



Supporting Employment for Newly Ill and Injured Workers

Evidence on Early Intervention

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This brief is part of A New Direction for Disability Policy, a series exploring how federal policy could improve the employment of people with disabilities by expanding the use of early intervention. The series began by examining how focusing on Social Security Disability Insurance has driven federal policy, leading to missed opportunities to more effectively support the employment of people with disabilities and why other federal and state programs have not adequately intervened early with newly ill or injured workers. This brief continues the series by reviewing the evidence base supporting early intervention. The series will conclude by exploring options for how a new universal paid family- and medical-leave benefit could be paired with grants to states to test promising models and scale up federal early intervention programs over time.

In the US, 10.6 percent of adults ages 18 to 64 report having a disability; of these, only 36 percent were employed in 2016, a rate less than half that for people without a disability (Kraus et al. 2018). Some of these people have long-term disabilities acquired at birth or at an early age. Others are workers who experience a new illness or injury or whose worsening health condition forces them to at least temporarily leave the labor force. Although existing data and surveys make it difficult to know how many people are in this latter group, the best estimates suggest it could be millions of workers each year.

Although the system of employment supports for people with long-term disabilities, such as those acquired early in life, are relatively well established and understood, less is known about support for workers who develop a new illness or injury or have a chronic condition worsen. In the United States, not all workers have access to early intervention services provided through their employer. The most effective early intervention services are those offered to workers soon after they develop a new potentially disabling medical condition and while they are still adapting to life with the condition. These

services focus on assisting the person in staying at or returning to work. Ideally, early intervention occurs long before a new or worsening health problem leads a person to apply for Social Security Disability Insurance (SSDI). Unfortunately, many workers do not have access to these employer-based services because they are provided voluntarily, often to higher-wage and skilled workers employed by large firms with higher rates of workers compensation claims.

This brief provides policymakers with an overview of what early intervention is, who can benefit from it, how different models for early intervention work, and the evidence base of those models, with the aim to inform options to expand early intervention. We examine evidence from employer-based programs inside and outside the US as well as from two US models of early intervention that are not employer based but instead leverage a worker's connection to his or her health care provider: the Washington-based Centers for Occupational Health and Education (COHE), which focuses on workplace injuries that are often musculoskeletal in nature, and the Individual Placement and Support (IPS) model, which supports people with mental illness.

Overall, evidence from the US on the effectiveness of early intervention is somewhat limited because of the voluntary, employer-based system for providing most services. But a large body of relevant evidence is available from developed democracies outside the US. Our review of the research provides four key takeaways that could inform policy:

1. Early intervention is effective in improving employment outcomes (such as reduced time spent out of the workforce and higher employment rates).
2. Early intervention is effective across a range of medical impairments, from musculoskeletal conditions such as back pain to common mental health disorders such as depression.
3. Effective models of early intervention address gaps in communication and coordination across the domains that a worker must navigate when struggling with a difficult new medical condition.
4. Effective models can be successfully provided through an employer, health care provider, or a government-sponsored intermediary.

In other countries, expanding access to early intervention has been largely accomplished through employer mandates. In the US, expanding access could likely require looking outside of employer-based models to approaches that facilitate services through other settings, such as workers compensation programs, local vocational rehabilitation agencies, or state paid-leave and temporary disability programs. Our review of the evidence suggests these approaches could be successful if they include the key elements of effective early intervention models. Policymakers could consider options to incentivize state experimentation in this area that builds on the recently awarded Retaining Employment and Talent after Injury/Illness Network (RETAIN) grants. Expanding early intervention through avenues outside the workplace that use federal and state funds will require testing and evaluation to ensure they are replicated faithfully as they scale up. One option would be to use a tiered-evidence approach to funding state experimentation.

What Is Early Intervention and How Does It Help?

Early intervention strategies are aimed at supporting continued employment for workers who develop a new potentially disabling illness or injury or who experience the worsening of a chronic condition that could limit their ability to work. In this brief we describe conditions as “potentially disabling” because what constitutes a disability is complex and often misunderstood, or it can be confused with a person’s conceptions of his or her own health and well-being. For this reason, many of the workers targeted for assistance through early intervention may not view themselves as having a disability.

Early intervention is targeted to workers who develop a potentially disabling medical condition and includes services provided to a person as soon as is practical after he or she acquires the new medical condition or experiences a worsening of an existing condition. Ideally, these services begin while the person is still adapting to life and working with the condition. In general, interventions that occur after a person has been out of the workforce for a substantial period are not considered “early.” Early intervention services can take many forms, but the most effective approaches improve coordination, communication, and services among the employee, the employer, the health care provider, and the worker’s personal environment, with an overriding focus on the person’s functional capacity and ability to stay at or return to work. This is referred to as a multidomain approach because it addresses all the environments a worker must navigate as he or she adjusts to life with the new condition.

Early intervention services are typically facilitated by a disability management coordinator who is assigned to a worker by his or her employer or health care provider following the onset of an illness or injury. The coordinator helps the person better understand his or her new medical condition and ability to function at work, often by communicating with the worker and the health care provider directly. At the same time, the coordinator may help the employer understand how reasonable work accommodations could facilitate the employee’s ability to return to work, including the employer’s legal responsibilities to do so.

Effective early interventions can range in complexity. In some cases, they involve an employer providing an accommodation to the employee for ongoing medical visits under the Family and Medical Leave Act, or a workplace accommodation under the Americans with Disabilities Act. Under the Americans with Disabilities Act, an employer is obligated to provide reasonable accommodations.¹ Frequently, breakdowns or gaps in the delivery of health care services need to be addressed (Franklin, Wickizer, et al. 2015; Christian, Wickizer and Burton 2016). For example, workers who do not receive adequate physical therapy may underestimate their own functional ability as they recover from an injury. Other times, a worker may be treated for only one medical condition when another is also present. More intensive services and coordination between providers may also be needed when a mental health issue, such as depression, is present in addition to a physical illness, which can greatly increase the risk of long-term unemployment for the newly ill or injured worker (Conti, Berndt, and Frank 2008).

The timeliness of the intervention is important for several reasons. First, intervening early, while a person is still connected to an employer (e.g., while on paid sick or medical leave), preserves his or her

best chance at staying employed and securing a workplace accommodation. The worker's current employer has the greatest incentive to provide necessary accommodations because it allows the employer to retain an experienced employee and avoid the cost of recruiting and retraining a new one. For newly injured or ill workers who become disconnected from the workplace, time away from work can erode skills and deteriorate emotional and psychological well-being. A person who experiences long-term unemployment as well as the personal and financial costs of a medical condition may find it even more difficult to navigate the hurdles involved in finding new employment. For example, return-to-work programs targeted to people receiving SSDI are not considered early intervention, and evaluations of those programs underscore the limitations of waiting to intervene until the person has been out of work for an extended period (Wittenburg, Mann, and Thompkins 2013; Romig 2016; Smalligan and Boyens 2018).

Helping workers stay employed or return to work quickly also means addressing factors in their personal and social environments. Cutler, Meara, and Powell (2014) examined Health and Retirement Study data and found that older workers who experience a health shock, such as a stroke or cancer, are twice as likely to transition onto SSDI if they also experience adverse events in their personal environment, such as substance abuse or a breakdown in relationships or social networks. Research by health policy experts indicates that important social determinants of health (including education, living conditions, and community supports) also affect how people cope with and respond to adverse life events and conditions, such as a new illness or injury. Deficits in the social determinants of health can contribute to health disparities across different social and economic environments (Woolf and Braveman 2011) and can affect whether and how well a person can successfully navigate the challenges associated with an adverse life event or condition. If early intervention can help a person navigate those challenges, it could also mitigate health disparities.

Early Intervention in the United States

In the US, most workers who have access to early intervention services have it through an employer. These services are provided voluntarily by employers; in other countries, services are typically mandated and cover more workers. In the next section, we describe the model of employer-based early intervention in the US; we then provide a summary of the evidence from similar programs inside and outside the US.

In addition to employer-based programs, there are two other promising models of early intervention in the US that are facilitated through a person's health care provider. These programs reach far fewer workers but provide important evidence on the effectiveness of early intervention and demonstrate the potential for successful approaches outside the workplace. The first is a statewide workers compensation-based program developed in Washington State. The second is an intervention model targeted to people with serious mental health conditions. These approaches are discussed in a later section.

Employer-Based Early Intervention

Early intervention services in the US are typically provided by employers through work disability management programs. These programs may be one component of an employer's overall approach to managing ill, injured, and impaired workers as well as those who have a disability. Depending on their size and sophistication, some employers may have anywhere from two to four discrete programs in place. These programs may be coordinated by human relations staff who also manage the employer's obligations under the Americans with Disabilities Act and who put procedures in place to assure compliance with ADA-related requirements in hiring, promotion, and responses to requests for reasonable accommodations. Likewise, human resources staff also manage leave under the Family and Medical Leave Act.

Employers who provide early intervention services through a work disability management program do so most often, but not exclusively, as part of their response to workers compensation injuries. However, only some of those work disability programs are consistently employed early; often interventions are selective and reserved for special cases of prolonged work absences (several months or more). These programs often employ occupational health staff and consultants to coordinate services and communication across homes, workplaces, health care settings, and social environments. The scope of these privately supported services depends on each employer's array of voluntary benefits and obligations under workers compensation laws. This stands in contrast to other countries, where governments mandate employers provide certain services to workers with disabilities. Often these programs reflect the employer's desire to retain skilled workers and reduce the employee's time away from work.

ACCESS TO EMPLOYER-PROVIDED PROGRAMS

Data are limited on the extent of worker access to employer-funded disability management programs in the US. However, employers who provide disability management services typically do so in conjunction with private disability insurance, which could include short- and long-term disability insurance. Data on private disability insurance coverage is more readily available and provides a rough proxy for the extent of employer-provided early intervention. According to the Bureau of Labor Statistics, 40 percent of private industry workers had short-term disability insurance in 2017.² The data shows that private disability insurance coverage is heavily skewed toward higher-wage workers. Of the highest-paid 25 percent of wage earners, 62 percent have coverage compared with 16 percent of the lowest-paid 25 percent of wage earners. Similarly, only 20 percent of service workers had short-term disability insurance compared with 54 percent of managers and professionals in 2015 (Monaco 2015).

Although there are connections between employer-provided disability management services and the provision of private disability insurance benefits, the two are often in tension. Mitchell (2010) described disability benefit insurance and disability management as an "odd couple." Cost control and eligibility criteria drive the insurance benefit decision whereas disability management is focused on the needs of the newly ill or injured worker. The employer provides disability insurance benefits primarily as a component of a competitive benefit package meant to attract employees in certain market segments.

Whether an employee receives benefits from his or her insurance policy is largely driven by the insurer's claims process and strict definitions of what constitute a disability under the insurer's terms.

Provision of disability management services, meanwhile, is primarily driven by the employer's need to address workplace illnesses and injuries, reduce costs by limiting workers compensation claims and the number of days employees are out of work, and increase retention of skilled workers. Disability management services can be provided by a third party contracted by the employer for that purpose. Sometimes, they are provided by the disability insurer, putting some of the goals of insurance provision and disability management more directly in conflict. The Burton Blatt Institute (Adya, Cirka, and Mitchell 2012) surveyed 128 employers with a wide mix of firm sizes regarding return-to-work programs and found that "insurers were identified as not influential in the decision to implement a formal return to work program." In addition, Gould-Werth, Morrison, and Ben-Shalom (2018) found that an employer's willingness to accommodate and retain an employee depended on the employer's level of understanding of what could be done to accommodate a condition and the resources available to facilitate an accommodation.

Although most early intervention services are offered in connection with workers compensation injuries, they are sometimes extended to employees with non-work related conditions. Nationally representative survey data are not available, but experts and nonrepresentative surveys suggest that many large employers and firms employing higher-wage and higher-skilled workers have formal or informal disability management programs and are increasingly seeking to integrate their approach to work-related and non-work related episodes (Adya, Cirka, and Mitchell 2012).

The reliance on a voluntary system of employer-provided supports means access is typically limited to those with employers who have high internal cost incentives to retain workers. However, this ignores the potential benefits from early intervention to the individual, smaller employers, government programs, and broader economy (Bardos, Burak, and Ben-Shalom 2015). These benefits can include higher employment rates, shorter absences from work, higher employee retention, delayed claiming of SSDI benefits, reduced reliance on other public assistance programs, and higher tax revenue.

In many other developed democracies, these services are more widespread because employers generally have more responsibilities in this area and face stronger mandates. Unfortunately, most workers in the US who do not have access to employer-based programs will also not be served by government-funded employment support services, such as vocational rehabilitation (Smalligan and Boyens 2018). Existing programs face limited resources for early intervention and a large need that forces them to prioritize services to the most vulnerable. Workers who develop a long-term disability and go on to receive SSDI benefits eventually become eligible for certain return-to-work incentives and programs, but these opportunities often become available when it is too late to effectively help workers return to work.

Evidence from Employer-Provided Early Intervention

Most of the evidence on early intervention comes from evaluations of employer-provided programs in developed democracies, largely in North America and Europe. Research and data from the US is more limited than the other countries because its employer-provided services are largely voluntary. The richest data in the US come from workers compensation-related illnesses and injuries because of the additional requirements and regulations governing employer responsibilities in those cases. But research from outside the US is highly relevant to US policymaking because the interventions themselves are similar.

The research base on early intervention is broad and deep. Consequently, there are several recent systematic reviews of the literature that synthesize the findings from many high-quality studies of early intervention. We summarize the findings of nine studies, mainly systematic reviews, that focused on outcomes in employment (both worker and employer benefits), health and well-being, and savings to government programs.

EMPLOYMENT OUTCOMES

Six systematic reviews of employer-provided early intervention programs found strong evidence that they were effective in improving employment outcomes. Two of these studies focused on improvements in the likelihood an employee would **return to work**. One found that effective early intervention programs that address multiple domains, including the workplace, health care and socioeconomic status, were the most effective at increasing the likelihood of a person returning to work. This finding applied to a wide range of medical conditions, including common mental disorders, cardiovascular diseases, and cancers, and they concluded there is support for “the validity of a cross-disease approach” (Gragnano et al. 2018). Similarly, two studies found early intervention had a significant, positive impact on the likelihood of workers with common mental disorders returning to work (Mikkelsen, Bjornskov, and Rosholm 2018; Joyce et al. 2016).

Three systematic reviews found early intervention that addressed multiple domains was effective at **shortening the duration of work absence** following the onset of a range of new potentially disabling conditions, including musculoskeletal, pain-related, and mental health conditions (Cullen et al. 2018; Johnson et al. 2012; Franche et al. 2005). Evidence was mixed on the effectiveness of interventions that only addressed one domain (Cullen et al. 2018).

One study by RAND looked at benefits to employers from early intervention. This survey of large California employers found that those with established disability management or return-to-work programs **retained workers** who developed work-based impairments at a significantly greater rate, and injured workers **returned to work** 1.4 times faster than a comparable group (McLaren, Reville, and Seabury 2010). Similarly, Hill, Maestas, and Mullen (2016) found workers who were accommodated were 40 percent more likely to continue working, though the impact faded over time.

HEALTH AND WELL-BEING

For workers with depressive disorders, one systematic review of randomized controlled trials from many countries found moderate evidence that a multidomain intervention **led to fewer employee sick days** than did a clinical intervention alone (Nieuwenhuijsen et al. 2014). Another found that workplace interventions showed promising results in improving the treatment of workers with depression, but many studies had small sample sizes, so more research is needed (Yunus et al. 2018).

COSTS TO SOCIAL SECURITY DISABILITY INSURANCE

Using workers compensation data, one study estimated that injured workers who were provided workplace accommodations, one component of early intervention, **delayed their SSDI applications** by 4.4 years on average (Burkhauser, Butler, and Weathers 2002).

SUMMARY

Overall, effective early intervention programs have some common features. They include highly coordinated services and supports that address each of the domains that a person must navigate to successfully stay at work or return to work, and they include strong communication between the employee, employer, and health care provider to facilitate better integration of services. Early intervention has shown promise across a range of impairments, producing benefits for the worker, employer, government, and society more broadly. One caveat to the literature is that much of it comes from outside of the United States and discusses services provided by employers under a mandate. Expanding early intervention in the US, where employer mandates are not as widely accepted, will likely require reaching workers through avenues outside the workplace, such as other government agencies or health care or social services providers. It is unclear how easily and faithfully these employer-based approaches can be replicated elsewhere. As discussed in the next section, two promising models suggest this can be accomplished, and the strength of the evidence summarized here suggests further investments in early intervention are warranted.

Health Care–Facilitated Early Intervention

Most early intervention services are provided through employer-based disability management programs. However, there are two examples in the US of early intervention programs developed outside the employer framework. These models use government funding to provide early intervention services through a worker's connection to his or her health care provider. In these contexts, access to health insurance or a strong community health care system is vital. Because of the connection to health care, these approaches are usually focused around particular types of medical impairments. Two examples of these interventions include COHE, which primarily addresses musculoskeletal conditions that arise from occupational injuries, and the IPS model, which assists people with serious mental illness. These models and evaluations of their effectiveness are described below.

WASHINGTON STATE CENTERS FOR OCCUPATIONAL HEALTH AND EDUCATION

COHE is a state-based model for early intervention developed within Washington's workers compensation program and funded by premiums paid by employers. Because of its connection to

workers compensation, COHE addresses occupational injuries and illnesses, most often musculoskeletal conditions. In contrast to the employer-provided models discussed previously, COHE is an example of early intervention services facilitated through a government program.

Established in 2001, the COHE intervention focuses attention on employment outcomes of the injured workers through health care and other settings. The COHE staff improve communication between the injured worker, the physician's office, and the employer. They also provide education on best practices to health care providers. COHE identifies obstacles to the employee returning to work, whether they originate from the employer, physician's office, or injured worker, and emphasizes that simply returning to work is an important health care outcome.

Evidence from COHE Evaluations

In a recent eight-year follow-up evaluation of the COHE model, Wickizer, Franklin, and Fulton-Kehoe (2018) found that relative to a comparable group of injured workers, workers receiving the COHE intervention had a 30 percent **reduction in workplace-based disability** and 30 percent **lower rate of injured workers transitioning to SSDI**. For every worker in COHE who returned to work and avoided SSDI, there are another two workers whose condition may not have led to their receiving SSDI but who avoided experiencing long-term unemployment because of their work disability. The study was not a randomized controlled trial, but it provides moderately strong evidence. It identified a reasonable comparison group for study, but differences in the demographics of the workers and employers should be kept in mind when extrapolating from the findings. Another study of the COHE program by Franklin, Sabel, and colleagues (2015) found that the program's innovations can also help combat the opioid crisis by detecting and addressing excess prescriptions of opioids. This insight was possible because COHE assists many workers with pain-related conditions. A recent randomized controlled trial in the United Kingdom tested practices similar to those used by COHE with a focus on patients with musculoskeletal pain. The authors found a reduction in days off work and improved performance at work, for a substantial net estimated return on investment (Wynne-Jones et al. 2018).

Washington State's legislature expressed bipartisan support for expanding COHE across the state because of early evidence showing lower costs for employers and improved outcomes for injured workers. Building on the model provided by COHE, the Department of Labor Office of Disability Employment Policy, in collaboration with the Social Security Administration, initiated a demonstration project known as RETAIN. RETAIN will test whether a small group of other states can replicate the approach used by COHE and will create an opportunity to rigorously evaluate the efforts.³ RETAIN was funded by Congress, and the initial grant awards were announced in September 2018.⁴ In addition to federal support for further research on the COHE model, leaders in the workers compensation field have issued policy statements emphasizing the need to focus on helping employees return to work and act on the lessons from Washington State's experience (for example, IAIABC 2016). The RETAIN grants aim to expand the amount of rigorous evidence regarding the COHE approach. Further, other countries are undertaking initiatives to assist workers with musculoskeletal conditions (Anand and Ben-Shalom 2017).

Individual Placement and Support Model

Individual Placement and Support (IPS) is an employment intervention for people with serious mental illness. IPS is just one model of a class of interventions known as supported employment. IPS is highlighted here because it has been the most rigorously studied and shows the most promise. The IPS model places an employment specialist within the health treatment team and can be delivered through community mental health centers. When a client expresses an interest in employment, the specialist provides job placement assistance and support while the person is working. The IPS model is based on eight principles that include honoring client preferences, initiating a job search as soon as a person is interested, and integrating the employment services with mental health treatment services.⁵ Developed by academics and health experts, IPS is a proprietary model and has been adopted and implemented by many providers in the US and abroad. Although it is similar to the other early intervention models discussed in this brief, IPS is often not truly an “early” intervention. As currently implemented in the US, there are funding challenges to serving people with mental illness that often lead to the intervention starting relatively late in a person’s treatment and after they are already unemployed or, because onset of serious mental illness often occurs early in life, while he or she is too young to have a significant work history. However, intervening earlier is an important objective of many IPS experts and may enhance the effectiveness of the intervention.

Evidence from Evaluations of IPS

IPS has benefited from an impressive array of studies in the US and abroad, including 21 randomized controlled trials. Under the Obama administration, both the US Department of Health and Human Services (HHS) Assistant Secretary for Policy and Evaluation and the HHS Substance Abuse and Mental Health Services Administration commissioned systematic reviews of the research base for IPS as well as other models of supported employment for people with mental illness.

Overall, experts agree that IPS is the most effective model of supported employment for people with mental illness. Studies of IPS have found it is effective in **increasing employment rates**, but more data is needed to determine whether there is a lasting long-term effect on employment from the intervention (O’Day et al. 2017; Marshall et al. 2014). Others investigated whether IPS was effective at **increasing earnings** and enabling people to leave SSDI or SSI. One study found that the impact of IPS on employment outcomes is strong and that scaling it should yield offsetting cost savings to the government, such as lower mental health costs and disability benefits, though the potential for savings has yet to be demonstrated (Luciano, Bond, and Drake 2014). Two other studies found evidence of **higher employment rates and earnings levels**, but they were not sufficient to allow workers to leave SSDI or SSI (Baller et al. 2017; Cook, Burke-Miller, and Roessel 2016).

As mentioned, many IPS interventions are often not truly “early.” In this context, early intervention would occur soon after onset of a mental illness and before or immediately after the first serious episode occurs. Consequently, there are very few rigorous evaluations for truly “early” interventions, but experts in this field conclude intervening earlier could have a stronger impact on outcomes (Luciano et al. 2014).

The potential impact of successful interventions for people with mental illness is significant. Serious mental illness is usually initially diagnosed in late adolescence and young adulthood. An intervention that successfully redirects an at-risk young person may lead to improved outcomes over his or her lifetime, with benefits to the person and his or her family and potentially government assistance programs (Luciano et al. 2014; Bond and Drake 2014; Jäckel et al. 2017; Bush et al. 2009). Researchers considering policies for people with common mental disorders, such as anxiety and depression, have also concluded that focusing on reattachment to employment can lead to improvements of those conditions (Alegria et al. 2017). Given the enormous personal and societal cost of mental illness and the promising results of several evaluations to date, there is a strong case for continued testing and evaluation of IPS.

A major limitation of IPS, however, is access. The Medicaid home- and community-based services option will fund rehabilitation services, permitting some states to use those funds for IPS. Before the Affordable Care Act, however, a childless adult would typically need to become eligible for SSI to receive Medicaid, requiring them to essentially stop working and spend down most of their assets. This also delays their access to the intervention. Supporters of IPS have also used funding from other sources, such as vocational rehabilitation and the Social Security Ticket to Work program. Karakus and colleagues (2011) found that organizations usually needed to blend multiple funding sources, with Medicaid being the most important. However, they concluded that “Medicaid is extremely limited as a funding source for early interventions that might favorably change the long-term prognosis of individuals who have had a first episode of serious mental illness but for whom mental illness is not yet a chronic condition requiring long-term -- perhaps even lifelong -- medical care and social supports” (ix). In an effort to provide more federal funding and flexibility, the Consolidated Appropriations Act of 2016 (the fiscal year 2016 omnibus appropriations bill) directed the HHS Substance Abuse and Mental Health Services Administration to set aside 10 percent of the funding within the Mental Health Block Grant for early intervention programs to treat people with early serious mental illness,⁶ and the set aside has continued in subsequent appropriations.⁷ Although this additional funding flexibility could support the expansion of IPS, it is not sufficient to meet the overall need.

The IPS and COHE approaches are substantially different but provide important insights. The IPS model has been rigorously tested and replicated in many settings, though not often as a truly early intervention. Although it is primarily targeted to people with serious mental illness, providers are beginning to use the IPS approach to address a broader range of mental health conditions. In contrast, the COHE intervention covers most workers with occupational illnesses and injuries in Washington State and addresses a range of conditions, though primarily musculoskeletal issues. These programs demonstrate how early intervention models can be effective across a range of different medical conditions and that they can be successfully facilitated through government-funded programs outside of the workplace.

Conclusion

Our review of the research finds that early intervention programs can have significant positive impacts on workers who experience a new illness or injury or the worsening of a chronic condition (Ben-Shalom, Christian, and Stapleton 2018). Effective programs increase the likelihood of workers returning to their job, reduces the amount of time a worker stays away from work, increases earnings, reduces the likelihood of a medical condition leading to a long-term disability and of long-term harm from the incident, helps combat depression, increases worker retention, and delays application to SSDI.

Despite these important positive impacts, access to early intervention is limited and uneven. Most employer-based early intervention programs are only available to a portion of higher-paid, higher-skilled workers who work for large employers. This means effective early intervention is largely unavailable to many workers, notably lower-paid and lower-skilled workers and those in alternative work arrangements. These workers are also not well served by existing federal employment support programs (Smalligan and Boyens 2018).

Expanding access to early intervention programs could be accomplished in several ways, but the evidence suggests that key elements must be included for any approach to be successful. These elements include addressing all the domains in a worker's life that are affected by the onset of the new illness and injury and improving coordination and communication between the employee, employer, and health care provider while emphasizing a return to work. The intervention must also engage the worker as soon as is practical after the onset of a medical condition.

Early intervention models that include these elements can be used to effectively assist workers with a range of medical conditions, and they can be facilitated through the workplace and health care settings. To date, the most promising state- and federal-funded models include the COHE and the IPS models. Both are facilitated through health care providers, and COHE is administered through the Washington State workers compensation program. Both models point to the potential to provide early intervention services outside of the workplace and suggest it may be possible to experiment with other government programs. Examples beyond workers compensation include state temporary disability insurance and paid-leave programs as well as local vocational rehabilitation agencies. States with weaker workers compensation programs could find these options more attractive and feasible.

Although the elements of successful programs are common across employer- and health care-driven models, whether they can be successfully replicated and scaled up within other states or through other federal and state programs remains to be seen. Policymakers seeking to expand access to early intervention services should consider incentivizing states to do more widespread experimentation. Experience shows that a multistate experimentation strategy is better able to accelerate the policy development process. The RETAIN grants initiated this year are a step in this direction, but they are modest and short in duration. Grants to states could be based on a tiered-evidence funding structure that allows states to identify, test, and evaluate new models. This would provide a knowledge base that can be regularly updated and used by states to learn about what works. In our next brief in this series, we will analyze options for the design of federal early intervention state grants and how such grants

could be integrated into a national paid family- and medical-leave program. Establishing universal paid medical leave could provide a new opportunity to identify the newly at-risk workers who are most likely to benefit from early intervention.

Each year, millions of people leave the labor force because of medical conditions. Many will return to the labor force without any government assistance; others will start a process that leads to long-term disability. The personal and societal cost of the decline in labor force participation of people with disabilities is immense. It is time begin testing and evaluating a range of strategies to address this challenge.

Notes

- ¹ “Accommodations,” United States Department of Labor, accessed December 18, 2018, <https://www.dol.gov/odep/topics/Accommodations.htm>.
- ² “Table 16. Insurance benefits: Access, participation, and take-up rates, private industry workers, March 2017,” US Department of Labor, Bureau of Labor Statistics, accessed December 18, 2018, <https://www.bls.gov/ncs/ebs/benefits/2017/ownership/private/table16a.pdf>.
- ³ “U.S. Department of Labor Announces Availability of \$20 Million in Grants to Help Injured or Ill Americans Remain in Labor Force,” news release, US Department of Labor, May 24, 2018, <https://www.dol.gov/newsroom/releases/odep/odep20180524>.
- ⁴ “U.S. Department of Labor Awards Nearly \$19 Million to Projects Designed To Keep Injured or Ill Employees in the Work Force,” news release, US Department of Labor, September 26, 2018, <https://www.dol.gov/newsroom/releases/odep/odep20180926>.
- ⁵ See “What Is IPS?,” IPS Employment Center, accessed January 14, 2018, <https://ipsworks.org/index.php/what-is-ips/>.
- ⁶ Substance Abuse and Mental Health Services Administration, “Guidance for Revision of the FY2016-2017 Block Grant Application for the new 10 percent set-aside,” US Department of Health and Human Services, February 8, 2016, <https://www.samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>.
- ⁷ “Consolidated Appropriations Act, 2018,” H.R. 1625, 115th Cong., (2018) <https://www.congress.gov/115/bills/hr1625/BILLS-115hr1625enr.pdf>.

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