

Completing Disability Forms Efficiently and Accurately: Curriculum for Residents

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Abstract

Introduction: The completion of a patient's disability assessment form (DAF) is a task expected of family and internal medicine physicians. Residency curricula rarely address this task. Thus, some residents are reluctant to conduct functional assessments because of inadequate training, the time required to conduct such an exam, and fear of jeopardizing the doctor-patient relationship. This article describes a curricular intervention to prepare residents to complete a focused functional capacity assessment during a 30-minute office visit.

Methods: Developing the curriculum for DAF completion involved a literature review, conducting needs assessment interviews, and a review of existent residency training materials. Instructional strategies included lecture, panel discussions, and demonstrations. The learner evaluation strategies were knowledge tests, direct observation of residents, and a review of disability cases with an expert panel consisting of federally certified Social Security Administration workers. This work represents information gained from four pilot tests.

Results: The residents' knowledge scores increased significantly. Knowledge of state, federal, and employer disability programs increased as well as their ability to distinguish sedentary, light, medium, and heavy work capacity when related to patients' medical conditions. All the residents could perform the assessment, but none of them were confident that they could complete the DAF in a 30-minute office visit. This was an expected outcome.

Conclusions: It is possible to teach family and internal medicine residents the knowledge and skills required to determine their patients' functional capacity as it relates to a specific problem. By applying what they have learned to their patients, they will eventually be able to complete a DAF during a 30-minute office visit. Residency programs are encouraged to incorporate a functional assessment curriculum.

Introduction

The completion of patients' disability assessment forms (DAF) is a task frequently performed by family physicians.¹ Each year, approximately 2.5 million new disability applications are submitted to the Social Security Administration (SSA).² Each application requires assessment of the patient's residual functional capacity (RFC), level of education, work experience, and age prior to determining work ability.³ An accurate RFC assessment is critical because it determines the future work and benefits available to the patient.

The SSA asks primary care physicians to complete DAFs because they represent the physician of first contact, the broad base of their training, and established doctor-patient relationship.^{1,3} Lack of familiarity with the process of disability determination, inadequate skills to conduct such an assessment, insufficient clinic time, and fear of

jeopardizing the doctor-patient relationship make DAF completion a daunting task.⁴ Most primary care residency training programs do not provide structured training in determining RFC nor much information about state and federal disability programs.⁴⁻⁸ RFC exams include testing for a patient's consistency of effort and strength as it relates to things like maximum voluntary effort at hand grip, rapid exchange grip, standard hand grip, and pinch strength.⁹ Such training is helpful in completing a DAF. When comparing information attained based on a clinical exam versus a residual functional capacity exam, the latter was found to be most helpful in disability determination.^{9,10} Evidence supports the utility and reliability of an RFC to provide objective data on a person's functional capabilities in a clinical setting.⁹⁻¹¹

A search of health professionals' literature returned several articles addressing the importance of providing residents and practitioners with the appropriate knowledge, skills, and attitudes for working with their impaired patients.¹¹⁻¹⁵ These subjects, in addition to completing DAF and RFC assessments, are prevalent amongst physical medicine and rehabilitation residency programs as well as physical therapy training programs. However, the search did not yield curricula for family or internal medicine residents (FIMR). The Association of American Medical Colleges does not list such information as necessary for completion of FIMR programs.

PGY1-3 residents of the Sparrow Hospital FIMR Programs were facing similar challenges in completing patients' DAF. Thus, the Sparrow-Michigan State University residency faculty decided to champion a pilot curricular intervention that would better prepare their residents for completing an RFC assessment and DAF during an office visit. The overall goal of this pilot curriculum was to conduct a focused RFC assessment during a 30-minute office visit and write appropriate work restrictions. This curricular intervention is an attempt to highlight curriculum deficits as they relate to SSA disability form completion training. It may encourage others to do more trials for further development.

Methods

Developing the curriculum involved a PubMed and Google Scholar literature review, interviews with FIMR faculty, physical therapists' input, and federally certified SSA workers. One researcher was trained and certified by the federal government in SSA criteria for disability. The curriculum was developed and implemented as two 3-hour sessions for each program of FIMR.¹⁹ A total of 66 FIMR participated in the pilot curriculum project from October 2013 to October 2016. Table 1 shows a summary of curriculum implementation.

The learner evaluation strategies involved the use of (a) pre and post optional knowledge questions, (b) a structured checklist for direct observation of selected components of the RFC exam (Figure 1), and (c) a review of mock disability cases with an expert panel consisting of federally certified SSA workers.¹⁹

The curriculum for FIMR was evaluated on a 5-point Likert scale using: (a) 10 mandatory curriculum evaluation questions administered during the final workshop section for all 66 residents (Table 2), (b) 15 Yes/No pre- and postworkshop test questions (Table 3), and (c) four 5-point Likert scale perception questions pre- and postworkshop (Table 4). Independent sample *t* tests were used to compare pre- and postworkshop data. Statistical significance was set at $P < 0.05$. Michigan State University and Sparrow Hospital's institutional review boards approved this curriculum project.

Results

All 66 FIMRs completed the curriculum evaluation. The mean scores ranged from 3.83 to 4.68, with an overall mean of 4.44 on the 10 questions (Table 2). A total of 27 out of 66 FIMRs completed the knowledge test and perception questions. Results showed significant improvement on nine out of 15 knowledge test questions regarding SSA programs and disability criteria. The posttest scores for the remaining six questions were higher than the pretest scores, but not statistically significant (Table 3).

Table 4 indicates the perception of FIMRs in their ability to complete disability forms before and after the workshop. There were significant improvements in two of the four pre-perception questions. All four post-perception questions

revealed there was improvement for completing DAF.

Discussion

People with disabilities are twice as likely to find health care provider skills and equipment inadequate to meet their needs, three times as likely to be denied care, and four times as likely to be treated badly by health care providers.¹⁶ It is a known fact that impairment is more common than death before the age of 65.¹⁶ For these reasons, it is essential that FIMR programs intentionally incorporate curriculum directed at acquired disability, as a result of eroding RFC secondary to chronic disease.^{13,17,18} Such information will improve historic documentation of chronic disorders and make completion of DAF less daunting.

Encapsulated by the learning objectives of this pilot curriculum was the intent to increase residents' knowledge, skills, and perceptions of completing patient DAF during an office visit. Through the curriculum evaluation, residents indicated that they did learn information they had not received or mastered in other learning activities. All residents demonstrated increased knowledge of SSA criteria and RFC exam skills (specifically arm, hip, and low back), but were not confident they could complete a DAF in a 30-minute office visit. Even experienced physicians struggle with this. It requires familiarity with tools in one's electronic medical record software, a process for handling DAF requests, and some knowledge of the SSA definitions of sedentary, light, medium, and heavy work. Educators made it clear that the 6-hour workshop shared information that, when used over the years, would make DAF completion less daunting.

Studies that have shown that clinical exams coupled with functional capacity exams give the best information for disability determination.^{9,10} Unfortunately, medical insurance plans do not cover functional capacity exams. However, they do cover problem-focused exams done by physical therapists and physiatrists. Clinicians can refer to such professionals for consultations that will help them in completing the DAF.

Teaching residents how to determine a patient's RFC can reduce anxiety, frustration, and time required to complete related paperwork. This translates to practicing physicians that are more comfortable with the SSA process of disability determination. The societal benefits are timely and accurate information that will expedite the disability process, and in some cases may allow determination to be made without requiring additional resources. This benefits the patient in that they are privy to Medicaid services and financial assistance.

In future iterations of this curriculum, we plan to create an office protocol for handling DAF requests. We will add more exam room skills that will enhance residents' ability to determine how long a patient can sustain activities during an 8-hour work day. We will also add a structured didactic component that involves videotaping such office visits so that residents can review the process with their faculty for direct feedback.

When using this curriculum, it is recommended to choose patient cases based on the needs of residents. The developers of this curriculum suggest that DAF forms from the local state department of human services be used and that the educational team consist of local SSA workers, physical therapists/PM&R doctors, and a clinician well versed in the musculoskeletal exam.^{1,4,5,7,16}

Tables and Figures

Table 1: Curriculum for Determining Functional Capacity

Session	Learning Objectives	Instructional Strategies	Evaluation Strategies
Session 1 (3 hours)	<p>1. FM residents will be able to explain essential concepts and terminology for determining functional capacity.</p> <p>2. Given a mock patient case, FM residents will be able to determine the residual functional capacity of that patient.</p>	<ul style="list-style-type: none"> • Presentation and explanation of different types of disability forms (Federal, State and worker), and key terminology associated with each. • Paper case simulation of a patient's record and supporting documentation where residents had to determine level of functionality and how they would conduct the assessment. Three small groups reviewed different cases and were led by State disability assessment experts. 	<ul style="list-style-type: none"> • Cognitive 24-item pretest of essential concepts and terminology. • Small group assessments presented to entire group for review of accuracy and completeness. • Instructor review of solutions to the simulated patient case and discussion.
Session 2 (3 hours)	<p>1. FIMR will be able to conduct a functional capacity assessment exam.</p> <p>2. FIMR will be able to write work restrictions appropriate to the RFC of patients.</p>	<ul style="list-style-type: none"> • Lecture and demonstration of how to conduct a focused physical exam to determine functional capacity. • Residents practice conducting the exam on each other. • Residents are given documents from a simulated patient case to review and determine level of disability and work restrictions. 	<ul style="list-style-type: none"> • Peer and instructor direct observation and feedback. • Posttest of essential concepts, terminology and perceptions of the curriculum.

Figure 1: Residual Functional Capacity Skills Assessment

- A. Low Back assessment
 - a. Location of pain
 - Lumbar paraspinals
 - Posterior hip
 - Sacroiliac
 - Anterior hip
 - b. ROM
 - Trunk ROM: percentage and easy evaluation used by University of St. Augustine
 - Hip ROM using goniometric measurements
 - c. Special tests
 - Slump test – neutral tissue tension
 - SLR test – possible herniated disc or for sciatica
 - Faber test – for possible SI joint dysfunction
 - Thomas test – hip flexors tightness leading to increased stress on lumbar spine and causing pain
 - Piriformis Tightness test – possible piriformis syndrome or for sciatic nerve impingement
- B. Shoulder pain
 - a. Assessing the joint complex
 - Isolating shoulder problem/dysfunction-location
 - Muscle guarding around cervical, thoracic and shoulder scapular area
 - b. Assess joint play
 - Sternoclavicular
 - Acromioclavicular
 - Scapulothoracic
 - Glenohumeral joints
 - c. Assess active and passive ROM
 - Goniometric measurements to be discussed
 - d. Special tests
 - Speed test – bicept tendonitis
 - Empty can test – supraspinatus pathology
 - Drop arm test – rotator cuff tendonitis
 - Painful arch for subacromial bursa

Table 2: Residents' Evaluation of the Curriculum (n=66)

Statement	Mean	SD
Q1. The presentation was clear and organized.	4.55	0.532
Q2. The presenter demonstrated mastery of the information presented.	4.62	0.519
Q3. The presenter answered student questions effectively.	4.68	0.469
Q4. The presenter delivered information relevant to my level of knowledge.	4.41	0.656
Q5. The presenter effectively involved students in discussion.	4.55	0.587
Q6. The presenter created a learning environment in which differing points of view were respected and could be freely expressed, and questions could be asked comfortably.	4.65	0.568
Q7. The module covered information I had not mastered previously in other learning activities.	4.33	0.730
Q8. This module met the written learning objectives.	4.35	0.712
Q9. Since completing this workshop I believe I can complete forms within a 30-minute office visit.	3.83	0.840
Q10. I felt that this workshop was the right length of time.	4.39	0.713
Average	4.44	0.633

Scale: 1="strongly disagree," 5="strongly agree"

Table 3: Resident Knowledge Test of SSA Programs and Disability Criteria Mean Percent Correct (n=27)

Question State vs Federal programs (1-4)	Pre	Post	t	Sig.	95% CI of the Difference	
					Lower	Upper
Q1.	60	95	7.87	0.000	33.12	55.77
Q2.	75	98	5.56	0.000	18.47	39.31
Q3.	77	96	2.37	0.021	3.44	41.00
Q4.	74	85	1.60	0.116	-4.71	41.75
Medical Records (5-6)						
Q5.	27	66	4.48	0.000	28.62	75.08
Q6.	82	92	2.21	0.032	1.09	22.62
Differentiating Work Capacity (7-15)						
Q7.	67	77	-0.59	0.560	-32.74	17.92
Q8.	26	29	-0.59	0.560	-32.74	17.92
Q9.	79	85	1.00	0.320	-11.09	33.31
Q10.	59	82	2.69	0.010	8.43	58.24
Q12.	77	93	1.54	0.130	-4.52	34.15
Q13.	19	44	-2.68	0.010	-45.37	-6.48
Q14.	70	94	-2.39	0.021	-54.54	-4.72
Q15.	92	98	-1.00	0.322	-16.70	5.59
Mental Health						
Q16.	70	81	1.99	0.052	-0.16	32.26

*Question 11 was discarded because it was worded incorrectly.

Table 4: Residents' Perceptions of Disability Form Completion (n= 27)

Statement	t	Sig. (2-tailed)	Mean Difference	95% CI of the Difference	
				Lower	Upper
I view disability form completion as complex.	-2.35	0.02	-0.25	-0.46	-0.04
I feel confident about the information needed to complete disability forms.	0.72	0.48	0.10	-0.18	0.38
I feel overwhelmed.	-2.09	0.04	-0.34	-0.67	-0.01
I am confident that I can complete the forms within a 30-minute office visit.	-0.07	0.94	-0.01	-0.35	0.33

Note: All the questions show the posttest score higher than the pretest.

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