THE NEED FOR BETTER PROFESSIONAL COOPERATION, STANDARDS, AND EQUIPMENT IN PHYSICAL CAPACITIES ASSESSMENT

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Abstract

The recent expansion of physical capacities assessment (PCA) programs is the result of more liberalized workers' compensation laws. Workers' compensation regulators, physicians, insurance companies, rehabilitation providers, employers, and lawyers have found the information provided by the PCA useful. Recent improvements in testing have produced more useable information compatible with standard work/worker rating methods. Because of the features and benefits of PCA's, a fast expanding user and provider market exists. This has produced more PCA professionals than ever before. Problems have resulted from this situation that impair good PCA service. These problems include: 1) poorly trained professionals; 2) short cuts are used to bring income into new PCA programs; 3) fees are excessive; 4) equipment is of questionable use and/or effectiveness; 5) equipment costs are sometimes excessive, raising service fees; and 6) various professional disciplines are fighting over who is qualified to provide PCA services. Solutions are suggested to improve these problems. These solutions include: 1) VEWAA, AOTA and APTA jointly developing a PCA/work hardening education and training curriculum; 2) the Commission on Accreditation of Rehabilitation Facilities (CARF) should establish PCA/work hardening program certification criteria using the joint curriculum as the foundation for standards; 3) PCA equipment use criteria should be jointly established and used; 4) PCA equipment must reflect assessment methods, service delivery needs, and true manufacturing costs; and 5) there is need for a professional organization responsive to the needs of the PCA/work hardening professional. Trust and cooperation are needed now by all parties.

Introduction

Physical Capacities Assessment (PCA) for many years was a small but significant part of the vocational (work) evaluation process (Pruitt, 1977). Occupational Therapy worldwide has used forms of physical capacities assessment since the late 1940's (Shervington & Stewart, 1983). In recent years, specific interest has been expressed by state workers' compensation regulators, physicians, insurance companies, rehabilitation providers, employers and lawyers about physical capacity assessment data.

Each of the above parties has something to gain when using quality PCA information. The state regulator wants to know whether an injured worker can return safely to his/her job or the extent of work functioning loss caused by an industrial accident. The PCA provides the documentative data for regulatory decision.

The physician wants to know what the patient can vocationally perform prior to and/or following acute or rehabilitation care. Often the physician is asked to rate the patient/worker's work capacity but has limited data that relates to work and the patient as a worker. Again, the PCA provides information that allows the physician to make an informed rating or to plan or monitor the patient/worker's recovery process.

The insurance industry needs to know a claimant's work status to make decisions on services needed to return the worker to employment and to set reserves for payment of benefits. The PCA provides objective monitoring of the claimant's work capacity as services are provided and allows realistic timetables to be established for reserve set-aside.

Rehabilitation providers have need for baseline client/worker functioning when initiating restorative therapy. They also need to know how much potential exists for improved physical functioning so that obtainable, restorative goals can be established and monitored. The PCA not only provides baseline functioning and estimates for recovery, but does so with a common language that can be understood by vocational, medical, legal and rehabilitation entities.

Employers need to know that an injured worker is fit to safely return to work. They also need to understand what restrictions exist in those situations where a worker's loss of function requires job modification, adaptation or change. The PCA provides the information the employer needs and helps reduce the risk of worker reinjury. It provides useful information in terms the employer understands and that relate to work.

Lawyers need to have documentary evidence that is measurable and reproducible concerning loss or lack of loss of a litigant's work

functioning. The PCA provides objective evidence that can be understood by all litigation parties including the finder of fact.

Recent PCA Developments

It is easy to see why the PCA has met expanded acceptance in recent years. Better testing techniques developed by vocational evaluation, physical therapy, occupational therapy and human factors engineering have refined recent assessment and reporting methods (Blankenship, 1985; Harrand, 1982, 1986; Liles, et al.; Lytel & Botterbusch, 1981; Matheson, 1984, 1986; Niemeyer & Matheson, 1986; NIOSH, 1981).

The most successful PCA programs appear to use the specific rating method to report worker performance. The specific method relates physical performance to job requirements and is easily understood by all parties. It uses the same rating system as the U. S. Department of Labor and is based on the early work of Bert Hanman. Hanman, during World War II, was responsible for identifying which disabled workers could fill critical jobs at the Kaiser Shipyards when skilled manpower was in short supply (Hanman & Kuh, 1944). The Hanman method was developed for the War Manpower Commission and is currently used by the U. S. Department of Labor since it not only applied to disabled workers, but to all workers in general (War Manpower Commission, 1945; U. S. Department of Labor, 1972). The "specific method" rates each worker and job by physical demands and environmental conditions (Hanman, 1958, 1959, 1968).

It is the specific method physical demands rating, in particular, that has received much attention since it documents the injured worker's physical capacity. The documentation provided by the PCA has resulted in a dramatic explosion of new service programs throughout the United States. Some estimates suggest a yearly increase of 100% or more in start-up physical capacities assessment programs (Matheson, 1986). The author's own market analysis supports this observation which produces questions and concerns.

Because of recent liberalized workers' compensation laws in the United States and Canada, regulatory support is provided in most jurisdictions for payment of PCA service if prescribed by at least the treating physician. Only two states appear to question payment for such services under medical services benefits (Chamber of Commerce, 1987). This has been attractive to the business of health care and rehabilitation. Consequently, most hospitals, private therapy businesses, medical clinics, not- and for-profit rehabilitation service providers, health clubs and universities are scrambling to get a piece of a very profitable pie. Income return from this service business is typically 18-29% after investment and depending on overhead costs.

Problems with Recent PCA Expansion

Because of a burgeoning new industry with few trained or experienced professionals, many programs can be considered marginal at best. Reports often reflect medical therapy form work rather than useful and understandable data. This reflects the short cut methods being taken to produce quick PCA income. The wisdom of this is questionable and could produce a backlash much like that experienced with "pain centers" in recent years. Currently, there are facilities charging up to $1800 for a PCA. This leads to unfavorable acceptance by employers and insurance carriers who pay the bill.

The results of excessive service fees are predictable if recent state workers' compensation rehabilitation recisions are any barometer. States like Washington and Hawaii have removed elements of their workers' compensation rehabilitation benefits because of perceived "excesses" in the cost of services. Currently, Georgia and other states are reviewing their workers' compensation laws in response to insurance and employer concerns about out-of-control costs for medical and rehabilitation services. To some extent, the high costs of some programs reflect the expense of equipment used to provide physical capacities assessment. It would appear that chrome and gadgetry influence many organizations starting PCA and work hardening programs. Appearance rather than function is used as a sales gimmick, with the result being unsatisfied users of what little information is generated and injured workers who do not return to employment. One example of this is a piece of equipment used to measure "static lift." Reverse engineering revealed an electronic load cell and off-the-shelf computer software that had been slightly modified from a well-known university biomechanics department. The load cell and software cost less than $1,000 if purchased separately. However, this manufacturer offers it with a computer and much chrome for $50,000 plus. What is of concern is that production can't keep up with demand as each new PCA program tries to keep up with the next with the newest "in" equipment. Unfortunately, what is ignored is the fact that the only training often provided to new PCA evaluation staff is that which comes with equipment. This produces a PCA product that does not reflect profession or discipline body of knowledge. Regrettably, the equipment becomes the PCA rather than the tool of the evaluation professional.

Disputes Over Who Provides PCA Service

In recent months, some dispute has developed over who is qualified to provide PCA and work hardening services. The most visible of this dispute has been the vocational evaluators (VEWAA) and occupational therapists (AOTA). This is regrettable, since both professions have much to offer each other and this new discipline. The most successful programs in terms of returning injured workers to employment operate using the interdisciplinary approach. This model of service delivery uses the best of vocational evaluation, occupational therapy and physical therapy. The ERIC model is perhaps the best known interdisciplinary PCA model, thanks to the efforts of Matheson and Ogden-Niemeyer (Matheson, 1984, 1986; Niemeyer & Matheson, 1986). Other interdisciplinary models like Work Recovery Centers, Inc., and Work Capacities, Inc., have produced successful programs by responding to the need for interdisciplinary staff development and using combined vocational/medical assessment equipment. The successful interdisciplinary models above have effectively respected the uniqueness of each discipline to produce usable, understandable and accurate measures of physical capacities.

While differences are voiced by some over who should perform PCA's, the reality is that other entities are positioning themselves as the primary provider of this service. Unless there is some resolution of our current differences, a "turf war" will result. The end product of this is losing out and more restrictive regulations being imposed by states as each entity tries to politically protect their turf.

Suggested Solutions

There are a number of solutions that will improve this situation greatly. We propose the following to improve the quality of PCA service and to advance the development of this evolving discipline:

1. Because concerns exist over who is responsible for performing PCA's, it is suggested that VEWAA, AOTA and APTA jointly develop a combined PCA/work hardening, education/training curriculum. Each respective discipline can offer much to develop a combined body of knowledge. A jointly developed curriculum could be used as part of university training. It could also be used as a jointly sponsored national training effort to upgrade existing PCA professionals having the same body of knowledge.
2. If a combined education/training curriculum could be developed, the Commission on Accreditation of Rehabilitation Facilities (CARF) could become involved to establish certification criteria for PCA and probably work hardening programs. The purpose of this is to use standards reflective of a multidisciplinary body of knowledge. CARF accreditation would establish standardization of service and, hopefully, reduce legislation and turf wars. What we need to be concerned with is quality/cost-effective rehabilitation services rather than who owns the turf.
3. Since some PCA equipment currently being manufactured is expensive, provides questionable data and is sold as the assessment process itself, efforts must be made to establish equipment use criteria. Again, a joint organization task force could accomplish this. Since VEWAA has had experience as an organization in establishing equipment use criteria, it could take the lead in this effort. This will help establish consistency in the type of data being generated by PCA and work hardening equipment. Assessment data should directly relate to work effort requirements. Without this, most data is open to interpretation, vague and disputable. Hopefully, equipment use criteria will influence equipment manufacturers to be more responsive to the true needs of the PCA professional.
4. Equipment manufacturers need to develop assessment tools that provide measurable, reproducible and documentable data. Properly designed PCA equipment will put more science *into* the assessment process. Assessments will hold up better under scrutiny. Equipment should reflect vocational, medical and human factor measurement methods. Data generated by equipment should relate to the U. S. Department of Labor's specific work capacity rating methods, manual lifting standards and safe biomechanics criteria. Equipment costs must reflect the true cost of manufacture. There is need for equipment that will reduce the 1:1 evaluator/evaluee ratio of PCA/work hardening. By increasing the volume output of client/workers served, more competitive PCA/work hardening costs will result.
5. It appears that there is need for a professional organization responsive to the needs of the PCA and work hardening practitioner. Hopefully, such an organization could reach beyond the parochial views of any one existing

discipline. The purpose of this new group would be to advance and further the new disciplines of physical capacities assessment and work hardening.

Conclusion

As physical capacities assessment continues to develop tools, discipline, process and body of knowledge, profession will also develop. The various practitioners now involved in physical capacities assessment have the responsibility and opportunity to further its development. To do this will require trust and cooperation in ourselves, allied health peers, regulatory bodies and equipment manufacturers.

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