Body System: Population-Based Care

Session Topic: Disability and Impairment Evaluation

Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
• Physicians have statistically significant and meaningful gaps in the medical skill necessary to optimally perform disability and impairment evaluations. • Physicians often find it difficult to determine in what manner the patient is disabled. • Physicians often underestimate or fail to recognize functional disabilities that are reported by their patients.	1. Determine ones role in the evaluation, whether as a treating physician, new consultant, second opinion, or independent medical examiner. 2. Classify the severity of the patient's condition based on a combination of complaints (subjective), physical findings (subjective and objective) and laboratory data (objective), where appropriate. 3. Use available guidelines (e.g. Department of Veterans Affairs, the American Medical Association, the Social Security Administration, and state workers' compensation boards) to assess the impact of impairment on affected organ systems, measured as loss of function. 4. Generate a comprehensive physician's report, including a summary of reviewed medical records, the detailed medical assessment performed, a summary of questions being addressed, and the degree of impairment from the identified condition that references the impairment scheme used.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge		Patient Care
	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide recommendations for determining ones role in the evaluation, whether as a treating physician, new consultant, second opinion, or independent medical examiner.
- Provide recommendations for classifying the severity of the patient's condition based on a combination of complaints (subjective), physical findings (subjective and objective) and laboratory data (objective), where appropriate.
- Provide recommendations and resources on available guidelines (e.g. Department of Veterans Affairs, the American Medical Association, the Social Security Administration, and state workers' compensation boards) to assess the impact of impairment on affected organ systems, measured as loss of function.
- Provide strategies and resources for generating a comprehensive physician's report, including a summary of reviewed medical records, the detailed medical assessment performed, a summary of questions being addressed, and the degree of impairment from the identified condition that references the impairment scheme used.

Needs Assessment

According to a 2010 *American with Disabilities* report from the U.S. Census Bureau, about 56.7 million people, or nearly 1 in 5 people had a disability in 2010.[1] Additional highlights of the report include:[1]

- People in the oldest age group — 80 and older — were about eight times more likely to have a disability as those in the youngest group — younger than 15 (71 percent compared with 8 percent). The probability of having a severe disability is only one in 20 for those 15 to 24 while it is one in four for those 65 to 69.
- About 8.1 million people had difficulty seeing, including 2.0 million who were blind or unable to see.
- About 7.6 million people experienced difficulty hearing, including 1.1 million whose difficulty was severe. About 5.6 million used a hearing aid.

- Roughly 30.6 million had difficulty walking or climbing stairs, or used a wheelchair, cane, crutches or walker.
- About 19.9 million people had difficulty lifting and grasping. This includes, for instance, trouble lifting an object like a bag of groceries, or grasping a glass or a pencil.
- Difficulty with at least one activity of daily living was cited by 9.4 million noninstitutionalized adults. These activities included getting around inside the home, bathing, dressing and eating. Of these people, 5 million needed the assistance of others to perform such an activity.
- About 15.5 million adults had difficulties with one or more instrumental activities of daily living. These activities included doing housework, using the phone and preparing meals. Of these, nearly 12 million required assistance.
- Approximately 2.4 million had Alzheimer's disease, senility or dementia.
- Being frequently depressed or anxious such that it interfered with ordinary activities was reported by 7.0 million adults.
- Adults age 21 to 64 with disabilities had median monthly earnings of $1,961 compared with $2,724 for those with no disability.
- Overall, the uninsured rates for adults 15 to 64 were not statistically different by disability status: 21.0 percent for people with severe disabilities, 21.3 percent for those with non-severe disabilities and 21.9 percent for those with no disability.

Physicians are frequently involved in the assessment of impairment and disability as the treating physician, in consultation, or as an independent medical examiner.[2]

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians have statistically significant and meaningful gaps in the medical skill necessary to optimally perform disability and impairment evaluations.[3] Physicians often find it difficult to determine in what manner the patient is disabled, and often underestimate or fail to recognize functional disabilities that are reported by their patients.[4] CME outcomes from 2015 AAFP FMX (formerly Assembly) *Disability and Impairment Evaluation: Fundamentals* sessions, suggest that physicians have knowledge and practice gaps with regard to decision making based on functional assessment; appropriate completion and management of necessary documentation and reporting; understanding state-by-state laws and regulations; and recognizing the need to have patients physically come into the office for testing and completion of forms.[5]

Physicians may improve their medical skills and knowledge to perform effective disability and impairment evaluations, or manage the referral for these evaluations by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[2,6]

- In the disability evaluation of low back pain, physicians should use validated questionnaires, such as the Oswestry Low Back Pain Disability Questionnaire and the Roland Morris Disability Questionnaire.
- The consultative examination report should be complete enough to enable an independent reviewer to determine the nature, severity, and duration of the impairment and, in adults, the claimant's ability to perform basic work-related functions.

- Conclusions in the consultative examination report must be consistent with the objective clinical findings found on examination and the claimant's history, symptoms, laboratory study results, and response to treatment. For adults, the report should include a description, based on the physician's own findings, of the individual's ability to do basic work-related activities. It should not include an opinion as to whether the claimant is disabled under the meaning of the law.
- Physicians should always determine their role in the evaluation, whether as a treating physician, new consultant, second opinion, or independent medical examiner.
- When performing an impairment evaluation: establish the diagnosis, determine the severity of the condition, assess impairment impact, and assess functional ability.
- When writing the physician's report, use clear language and remember that it is intended for nonmedical personnel.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Disability evaluations: more than completing a form[6]
- Impairment and disability evaluation: the role of the family physician[2]
- Social Security Administration. Disability Evaluation Under Social Security[7]
- AM Guides to the Evaluation of Permanent Impairment[8]
- Envisioning new roles for medical assistants: strategies from patient-centered medical homes[9]
- The benefits of using care coordinators in primary care: a case study[10]
- Engaging Patients in Collaborative Care Plans[11]
- A nursing home documentation tool for more efficient visits[12]
- Exam documentation: charting within the guidelines[13]
- Clinical decision support: using technology to identify patients' unmet needs[14]
- AAFP Clinical Decision Tools[15]

References

1. U.S. Census Bureau. Americans with Disabilities: 2010. In: Bureau USC, ed2012.
2. Taiwo OA, Cantley L. Impairment and disability evaluation: the role of the family physician. *American family physician.* Jun 15 2008;77(12):1689-1694.

3. AAFP. 2012 CME Needs Assessment: Clinical Topics. American Academy of Family Physicians; 2012.

4. Calkins DR, Rubenstein LV, Cleary PD, et al. Failure of Physicians To Recognize Functional Disability in Ambulatory Patients. *Annals of internal medicine.* 1991;114(6):451-454.

5. American Academy of Family Physicians (AAFP). AAFP FMX CME Outcomes Report. Leawood KS: AAFP; 2015.

6. Maness DL, Khan M. Disability evaluations: more than completing a form. *American family physician.* Jan 15 2015;91(2):102-109.

7. Social Security Administration. Disability Evaluation Under Social Security. 2014; http://www.ssa.gov/disability/professionals/bluebook/. Accessed November, 2014.

8. Cocchiarella L, Andersson G. *Guides to the evaluation of permanent impairment.* Amer Medical Assn; 2001.

9. Naughton D, Adelman AM, Bricker P, Miller-Day M, Gabbay R. Envisioning new roles for medical assistants: strategies from patient-centered medical homes. *Family practice management.* Mar-Apr 2013;20(2):7-12.

10. Mullins A, Mooney J, Fowler R. The benefits of using care coordinators in primary care: a case study. *Family practice management.* Nov-Dec 2013;20(6):18-21.

11. Mauksch L, Safford B. Engaging Patients in Collaborative Care Plans. *Family practice management.* 2013;20(3):35-39.

12. Kalish VB, Burns OB, Unwin BK. A nursing home documentation tool for more efficient visits. *Family practice management.* Mar-Apr 2012;19(2):19-21.

13. Moore KJ. Exam documentation: charting within the guidelines. *Family practice management.* May-Jun 2010;17(3):24-29.

14. McLeod W, Eidus R, Stewart EE. Clinical decision support: using technology to identify patients' unmet needs. *Family practice management.* Mar-Apr 2012;19(2):22-28.

15. American Academy of Family Physicians (AAFP). Clinical Decision Tools. *FPM Toolbox* 2014; http://www.aafp.org/fpm/toolBox/viewToolType.htm?toolTypeId=29. Accessed November, 2014.

