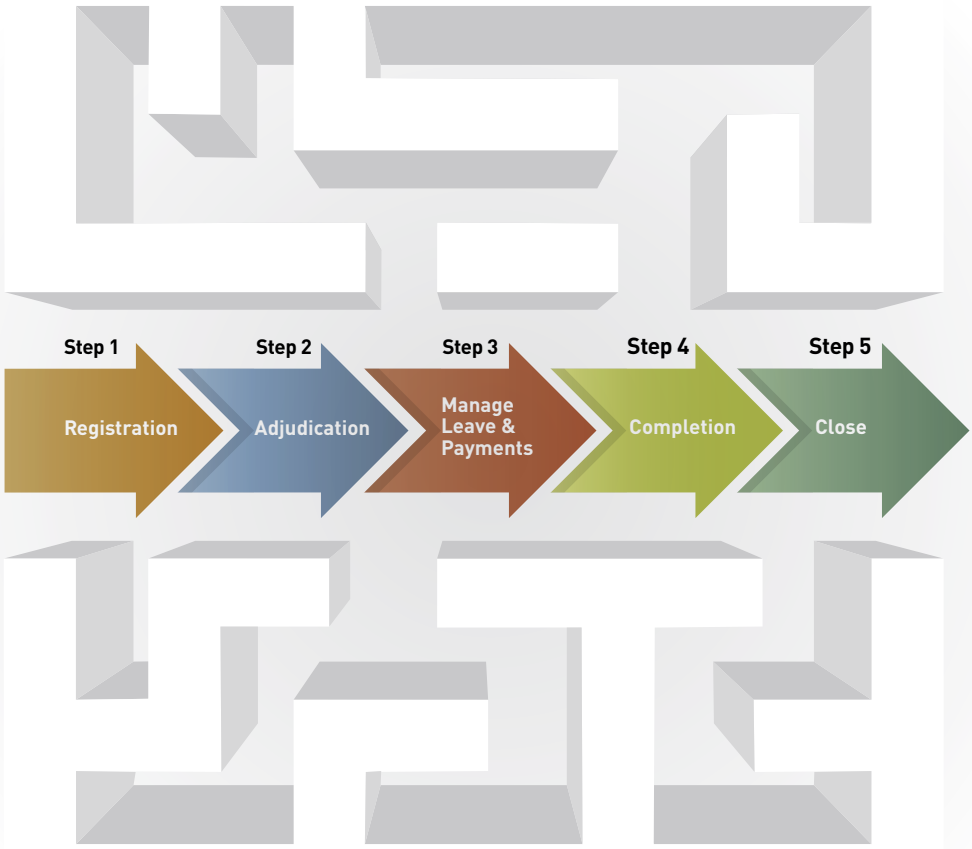

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Insourced Leave Management: Challenges, Advantages, and Unexpected Outcomes

By
Lisa Deeves, RN, COHN-S
Disability Case Manager
Hackensack Meridian *Health*

Fourteen years ago, the precursor to Hackensack Meridian Health in New Jersey began discussing whether we should bring our medical leave management program inhouse.

Workers' compensation (WC) claims were managed inhouse by registered nurses (RNs) supporting early return to work (RTW) using modified duty or reduced scheduling. This approach significantly decreased lost time and improved outcomes.

But our medical leave of absence program was not thriving after a few years with an outsourced provider located in the Midwest due to the provider's lack of familiarity with New Jersey's temporary disability insurance and the New Jersey Family Leave Act (NJ FLA). Managers from the WC claims program and human resources (HR) benefits wondered what might happen if we applied the same on-site case management approach to our medical leaves as we were using for our WC claims. They decided to give this idea a try, and our fledgling inhouse medical leaves program was born.

We reached out to other HR managers and occupational health professionals to hear their experience but couldn't find anyone to guide us. After many discussions, one incredibly informative FMLA class, and several conversations with our WC counsel, some key features of our program began to take shape. To deliver the best absence management for our employees, we would have to focus on policy, compliance, consistency, and, perhaps most importantly, connection. We envisioned a department that would act as the epicenter of communication for all stakeholders, so we named our department Meridian *Connect*.

Compliance and Policy Review

Our department began with the senior manager of our Occupational Health Departments, two RN case managers, and two disability associates. To acquire the expertise we would need for compliance, we began a leave of absence "education-palooza." We went to the New Jersey Department of Labor and learned about the state's temporary disability insurance, took FMLA and NJ FLA compliance classes, spoke to internal and external counsel, and tested each other until we had eligibility criteria, tracking time, notice deadlines, and claim determination mastered.

Next, we brought all our new ideas and information back and took a hard look at our leave policy. Actually, make that policies. It was critical to review leave of absence, paid time off, extended sick leave, work-related injury — any policy that came into contact with our department was reviewed, addressed, and readdressed. We made sure that our policies were specific, direct, and understandable. Policies that can't be understood by everyone will soon be used against you by *someone*.

Consistency

Even a polished and exhaustive absence management program is ineffective if it is not understood and followed by the end user. Another reason we took our program inhouse was to create a simple and uniform approach from the FMLA program provider, to the manager and employee, back to the program provider.

For each type of leave, we created an algorithm to help us map out our program from the employee's first phone call to their return to work and claim closure. Then we created a flow chart to help explain and illustrate our process to each campus and facility leader and frontline manager. In training sessions, managers could ask questions and give their feedback — and if they didn't completely understand protection, pay, or the process, they did understand where to call with their questions.

As we worked on the consistency of our process, we needed to uphold the importance of our *purpose*. This required that we adopt a consistent attitude and understanding of who we were here to serve. If focused exclusively on deadlines and guidelines, it's easy to lose sight of

one of our priorities: helping our fellow employee.

This became very clear when we opened our doors in the winter of 2005. During an intake, I was attempting to tick off the boxes when I glanced up to ask the next question. As I did, I saw a frail, frightened woman in tremendous pain who was caring for her adult daughter who had only a few weeks to live. Throughout the beginning of the intake, all I thought about was how to tell her that an adult child might not qualify (again, this was 2005). But when I saw a *person*, not a task list, I remembered my purpose and place in this team member's life. As a result, we changed our policy for care of adult children and have been able to support many of our colleagues during similar situations.

Living this principle in our practice has helped in adversarial interactions as much as in advocating opportunities. By going above and beyond to assist each team member to be successful in obtaining an approved leave, those cases that unfortunately end in denial, discipline, and/or dismissal are more defensible. When a claim can show that the team member was given every opportunity and assistance to obtain protection, interference and retaliation are that much more difficult to demonstrate.

Our practice of going above and beyond has included giving 16 days to return documents and not only sending a form reminder letter with additional forms, but also calling and giving two additional weeks for the completed forms to be returned. We also offer to contact the healthcare provider's office to assist in the completion and return of certifications with the employee's permission. Our "above and beyond" practice is consistent, which protects us against any potential charge of discrimination.

Connection

We believed that communication was the most critical piece to get right. We wanted to set up lines of communication to connect with our workforce. Whether on the phone, in person, or via email, we wanted our intakes, questions, and updates to all filter through one site. Our process addressed this in part, and educating the employee during the time of their intake clarified a bit more, but we still needed a way to pull it all together with leaders, HR, and payroll.

We developed a simple form to communicate required information to leaders, frontline managers, HR, and timekeepers. The form has all the necessary information, complies with the Health Insurance Portability and Accountability Act, and informs without overwhelming. It includes:

- *Dates:* Last day worked; first day out of work; and estimated return to work
- *Program type:* Employee's own serious health condition; New Jersey temporary disability; family leave; New Jersey family leave insurance; and intermittent leave (self or family)
- *Claim status:* Pending; approved; denied; closed; exhausted; and reasonable accommodation requested
- *Pay guide:* Specific instructions given for payment during leave parameters

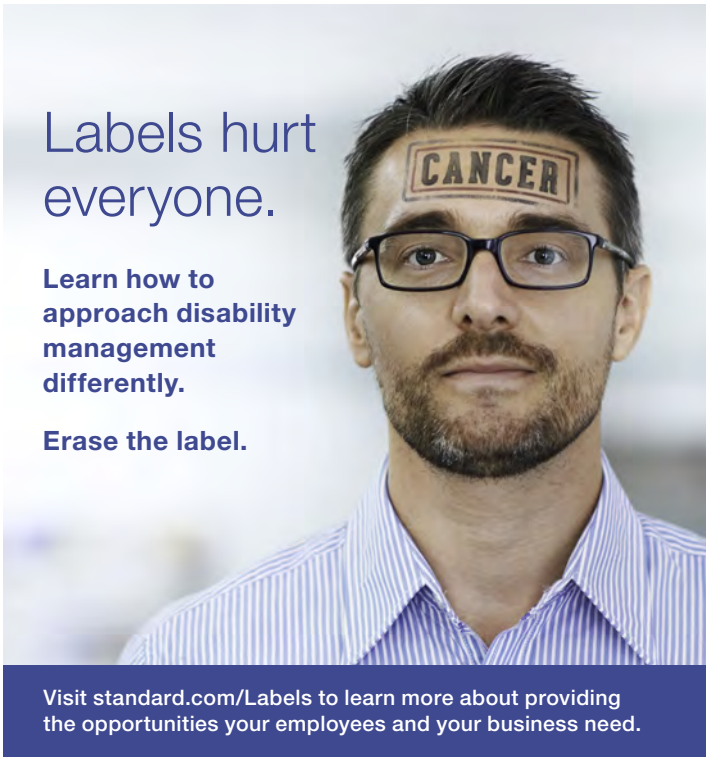
This communication form has been instrumental in getting and keeping all the managers and timekeepers on the same page with protected time calculation (i.e., New Jersey family leave) versus unprotected time (i.e., New Jersey temporary disability) as well as how to pay their employees correctly and uniformly. Additionally, each and every question on the form became an opportunity to educate (and often re-educate) a manager on our process.

With these features in place, we began to create the leave management program we had envisioned just the year before. As new hospitals and facilities merged with our organization, we educated more managers and employees on our simplified process for what was often a very complicated time in the lives of their team members.

Challenges and Benefits

In 2005, we covered about 5,000 employees; at our most

Insourced Leave Management continued on p. 37



The Domino Effect: Recurrent Work Disability Statistics for Chronic Conditions

By
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Epidemiologist
ReedGroup MDGuidelines®

Returning to activity following a disability leave is often complicated. In many instances, patients need multiple work leaves to heal or receive treatment for their medical condition. "Recurrence," or multiple work leaves for the same or a similar medical condition, is common,[1–3] and a previous disability leave is an important predictor of a future disability leave.[4] Therefore, understanding recurrence patterns is essential to project and manage a patient's full disability experience.

To my surprise, recurrent work disability statistics have never before been calculated in a U.S. population. Therefore, we recently calculated recurrence statistics and evaluated for predictors of recurrent disability to provide a better understanding of the disability experience and factors involved in the risk triage of complex cases.

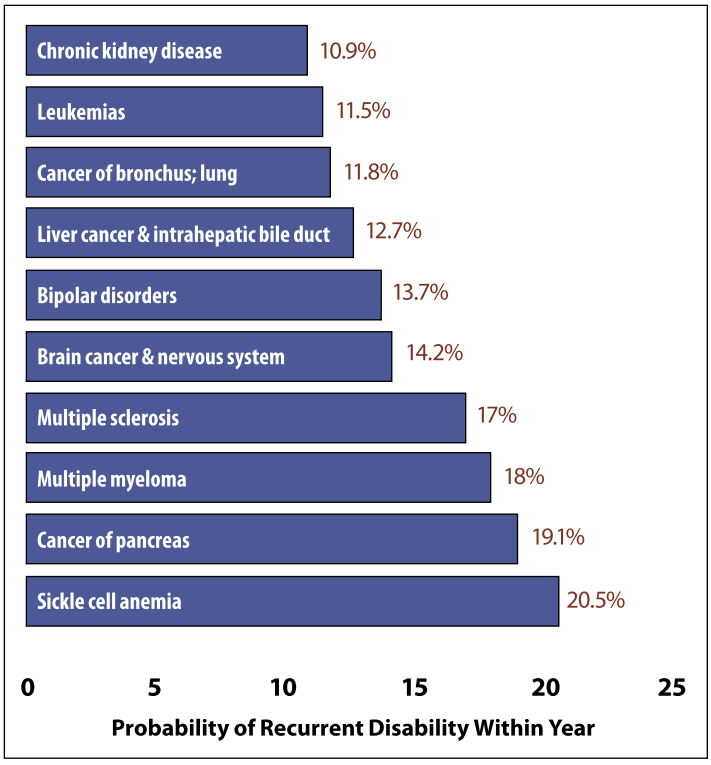
Methods

Our efforts to evaluate recurrent disability were twofold: 1) calculating recurrence statistics for all chronic conditions, and 2) performing an in-depth analysis of the factors that predicted recurrent disability for common mental disorders like depressive and anxiety disorders. Both analyses used short-term disability claims in the IBM MarketScan Health and Productivity Management database for the years 2007 to 2015 (more than 270,000 initial claims). We defined a recurrent disability as a disability leave occurring within one year after the initial leave with the same or similar diagnosis using the diagnosis grouper from Healthcare Cost and Utilization Project's multi-level Clinical Classification Software.[5] Our analysis on common mental disorders will be published in the open-access, peer-reviewed journal *PLOS-ONE* in the coming months.

Findings

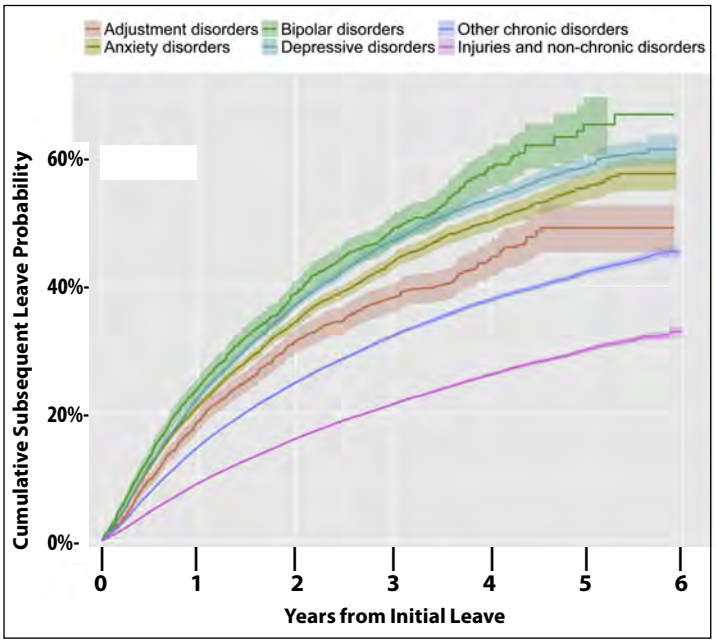
Individuals whose initial leave was due to a mental disorder had the highest probability of a future disability leave within the coming year, at 7.7% of total claims. The next most common recurrent diagnostic categories were for individuals with neoplasms (6.9%) and disorders of the nervous system and sense organs (6.2%). When we looked deeper into the specific conditions with the highest probability of recurrent disability (Figure 1), we found that sickle cell anemia (20.5%) and pancreatic cancer (19.1%) topped the list. We also found that recurrent leaves were typically 10% longer than the initial leave, suggesting reduced functional capacity through time — not what we had hoped to see.

Figure 1: Top 10 Conditions with Highest Probability of Recurrent Leave in the Year After the Initial Leave



Common mental disorders that included adjustment, anxiety, bipolar, and depressive disorders had high prevalence and high recurrence probabilities. We analyzed these at greater depth. One of the most interesting findings was that individuals whose first leave was for a common mental disorder were more likely to go out on a subsequent leave unrelated to their mental disorder (Figure 2). For example, across the four mental disorders studied, the probability of a subsequent disability leave for a condition distinct from the initial leave ranged from 18.7% to 23.3%. In contrast, the probability for a subsequent leave was 9% for injuries and non-chronic disorders, and for all other chronic conditions the probability was 14.6%. While our study had an overall focus on recurrence rates at 12 months, Figure 2 includes six years of claim activity, because we found that many of these conditions did not significantly flatten until after five years.

Figure 2: Cumulative Probability of a Subsequent Leave for Patients with Common Mental Disorders Vs. Other Patients



Finally, we were interested in whether we could identify which patients with mental disorders were more likely to go out on a recurrent disability leave. Using multiple variable modeling, we found that older, non-salaried employees were most at risk. Further, if an employee had a previous work leave for a non-mental health disorder (like a musculoskeletal injury), they were more likely to have repeat mental health work leaves. Interestingly, employees in finance, insurance, or real estate industries were also most at risk for recurrent mental health work leaves — perhaps due to the cognitive requirements of those positions. Other significant indicators for future recurrent disability were the duration of the initial leave, and the number of outpatient psychiatric visits in the year prior to the initial leave.

Uses and Implications of Research

We developed these recurrence statistics to help disability managers estimate the probability that a patient on an initial leave for a chronic condition will experience a future leave. Empowered by this vital information, disability managers can then proactively communicate with both the employee and employer the steps that may reduce the likelihood of a subsequent leave.

Useful strategies may include an extended accommodation process once back at work, or approaches to increase adherence to the employee's treatment regimen. Disability managers can further compare the disability durations of the initial and recurrent leaves to better understand the progression of the patient's medical condition, disease, or injury, and set realistic expectations for employee and employer alike. In the coming months, these recurrent disability statistics will be available to all our MDGuidelines subscribers.

Our finding that the probability of subsequent disability leaves distinct from the initial disorder is higher for mental health disorders than other chronic conditions suggests that patients with mental health disorders may benefit from additional care and disability management both during and after their initial work absence. These services may include increased provider or disability management touchpoints, which may facilitate a successful and timely return to activity.

While this research highlighted important factors associated with recurrent disability in mental health conditions, we plan future research to build predictive models for all chronic conditions to stratify employees most at risk for a recurrent disability leave. This model will help disability managers accurately place adequate resources on the most vulnerable claimants. We hope this research will be used to improve the continuity of care for the ever-increasing numbers of individuals with chronic disorders.

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Federal Project Promotes Integrated Approach for WC, Non-Occupational Claims

A new federal program is applying absence management best practices to workers' compensation (WC) claims and non-occupational claims in an integrated approach.

The new Retaining Employment and Talent After Injury (RETAIN) demonstration project of the U.S. Department of Labor (DOL) drew inspiration from the Centers for Occupational Health and Education (COHE) model that Washington state developed for managing the early phase of WC claims. When a federal agency does a "demonstration" project like RETAIN, it is exploring a concept that may result in new programs, regulations, or legislation. It is a formal process with higher evidence requirements than a typical employer pilot program, and this demonstration will take five years to complete.

In the COHE model that helped inspire RETAIN, a regional COHE group recruits physicians as members, and trains them to provide four specific services considered best practices in occupational health. The COHE pays physicians to deliver those services, and provides support by communications coordinators who facilitate information exchange among the parties during the stay-at-work and return-to-work (RTW) processes.

COHE has been very successful, said Jenny Haykin, Integrated Leaves & Accommodations Program Manager, Puget Sound Energy. "Providers participating in the COHE regional programs are the gold standard in injured worker care," said Haykin. "I get paperwork quickly and filled out correctly, and my goal of keeping employees working and/or bringing them back as quickly as possible is shared."

COHE was the primary model cited when the DOL invited states to apply for RETAIN grants. RETAIN is a five-year, $100 million demonstration project with initial grants totaling nearly $19 million to WC agencies in eight states: California, Connecticut, Kansas, Kentucky, Minnesota, Ohio, Vermont, and Washington state. The awards were announced on Sept. 27. In Phase 1, the chosen states will plan and implement pilots for 18 months. At the end of Phase 1, as many as four of those states will be funded to expand their pilots for three and a half years in Phase 2.

Jennifer Christian, MD, a frequent DMEC presenter, was a key player in developing the RETAIN demonstration. While the COHE model is focused on WC claims, RETAIN will also address non-occupational disability claims.

Christian noted several significant aspects of RETAIN:

- It is only a supplementary service; it doesn't replace existing programs, Christian said. RETAIN funds won't pay for medical care or wage-replacement benefits. It doesn't replace any existing program.
- The program focuses on the first three months after a worker is injured, and project assistance concludes six months after the injury.
- To apply for the RETAIN grant, states had to assemble leadership teams including agencies that typically do not collaborate closely and do not focus primarily on injured or ill workers. Those players are: the state Workforce Agency, the state Department of Health, a healthcare delivery system, and the state Workforce Development Board. Participation by the state WC agency was not required. Among the RETAIN phase 1 grant recipients, three had more than 10 agencies on their leadership team.
- RETAIN may be the first federal program to measure and seek to prevent job loss due to injury or illness. "This is a big shift," said Christian. "We have always said 'staying at work is good for you,' but we didn't say 'job loss is bad for you; it's a devastating outcome.'"

Christian points out that, although the Occupational Safety and Health Act (OSHA) 300 log requires many employers to track lost work days associated with recordable injuries, OSHA does not require employers to report job loss due to injury or illness. Attention to this new metric may give providers and employers fresh urgency to keep employees attached to the workforce. While praising DMEC members as

"activists" in promoting RTW, Christian said for many employers and insurers, "non-occupational episodes are still largely unmanaged during the critical early period."

RTW metrics are especially useful for employers, insurance carriers, and third-party administrators in tracking performance of employer programs. A job-loss metric may be most useful in analyzing demand for social safety nets and focusing efforts on reducing need for and cost of unemployment insurance, Social Security Disability, and other social safety nets. A DOL analysis published in 2016 concluded that COHE participants were 26% less likely to receive Social Security disability benefits.

The Social Security Administration will also award a research contract to evaluate the performance of the RETAIN grant winners.

It's too early to say what specific incentives the eight state RETAIN pilots might use to motivate healthcare providers to focus on job retention.

"For a long time the reformers of the U.S. health system have said we have got to stop paying for volume and start paying for outcomes," said Paul Papanek, MD, a member of the American College of Occupational and Environmental Medicine (ACOEM) in California. "It's a longer-term ACOEM goal to get a smarter set of fee schedules that aligns with this vision, both for WC and group health. RETAIN does not directly affect fee schedules, but may provide other incentives for providers to track functional status. RETAIN will give us new information about how provider incentives can affect health and employment outcomes."

Washington state originated the COHE model, so its RETAIN pilot will be watched closely. They have a goal to collect a cohort of 400 workers with significant injuries that may cause disability claims and loss of contact with the workplace. These will be either workers with denied WC claims, or state employees, said Toby Olson, MPA, Executive Secretary of the Governor's Committee on Disability Issues and Employment, and leader of the state's RETAIN pilot. They want to compare the outcomes of this cohort to outcomes of a similar cohort that will not receive RETAIN services. "I am interested in connecting with interested employers and vendors and engaging their participation as we plan for a possible Phase 2 program," Olson said.

To learn more about the eight state RETAIN pilots, including contact information for key personnel, visit https://www.dol.gov/odep/topics/SAW-RTW/grant-recipents.htm.

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Compliance Memos continued from p. 7

In *Easter v. Arkansas Children's Hospital*, an employee was unable to work after exhausting her FMLA leave, but she had an appointment to be evaluated by a specialist less than a month later. The employer denied the additional leave and terminated her employment. The Arkansas federal district court held there was no violation of the ADA. Attorney Tasos Paindiris of Jackson Lewis made this comment: "Employers are often faced with situations where an employee has a date in the near future for further evaluation but does not have a return to work date. While the Court agreed with the employer in this case, these situations are very fact-specific and employers must continue to proceed with caution." To learn more, visit http://dmec.org/2018/10/05/another-court-decides-that-extended-leave-is-not-a-reasonable-accommodation/.

Healthcare Consumers continued from p. 11

Costs of Care for Patients with Preference-Sensitive Conditions. *Health Affairs,* Vol. 32, No. 2, Feb. 2013. Retrieved from https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.0941

9. Based on independently validated ConsumerMedical ROI model using actual claims data. 2017 claims data not yet available. Avoided missed work days estimated based on 2015-2017 experience.

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Marti Cardi, JD
VP Product Compliance
Matrix Absence Management

Caregiver Protections: Employer Best Practices

As more employees get caught in the work/life squeeze — trying to fulfill both family caregiver responsibilities and work duties — employers need to be proactive to assist their employees and reduce potential liability. And it goes beyond legal issues like complying with leave laws. Here are some ideas on how employers can provide support to their employees and help ease the squeeze.

Adopt (or strengthen) nondiscrimination policies to reduce the risk of conflicts that may ultimately involve compliance issues.

- Address all forms of prohibited discrimination.
- Address harassment (and sexual harassment in detail).
- Explain how these apply to caregivers.
- An effective complaint procedure includes:
  - two+ avenues of complaint (e.g., HR and a designated company officer)
  - no employee ever has to register a complaint with the accused manager
  - assure a quick, thorough investigation
  - assure *no retaliation* for voicing a complaint.

Train supervisors on employee rights under the various laws. This is critical to minimizing liability. Untrained managers often act on illegal considerations, poor instincts, and stereotypes about caregivers; this appears consistently in cases that produced damaging precedents for employers.

- DO NOT train supervisors to be experts.
- DO train supervisors to spot issues, to recognize potential issues.
- DO NOT train supervisors to handle workplace caregiver issues alone.
- DO train supervisors to call HR immediately upon identification of a possible issue.
- DO train supervisors to resist answering employee questions; just direct them to HR.
- DO train supervisors to empathize with the employee — while avoiding being critical, judgmental, or irritated.
- Provide adequate staffing resources.

Make sure those well-trained supervisors have the support they need to cover caregiver absences as well as other employee leaves. It can be a challenge for a manager to be supportive of a caregiver leave when she is left short staffed either long-term or on an unpredictable basis. This can include scheduling assistance, overtime authorization, or even floating employees available to help out when a department is short-handed. Any additional costs are likely to be challenged by upper management, but it behooves employers to strongly consider options that will reduce business disruption and support employees who carry the load during caregiver absences.

Provide HR with the resources to be proactive in caregiver situations — training, materials, and enough personnel.

Adopt family-friendly policies — and train supervisors to honor them. Examples include flexible schedules, part-time options, telecommuting, and job sharing.

Encourage workplace affinity groups for employees experiencing the same challenges.

- Examples include elder care, disabled children, family members with serious illnesses, and wounded or ill servicemembers.
- Bring in speakers on topics of concern.

Make sure your EAP services can address the problems and stresses that workers with caregiver responsibilities encounter. For example:

- how to find care for an elderly relative;
- how to get counseling to relieve stress;
- how to find appropriate schooling for a child with a disability; and
- how to wade through the morass of insurance coverage.

Consider benefits that include legal and financial planning and education. Examples include:

- what a financial or medical power of attorney does and doesn't do;
- tax implications of various property decisions faced during elder care; and
- how to benefit from a dependent care flexible spending account.

Additional Resources

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Glenn Pransky, MD
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Preventing Opioid Deaths: An Opportunity to Integrate Health and Disability Management

Prescription opioid abuse has increased, with a surge in deaths from high-potency synthetic opioids — now over 150 U.S. opioid-related deaths each day, a four-fold increase over the last 15 years.[1] Of 10.6 million Americans with opioid use disorder in 2016, over 62% were employed.[2] The costs to employers due to absence, poor work quality and productivity, occupational injuries, healthcare costs, and other losses are considerable.[3] Unfortunately, employed persons are only half as likely to receive treatment for substance abuse as unemployed persons.[2]

Guidelines are available on how to achieve a drug-free workplace, including workplace policies, drug screening, and employee education.[4,5] Yet most employers feel unprepared to identify opioid use disorders in the workplace, and support treatment and recovery.[6]

Identification of a potential opioid or other substance abuse problem is the first step. Training programs can help employers and their supervisors recognize the signs of opioid abuse in the workplace. Issues of absenteeism, erratic performance and behavior, deterioration in personal appearance, drowsiness, and slurred speech are common indicators. Prescription benefits monitoring can provide alerts when employees are using high doses for extended periods of time, or visiting multiple doctors. Training should address how to approach an employee, effectively intervene, communicate concern and support, maintain confidentiality, and coordinate with an EAP to ensure referral to appropriate evaluation and treatment.[7,4] A written substance abuse policy provides consistent guidance for managers, and guides accommodations to stay at work (SAW) and return to work (RTW) under the ADA.

Effective treatment for opioid use disorders is challenging. A thorough initial assessment is important, and success may require inpatient treatment, then an intensive outpatient program. Scientific evidence favors drug-assisted withdrawal, active engagement in 12-step programs, and other forms of peer support; some patients may find additional counseling to be helpful. Relapse is not uncommon, but after additional intensive treatment, many do achieve long-term recovery.[8]

Research in healthcare professionals shows that RTW which combines an intensive outpatient program with a supportive workplace leads to consistently better outcomes.[9] The optimal SAW/RTW program includes a contract, behavioral monitoring, random urine screens, support groups, and peer and supervisor support at the workplace.[1] Based on this research, and experience in other settings, recommendations for returning an employee to work after undergoing opioid addiction treatment include:[7,11,12,13,14]

- Reassure employees that they won't lose their job while in treatment; employees may be eligible for FMLA leave that protects their job.
- Coordinate RTW planning before discharge with treatment facility (this could be facilitated by the disability insurer).
- Have a written SAW/RTW plan in place for the employee (often developed in partnership with the treatment facility).
- If recommended, incorporate random urine screens (may raise legal considerations, but can be part of a drug-free workplace policy or individual RTW agreement).
- The employer should encourage/facilitate attendance in a support group (Alcoholics Anonymous or Narcotics Anonymous); this may be a reasonable, helpful accommodation.
- Respect confidentiality, and encourage voluntary disclosure by employee to supervisor and others, and coworker education; this may lead to valuable support at work.

Opioid abuse is common, deadly, and has a major impact in the workplace. However, with the right approach, employers can reduce costs, keep valued employees on the job — and most importantly, save lives.[15]

References

All references can be retrieved from http://dmec.org/wp-content/uploads/Preventing-Opioid-Deaths-Column-References_November-2018.pdf.

Bryon Bass
SVP, Disability and Absence Practice & Compliance
Sedgwick

Creating a Workplace Culture of Health

While it may not be easy to define a healthy workplace environment, it's not difficult to recognize one. There is no single tactic that will produce a healthy workplace, but rather an amalgamation of strategies and initiatives needed to produce a culture of health. But nothing is more important than the behaviors — both individually and organizationally — exhibited by leaders.

Whether battling physical addictions or facing financial struggles, employees can be saddled with enormous pressures that impact their overall health and productivity. Employee assistance programs (EAPs) can be designed to foster healthier work environments. Many organizations offer access to behavioral specialists and counselors for those facing difficulties.

Resources and support for mental health and wellness are essential. While today's demands for higher productivity and efficiencies can be pressing, employee recovery time is necessary. This is part of the cost of building a culture of health, and it may include time off for relaxation and rejuvenation.

Promoting optimal employee wellness also involves structuring the workday with adequate breaks to minimize both physical and mental fatigue. In addition to traditional break rooms, some organizations are providing meditation rooms. Planned breaks for stretching and standing are encouraged, and some office environments are considering alternative furniture configurations allowing employees the option to sit or stand while performing daily tasks.

Leaders must recognize the value of health and wellness in the workplace and be willing to support the programs and changes needed to create such an environment. For example, health plans can be structured to encourage wellness checks and preventive screenings. Premium incentives can foster healthier habits among employees. One popular tactic is to charge non-smokers less premium for health insurance while offering smoking cessation programs to those wanting to quit.

Employee benefit programs can also be structured to encourage more exercise and physical activity. Some companies offer gym memberships, make exercise classes available onsite, build walking trails around a facility's perimeter, or sponsor league sports such as bowling, softball, or running clubs.

These measures can be taken to the next level by corporate challenges and employee competitions such as distance or step challenges to raise activity and engagement. Some organizations that have physically demanding jobs are employing athletic trainers who can design conditioning programs around job demands that will increase strength and reduce the risk of injury. Activity and exercise are core health measures, and organizations have many tools at their disposal to motivate and maintain these habits.

Organizations are also in a position to influence nutritional habits among employees. Nutritional education and increased awareness can begin by providing brochures, posters, and online materials to employees. A next step is sponsoring more formalized nutrition or weight loss programs onsite. Organizations with a cafeteria should offer fruits, vegetables, and healthy meals. Employers can partner with vending providers to replace traditional vending machine offerings of high caloric drinks and snacks with healthier choices. Water stations can be increased and made more convenient for all to promote adequate hydration, which is especially critical in hot work environments.

A vibrant and healthy employee population is essential to maintaining and improving productivity. The good news is that organizations can adopt and modify many proven measures to foster a healthy work environment.

Phil Bruen, VP
Group Life and Disability Products
MetLife

The Importance of Flexibility for Employee Wellness

In today's competitive job market, with unemployment at record lows and employers struggling to fill open jobs, keeping employees at work is a business imperative. To foster retention, employers must understand the evolving needs of their workforce, which now includes five generations of workers. Across all generations, employees crave flexibility — and employers that meet this important need are rewarded with engagement and loyalty.

Offering employees flexible working schedules, as well as environments, is a key way employers can create an atmosphere that prioritizes the health and well-being of its workforce. According to MetLife's 16th annual U.S. Employee Benefit Trends Study,[1] 72% of employees say that having the option to work remotely is important to maintain a balance between responsibilities at work and at home. And, as the Millennial generation is now the largest percentage of the workforce, it's important for employers to know that 77% of them believe that flex time — access to flexibility in the hours an employee works — is an important benefit.

Employees who have flexibility will be able to do what they need to do to be successful at work and at home, whether that's going to the dentist, taking an exercise class, or attending their child's awards ceremony. By taking care of their needs in key areas of their lives — themselves, their family, and community — they'll have less stress, more fulfillment, and increased overall wellness, including both physical and emotional.

Employers have more options to offer flexibility than ever before, with different or modified jobs and flexibility in schedule or work location. Assistive devices can support stay-at-work (SAW) or return-to-work (RTW) efforts, and their consideration is an important part of the interactive process.

Flexibility is important for both SAW and RTW for employees. Employers that offer just as much accommodation up front could potentially keep employees engaged at work and head off the need for a leave of absence altogether.

We know that when individuals feel they are productive and contributing, their overall health — mental, physical, and emotional — is better. Employers can incorporate accommodations such as: the ability to flex to a different job; modify an existing job; or move to a different location, schedule, or equipment. These options offer workers an environment that could better suit their specific needs and allow them to remain at work. Effective RTW or SAW programs should allow for customization for the employee, involve the interactive process, and allow for a period of transition.

Employers need to accept that being productive following a leave may look different — at least temporarily — than it did before. If the employer offers flexibility in work location and schedule, this can help the employee stay in a job during this transition, rather than having to take another leave.

Financial burden is also a major stress factor that contributes to lost productivity, increased turnover, declines in health, and increased expenses for employee medical coverage. As a result, tools that support employee financial well-being are key to an employer's stay-at-work strategy.

As employers continue to fight to attract and retain workers, it's imperative that disability, leave, and absence is viewed holistically. Flexibility continues to be one of the most important perks. Employers that offer flexibility to their workers will be rewarded with engagement, productivity, and loyalty.

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1. MetLife. *16th Annual U.S. Employee Benefit Trends Study.* 2018. Retrieved from https://benefittrends.metlife.com

Rachel Shaw, JD
CEO and Principal
Shaw HR Consulting

Disability and Discipline: A Case Study

Employee discipline and disability can be complicated issues, and even more so when they are combined. The management, however, can be standardized and straightforward.

It's important to understand that both roads lead toward employee performance. Whether you are on the route of discipline, or entering into the disability interactive process, the goal and needed outcome is the same: for performance standards to be met. Remember, if an employee cannot meet performance or safety standards, they will be separated — medically or through discipline.

Employee Case History

During counseling for performance, Ms. Smith indicated her deficiencies were due to a psychological disability and provided a medical note. The employer paused disciplinary actions and started the disability interactive process.

The first step for any interactive process is to obtain clear medical information. The employee's personal medical provider was asked to complete an in-depth questionnaire to help the employer understand if Smith had a serious medical condition impacting her ability to meet performance expectations. The employer did not request protected medical information, but clarification on her qualifications under the Americans with Disabilities Act (ADA) and a listing of work restrictions or functional limitations. The provider declined to complete the questionnaire.

At this point, the employer had two choices: conclude the interactive process, as the employee's claims were not substantiated, or proceed and use another doctor to clarify restrictions or limitations. The employer directed her to attend a third-party fitness for duty (FFD) examination. The FFD examiner determined while some of her past performance deficiencies were the result of a past medical condition, she was not disabled at the time of evaluation and had no work restrictions.

A reasonable accommodations meeting was held, and the employee agreed she was not disabled. The parties agreed that as she was now unrestricted, she could resume work. Her interactive process was concluded, and her disciplinary process resumed for areas not affected by her past medical condition. She was informed that now her performance would not be related to a disability, and the tool of discipline would be used if needed. Over time her performance continued to worsen. The employee then informed the employer her performance was due to a different disability — a learning disability — and requested accommodations for this, providing a new medical note.

Once more, the employer halted the disciplinary process and restarted her interactive process. The employer scheduled a second FFD evaluation in response to this new accommodation request; an FFD referral service was used to locate a medical specialist with appropriate skills and experience for this examination. The frustrated employer took a deep breath and continued. The FFD questionnaire focused on how the disability might or might not impact her ability to meet performance expectations.

The second FFD examination provided documentation for the conclusions that Smith: 1) did not have a disability; 2) was unrestricted; and 3) that her specific performance issues were not related to a medical condition but likely related to her intellectual abilities to keep up with the changing profession.

In a second accommodations meeting, Smith stated she understood the FFD results, and had no additional comment. The interactive process was then concluded for the second time. The disciplinary process resumed, having completely ruled out disability as a reason for not meeting performance standards, and she was ultimately terminated for performance deficiencies. One year passed after this action, no appeal occurred and her statute of limitations exhausted.

Though this process required financial expenditures on the front end, it ultimately saved significant time and cost. It also ensured the employer used the right process to manage performance issues, doing its due diligence by both the employee and the company.

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Roberta Etcheverry, CPDM
CEO
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Bright (or Blurred) Lines for Medical Information

When considering reasonable accommodations for employees with disabilities, the core issue is assessing how the disability impacts successful performance of the essential job functions. With privacy of personal health information looming large under the Health Insurance Portability and Accountability Act and other laws, employers are often unclear — and cautious — about requesting medical information during the interactive process. What information is the employer entitled to and how do we obtain it? What must employers avoid in the process?

Francesca Moore, Manager of Health and Welfare Benefits and Integrated Disability and Absence Management with Lawrence Berkeley National Laboratory, has extensive experience leading employer disability management teams through this analysis. The first step, Moore notes, is ensuring that the employee and their physician understand what documentation is needed and why, so that the request is not seen as pushback or delay in providing accommodations. Remember that employees and physicians are generally not familiar with the process and educating them can ease their concerns and support a more productive dialog.

In order to effectively determine the "reasonableness" of accommodations, employer and employee must understand what job functions are impacted and how. The dialogue should focus on the job-related effects of the disability, and not delve into diagnoses or treatment plans. Moore's prior work in the healthcare industry taught her that these organizations need to be particularly mindful of keeping "firewalls" in place between the interactive process and employee health plan/benefits information.

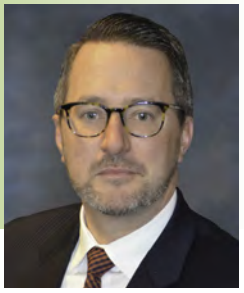
The Americans with Disabilities Act (ADA) can apply to both workers' compensation (WC) claims and to non-occupational health conditions, but those two systems have different rules about sharing medical information. For ADA purposes on non-occupational conditions, Moore reminds us that best practice is to have the employee obtain documentation directly from the physician, rather than interject into the doctor patient relationship. In Moore's experience, having standardized methodologies and tools supports consistent employer practices. Questions to the medical provider should include verification that the employee has a qualifying disability, what the work limitations are, and the projected duration of the disability or limitation.

If the employee is unable to obtain the information from the physician or requests assistance with this, employers can communicate directly with the physician, provided that the proper authorization is documented. Release of information forms should clearly indicate who the information will go to; what the information will be used for; that the limitations or effects of impairment are the only information to disclose; and how long the release is valid for.

Another potential challenge in the process occurs when the employee does not agree with the physician's documentation. Moore cautions that employers cannot simply ignore the employee's statements and must problem-solve through these issues. Ask the employee to specify what they do not agree with and explain the importance of seeking clarification from the physician as the employer cannot simply ignore or discount the physician documentation. Drafting specific follow-up questions for the physician can be helpful at this point to ensure employer, employee, and physician are all working with the same understanding of the employee's limitations.

Moore reminds employers that according to the ADA, the interactive process is very much intended to be a case-by-case analysis of the facts at hand and employers must not make assumptions regarding an employee's capabilities. Employers must instead rely on the information and documentation obtained.

Finally, the interactive process is rarely a one-time discussion; as an employee's condition or capabilities change, the analysis must continue in an effort to support ongoing employment.



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Generation Z: Evolving Benefit Needs and The New Normal

After years spent studying Millennials, socially-conscious Gen Z has arrived, and they are completely different. Indeed, early research into the work, financial, and consumer behaviors of Gen Z suggest that they may have more in common with The Greatest Generation (who preceded Baby Boomers) than any other generation.[1]

From a work perspective, Gen Z is already quite active. Approximately 77% of Gen Z (those between the ages of 14-21) are earning spending money through freelance work, part-time jobs, or earned allowance. This bodes well for Gen Z being a self-reliant and entrepreneurial group that is not afraid to roll up their sleeves and get to work. Moreover, Gen Z is already thinking about and saving for retirement. A surprising 12% of Gen Z is putting money away for retirement. While that number may seem relatively small, keep in mind that most of Gen Z is too young to be in the workplace.[1]

Gen Z also brings a mix of new and old perspectives about what group benefits they find most valuable and — just as importantly — how they want to interact with those benefits. For disability and absence professionals, understanding what benefits this generation values may help craft new and innovative solutions:

- Personal and Professional Growth: From formal and informal mentorship programs to career-pathing, learning-based project work, and volunteer opportunities, Gen Z is interested in learning and growing both personally and professionally.
- Financial Wellness: Gen Z, like other generations, is facing mounting debt. To attract and retain Gen Z, employers may need to think more broadly about how they help their workforce address pressing challenges like student loan debt. Programs where employers contribute dollars toward student loan repayment and provide access to financial planning services are benefits that may be especially attractive to Gen Z.
- Flexibility and "Lifestyle" Benefits: Like other generations, Gen Z values flexible workplace policies such as remote work and part-time arrangements. They also value additional "lifestyle" benefits such as: modern and open workplace layouts, a place to park and store their bicycle or scooter, a casual dress code, and commuting or public transportation assistance. In addition, a benefit that has been popularized in Canada is grabbing Gen Z's attention: lifestyle spending accounts (LSAs). LSAs can be used for things like continuing education, pet insurance, charitable giving, or any other expense that supports a Gen Z lifestyle.
- Technology: Gen Z grew up with technology and expects employers to offer solutions, education, and insight through technology platforms. These platforms need to be interactive and create a gamification experience to keep Gen Z's interest.[2]

For absence and disability professionals, insight from Gen Z raises some interesting questions about how we should think of evolving our own solutions and programs to meet the needs of this newest generation. For instance, how do we better connect financial wellness with health and productivity, as Gen Z may see these as inextricably linked. Additionally, how do we add gamification and technology upgrades to support return-to-work and stay-at-work efforts? These are the new and emerging questions and challenges that our industry will need to solve sooner, rather than later.

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Geoffrey Simpson
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Adding a Task Bank to Your SAW/RTW Game

As the shift to a knowledge-based economy continues, employees become increasingly valuable to their employers, and retention becomes a key factor in company success. Studies have shown that the average cost of turnover is 33% of an employee's salary, equating to $15,000.[1] However, for highly paid and more senior jobs, the percentage can rise to 213%.[2] This demonstrates the need to focus on strategies that keep employees engaged in the workplace. The stay-at-work/return-to-work (SAW/RTW) program is one such strategy, and for the sixth pillar in this column, we'll examine an often-overlooked SAW/RTW resource: the task bank.

During the ADA interactive process, we tend to focus on accommodations like providing leave, reducing schedules, modifying work, and providing adaptive equipment. But what happens when your employee still can't perform the essential functions of the job? Recognize that this valuable team member in whom you've invested might be able to perform another role temporarily!

This is where the task bank comes in; a task bank is a database of tasks that need to be performed in your organization on a temporary basis. This work can be used to keep employees engaged in the workplace by matching them with tasks aligning to their current physical and cognitive abilities. This provides the employee with interim work that progressively matches their abilities until they can perform a permanent position.

To begin developing a task bank, identify your key stakeholders. Typically, the absence and disability management team is the driving force. The human resources team holds valuable knowledge about the types of jobs across your company, while supervisors know specific jobs and skill sets in their departments. Executives need to understand the bottom line value and lend their support to promote the task bank. Rounding out the group is the employee population who needs to know that this resource is available.

Next, look for tasks. These are activities that:

- no one has time to do;
- are short-term projects;
- would allow other employees to focus on their higher priority work;
- are valuable to a department; and
- meet business needs.

The task bank is a dynamic tool, and you should train supervisors and others to automatically add new tasks as they become available. Make sure you capture the following information for each identified task:

- Task name
- Description of work
- Location
- Education or training requirements
- Work hours and dates
- Name of supervisor
- Detailed essential functions to compare to an employee's current abilities[3]

In addition to capturing and managing tasks, it's important to keep sight of the processes that underpin your task bank, including:

- Stakeholder collaboration
- Efficient methods to add/delete tasks
- Training for employees and supervisors
- Continuous progress reviews of employees performing transitional work

Your task bank will require ongoing maintenance. You should continually look for ways to adapt the tasks to the specific needs of your workforce in order to keep your valuable employees on the job. And there are even bigger payoffs; a successful task bank can help drive a fundamental shift from focusing on an employee's disabilities to instead looking for their abilities.

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Potential Synergies: Wellness, Workers' Compensation, and Disability Programs

Multiple studies show that obesity and other common chronic comorbid conditions drive up the cost and duration of workers' compensation (WC) claims. Effective wellness programs should, in fact, be the place where risk management and benefits find it easy and mutually beneficial to cooperate and share resources. In addition, WC may be the best avenue for demonstrating the impact of good wellness services, since return to work (RTW) deals with the whole person, not just episodes of care.

Since each employer's approach to wellness plans and WC risk is different, metrics and general program ideas that have broad application are the best way to understand potential shared turf between these two program areas.

Let's begin by assessing your WC and non-occupational disability risks, especially the role of comorbid conditions in delaying return to work. Significant comorbid conditions include obesity, metabolic syndrome, diabetes, chronic obstructive pulmonary disease (COPD), and arthritic disorders. When these comorbid conditions are present, a relatively routine WC or disability episode can last longer than normal, running up both indemnity claim costs and replacement costs when a necessary employee is off work for a significant period. Good wellness programs are designed to target exactly these types of chronic, productivity-sapping conditions.

Your colleagues in risk management should have access to analytic reports that address these WC cost drivers; the amount of data allowed may vary from one state to another. To gather parallel metrics for non-occupational cost drivers affecting short-term disability (STD) and long-term disability (LTD), you can consult your carrier, third-party administrator (TPA), or your internal self-administration department.

Your first question should be: what are the top three or four comorbid factors driving WC and non-occupational disability costs? TPAs can usually provide very informative benchmarking reports that not only answer this question, but also show you how your organization compares to others in your industry class.

The second question is: does your suite of wellness programs appear to address these major comorbid factors effectively? For example, if obesity is causing your WC and non-occupational disability claims to balloon, is your wellness program effectively applying resources to counter this trend? Ask for historical trend analytics. If you implemented a major weight loss program, several years ago, do you see this reflected in fewer obesity comorbid conditions in the last couple of years? If you implemented a well-back program, are you seeing fewer disability days attributed to lower back complaints?

The most important takeaway is that we often expect wellness programs to impact health plan costs. Ideally, this can happen, but it takes time and the signals may be difficult to quantify without intensive investigation. If you help your people improve their health, lose weight, and strengthen their core muscles, you may see the payoff sooner and more dramatically in better RTW results for WC and non-occupational disability.[1] You can benefit from industry research and reports, but analyzing data from your own experience is your best source of actionable intelligence. Don't leave WC and disability outcomes in their own silos. They can offer a wealth of information to help guide effective wellness plans.

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DMEC's New Education Model Takes Shape

In 2017, DMEC announced its transition from local chapters to a new education model. With a goal of extending the reach of our education events and providing additional resources to more of our members, the new education model has begun to take shape in 2018.

Regional Update Webinars

In October DMEC launched a new series of regional compliance update webinars. Increasingly, employers must comply with legal requirements that are driven by legislation at the state, county, and municipal level. These changes could be expansions or additions to state family or medical leave programs, sick leave mandates, or workers' compensation (WC) laws. To address this complex patchwork of laws, the four sessions in October focused on legislative updates, major circuit court rulings, and changes to WC law in states of the four regions. If you missed any of the webinars, you can access the recordings at www.dmec.org/resources/webinar-archives/.

New in 2019

In 2019 DMEC will be adding new components to the educational model that we believe will help our members connect with each other in unique ways, while taking advantage of cutting-edge education and technology.

Online Community Forums

Watch for new online community forums and a member directory in Spring 2019, which will allow DMEC members to share resources, ask questions, and gather insight from their industry peers in a secure, online environment. Whether you're interested in connecting with employers in your local area, your industry, or your organization size, you'll have the opportunity to select and customize the groups you participate in. In addition, you'll have a chance to build your network and find like-minded peers who understand your unique challenges through the online member directory.

Conference Roundtable Discussions

Based on feedback from conference attendees, we'll be adding new roundtable discussions at our 2019 events. Look for roundtables based on location and topic at the 2019 DMEC Compliance Conference, and roundtables based on industry and topic at the 2019 DMEC Annual Conference. Roundtable discussions allow individuals to delve into detailed absence and disability management questions and share lessons learned and best practices.

Summit Events

In Fall 2019, we will introduce our first DMEC Summit event. Using an online platform, the DMEC Summit will feature three to four hot-topic sessions with leading industry speakers. Networking and interactive discussion will be provided through "local hosting parties." Watch for more information about this exciting new event in the *DMEC Bulletin*.

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Enhanced Webinar Features

As more and more professionals utilize DMEC webinars for education and training, we'll be adding further opportunities for attendees to chat and connect with one another during the events. We'll also be introducing some dynamic, interactive elements for speakers and resources. Look for these changes in Fall 2019.

Continued Evolution

As the new education model evolves, DMEC will continue to review and incorporate new learning and networking opportunities. Our goal is to provide timely, high-quality education and training for absence and disability management professionals. If you have feedback or ideas to share, please submit them to Tasha Patterson at tpatterson@dmec.org.

The CEO's Desk continued from p. 5

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Reliance Standard / Matrix ADA Accommodation Data: 2017 Benchmark Analysis

Drawing from a sample size larger than the inaugural benchmark analysis, this statistical analysis is based on a review of more than 6,966 accommodation requests collected over a period of 12 months from employers representing a universe of 185,000 employees.

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STD Impacts continued from p. 14

factors, employers are paying a higher percent of total spend, and reducing the relative burden to the employee.

Figure 4: Expected Medical Spend Based on STD Impact

Expected Medical Costs from % STD Wage Replacement Vs. % Member Paid Medical

% STD Wage Replacement	% Medical Spend Paid by the Member					
	10%	15%	20%	25%	30%	35%
50%	$ 4,397	$ 3,744	$ 3,417	$ 3,221	$ 3,090	$ 2,997
55%	$ 4,593	$ 3,875	$ 3,515	$ 3,300	$ 3,156	$ 3,053
60%	$ 4,789	$ 4,005	$ 3,613	$ 3,378	$ 3,221	$ 3,109
65%	$ 4,985	$ 4,136	$ 3,711	$ 3,456	$ 3,286	$ 3,165
70%	$ 5,181	$ 4,267	$ 3,809	$ 3,535	$ 3,352	$ 3,221
75%	$ 5,377	$ 4,397	$ 3,907	$ 3,613	$ 3,417	$ 3,277
80%	$ 5,573	$ 4,528	$ 4,005	$ 3,692	$ 3,482	$ 3,333
85%	$ 5,769	$ 4,659	$ 4,103	$ 3,770	$ 3,548	$ 3,389
90%	$ 5,965	$ 4,789	$ 4,201	$ 3,848	$ 3,613	$ 3,445
95%	$ 6,161	$ 4,920	$ 4,299	$ 3,927	$ 3,678	$ 3,501
100%	$ 6,358	$ 5,051	$ 4,397	$ 4,005	$ 3,744	$ 3,557

In Figure 4, STD wage replacement levels are found on the left, and member paid medical spend percentages are found across the top.

This provides insight into the problems created by shifting more cost to employees rather than attempting to correct the issues that drive healthcare costs. Even for companies in this study where employees paid more than 30% of their medical care, the general trend for that metric is decreasing. This means that even though total dollar costs for both the employer and the employee are rising, the percentage paid by the employee is still decreasing.

Some U.S. employers have responded to this trend with continued aggressive medical cost-shifting to employees. However, the 2017 Kaiser Family Foundation Health Benefits Survey[1] illustrates that although employee deductibles and premiums are increasing, the total cost of care to employers is also still increasing. This implies that health plan cost shifting has not completely solved the issue of rising healthcare costs to employers; other cost drivers such as employee health behavior and ineffective care remain important areas for employer improvement efforts.

The findings of this study suggest a different approach to analyzing medical cost trends. Identify if your employees are paying a decreasing or low percentage of the costs for their care, and what factors are driving that trend. Also, understand that while your medical and STD benefits may be managed by two different teams, the impact that your STD plan has on your medical spend should be highly visible to all members of both teams.

Although not all industries are represented in this particular study, the link between STD claimants and medical spend referenced at the beginning of this paper has been present in all employers that we have analyzed. If you have never taken the opportunity to view the medical spend of your STD claimants, now is the time. It is becoming increasingly critical for employers to view their benefits from an integrated perspective and understand if the STD policies they have in place protect employees, while not increasing medical spend.

Reference

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Insourced Leave Management from p. 17

recent count, we serve over 16,000. Our challenge now is to maintain the same level of care with an ever-increasing number of claims. To support this, in 2015, we began using a software technology that provides electronic records, an efficient automated tracking system, compliance updates, and entitlement and correspondence requirements. We believe this is a significantly reduced cost compared to cosourcing or full absence management outsourcing, with the same staff count as in 2005. Also, our two disability associates are now Certified Leave Management Specialists through DMEC.

In 2005, our absence rate at its highest was 10.5%, and according to our technology vendor, this was close to most healthcare averages. By 2006, we were down to 7.43%. In 2017, our absence rate was at an all-time low of 3.7%. The resulting 6.3% savings (from a 10% industry average) combined with our average hourly wage created nearly $35 million in savings for 2017. This makes our program a successful return on investment as well as a benefit to our team members.

Conclusion

One of our neurosurgeons explains foot numbness to his post-operative patients in this way:

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"And the bad news is?" they ask.

"You get your feelings back."

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The recent merger of Hackensack University Medical Center and Meridian Health created Hackensack Meridian *Health*, and our department name has changed to HM*H* Connect. Our department is growing to accommodate the new team members we will soon be adding, but our goal to connect remains at the top of our priority list. This desire has been a driving force in our success and will continue to help us serve this incredible community well into the future.

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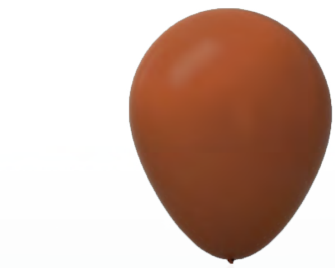

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– **ALLYSON KAMBACH**
CLMS, Director, Disability & Absence Product Management

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