Outcome-Oriented Clinician Training in RETAIN:
Strategic, Collegial, Purposeful, Tightly-Focused, and Operationally-Oriented

This presentation consists of unofficial advice and guidance based on the professional training and years of experience gained by working at the SAW/RTW interface in healthcare delivery, workplace, and payer settings of

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Intended Audience

This session will be most useful for people who:

- Are responsible for ensuring that your program receives a good flow of referrals from physicians.
- Are responsible for the clinical/medical end of your state's RETAIN project.
- Are the ambassador(s) to the medical community.
- Have been / will be the author of marketing materials, brochures, and training aimed at "healthcare providers."

If that's not you, please write in the checkbox what your role is in your state's program.

Educational Objectives

As the result of attending this webinar, I hope you will be able to:

- Describe one overarching strategy that should undergird all physician communications, including all occupational health training.
- List three features of communications with clinicians that must always be present in order to drive the success of your state's service program and RETAIN.
- Describe why it is preferable to position your program as a service that will help them improve patient outcomes.
- Explain why the term "clinician" is far preferable to "provider".
- Explain why paying physicians to conduct the four best practices was such a brilliant feature of the COHE design.

Plan for This Session – with a caveat!

- 40-45 minutes: Rapid-fire overview of outcome-oriented communications and training aimed at treating clinicians.
    1. Key Terminology
    2. Strategic
    3. Collegial
    4. Purposeful
    5. Tightly-Focused
    6. Operationally-Oriented
    7. Do's and Don'ts of specific aspects / features of communications based on review of existing training materials and brochures
- All slides will be available for download.
- 15-20 minutes of Q&A / dialogue
- Invitation: Set up a time to meet one-on-one with Dr. Christian to discuss clinician relationship-building.

Terminology A

1. **Your Service Program** – the delivery of one-on-one services in individual workers' situations AS DISTINCT FROM RETAIN – the larger grant-funded organization / project, which has two parts: (a) your service program and (b) the research project.
2. **Treating physicians.** Only professionals defined as "treating physicians" in law and policy are authorized to make SAW/RTW decisions. So make it clear that's who you are inviting to be part of your program -- though, in reality, you will be talking to / working with both them and their support staff. **AVOID the term "provider" for diplomatic reasons**. (More on this below.)

Strategic – 50,000 feet

- RETAIN is about weaving new social fabric: creating a web of real working relationships among professionals in organizations in different sectors of society – all of whom will help newly-injured workers get back on their feet.
- A real working relationship means the parties interact regularly in the course of their work.
  - It is not a signed contract or financial agreement.
  - “Traffic” is what makes it real.
- So, make sure **every interaction** with clinicians -- and the organization in which they work – **mentions, builds / nurtures your relationship** with them.
  - This includes recruitment letters and phone calls, training sessions, discussions about specific patients, your response to their input, questions, or complaints.
  - Make sure it is a two-way relationship.
  - Make it real. Keep it alive. Stay in touch. Give them updates and ask for feedback.

Strategic – 5,000 feet

- Every communication / training session for clinicians should be focused on driving:

  (#1) Referrals to your Service Program, and

  (#2) Increasing the frequency with which the four best practices occur.

- At this early juncture, strongly focus on the FUNDAMENTAL REASONS why you MUST have good working RELATIONSHIPS with clinicians:
  - So they will want to work with you.
  - So they will be willing to entrust their patients to you.
  - So they will start and keep recognizing and referring appropriate patients to your service program.
  - So they will start doing the four best practices-- and keep doing them more.
  - So they will give you straight feedback so you can improve your program.

Strategic – 50 feet

- Position your program in their eyes **as a resource for them** to call on.
- Establish you/your program **in their eyes** as a benevolent, trustworthy, and capable source of expertise and practical solutions that:
  - Help their patients achieve better and more complete recoveries;
  - Make the clinician's job easier and (preferably) create new revenue.
- Regularly **refresh their awareness** of your program to keep it front of mind.
- Create and nourish your program's reputation in the "grapevine" by staying alert to what people are saying. Use that info to make changes rapidly when warranted.

Strategic – 5 feet

- Communicate your respect for the expertise and social position of those who treat patients (and make decisions about SAW/RTW) – and the culture of their profession(s).
  - Have MDs talk to MDs as much as possible – and involve them in training MDs.
- Demonstrate your sensitivity to the complexity, pace, and pressure of their work; the value of their time; and the centuries-old culture of the healing professions.
  - Be succinct and very organized, get rapidly to the meat of the matter, especially in initial meetings/training sessions.
  - Since average MD IQ = 125, you can go fast; no need for a lot of intro & repetition
  - Be specific and concrete about what is needed / the specific activities you want them to perform / how things will work.
  - Make it look easy and quick.
- Offer your assistance– Let clinicians think of you as assisting THEM in the matter of their patient's functional recovery and SAW/RTW.

Real World Evidence of Your Strategies' Success

1. An ever-growing stream of increasingly appropriate referrals
    - Which enables you get to get involved with affected workers and do your part

2. An increase in the frequency with which the Four Best Practices occur
    - Which reduces certain common sources of delay in SAW/RTW which improves outcomes

3. Positive reputation of your program on the "grapevine"

Collegial

KEY: Position your program as “inside” the therapeutic envelope, assisting with the care /recovery process – NOT as a “government employment program.”

- Emphasize the goal you share with them: helping working age patients whose lives are disrupted by illness or injury to feel better, achieve the best possible recovery which means resuming full participation in life, which usually includes work.

Express interest in the clinicians as potential colleague-collaborators, their perspectives, and reasonable needs.

- Explain why you see clinicians in general (and this particular one or group) as an important ally for your program.
- Ask who is in the room with you and the role they each play in the clinic.

- Acknowledge that patients / employers must rely on clinician guidance re: activity and work.
  - Ask them what their philosophy is about people resuming normal activities as soon as possible and working during recovery. (Data show this predicts their SAW/RTW decisions.)

Collegial

- Explicitly state your commitment to assisting them to achieve good outcomes for their patients AND to respecting the value of their time AND to growing your relationship with them over time.
- Describe your Service Program staff's savvy and expertise – what you bring to the table.
  - "We, as well as you, see the variability among patients in how they respond to the challenge of an injury/illness/impairment."
  - Highlight your shared commitment to avoiding harm – and point out that prolonged life disruption and job loss is a very poor outcome of a health problem.
  - "We've helped hundreds or thousands of people [or "we know what it takes to help people"] get their lives back on track and back to work, and are prepared to do so."

Purposeful Communications

1. Most likely, you will only have SECONDS in which to deliver the **core** message. (Your clinician readers are rushed, impatient, and only mildly interested.)
   - Use the subject line or first paragraph like a headline.
     - Assume they will NOT READ the whole thing unless you hook them with “real” info.
     - Move the “action item,” “sound bite,” or “bottom line” to the very top.
   - Clarify who you’re talking to.
   - Simply /clearly state the purpose and intended outcome of the commo/training
   - Background information and details should follow later.
2. Always include a little something to remind them of your therapeutic and benevolent intent: you are available to assist the clinician in helping their working patients new or changed medical problems achieve the best possible functional outcome – and keep their job.

Tightly Focused Training

- Prepare clinicians to succeed at doing what you want them to do!
- Give an overview of the general design of your program
  - Who does what, why, when, and how the parties interact.
- Briefly review the specific things you want the clinicians to do and why.
- Briefly review what they can expect from you and when. (*see more later*)
- Succinctly provide the practical operational details. (*see more later*)
- Forecast likely future course of your ON-GOING relationship:
  - They will get comfortable making referrals and depending on Coordinators for help with multi-party communications and SAW/RTW in individual cases.
  - Your network staff will respond to their requests for assistance with responsiveness or other relationship hiccups.
  - Your network staff will give them periodic feedback on volumes, outcomes, quality, etc. and request feedback and suggestions for improvement from them.
  - As time goes on, they will probably be asked to take additional training/education.

Operationally-Oriented Training

1. **Display a short list of the activities for clinician to carry out**, e.g.,
   A. Keep an eye out for patients who are not recovering rapidly and meet referral criteria.
   B. During clinical encounters with candidates for /clients of your program:

      BP #1: Make referrals to your program after discussing with patient.

      BP #2: Formulate and document activity prescription on form, and give verbal instructions and reassurance to patient.
   C. BP #3: Promptly respond to questions about a shared patient's ability to function and work that come in by phone or electronically from your staff (or patient's employer, or insurer) – **when patient is not being seen that day**.
   D. BP#4: In complex or delayed cases, formally assess obstacles to SAW/RTW on your form and send it to you.

Operationally-Oriented Training

2. **Explain precisely what each item involves -- for clinic operations**:
   a) Define the required elements of each of the 4 Best Practices.
   b) Specify who can conduct each of the best practices, on what occasions, and how frequently.
   c) Describe medical record documentation requirements each time a best practice is conducted.
   d) Describe any additional data entry required by grant.
   e) Provide fee schedule and billing instructions: CPT code (or equivalent), what supporting material to attach, where to send the bills, and to whom.
   f) Describe your bill payment process, expected turnaround time, and whom to contact in case of questions.
   g) Explain the kinds of issues they can ask the Coordinator to handle.

Operationally-Oriented Training

3. Offer handouts: Stuff they can use as the clinic cares for patients.

a. Things that will make it easier for them to CARRY OUT some of the tasks.
   - A supply of printed referral forms and/or an electronic template.
   - Brochures to give to workers that explain your service – and how to contact you?

b. Things that will make it easier for them to REMEMBER to do them – and how.
   - A one-page sheet for clinicians with a list of referral criteria, the 4 best practices (BPs), and billing codes?
   - A one-page sheet for the billing office that lists the 4 BPs, the codes, the fees, billing instructions, and the name/contact information for billing questions?
   - A list of contact information for your program staff
   - **Their method for flagging the charts of patients who are participating in your program.**

c. Answers to questions their business office might reasonably want to know – before permitting/encouraging clinicians to devote their time to these things?
   - Predicted volume, clinician and staff time required per encounter, medical office time saved by having the Coordinator handle communications, and revenue offsets-- so they can predict the impact on THEIR workflow and economic well-being.

Dr. C's "Do's and Don'ts" for Written Communications / Training Aimed at Treating Clinicians

Based on my review and analysis of materials

submitted by RETAIN states in October 2019

Specific Aspects / Features

- Appearance
- Terminology B
- Length, Extent
- Scope, Emphasis
- Inspiring Confidence
- The Four Best Practices
- Talking about Money

Appearance *(This is 44 font)*

DO – ☺

- Do keep brochures and slides graphically simple and clean so the flow of information is easy to follow.
- Do use a similar template or format for slides -- so the reader can easily predict where the "meat" will be.
- Do use fonts that are simple and large enough to be easy to read.
- Do use photos that are relevant and will create a positive feel, such as ones showing helping or collaboration.

DON'T – ☹

- Don't pack brochure or slides full with many many words.
- Don't use tiny fonts. (This is 24 font.)
  - For a projected slide show, the minimum font size is 24 font.
  - For self-paced instruction, can use minimum font of 22. *(This is 22).*
  - *(This font is 20; this one is 18.)*
- Don't allow layout / format of text to vary needlessly through the set.
  - Too much variety feels like things are jumping around rather than proceeding smoothly, logically.
  - It is visually fatiguing for the reader who must find the main message in a new place on each slide.

Terminology B

DO – ☺

As a courtesy and gesture of respect, do use the term “physician,” “treating clinician” “practitioner”, “clinical practice”, “clinical office” or “medical office*” to refer to the SEVERAL different types of healthcare professionals who, have the authority / legal standing to:

- diagnose and treat disease and
- write notes that put patients off work, release them to work, and set work restrictions.

This terminology will cover (and not offend) physicians, physician-assistants, nurse-practitioners, psychologists, podiatrists, chiropractors, clinical social workers, and other types of licensed mental health professionals.

DON’T – ☹

Don’t use the term “healthcare provider” or “provider.”

- These terms were invented by purchasers and payers to cover the entire array of health-related goods and services they PAY FOR. “Provider” includes nurses aides, lab techs, vendors of medications, X-ray machines, wheelchairs, bed pads, etc.
- You do NOT want to be seen as a payer. You DO want to be seen as “inside the tent” – as a collaborator within the caring team who helps treating clinicians take better care of their patients.

SENSITIVITY MOMENT: Saying “provider” to physicians sends a subtle signal of disrespect -- a failure to acknowledge their advanced education and training, specialized expertise, level of authority and and standing under law.

Terminology = Diplomacy

It is wise to bend over backwards to ensure your staff is equipped to communicate **both diplomatically and directly** with treating clinicians, especially physicians, because:

- They are free to decide whether they like you, want to team up with you, make the effort to send you referrals, do the best practices, etc.
- They have more volume of patients than other treating clinicians.
- They have a LOT of INFLUENCE over those patients.
- They have very low tolerance for “blah blah blah” (bureaucratic talk).
- Their willingness to make the effort to interact with you on a day-to-day basis in actual cases will be a major determinant of your program’s success.

Thus, your staff’s skill at diplomatic clinician relations is one of the “critical success factors” for your program.

Length, Extent

DO – ☺

- Do make the purpose of the training clear: to prepare them (clinicians) to work with you in your new service program.
- Do make the initial training short, well-organized, and adhere tightly to its purpose. Think 30-60 min max.
- Do keep content tightly focused on the BARE MINIMUM set of philosophy, concepts, and facts that the clinician needs to get started with your program and help it succeed.
- Do begin by forecasting what you will cover, and then summarize it well at the end – and provide HANDOUTS.

DON'T – ☹

- Don't begin the training without giving your a preview of where you are going to take them.
- Don't forget to organize the content in a sequence that makes sense to the learner.
- Make it clear you are moving stepwise through your plan for the session.
- Don't provide extensive initial training with a lot of detailed material and a lot of "self-study" modules.
  - It does not serve your main purpose which is to teach how to work together with you.
  - It obscures the main messages and few facts are likely to be recalled.
- Don't get to the end and stop abruptly.

Scope, Emphasis

DO – ☺

- Do get right down to the part that is relevant to the clinician.
- Do communicate respect for clinician priorities and interests.
- Do reflect an awareness of realities in patient encounters and clinical operations.
- Do make it very clinician-oriented.

DON'T – ☹

- Don't devote several slides at the start to explaining grant facts, organizational and administrative structure, other participants, relationship to benefits systems, etc.
  - This drives clinicians wild because it is seen as irrelevant -- not part of their world.

Scope, Emphasis

DO – ☺

Do ensure that by the end of the initial training, the clinician:

- Sees the DIFFERENCE between the purpose and intended outcomes of their collaboration with your staff in the service program vs. the RETAIN research project;
- Is very clear how referring patients to your service program and doing the part in it will benefit BOTH them AND their patients;
- Understands the differences between their role in usual patient care and in your program's service delivery vs. the research project;
- Is clear about the precise activities that count as "best practices" and the documentation / work products they are supposed to produce (and bill for?)
- Knows what to expect they will get in return from your staff (e.g. less hassle, practical help, answers to questions, $$, etc.).

DON'T – ☹

Don't provide "traditional" CME at your initial training.

- Traditional CME is mostly theoretical and IS NOT operationally-oriented.
- In the future or as enhancement, they will need to learn the theory and philosophy of SAW/RTW, have a chance to review the evidence base on which your service program is based, and be instructed how to make better clinical decisions in the SAW/RTW process.

Don't provide training that consists of self-study modules with a quick test at the end – without any requirement for meaningful interaction as the module proceeds.

- This design allows the busy clinician to earn a lot of free CME by merely flipping through it and not really engaging with the material.

Inspiring Confidence

DO – ☺

Do position your team as experts in working at the health and work interface.

- Point out that you have experience and have helped many people recover and get their lives back on track . You know how to serve as the go-between who can clarify issues and make good things happen – and you have extra resources to call on.

Do create confidence in the design of your whole service program.

- Make it clear that the four best practices are evidence based and have been shown to improve patient outcomes.
- Say things like: "Studies have shown that outcomes for workers are better when professionals collaborate to guide and support them this way. "

DON'T – ☹

- Don't create uncertainty about whether the best practices and your services will make a difference by describing the program as an attempt to improve strategies or to figure out what works best, e.g.,

  -- Don't say "*we are looking for ways to improve return to work outcomes*"

  -- Don't say this is "*a federally-funded initiative exploring SAW/RTW strategies*"

Don't decrease clinicians' motivation to make referrals – so soft pedal the possibility that their patients may or may not be in "the treatment group".

The Four Best Practices - BPs

DO – ☺

Do try to emulate the COHE's implementation of the four best practices model as closely as possible – for three reasons:

1. The availability of fees and precise definitions draw attention to and reinforce the performance of very specific clinician behaviors that are valued by other parties. It sends a signal they really mean it!
2. CPT codes and bills create markers in data sets that document when and how often a specific service was delivered.
3. It is effective. Outcomes improved as the number of BP's per clinician rose. Cost-benefit could be calculated and proved favorable.

Do define each BP precisely – with elements similar to those used in CPT codes.

Do ensure that each is verified by the existence of a work product (a competed form) or medical record documentation.

Do create a billing code and fee for each of them.

DON'T – ☹

Don't embed a discussion of the four best practices in a broader / longer presentation on the treatment and management of injured / ill workers.

Don't just recommend the four best practices and define them conceptually.

Don't leave it up to the provider to determine what activity constitutes doing a best practice.

Don't make it hard for others to figure out whether a best practice has been performed or performed adequately.

Talking About Money

DO – ☺

Do find the right tone and balance because it is critical.

Do acknowledge that clinicians earn a living with their time and expertise, so they deserve to be paid fairly for activities that require those things.

Do acknowledge that the four best practices are typically not reimbursed today.

Do be aware of pressure on clinicians to generate billings per hour (revenue) because "productivity" is often tied to their salary, either explicitly or in the background.

Do be aware that if you ignore the issue of payment means asking physician practices to forfeit revenue by spending time "doing the right thing" instead of providing a billable service. The clinicians may be willing, but the business office may not be.

DON'T – ☹

Don't offer such generous payments for participation that greed is aroused and is the main inducement.

Don't use the word "incentives" at all. That word and large amounts of money will make many "good" clinicians uncomfortable and shy away.

Don't offer to pay for a particular outcome in an individual case (e.g., a release or return to work) -- because it will feel like a bounty per scalp.

Beware of sending ANY message about money that could possibly be interpreted as a bribe for unethical behavior ("earn lotsa money for pleasing us at the expense of your patient's well-being").

Note: Most physicians have sworn a sacred oath to put the patient's welfare above their own.

Wrap-up: What a Rapid-Fire Review of Topics!

1. Key Terminology
2. Strategic
3. Collegial
4. Purposeful
5. Tightly-Focused
6. Operationally-Oriented
7. Do's and Don'ts of specific aspects / features of communications based on review of existing training materials and brochures

- All slides will be available for download.
- 25 minutes of Q&A / dialogue
- Invitation: Set up a time to meet one-on-one with Dr. Christian to discuss clinician relationship-building in YOUR setting.

Real World Evidence of Your Success with Clinicians

1. An ever-growing stream of increasingly appropriate referrals
    - Which enables you get to get involved with affected workers and do your part

2. An increase in the frequency with which the Four Best Practices occur
    - Which reduces certain common sources of delay in SAW/RTW which improves outcomes

3. Positive reputation of your program on the “grapevine”

Did you get your questions answered?

- How, specifically, could the requirement to train physicians in occupational health best practices support the overall success of your RETAIN program?
- In addition to transmitting information, what other important purposes should the initial physician/clinician training serve?
- In order to deliver the most value to the physicians and to your RETAIN program, what should the main messages in the initial training be?
- Who besides the treating clinicians need training – and on what topics?
- What features of the training program – and the handouts -- will the physicians and their staff be most likely to find useful?
- What are some specific examples of Do's and Don'ts to avoid turning clinicians off with the RETAIN training?
- How is the clinician training strategy likely to change over time?
- How will you be able to tell whether your physician training strategy / program is having the intended effect?
- What will CQI probably look like in the physician/ clinician training arena?

Next Steps and Your Opportunities

- Q&A coming up.
- Downloads available: Today's slides and recording of webinar
- We hope you find these materials useful in discussions and training within your team – especially:
  - Those who produce written materials aimed at clinicians.
  - Those who interact directly with clinicians:
    - Those responsible for recruiting and building / maintaining relationships with clinicians.
    - Coordinators who will be communicating with clinicians about individual patients.
- Contact your FPO to schedule a 30-minute session with Dr. Christian.

Thank you for listening – and for your commitment to RETAIN.

Questions? Confusion? Comments?
(Skeptics welcome.)

Schedule a One-on-One?

To schedule a one-on-one session with Dr. Christian, contact your FPO at ODEP.

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