RETAIN Webinar

Attuning your retain program to worker's concerns, wants, and needs

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>> Meredith Sedona at ODEP who tells me she needs no introduction. Meredith?

>> MEREDITH: Thank you, Mona and thank you for everyone for joining us for today's webinar. This is being offered by Jennifer Christian who you know is serving as subject matter expert and assisting us with the RETAIN project. Before I get started I have a few brief announcements. First we would like to clarify what is allowable with respect to cross-state collaboration. Any state is permitted to share information and collaborate with other RETAIN states as much as you are comfortable doing. We have no restrictions on that from your end but similarly there is no requirement to do so. There are restrictions that are applied to the federal partners, so that would be ODEP, ETA and Social Security, as well as to our contractors.

None of us will share information about one RETAIN state or project with another RETAIN state. And in fact, we actually had our contractors sign nondisclosure agreements to that effect. However, you may share and collaborate as much as you would like to. And we know that many of you have found that beneficial. So we hope you continue doing so.

Second, regarding the evaluation, we just want to reiterate one more time that there is no formal evaluation in Phase I. The activities that the evaluator are to prepare them to conduct rigorous evaluations during Phase II. Finally during Phase I you are allowed and indeed encouraged to experiment with various strategies to improve recruitment and enrollment. This could even include some of the strategies that you will hear about on today's webinar. It is critically important that you keep your FPO in the loop about changes you are making. Please, be sure to always check in with your FPO about major changes prior to implementing them. And that is an excellent segue back to today's topic, messaging. We know that it can and does have a big impact on your ability to grab your target population's attention and move forward with the recruitment and enrollment process. Of course, you want to tailor your messaging to

your particular State and make sure it's culturally appropriate and resonates with your target population, and all that good stuff.

We hope you will consider today's suggestions very carefully against that back drop and think about if or how some of the strategies and concepts might be applied within your project's context.

With that I will turn it over to our speaker, Jennifer Christian.

>> Jennifer Christian: Hi, everybody, this is my first webinar with you. I'm delighted to be with you and to be part of this great effort of RETAIN. I'm just enjoying the heck out of what my contacts with the states and also my collaboration with the team at ODEP and AIR.

My personal goal is to learn how to move my slides. Because I am unable to move them at this time can somebody advance to the next slide? The objectives,.

The intended outcomes for you for today was to review the typical questions, concerns, wants, needs of the target population for RETAIN, workers whose lives have been in disarray by a new health problem. The reason for that is to customize your communications so they look good to them, attractive to them. Then supply you with factual data that reveal the differences between this group of targeted workers in the levels of distress and the issues worrying them. Again you can target your offering to address things that are important to them. A third objective was to provide you with more detailed information and tools that can help you design and engineer your initial as well as your ongoing relationship with workers. Once you attract them, the goal is to work with them in an ongoing way.

All that, the intended outcome is to prepare you to increase the attractiveness to your workers. We notice that everybody has trouble with volume. Ensure their satisfaction with their subsequent relationship with you. If they are not satisfied they'll disappear or tell bad stories about RETAIN. All of that is a commitment to helping you increase your client centeredness.

Next slide. So in the plans for this session is to spend about the next 40 minutes orienting you to this typical worker's current situation and the sources of risk that lead to unnecessarily poor outcomes. To review the findings of 205 phone interviews we conducted with newly injured workers, and to introduce three big ideas which are that A, events during the early unfolding of an episode can increase or decrease risk of a poor outcome.

And that RETAIN is about orchestrating events during that early unfolding in a timely and positive way so that we can push episodes towards the positive outcome and away from the negative and that in reality the most important tools that RETAIN and the coordinators have in this situation is words and relationships.

Because I was asked to do a review of the draft term, re-recruitment and enrollment brochures from the states, I did do an analysis of them and I have dos and don'ts based on that review. Hopefully we will have 10 or 15 minutes at the end for review.

Let's start with workers wonderings, worries, and concerns.

So if we think about a person who in the last couple of weeks left work, they are faced with a lot of stuff at the same time. Most

of them will be trying to cope with pain and other distressing symptoms due to a new or changed illness or injury. They haven't been living with it or if they have been living with it, it's gotten worse. That means they are involved with the medical care system, trying to make it feel better, get better, make it go away. They will be absent from work, which means they are absent from the social relationships, from their coworkers, their supervisor, leaving the house every morning at 8:00 o'clock, their daily rhythm of life has been disrupted.

They are suddenly having to deal with things they haven't dealt with before, FMLA, workers compensation processes, it is quite are for the ADA to be playing a part in this time period. A lot of them have financial stress. So many workers are living paycheck to paycheck. Suddenly the stream of money has been interrupted. As I said, their practical predicaments having to do with the disrupted daily routine. The childcare is confusing. Mom used to work in the day, dad works at night. Now they have to figure out who is going to take care of the kids. They are adjusting to the upset and the uncertainties about the implications of their condition for their future and livelihood. Some are worried and some are very worried. Often what has happened, because of all this disruption, they are simultaneously feeling physically uncomfortable, feeling vulnerable and needy in a way that they are not usually. Suddenly socially isolated sitting home on the coach. They may or may not be looking for guidance at this point.

So one way to look at it is, these people are standing looking at a maze and trying to figure out how to get through it.

So if you start to think, and maybe I hope most of you on the phone never had a sick day in your life. Most of us have. Most of us often had either an injury or sudden on-set of a disabling illness or injury for even short-term. And we wonder about it. We wonder what the impact is going to be on our lives.

And so we often, what we are taught in medicine is what most patients really want, they want to know what is the matter with them. What caused it? They are wondering what care they need in order to feel better. They are wondering how long they are going to be out of commission or, as they say in some parts of the country, how long are they going to be laid up, unable to function normally. How long are they going to have to take it easy? What can I still do? What shouldn't I do? What should I do to speed my recovery? When is life going to be back to normal, if ever?

What does this mean about me? Who I am? My identity? My future?

What is my role in this situation? Am I passive? Am I a pawn? Am I in charge? Do I have an impact?

Who is going to really help me with this? I'm not expert at this. Is there somebody who does know about this? Who can I trust?

Now, I've put this list together actually because I was going to give a talk on Capitol Hill. I wanted to alert people who hadn't thought about it to what it is like to be newly injured or ill. This list of questions came from me and from my family and from patients I worked with. It came from any time I've actually started to really

try to think like a newly injured person. The thing that struck me as I was talking to people in Congress, nothing in a standard medical visit, none of these questions have doctors been trained to address in a standard medical visit except for the first and second bullets.

The doctors are generally speaking not addressing these questions. Or often are not addressing them. The problem is that where are people going for the answers?

So part of our opportunity in RETAIN is starting to be, starting to make sure that people get solid and wise answers to these questions because I think sometimes what happens is people come up with cockamamie crazy ideas about what these answers are or they go to unfortunate parties that give them bad advice. Our job is to make sure they get good answers.

Next slide. Workers are often thrust into a maze by a new health problem. Many people don't have a regular doctor or they have to suddenly seek care at an awkward day or time of week. They get thrown into this world of a whole lot of terms and terminology with which they have absolutely no familiarity. This is part of the reason why they are feeling so uncertain and so vulnerable.

And each one of these people is in a different situation. So one of the most important ideas that led to the development of this work disability prevention model, we are trying to find the answers to the questions: Why do workers with seemingly identical biology at the start have such wildly different functional and life outcomes? So in general, we do know that outcomes of common musculoskeletal and mental health conditions like low back and joint pain and mental health conditions, that you have trouble explaining the impact on somebody's life by looking at the biology. In particular, in these cases, common musculoskeletal and mental health conditions. And workers vary in educational and skill level, personality, past history, what happened to them, and particularly what happened to them as children. Did they have a deprived or abusive childhood? Did they come from a loving family that taught them how to cope with difficulty? What their world view is, what their intentions are. Physicians and healthcare professionals vary in their competence,in their philosophy, particularly about work. Their attitude towards patients, particularly patients who are having difficulty or are needy. Their attitude and concern about life outcomes as opposed to strictly medical ones, et cetera.

And employers vary. Some of them are highly responsive and step right in when somebody has been injured or ill. Others believe in letting people alone, which translates sometimes to abandonment or neglect. Some have risks in their tangible and intangible environment. Others are very attuned to trying to make a safe workplace and have everybody be included. Some employers are willing and others are unwilling to support on the job recovery. Some are much more sophisticated in their knowledge of what the needs are of a person during recovery.

Lastly, claim payers, including legal systems vary. You can have a very well managed insurance company. You can have a very poor individual claims handler. You can have a legal system or a lawyer

who is very, whose behavior is very distorted by their own economic interests or who is really working towards a good outcome, et cetera.

If we imagine workers coming towards us with variety in all of these things you can imagine there are some people who are in kind of a perfect storm. The worker themselves isn't prepared to cope, they sought out a doctor who is subpar, that they work for an uncaring employer and their benefits person is scheduled to be fired next week for incompetent, right? So some people are going to come to us in much more risky situations than others.

Okay. So now I would just like to talk a little bit about what we found during a project in which we did 205 interviews with workers. They did have work related injuries, this is for a workers compensation system. We were making outbound calls to workers two to four weeks post-injury. This is the situation you are aiming at now with your RETAIN recruitment process.

And 205 conversations were held, 136 of them we used the longer version of our call script in which we made a lot more inquiry about their experience and their level of distress, what they were worried about.

The people who were selected to get these outreach calls had injuries that were characterized by high variability in outcome. This he were mostly musculoskeletal. In fact in the workers compensation the vast majority of conditions are musculoskeletal. These were more -- less often a fracture because fractures don't have so much variability in outcome, and much more often low back strain, strain, knee sprain, shoulder strain, et cetera. The most striking discovery from all the calls is how unfamiliar the territory was that they were now in to most of the newly affected workers.

They don't know much about workers compensation because they've never had, lost time from work due to workers compensation before. They lack a significant fraction of them lack the confidence that they were prepared to deal with their predicament. They were willing to listen, surprisingly willing to listen to an orientation by phone. The insurer thought we wouldn't be able to keep them on the phone for longer than five minute. The average length of call was actually more than half an hour.

They overwhelmingly reported that they saw it as helpful and that the calls increased their confidence. They also appreciated mailed informational packet that told them the title of it was how to manage a health related work disruption. But very few of them made use of an informational website.

Now, in the 136 that we got the deeper calls with them, we were asking about their level of distress. Almost a tenth of them said my injury caused such an upset state, I'm worried I won't get back to my feet if ever. There is research that says what the worker's expectations are for the length and difficulty of recovery are a very good predictor of what is actually going to happen. If they have negative expectations like this, that is likely to be putting them at increased risk.

Another quarter said this is really a hard time for me, but I'm trying to hang on. That signaled they were having trouble. The

biggest group in the middle said it's a challenge but I'm coping pretty well with it.

So that's 35 percent total are people having a hard time coping.

We asked them about their satisfaction or dissatisfaction with the way that things had gone so far. Remember, this is in the first two to four weeks. Roughly half were dissatisfied with the way that some aspects of this situation had been handled, either the way their access to medical care, the medical care they had gotten shall the way their supervisor and their coworkers had responded, the way the benefits process was going, and their interactions with particular individuals.

And so, a significant fraction between five and twelve percent were very dissatisfied or very distressed about something.

We also asked them, we offered a menu to them of stuff that they might be concerned about. We were wondering what are they thinking about? In this slide the nature of the concern is appearing sideways. So the concerns, for example, the first one on the left says understanding my injury, my pain and symptoms. And I'm going to skip to the ones that have red percents or numbers. These were the most important to them. Overwhelmingly, understanding the system of worker's comp was the concern that most of them had. People are suddenly thrown into a system that they don't understand. That would also be true, by the way, if it's a benefits, disability benefits program of some sort. They will have the same wondering.

The next highest concern was the risk of reinjury of their own safety, have the conditions hat work been changed? Am I going to be made to work in a way that my working will injure me?

Now, the next most common was understanding my injury, understanding what is the matter with me? That really included how what caused it, what could cause it again, what does this mean about the future, et cetera.

And then the fifth most were why are there delays, understanding because the delays were so upsetting to them, and life disruption and personal worry.

As you can see they are concerned about a lot of things. In fact, three was the most common number of concerns they picked off of this menu. Half of the affected workers were concerned with more than four of niece things. And if they were concerned about something, the average rating of it was more than five or five or more on a scale of one to ten. So these were not minor concerns.

And the, in the project, we made the calls. Then the payor made a follow-up survey, 30 to 90 days later. They weren't very precise about when they did it. What they discovered was that although things, life was going better, about the same or worse for most of the affected workers and for most of them their level of confidence had stayed the same or increased a bit. 11 percent, a tenth said that the impact on their life had gotten worse. Nearly a quarter were significantly less confident. The passage of time in an at-risk group is making things worse.

So as one of the party favors we have prepared for you today, you got, you received yesterday a mailing, an email with this chart. I just want to orient you to it because it has a lot of powerful

information packed into one teeny page. This chart was developed while I was a member of the state return to work group and I engaged the group of the work fitness and disability section as well as the members of a multi-stakeholder group in creating this with me. I said this is the design we want to have. We want to talk; the center part of this diagram is taking an episode from inception to completion. So time is passing as you go from the top to the bottom of the page. And the idea here is that as episodes unfold and as time progresses, predictable challenges or questions or events occur and how those things are handled, what happens in those episodes or events is going to either drive this situation toward a, to make it more likely to have a good outcome or more likely to have a poor outcome. So I'll just use as an example in the second box in the middle it says does the worker receive prompt evidence informed healthcare and or other services that identify and mitigate added risks as well as preserve or restore ability to function and work?

If they do, that is going to push the case in a good direction. If they don't, it is going to push the case in a bad direction.

So you could say that the purpose of RETAIN and the intervention of the coordinators and the program to engage the physicians is to make the things that are happening make favorable things happen during this early period up until the end of the 12th week. At 12 weeks here is when you see the box no, recovery is prolonged or the condition becomes prolonged, that is 12 weeks and the person has not fully recovered function by 12 weeks. The early part up to 12 weeks was the convention in a COHE program in Washington state and the activities now are the extra activities that occur for whom the simple interventions did not work. I call these job saving services. Things are really in jeopardy now. This person hasn't made a rapid recovery by six weeks or things may be in jeopardy. The kind of interventions we are going to do, we can call them job saving services.

So the ones at highest risk can be quite hard to deal with. There are -- if the risk is in the workplace and it has nothing to do with them, if the risk is in the doctor and has nothing to do with them they may not be as hard to deal with, but there are people who come into the system and things have happened and they have made decisions and they have a view of the situation and how to cope with it which makes them hard to deal with.

So I have put this slide together. I've put it in front of a whole lot of doctor audiences, claims people audiences, nurse case management, vocational rehabilitation audiences and they recognize the people that I'm describing here. The ones who are most at risk for an unnecessarily poor outcome are people who behaviorally are very hard to work with.

So this is a challenge for us if in RETAIN what we are supposed to be doing is working with people who are at risk for a poor outcome, we may not like them. They may be hard to work with. We are going to have to really build our interpersonal skills at building trusting and positive relationships.

So a lot of the role of the return to work coordinator or whatever you are call them. I hope it is not called the return to

work coordinator, is to do communication. It is a truism that communication fixes most things.

So I was asked to do some thinking about communication that actually does improve things. I realized there are some features of it. One of them is communication is most effective if information is shared between people. So that both parties have the same data and are looking at the same picture. A lot of times dissension happens because they know different things or see different things.

And it is hard to share information unless you have an easy method for sending and receiving that information so that people actually can do it efficiently.

But it also doesn't actually really matter what information you send to somebody unless they trust you. So in the absence of a relationship of trust, respect, and connectedness, it almost doesn't matter what you say or what you send because what you need is for the receiver to believe it.

It is most powerful and communication works the best when there is a mutual understanding of the parties of what each one wants and needs. And there's a real human connection. There's empathy in which it is clear to party B that party A understands their predicament and cares about them as a human being.

And lastly, communication that really makes good things happen is when the parties have a shared goal and are actively collaborating to reach that shared goal. Now, they don't necessarily have to be this exact same goal, right? It could be that your goal is for me to exercise more regularly and my goal is to get my husband off my back and feel better, right?

So we cannot see it exactly the same, but the actions required for us to each to accomplish our goal may be aligned.

Next slide.

So I want to draw attention to the power of words in communication. Actually, the word communication kind of implies words, but so when we are talking about words that are going to forward the action and make the things we want to have happen happen, we have to be extremely thoughtful about the power of words because words can reassure or frighten. They can signal interest and empathy or not. They can build trust and confidence or they can create distrust and insecurity.

They can create expectations, whether positive or negative. They can grow relationships or cause alienation. And, of course, obviously they can transfer factual information that is necessary. And in very subtle ways words can empower or undermine people.

>> Jennifer we are at the 30-minute mark.

>> Jennifer: Very good, thank you very much. The science of persuasion and influence is of help to us. There is a growing body, particularly it has been influenced by neuroscience. Words have more impact when the listener believes you are a credible authority. One way toll summarize how you establish your credible authority is that they perceive you as benevolent, perceive you as trustworthy and perceive you as an expert in the matter at hand. You don't have to be an expert in astrophysics or neuroscience but you have to have been watching people who are injured or ill and have a sense of what

actually works to help get life back to normal. The listener needs to believe that you see them and are familiar with their specific situation, who they are as a person, what happened so far, what they are wonder ng and worried about and what they want to accomplish. They don't want to be a number.

And overall, the psychotherapy people years ago realized that you don't have to be a psychotherapist to help people. People are energized by some pretty benign and non-technical interventions, by being respected, by being encouraged to face difficulties and overcome them, being accepted and for given for making mistakes or feeling scared or having your confidence shaken and they certainly are energized by regaining their confidence and restoring their hope. So as I say, I was asked to look at some brochures and websites that states had put together. I don't know if I was able to look at all of them. I looked at all I could find. I just would like to point out the way that the dos and don'ts document is set up and go through a couple of the points on it. This is one the other party favors that you were sent is this detailed analysis.

So when I was looking at the resumptions I looked at the overall purpose and strategy that they seemed to be reflecting. And really for the adequacy of that purpose and strategy. I looked at the utility, how they appeared to be being used or might be being used. I looked at the main messages being delivered. In particular I looked at the offer that was being made to the worker. What are we offering them?

I looked at the style and the feel of them from like what emotional impact do they create from the way the words and the way they appear on the paper.

Do they establish confidence and trust in your expertise and your benevolence? And do they signal that the worker will be safe and will still have autonomy and self-direction?

And lastly, what kind of use of evidence-based persuasion and influence techniques? Because we are selling our services. This is a sale that we are making. And so it is silly not to make use of evidence-based persuasion and influence techniques.

So I am going to go on the right-hand here with a little cranky face, the sad face. Some of the states don't even appear to have yet written worker oriented information about RETAIN available. On paper and less critically on the Internet. As I said in our project it turned out not very many of the workers were going to the Internet for information. And it is also important to have a different brochure for workers and for employers. They need different messages. They are in different situations. It isn't particularly good to have a generic brochure and super not good if the information for employers comes before the information for the workers. Who your real customer is that worker because their decisions about whether they want to participate in the program are going to drive the success of RETAIN.

So the worker and the employer are not always on the same page. Many people, some people actually consider return to work the employer's goal, not the worker's particularly in this early phase. Worker's see the priority as getting their life back together, and

obviously that is going to include work. From a purpose and strategy perspective, the brochures are a way, Smiley face here, we want to think of brochures as a way to attract workers to the program and persuasively inform them about it in order to increase the likelihood that they will accept our services and incidentally participate in the study.

Not only are we trying to recruit them into a program, we are inviting them to engage with us in an ongoing relationship. The one purpose and strategy of the brochure is to introduce or signal what that relationship with us is going to be like.

In order for brochures to be effective, the data on how a brochure actually gets people to do things is that it often is, you need to make it super clear, it's clear what the next steps are: how to contact you, things like that. Thank you for whoever did that.

The utility of the brochures also is that they can be used by other referral coffers sources, by medical offices, insures, they should have a supply to hand out so one of the weak points in these programs is often going to be the doctor, the employer, the insurer who doesn't know how to describe the program. An easy way to do that is to hand the worker the brochure and to make sure that they have them in their hand so they can talk about the program with their family. And Wednesday has been tending time on projects before they even have the introductory brochure about what it is they are being offered.

The main messages unfortunately in several states were about the research program. And they often were using the same bureaucratic wording that the RETAIN grant does, which is aimed at policymakers, not at actual injured workers. And some of the brochures also were using the phrasing used in other disability programs. It is important to realize that the target population importance RETAIN is not people with a disability. It is people who think of themselves as sick or injured and they are not looking at the world the same way the usual population of people with disabilities are. And don't presume they feel currently ready and are eager to return to work. Don't imply that their main goal should be to go to work or stay employed. The ones at the highest risk may not currently feel they are well enough, may not believe that work is safe or appropriate, they may not be emotionally ready and they may think you are rude for implying that they should think about it now. Don't imply that you are only interested in getting them to stay at work or return to work. If you had to feed a child medicine or feed a dog a pill, you know you often have to put something sweet around the medicine or a flavored medicine or you have to put some hamburger around the pill in order to make somebody do something that is go for them.

It is important for you to think about the honey or hamburger is what you have to put around the pill. Do express compassion and awareness of all the things that they are fully dealing with and you might even name some issues in the brochure to signal that you are aware of what it is they are dealing with.

I think you skipped one. So the offer is -- I don't think that the proposal for an opportunity to be a research subject in a federal study which may or may not involve the recipient receiving services,

to my mind that doesn't seem like a very attractive proposal. I wouldn't lead off with research. I would underline the service, a free and helpful service that you may say it is only available for a limited final because we have a grant and there are requirements set by the funding agency but put the things that workers feel are important to them,.

And with regard to look, style, and feel, you don't want to use small font, long sentences and fancy words like detriment. Many of the workers, particularly the ones most at risk have less than a high school education. You don't want to emphasize the connection to government, especially the federal government since it makes many people wary. You don't want to waste people's few seconds of attention they are willing to give you by going into detail and research and the funding. All of this is government centered rather than client or customer centered. Move to the left here and do use easy to read font, simple word, plain language. Even people with limited interest, even people with not that much ability or interest in reading should be able to get the message. And use photographs. One state has done a particularly wonderful job of this. With photographs that reflect what, the empathy for the person who had their life upset, like a person wearing a sling, feeling unsure, looking worried while holding paperwork.

They also are portraying a happy future that is the goal. Such as photos showing a smiling worker at a job and someone playing outdoors with kids or friends. This emotionally, on an emotional level creates the situation you are in now and the future we are going to help you with.

And it is true also that we, in order to be seen as credible authorities that could actually help people they have to have confidence in our expertise. Some of the brochures are saying we are not sure whether our systems will help you. We are looking for ways to improve return to work outcomes. This is to explore different strategies. Don't start off by creating uncertainty about whether you can actually help them or whether they can actually get the service. You should position your team as experts in helping people deal with their current predicament. Point out that you watched or helped hundreds of thousands, so you know what needs to happen. You can create confidence very legitimately in your services by saying things like studies have shown that people in situations like yours can benefit from services just like what we are offering you.

If you were going into a cancer drug trial, they would not say we have no idea whether or not this will help you. They will cite the evidence to date that it might help, right? And they will also say but we can't guarantee you'll get this result, but I have been actually in a cancer research trial and they had to show me that I had a good shot of it working before I would put myself at risk.

Next slide. And also this one is a slower, I was slower to realize this. In workers compensation, there is -- often the stay at work or return to work process doesn't have a voluntary feel. Nominally it does, but since the workers compensation system is paying your paycheck, when they say to you work with this case manager or work with these people, about stay at work, return to

work, you feel coerced, right? In the nonoccupational study, RETAIN isn't paying them their paycheck. They are totally free to say yes or no to the service. And these people all still have a job. And why would they trust you to take the ball and run with it when the way you run with it, they don't know you. They don't know how tactful you are going to be. You may make them lose their job or ruin their relationship with their employer. So don't send the message you are going to take over the stay at work or return to work process and handle the communication behind their back without their involvement. Do demonstrate that you are trustworthy and aware that they might have reasonable concerns. Make it clear they are going to be in charge and make the decisions. You can say things like we'll work together with you to design a plan. I would think about describing one of the roles of the coordinator as a guide rather than taking over for you.

And as an example, you might say you can prepare the worker for important conversations with their doctor or employer or even participate in those conversations. But they are going to have to feel like they can protect their own future wellbeing.

And you can read the detail in this slide because I know we want to get on. I am not actually an expert in evidence-based persuasion techniques. I have read the book influence by Robert Shaldini from Arizona State University. I'm tuned in to the need for persuasion techniques but I don't know about all of them. I would suggest that you get yourself somebody that can advise you. So there are some messages here. One is free is attractive. Offer something they are going to value, which is going to probably be that somebody who is interested in them listens and cares. If they are left alone to fend for themselves in unfamiliar territory, the most valuable thing may be that you are really interested in them and want them to have a good outcome.

You want to promise practical help, if that's what they are needing and want. Giving a free sample during the interaction is probably a very smart idea because first of all when people get something for free they naturally as human beings, we are hard wired to feel beholden and want to give something back. If somebody offers you a free sample, particularly if it's something you like, you feel the inner urge to say yes.

Here is -- the recruitment materials and interactions should give people a taste of what the relationship is going to be like going forward. As soon as you can get brief testimonials, this is a persuasive technique call social proof and it is very effective. Unfortunately some of the states are listing monetary incentives first. The down side, it eat pretty subtle. It almost signals that you think you have to bribe people to do this because the service itself isn't valuable enough. So I think I don't have any trouble. I think monetary payments to workers to ease the cost and inconvenience of participating are a fabulous idea. I wouldn't listen them as number one.

Scare techniques may work with one group but particularly for the ones already freaked out you may make them become so scared that they are paralyzed and not want to participate.

>> Jennifer, we are at the 46 minute mark.

>> Jennifer: There are more persuasion techniques listed here. If you download and go through these things in detail, I bet you have become aware as a result of this conversation that we are in the persuasion business.

So you have in your, the third party favor that we sent you is a generic sample brochure that I put together. It makes me anxious to send it to you because I don't think I'm the universe's best persuading person, but often until we see one we can't do one, right? I said okay, how can we in this brochure exhibit some of the things I was talking about? Let's look if he left-hand margin. We have a person looking concerned. It is not just a person but also the wife. So the family is involved. It's obvious he has a healthcare problem and he's looking at paperwork. There is the road to recovery. That is the hopeful thing. I also means it is a pathway; doesn't happen in a day. Below that our goal is to smooth your path back to a healthy, safe and productive life both at home and at work.

Then you see happy workers at the bottom. Like this is the future where we're going to try to take you.

On the right-hand side the top line has an injury disrupted your life or work. We can make things easier for you at no cost. Acknowledging what they are dealing with. Are you dealing with any of these challenges? Offering practical support and at the bottom how to contact us and there in the very little line at the bottom that says you will be contacted by a care advisor who will describe the requirements of this grant funded program and walk you through the enrollment process. You can see that the research part of this has been turned into a tiny piece. Next slide. So next steps. We hope you are going to use these materials for discussion also within your team. And especially those who are producing the written materials and those who are going to be interacting directly with workers and the slide are always available for download. An I don't know how. I hope some of you would like to have half hour sessions in the next while to talk about, A, whether this came through clear to you and to brainstorm some ideas about how to maybe move from where you are today to the next place in your more worker-centered worker-sensitive communications.

So just as a forecast of coming attractions, think ahead here just for a second. Once you start getting people coming in, how are you going to identify those at risk and document that risk? And how are you going to figure out what particular issues or obstacles in their situation are amenable to our interventions? How are you going to figure out what need to happen, who can do it and will do it, how and when. If you're interested, I'm planning to do some webinars on these topics. This is where the real meat of the matter is. These are the things that are going to change what happens and actually improve outcomes.

Thank you for listening. And I am open for questions or confusion or skeptical comments.

>> MODERATOR: If you have questions, go ahead and type them into the chat box. And while we wait for them I'll let Meredith post what we have so far.

>> MEREDITH: Thank you, Jennifer. We do have a few questions. We have some more coming in.

I think to start, I would like to ask you to reflect back on your presentation today. What are the two or three top lessons that you recommend everyone keep in mind as they move forward?

>> JENNIFER: Okay. First of all, since this is a voluntary program, it's got to look good to the worker. In order to look good to the worker, it needs to address their concerns, their worries, and answer their questions.

And include work as just a natural part of restoring and getting life back to normal. I would say that, it has to be worker centered.

And the second thing is that communications with workers need to be strategic. And that at the first step we are trying to recruit or attract or start a relationship, but we also need to keep them engaged with us and have them be satisfied with what they are getting or they will drop out. So worker communications are designed to, should be the strategic use of these initial communications is to A, do that initial traction, but also to portray what the ongoing relationship is like and that what we need to realize is we really want to enter into a relationship with people during a critical point in their lives. That's all I have on that one for now.

>> MEREDITH: Okay. Thank you for that.

>> MODERATOR: Meredith, we have a question on if there are any model brochures that would be good for them to look at as examples.

>> JENNIFER: Well, there is that one we looked at ab minute ago. Can you go back a slide or two?

There we go. Among the three things that were sent to you today is this generic sample brochure.

>> MODERATOR: All of the hand outs will be posted on the RETAIN online community.

There is also one other question related to after enrollment, there's still the challenge of keeping a worker engaged in the return to work process. Any thoughts to offer on this?

>> JENNIFER: Well, yes. I think actually one of the other questions somebody asked me but I didn't have time to squeeze in here is what does continuous quality improvement look like? I think if you drive everything through the lens of are we meeting the reasonable needs of this person and are they getting practical value, what they think of as practical value, that's how we are going to keep them engaged. It is also how we are going to grow the referral stream. There is a grapevine in every community. What we want for sure is that any worker who touches any piece of RETAIN to feel that it was worth their while to have that contact. What we sure as heck don't want is workers going back to their doctors and saying boy, that was stupid.

So the idea of being driven by satisfaction and delivering value rather than checking boxes and doing the things that are required is going to require that we have that in our hearts, right? That we are really there to make a difference in people's lives and to have them see and value the difference that we're making.

So we can't be Johnny one-notes and only work on stay at work, return to work and have them perceive that as valuable. Because they

are dealing with an entire situation. Part of the will reason why I got attracted to this whole population is realizing that when a working person has their life disrupted and is enable to work because of injury or illness they are basically left alone to fend for themselves in managing the impact on their life and livelihood. The doctor tends to be working on diagnosis and medical treatment and the employer tends to be just administering their absence program and FMLA and their attendance program.

And the benefits people are making sure that they are administering benefits and paying benefits in accordance with the law. Nobody is really saying: Geez, we would like to stand by you and have this have the least possible impact on your quality of life. In fact when we did the project with the 205 calls, I was writing a lot of the scripts. We had to go up to the tip top boss of that organization to get that authority to say we really hope that this has the best possible outcome from you. It was so foreign to them. To express that idea.

I hope that was an answer to your question.

>> MEREDITH: Thank you. I have another question here which is sort of a two-part question. What would make a worker decide to say yes, I want to be part of this program? And then stay in the program and.

And conversely, what would make a worker decide no, this is not for me. Or to -- we have had this happen in some of the states. To sign up and then change their mind and disengage.

>> JENNIFER: Okay. Okay. I think that the emphasis that I have been making on understanding, they are going to be interested in a program where they are going to be treated like a human being, where the people who are going to be dealing with them understand the realities and challenges that they are facing and are offering what the worker thinks of as practical help. And encouragement. And moral support.

I actually ran a program for a short while with people who had already had really bad outcomes. What was really important to them was to not feel alone. I think these ones that are newly vulnerable an lost, they are going to appreciate the practical tips and guidance and moral support. As long as they are getting that I think they'll stay in. While they may leave, there might be many reasons. One is if there's a service failure. There is a promise and it is not delivered. The slide about worker safety and autonomy is, if they feel that you have taken their fate in your hands and are just willy-nilly doing what you think is right without their permission or knowledge or working behind their back, I thill they'll get right out. If they ever feel that you actually do not have their best interests at heart, you have somebody else's, either the employers' or the doctor's or the governments. If you have the government's interest at heart and not theirs, they'll hit the door.

That's my best guess.

>> MEREDITH: We have about two and a half minutes left. Mona, did we get any other questions in from the chat box?

>> There was one, the worker needs to know early that this is a research grant, they may be in the group that gets the establishes

and they may be in the group that doesn't. When does this need to be done to establish trust?

>> JENNIFER: In the dos and don'ts paper I sent you, said at the beginning when you are doing the very first outreach to them, you can definitely soft pedal that they may be in the control group. Because very few people are going to do the bother of going through recruitment process if they think it's a fifty-fifty shot that they'll get anything. And super-duper that will be true if they don't think they will get anything they value. I think there is some merit to considering using the recruitment interview as something of value. And that there are studies where there is inactive control and active control as well as treatment. Active in active control what they'll Git is an informational -- get is an informational brochure. I would try to figure out if there is a way that you can offer people a conversation, design it so that it is interpersonally satisfying and attractive and at the end of that conversation, say: I can work with you more if you enter this trial. And then now you have given them a little free sample of what it would be like to work with you. And what it is that the topic is. And you are offering them to go deeper by entering the trial.

I have a concern, if you listen to Glen's podcast which I strongly recommend to you if you haven't done that, he more or less said that. They are finding in this research area that you have to offer something of value to everyone. Because as I said, if anybody goes back to their doctor and says what a total waste of time. I went to talk to those people for half an hour and what I got was you're in the control group and don't let the door slam you in the butt when you leave. You can't do that.

Think about how to create a positive experience for everyone even if they don't end up in the full agreement group. That is Glen Pransky -- if people haven't listened to this session, I thought it was really, really good.

>> OPERATOR: Great. We are at time, everyone. I wanted to thank you all for attending today. I am putting in the evaluation survey and we will also be sending you a link to that survey as well. So take a moment, please, to complete our survey about the webinar. It helps inform the content that we create for you as technical assistance help.

There were a few additional questions that came in. We will be writing up responses to those and getting them out to everyone as well. So thank you again for attending today and have a good rest of your day.

>> MEREDITH: If anyone would like to set up a one-on-one with Dr. Christian, please reach out to your SCO. Thanks, everyone. Take care!

(The webinar concluded at 3:00 p.m. CST.)

(CART captioner signing off.)

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