

BACK TO THE ORIGINAL JOB: LESS LIGHT-DUTY DAYS THROUGH JOB-SPECIFIC TESTING

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Many improvements have been made in return-to-work systems over the last 10 years. Yet, there still remains one big black hole: the high number of days a worker is on light, restricted, or transitional duty.

A worker's use of light, restricted, or transitional duty is, by itself, a good development in a workers compensation claim. The best employers use it as a means to cut lost-time days and to make workers feel once again part of the workplace rather than isolated and disabled at home, thereby also improving medical outcomes. What the "duty" is depends on the employer's needs and the worker's medical restrictions, but it typically is a relatively easy job created for the purpose of bringing workers back to the worksite.

Some of the work is make-work. Some of it is from departments where simple and nonstressful tasks are done. A few employers will even bring the person back to the original department doing lighter tasks. Depending on the venue, it is called light, restricted, or transitional duty (all to be called light duty for the rest of the article).

In settings where light duty has a time limit, most often the employee assumes the work for the full number of days. In some cases, the light-duty work is so appreciated by both the worker and the supervisor that it becomes an unofficial job. Both of these aspects have the effect of prolonging the time before the employee returns to full duty.

On the downside of light duty is the perception of coworkers that the work is less than meaningful. In some workplaces, those on light duty suffer a stigma due to the perception that he or she is not doing real work, which creates another barrier for the worker to return to the original job.

So, one problem solved (less lost-time days) may be another problem created (excessive light-duty days). Many managers can identify the cost of a lost-time day, but rarely can one do the same for light-duty (at the expense of full-duty) days. Light-duty days have not had the focus that lost days have had. The result is one more opportunity for change. This article will focus on a solution that is beginning to work in the industries that have adopted it.

FACTORS IN EXCESSIVE LIGHT-DUTY DAYS

There are two factors primarily responsible for excessive light-duty days. The first is that the relationship to the employee's regular job is not maintained from the beginning of the work injury, causing the worker to feel more like a claimant or patient rather than the particular worker he or she once was and is trying to become again. The second factor is that insufficient care is taken to provide a return-to-work plan that meets the worker's physical needs. In reviewing worker surveys, Pransky and colleagues found that "dissatisfaction with return to work accommodation" ranked in the top three factors for both lost time and reinjury.¹

Both of these factors are fueled by a medical system designed to treat patients rather than workers. Creating a "patient" from a "worker" is the first step in reducing a workers compensation claim to only its medical component. Consider this scenario: A band-press operator from a local industry comes to a medical practitioner (physician, physical therapist, or chiropractor). If the first thoughts are, "Here comes a new back case," then the problem begins. The words of the practitioner will be, "Where does your back hurt? How much does it hurt? On a scale of 1 to 10, tell

me what level of pain you are feeling.” The worker will be invited to show exactly where the pain is on a pain chart, to describe whether it is sharp or dull, and so on. The injured worker has instantly become a patient and the focus is on pain, leaving the worker with the impression that healing will be accomplished only when the pain is completely gone.

What would happen if the medical practitioner knew the person’s job and respected the fact that the worker was a valued and talented person? Perhaps the first medical encounter would proceed thusly: “Hello, Bob. I understand you are a band-press operator at the File Plant. You are having difficulty with some of the lifting and bending at work because of your back. Tell me what you are having difficulty doing, what you can still do well, and what makes your back feel better. Our goal is to reduce your symptoms so you can return to work and your daily activities as soon and as safely as possible.” With this approach, the person retains the worker role and the focus is on regaining function.

The critical pieces here are that the practitioner knows the worker’s job, respects the worker as a worker, and uses function as the goal while meeting the obligations of caregiver.

PROGRAMS THAT COMBINE MEDICAL CARE AND WORK SHOW LESS DISABILITY

In Canada, Loisel and colleagues have promoted the occupational-focused Sherbrooke Model, which provides that both medical care and the worksite need to be involved in workers compensation cases.² Their research demonstrates that when the model is adopted, the result is less disability for injured workers.

Lemstra and Olszynski published research with similar conclusions based on one large plant in Canada.³ They compared both the traditional medical model and a model of clinic-based physical therapy with an occupational-management model in which the physician, an onsite physical therapist, and the worker combined medical treatment with ergonomic adaptations at the worksite. Also, assurance of good prognosis was given. The occupational-management model resulted in considerably less disability costs than either of the other models.

The key to these outcomes was the physician’s and physical therapist’s knowledge of the particular job involved and their ability to intervene, at least to some degree, at the worksite during the return-to-work stage. While this suggests that the pivotal person is the physician or the physical therapist, realistically, it is the worker. When a worker is evaluated competently — and when healing and work aren’t held out as mutually exclusive

— then the worker feels both important in the process and safer, and the return to work is no longer problematic. The worker’s involvement assures that he or she does not feel like a pawn in someone else’s chess game.

MEDICAL RESTRICTION FORM PRESENTS BARRIER TO RETURN TO WORK

Ontario physicians Schweigert, McNeil, and Doupe reported the results of physician questionnaires on barriers to return to work.⁴ Their main finding was that physicians felt uncomfortable with their role in the return-to-work process as determined by the worker compensation system. Foremost, in completing medical restrictions forms, they felt pressured to give more information than they were able to give. They were also uncomfortable with:

- arranging light-duty work with little or no knowledge about this work;
- dealing with return-to-work issues in a limited amount of time; and
- operating without enough appropriate information.

When asked about their role in return to work, most U.S. physicians identify the medical restriction form as the main part of the information they provide (see Exhibit 1). They use the form because “it is what we were given.” Most do not question completion of the various restriction forms as part of their job, nor do they question that they should estimate necessary restrictions on lifting, pushing, pulling, bending, and so on, even if they are uncomfortable doing so.

EXHIBIT 1				
SAMPLE MEDICAL RESTRICTION FORM COMPLETED BY TREATING PHYSICIAN				
Lifting:	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently	<input type="checkbox"/> Constantly
	Limit of _____ pounds			
Push-Pull:	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently	<input type="checkbox"/> Constantly
Bend:	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently	<input type="checkbox"/> Constantly
Hand Activity:	<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Frequently	<input type="checkbox"/> Constantly

Physicians' Restrictions Often Overly Conservative

There is a perception by many employers and case managers that any given physician's medical restrictions are more limiting than the worker's underlying condition requires. Employers feel great frustration when these overly conservative restrictions prevent the worker's return to work. Oftentimes, restrictions are so conservative that the employer knows the worker must be violating them at home, or having everything done by family members, to function at all. For instance, few believe that a worker at home will not have to do lifting over 10 pounds or some bending or to use the right hand (when it is these actions that are forbidden on the work restriction form).

Physicians may issue overly conservative restrictions because they feel they need to be the patient's advocate against a tough and difficult workplace. In other cases, physicians may perceive a job or a workplace as dangerous or difficult. Physicians may see a few injured workers from a plant and conclude that the plant must be a dangerous place, not realizing that they don't see the hundreds of others who work there doing their jobs safely and effectively.

Certainly, the problem doesn't entirely reside with the physician. When asking the worker what his or her job requires, many physicians hear high estimates of work requirements, such as having to push 300 pounds. If the work requirement were measured objectively, what is often found is that the worker pushes a cart that has 300 pounds of product on it, but that this cart requires only the effort needed to push 45 pounds to make it move.

In most cases, physicians have to rely on what their patients report about their work requirements because physicians don't have a job description from the employer. Without a job description or being able to view the job in action, physicians may overestimate the difficulty of that job. On the other hand, physicians who do get a job description often can't read it because it is too complicated and uses terms that they don't understand. (A similar statement is made by employers who don't understand the physician's medical terminology.)

Restriction Forms Assume Generic Jobs

Another facet of the problem with medical restrictions is that the same form is used for all jobs. The forms do not take into consideration either the modifications an employer could make on a temporary or permanent basis to alter a function or the differences in job maneuvers.

As a first example, consider a job that has 10 tasks. Only two of them require lifting 40 pounds or more; eight do not require any lifting. A ge-

neric form, such as the one in Exhibit 1, will consider this a 40-pound job. Therefore, a 20-pound restriction will keep the person off that job until the restriction level is slowly upgraded to 40 pounds. In fact, if the job tasks were specified, the restriction would affect only 20 percent of the job, perhaps allowing the person to return to the remaining 80 percent, depending on how various parts of the job intermesh.

In a second example, consider the differences in, say, lifting among many types of jobs. If a pivot transfer in a nursing home requires a 50-pound lift, is this the same as someone lifting a 50-pound manhole cover from the ground or someone lifting and sliding a 50-pound box onto a conveyer at waist height? All three tasks might read as 50-pound lifts, but they all require different body actions and abilities. An employer may wish for more specificity from the physician, but the employer, by providing the physician only with a generic restriction form, hasn't done its part in helping the physician achieve the needed specificity.

What an employer is looking for is specific information on what parts of the job the worker can do, so that the decision to place the person back at work, and where, can be made by the supervisor. How can obtaining this information be achieved?

SOLUTION LIES WITH COMMON METHOD FOR EXCHANGING RETURN-TO-WORK INFORMATION

Neither physicians nor employers are satisfied with the current system for providing and receiving information related to a worker's restrictions vis-à-vis returning to work. Physicians feel uncomfortable specifying numerical weight restrictions for job functions that they have never witnessed or that they do not understand, whether as reported by the worker or by the employer-provided job description. Employers crave specificity from the physician, but not overly conservative or overly general restrictions.

When physicians and employers are having difficulties communicating, the worker is the one with the real difficulties. Early on in most incidents, the injured worker believes that returning to life as it was before the injury is around the corner. But with return-to-work complications, thoughts can turn to feelings of being harmed and not able. When a restriction is given, the worker has two choices. One is to follow it. If it is too conservative, then the worker can become a victim of the "glass back" syndrome: "If I bend or lift, I might be harmed more." Conversely, if the worker needs to do more at home and in life, and does so successfully, then the worker determines that he or she has more ability than the restrictions indicate. This creates distrust in the accuracy of the restrictions and the worker is left

not knowing what his or her limitations are at all. Either way, the worker has entered an area of uncertainty, and opinions, rather than facts, become the driving forces: “My employer must not want me back,” or “Maybe my doctor is trying to protect me from something.” In the worker’s eyes, the limitation of his or her activities becomes a battle of opinions.

What is needed is a means of exchanging return-to-work information that is based on a common method and language for both employers and physicians. To achieve this, medical practitioners and employers first have to agree on an attainable return-to-work goal. Ask a medical professional what percent of workers on workers compensation eventually go back to their original job. In focus groups, the answers are in the range from 50 percent to 90 percent. When this question is posed to employer groups (and it may be that the best and most progressive employers come to discussions on return to work), the figure is 95 percent to 98 percent. The discrepancy in perception is interesting. Are medical professionals more likely to be involved with hard cases, or is it somewhat a self-fulfilling prophesy that workers don’t or shouldn’t return to their original full-time job?

When we recognize the actual high rate of eventual return to regular duty, it is clear that the return-to-work goal should be performance of the original full-time job at the onset. The worker’s abilities should be matched against the job from the beginning. If employers desire actionable information to place a worker back to work, then specific job tasks need to be addressed, not just global lifting or bending restrictions. If it were known exactly which tasks of the original job the worker could do, the employer could immediately assign the worker those tasks and the medical and rehabilitation goals could be set toward those tasks of the original job not yet able to be done.

How does this work? To derive correct information, the following must happen:

- Employees, supervisors, and, if relevant to the industry, union representatives articulate the functions of a given job. An objective, measured job description results from a final determination of essential functions, measurement of forces, and documentation of positions and movement patterns. The job description must be short and easy to understand. Prior to injury, a worker in the given job would agree that the job description indeed reflects the job.
- A test is developed from the objective, measured job description. This test involves all functions, not just the difficult ones, so that the employer can

be informed, later on, as to what the worker can do as well as what tasks cannot be performed. The test is created by an expert in kinesiophysical function, such as a physical or occupational therapist.

- To be effective, the test is given by a physical or occupational therapist within the first week of injury. Safety during testing is important. The results of the test are straightforward and should be shared with the physician, the employer, and the worker, so that everyone can appreciate just which job tasks can be performed. (See Exhibit 2 for the results of a sample return-to-work test.) The results should be used as a main part of the return-to-work release. If the case is of a musculoskeletal nature, the test results should also be used to set the rehabilitation plan, as well as provide the basis for ergonomic return-to-work modifications (see Exhibit 3). Each week thereafter, retesting and job-function upgrading should be done.

This process meets the need of keeping the focus on the original job at all times. It also ensures correct information for the physician related to the functions of the worker's job and for the employer related to the worker's abilities vis-à-vis the original job. Foremost, the worker feels very comfortable with return-to-work placement as he or she appreciates that

EXHIBIT 2

RETURN-TO-WORK TEST

Job Demand	Score	To Pass	Passed
1. Transport material	Lifted 30 pounds Pushed 20 pounds	20 pounds 15 pounds	Yes Yes
2. Insert molding on core	Pinched 10 pounds Gripped 50 pounds	10 pounds 30 pounds	Yes Yes
3. Activate press	Gripped 50 pounds right Gripped 40 pounds left	40 pounds on right 40 pounds on left	Yes
4. Remove mold strip	Lifted 30 pounds	40 pounds	No
5. Refill bin	Lifted and carried 25 pounds	20 pounds	Yes
6. Place raw material on shelves	Lifted 30 pounds	50 pounds	No

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the physician understands the job and that existing work restrictions are based on actual testing rather than estimates.

ESTIMATING FUNCTION VS. TESTING FUNCTION

Job-specific testing involves a physical or occupational therapist conducting functional testing of the various aspects of a worker’s job. Research supports that job-specific testing is superior to functional estimates by a physician outside the workplace.

Brouwer and colleagues studied functional capacity estimates and testing by comparing how injured workers perceived their own capabilities, how physicians perceived those capabilities, and actual functional-capacity testing of the worker’s abilities by physical therapists.⁵ They found that when patients with chronic low-back complaints were asked what their capabilities were, their estimates were the lowest of the three categories. The physicians estimated somewhat more capability than the patients, but the highest level of ability was shown by the functional testing.

Multiple studies have confirmed the reliability of kinesio-physical functional testing,⁶ which requires identification of maximum safe function through researched observational criteria rather than the participant’s statement of ability.

When objective testing is performed, the results become evidence-based information on which a physician can rely to release a worker to a specific

EXHIBIT 3			
RETURN-TO-WORK MODIFICATIONS			
Job Demand	Pass	Modify	Pass With Modification
1. Transport material	Yes		Yes
2. Insert molding on core	Yes		Yes
3. Activate press	Yes		Yes
4. Remove mold strip	No	With new tool	Yes
5. Refill bin	Yes		Yes
6. Place raw material on shelves	No	With vacuum-powered hoist	Yes

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job or, at least, to specific job tasks. The information assists the medical decision-making process, while saving the physician time and improving job-function specificity.

JOB-SPECIFIC TESTING: IMPLEMENTATION AND BENEFITS

Once developed for a given job, the job description and the associated test can be used for all employees in that job category immediately after injury. Physicians with whom the employer has worked should be approached regarding how to integrate the new information they will receive in case of future injuries. A critical next step is that management for the company must develop cohesive and directed policies regarding use of the testing results so that injuries can be appropriately managed from the first minute. Employers often feel outside the loop in work-injury cases. They wait for medical opinions and for restrictions to be lifted, although they may develop good light-duty policies while they are waiting for the final releases. In the job-specific testing system, the employer is not a passive player. With objective testing done soon after injury, the employer has what it needs for decision-making and getting the worker back to the original job.

While job-specific testing is often the first step in improving full return-to-work rates, there are other benefits.

- If employers sometimes hire workers who misunderstand the job, quit, and cause additional costs of turnover, the use of the objective, measured job description in the hiring process will make the physical demands of the job clearer to the applicant.
- In injury cases where testing has not been done already, the job description sent to the physician at or before the first visit clarifies the physical requirements of the job. This prevents misunderstanding or overestimation of the difficulty of the job.
- Employers can utilize job-specific testing after a conditional offer of employment (for purposes of compliance with the Americans With Disabilities Act) to ensure that the worker is able to meet the physical demands of the job at the time of hire and, thus, prevent high new-hire injury rates.
- Job-specific testing can also be used in deciding on job transfers and benevolently and voluntarily for those with changing work abilities (aging workers or those with changing medical conditions) in order to lessen the chance of work-related injuries.

- The job-specific testing system also follows guidelines set forth by the American College of Occupational and Environmental Medicine (ACOEM).⁷ According to these guidelines, physicians should be able to give specific return-to-work recommendations on physical and functional limitations by matching “the employee’s functional capabilities and vulnerabilities ... against the demands of the job and working conditions,” and on specific restrictions by specifying “any protective measures to prevent injury or foster recovery,” such as “exact weight and height for lifting restrictions; the amount of time per hour and per shift an activity can take place; postures to be avoided.”

SUMMARY

Employers and medical professionals have made significant advancements in reducing lost-time days through return-to-work management. The costly item now, both in medical costs and productivity, is excessive light-duty days. While workers are back at the place of employment, they are sometimes delayed in reaching their final destination — the original full-time job.

Job-specific testing can add objectivity to a process where a common format and language for work-specific information is needed for employers and physicians. The testing meets this goal because it is medically based and has been performed on work-specific activities. The testing also makes workers the focus of the system, rather than being kept outside of the return-to-work decision-making altogether.

The cornerstones of job-specific testing are communication, mutual respect, and an orientation toward outcome. Return to the original job full time should be the goal from the first report of injury. By providing sequential and brief job-specific testing, this goal will be achieved much sooner and more safely.

ENDNOTES

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Volume 15, Number 4; Summer 2006.
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