RETAIN Webinar

Outcome oriented clinician training in RETAIN: Strategic, Collegial, Purposeful, Tightly focused, and Operationally Oriented!

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>> MODERATOR: Hi, everyone. Welcome to today's webinar "Outcome-Oriented Clinician Training in RETAIN: Strategic, Collegial, Purposeful, Tightly-Focused, and Operationally Oriented". I am Mona Kilany, welcoming you to today's webinar. Before we get started, I want to cover a few housekeeping things. I am putting the captioning link in the Chat Box, so if you need it, please click on the link and it will open a separate window.

If you have any questions during today's webinar, please put them in the Chat Box and we will respond to any questions at the end.

Everybody will be muted during today's webinar and we will be taking all the questions via the Chat and we'll answer them in the last 15 minutes. With that, I'm going to hand things over to Dr. Chris McLaren at the Office of Disability and Employment Policy to introduce our speaker Dr. Christian today. Chris?

>> Thank you, Mona. So today I have the pleasure of welcoming Dr. Jennifer Christian for her second webinar in two weeks. Last week she discussed strategies and approaches for strategic relationship building and tailoring your program messaging so that it focuses on the workers' perspective and their concerns.

This week, she's going to tackle another important program component, clinician training. We know that many of you have already begun your training materials, but Dr. Christian is here to provide suggestions and guidance that you can consider adopting or tailoring to your needs if it makes sense within the context of your program.

I'm sure all or most of you are familiar with Dr. Christian through the previous webinar, and some of you have had a chance to speak with her in the monthly check-in call. She brings a wide array of expertise. Designing clinician training is an area where Dr. Christian has extensive experience. She's been a State Medical Society President and VP and Medical Director of managed care and worker's compensation company and designed and led the

implementation of a primary occupational physician network. She's runs mobility company since 1998 that specializes in the health and work interface by providing services focused on improving absence management, worker's compensation, and disability benefits, programs, and systems, and she has developed and delivered many online and live training materials on work disability prevention and the state work return to work process for physicians, claims, and case managers and first-line work supervisors.

So, with that, I would like to turn it over to Dr. Christian.

>> JENNIFER CHRISTIAN: Thank you very much, Chris and Mona. Hi, everybody. I shared the title of this webinar with a friend and he laughed. He actually sort of snorted and said "it's so much like you to have such a long title." (Laughing).

So, you're going to notice that there are a lot of words on these slides. I violated several of my own principles in doing this presentation, and the reason is that it isn't primarily a webinar, it's primarily I'm trying to give you a manual that you can use or that you can hand to other people in your organization who are going to be responsible for developing and nurturing your relationship with clinicians in your state.

So, what I suggest you do if you can is mostly listen to my voice today, and then the slide set that you take home, which you'll be able to download, will enable you to remember exactly what we said and tick off a lot of the lines if you want to because in the way the heart of it is words, this is what is becoming clearer to me as I work in this project more and more deeply.

Next slide, please.

So, I really developed this slide deck for the people who are going to be responsible for ensuring that your program receives a good flow of referrals from physicians, and people who are responsible for the clinical or medical parts of your states, it's RETAIN project and who are going to be your ambassadors to the medical community, and lastly, for those who have been or are going to be the author of written materials, marketing materials, brochures, and training aimed at what many of you are now calling healthcare providers.

If that's not you and you're attending this anyway, I would be interested if you would write in the Chat Box what your role is in your state's program so that I can get a better feel for who is actually attending my webinars.

Next slide.

The educational objectives that I set for this webinar is that I hope you're going to be able to describe the main, the single, most important overarching strategy that should be all physician communication, including all occupational health training in this program, in the context of RETAIN.

And then to be able to list three features of your

communications with clinicians that are going to always have to be present if you're going to drive the success of your state's program in RETAIN. I should say as a caveat, by the way, I'm kind of an opinionated person. You'll probably notice that. Sometimes I'm really right on and sometimes I'm not, so I authorize you to decide what ideas I'm presenting makes sense to you and you're going to really take in.

I also hope that you'll be able to describe why it's preferable to position your program as a service that will help those clinicians improve their patient outcomes, rather than as a research project. And you'll be able to explain why you've decided that the term clinician is preferable to provider, and you'll be able to explain why paying physicians to conduct the four best practices was such a brilliant feature of the design. Next slide.

By the way I still have a cold and I'm still making noises, so I apologize if I forget to mute myself every time.

The plan for this session, the caveat I've given you, I'm violating some of the rules in this presentation that I'm going to be suggesting that you adopt in your communications with clinicians because, as I say, this is really, I'm actually secretly have written a user manual with the slides.

So in the next 40 to 45 minutes I'm planning to give you a rapid-fire overview of outcome-oriented communications aimed at treating clinicians and terminology and why and how to make the communications and trainings strategic, collegial, tightly focused and operationally oriented, and five and six, tightly focused and operationally oriented are the key words right now because we're trying to launch a program with the doctors and clinicians as active participants, and because I did have a chance to review a lot of the communications and training materials that had been submitted by the states, the current versions of them, I was able to analyze and come up with a set of kind of dos and don’ts suggestions for those materials going forward. All the slides are going to be available for download and I hope you will use them. Hopefully we'll have about 15 minutes at the end for some time to talk together and clarify any things that weren't clear to you, and then I really would like to invite you to set up a time to meet one-on-one with me to discuss how this looks in your state with the medical community in your state, with the culture in your state, and with the design of your program. Next slide.

So, first, with regard to terminology, the more I have thought about workers and with doctors, the more important I think it is for you to be distinguishing the service part of your program from just RETAIN as a whole. You are offering services to workers and you are offering to collaborate with clinicians in the care of their workers, and that's -- and in the background you're conducting some research on how well that works, so I think you really want to really

think about positioning the service program in front, and RETAIN itself has two parts. It has a service program and it also has a research project, and I think you're going to engage people a lot more with the service program than the research project.

The second thing is treating physicians -- RETAIN is about connecting with treating physicians, and that is a term defined by law or defined in policy regulations or business practices as those clinicians who are authorized to make state work or return-to-work decisions. So, you're not actually talking to all providers. You're only really talking to people who can be seen as in the treating physician role, and so you know, a chiropractor, all of those can be seen as treating physicians under law and policy, and we're going to avoid -- I strongly suggest you avoid the term provider for diplomatic reasons and we'll be talking about this more. Next slide.

So, strategically speaking, from the 50,000-foot view, I see RETAIN as about weaving a social fabric and creating a web of real working relationships among professionals in organizations that are in different sectors of society, all of whom have a role and can help newly injured workers get back on their feet, but they haven't really had that web of real working relationships. RETAIN is investing in weaving that social fabric. It isn't that we're talking about signing contracts or financial agreements between these parties. A real working relationship means the parties are interacting regularly in the course of their work, and so it is the traffic between the parties that makes the working relationship real.

So, from the 50,000-foot level, the overarching strategy is that every interaction with clinicians and the organizations in which they work, mentors, builds, and nurtures your ongoing working relationship with them, and so that would include the recruitment letters and phone calls, training sessions, continuing medical education sessions, questions about specific patients, and then the way you respond to their questions, it's everything, ideally, will be occurring in the context of building a nurturing and ongoing working relationship.

And in order for that to be meaningful, it actually has to be two way so you have to keep it real, keep it alive, stay in touch, and give them updates and provide information to them on an ongoing basis after feedback from them on an ongoing basis to grow the relationship.

At the 5,000-foot level altitude, and these are obviously figurative, and at the 5,000-foot level, every communication and training session for clinicians needs to be focused on driving two things that are going to determine the success of your service program. One is driving referrals and the other is increasing the frequency with which those four best practices occur. Because if

you don't have the patience patients or the workers, you will have things to work on and if you don't increase the frequency with which the clinicians do the best practice, you will not get all the power of the proven work disability prevention model.

So at the early juncture then, I think in your communications, you really want to be focusing on the fundamental reasons why you have to have good working relationships with clinicians, and you want them to be willing or want to work with you. You want them to be willing to entrust their patients to you. You want them to develop the habit of recognizing and referring appropriate patients to your service program as a behavior, recognize and refer, so they'll start doing the best practices and keep doing them more and more so they give you straight feedback in their relationship with you so you'll have a good relationship and that will improve your program. Next slide.

At the 50-foot level, my recommendation, I think you will do the best as clinicians if you position your program in there as a resource for them that they can call on you, that you are actually -- this is part of the brilliance of the model, the return-to-work coordinators are positioned as basically an assistance to the clinician, and so you, in order for them to be willing to call on you, you need to look in their eyes, you need to be -- you need to establish yourself in their eyes as a benevolent, trust-worthy, and capable source of expertise and practical solution that are going to help their patients achieve better and more complete recovery and make the clinician's job easier and preferably create new revenue for them. And also at the 50-foot level, you want to be regularly refreshing their awareness of your program because you want to keep it in front of mind, remember, one of the things they have to do is to start to remember to look for patients to refer and to recognize patients that are being cared for in your program so they know to do the four best practices. How are you going to keep it in front of their minds, you have to take the steps to do that.

And then, incredibly importantly, you need to create and nourish your program's reputation in the grapevine by staying alert to what people are saying, and so that may mean you need to use that information to make changes or take steps to manage the grapevine rapidly when something happens.

Remember the saying that a satisfied customer talks to two people and a dissatisfied customer talks to ten, it's in the era of social media and we need to be good at that. Next slide.

And at the 5-foot level, strategically speaking, you need to talk right, too, to clinician, and I think first in terms of, remember that this is -- RETAIN is for building relationships among people in different sectors of society that aren't really familiar with working with one another. I spent the better part of the last

30 years of my life, I call myself a self-appointed envoy between sectors of society and there are a lot of hard feelings and charged relationships sometimes with certain members of these groups. Employers can have hard feelings about doctors, doctors can have hard feelings about employers, insurance can have hard feelings about each other, and everybody can have feelings go government, so it's like we're going into a foreign country and we want to have the right manners as we go into that country. So, doctors are proud, and you know -- proud of the expertise and social position and we are also as a profession under fire with about 50% of doctors now in physicians with serious burnout because of the changes going on in healthcare. So, if you want to build a good relationship with clinicians, I think you want to communicate your respect for those things and respect for the traditions of medicine which are hundreds of years old.

Historically, clinicians have been -- physicians, particularly, have been extremely independent and nobody has been the boss, and it's only been in the last few years that other parties are trying to muscle and push around doctors, and so there is a lot of concern and hair triggers about whether somebody is trying to push them around.

So, I think in general, it's a strategy of having MDs talk to MDs as much as possible and service the ambassador is really a wide strategy. They don't have to do it the whole time, but at least to start the relationship, that's a really good idea, and also to get them involved in at least developing the training for the doctors and, again, as relationships just start to maybe have the doctor in the front.

When I used to be the medical director for a large employer in a town, I would make a point and visit personally all the doctors myself first, the key ones that had a big impact in the company, and then I would introduce the case manager or the return-to-work coordinator, so it was clear that in the ongoing relationship between the doctor and the shipyard, that the return-to-work coordinator or nurse is sort of associated with me and that made it work a lot smoother.

The second thing is you have to demonstrate your sensitivity to the complex pace and pressure of medical work these days, the dollar value of every minute of their day, and as I said, the century's old culture, and so within medicine there is a lot of succinct rapid-fire communication so you need to be succinct and very organized, rapidly is the need of the matter, especially in the initial meetings or training sessions. We're trained to summarize all the key facts of the case in one minute, for example.

Also, since the average IQ of doctors is 125, and I did go on the web and check this out, you can go fast. There is no need for a lot of introduction and repetition and a lot of times if you

give a doctor a couple of powerful ideas, they will be able to figure out the implications of that.

You also need to be, and this is now because this is RETAIN, because we're trying to launch and implement and get a program into operation, we need to be really specific and concrete about what is needed and the specific activities you want them to perform and how things work, and because of this overload, rapid pace, complexity, figure out how to make it look easy and quick. And this is the problem I sometimes have had myself. I admire the importance of what we're doing so much, I want it to look important, but paradox ironically in order to get people to do it we may need to make it mostly look easy and quick. And as I said, offer ourselves as assistance to them, what the clinicians think of you as assisting them in the matter of their patient's social recovery and SAW/RTW instead of the other way around. Fundamentally they're going to make the call on whether or not the person is released to work and what restrictions they have, and so they feel responsible for their decisions, and if you are assisting them, that is a really good idea. You, taking it over from them is not a good idea. That would feel like they're intruding.

Next slide.

So, if your strategy works, whatever your strategies are, the evidence that they're working is you will get an ever-growing stream of increasingly appropriate referrals and you will see an increase in the frequency with which those four best practices occur, and you will see a positive reputation of your program on the grapevine. And if you don't see those things happening, that means that either you haven't really applied this strategy as suggested, or that my strategy was wrong, and you must modify it and figure out something that works. But the whole point of this demonstration project is to make it work.

Next slide. I keep pushing the down button trying to make the slides change.

So, but it's also, if we're going to have a real working relationship with doctors, it has to be collegial and doctors are used to working with a lot of other people in their work, and so I think what is important, particularly, it's more your service program is to do your best to position it as inside the therapeutic envelope, assisting with the care and recovery process, and not positioning it as a government employment program because doctors have a commitment to care and recovery, and they do not have a commitment to government or employment programs.

So, if you can really emphasize the fact that you have a shared goal, that both of you have the same goals to helping working-age patients whose live is disrupted by injury or illness to feel better, to achieve the best possible recovery, which means you're then in full participation this life, which usually includes work. This

sentence, it's a sentence that is going to work much better with doctors because we're including -- we're usually including work as kind of an afterthought because our main priority is helping people whose lives have been disrupted to get their lives back on track. That is what is the doctor's commitment and much more than it is to get them back to work.

And then to express interest in the clinician as potential collegial- collaborators and that means being interested in their perspectives and reasonable needs. Remember, you're trying to build a relationship, so one sign of that is you're interested in them. So when you visit somebody or you're training somebody, you might explain why you think clinicians, in general, and this particular one or group is an important ally for your program and we're sending the signal that they're important and we noticed them. And then also ask who is in the room with you and the role each play in the clinic, because it's going to be important for you to know whether the person you're talking to is just basically an administrative person, a non-clinical person, whether the person is the medical director and kind of has some boss-around authority over the frontline clinicians, or whether you're talking to the frontline clinicians, each of which more or less gets to do what they want to do when they're alone in the room with their patient.

I think it's a smart idea to acknowledge that patients are forced to rely on and really do rely on and really do count on clinician guidance about activity and work and that you see how important the doctor's role is and maybe to ask them about what their philosophy is about people resuming normal activities as soon as possible and working through recovery, because if you get them to articulate it, there is literature that once people have said what they're committed to, they're more likely to do that, so we might want to have them get it out and in front of their own mind, and it also can be a warning sign to us because people who think that doctors who think that people shouldn't work during recovery, that is a pretty good predictor of what kind of stay-at-work and return-to-work decisions they're going to make. Next slide.

So, in terms of assisting them, I think it would be a good idea to explicitly state your commitment to assisting them, and that what you're assisting them with is getting good outcomes to their patients, and also your commitment to respecting the value of their time and your commitment to growing your relationship with them over time. I think that some of the materials I was reviewing had this kind of once and done kind of feeling, we're going to come recruit you, train you, and then bye-bye, and I think the idea of building a relationship with people they enjoy working with, who are going to help them, who are going to respect their time and generate new revenue for them, that is going to be a very different proposition.

You also do need to describe your savvy and expertise, what

you're bringing to the table, right. This is a two-way relationship. So, one thing to note is that all doctors, by the way, see variability among patients in how they respond to the challenge of an injury or illness or impairment. Doctors see it very clearly, and you can say that you see that too, right. And what you're out to do is to reduce some of that variability and have more people have an outcome where they are able to participate fully in life going forward on, and to highlight your -- and try to make them agree that they also have a shared commitment to avoiding harm and point out that disruption and job loss are very poor outcomes being and in all the years I've been working with doctors, I hadn't noticed until about three years ago that almost every doctor, every human being is going to agree that job loss is actually a very poor outcome of a health problem, and I think this is going to be, since doctor's number one oath is -- I forgot the word, but it means first to do no harm, that doctors don't want to do harm by having their patients lose their jobs unnecessarily.

And it's also to describe your capability, is that you have helped hundreds or thousands of people and you're very familiar with what it takes to get people's lives back on track. You have to look like you know what they're doing in order for them to trust a patient to you. Next slide.

Then in terms of purposeful communication, again, the medical culture is very in a rush. They're working on an assembly line of care, and so you're only really going to have seconds in which to get their attention and deliver the core message. You have to assume they're rushed, impatient and only mildly interested and so in all communications, this is one of the things I use a lot, use a subject line with a first line like a newspaper man, don't put the meat at the end, put the actual item, the sound bite at the very top and presume they're not going to read the entire thing unless somehow you hook them with the top. Clarify when you're sending a communication, you're talking to them, are you fronting to the frontline treating clinician, the medical director, or are you talking to the business officers in the back end and make it clear the intended purpose and outcome of whatever it is that you're doing, and then you can give more information and details later.

So, in terms of communication as that overall strategy of relationships, you always want to do a little something to remind them of your therapeutic and benevolent attempt and variability to assist, you know, that this is never just a business relationship and this is never just about a government employment program. Next slide.

We want to keep the training tightly focused, and by the way, this is the unique requirement because we're talking about launching a new service program in the community, and we're not talking theoretically about occupational health, but we're talking about

working together in a relationship. We want to prepare the clinicians to succeed with what you want them to do, so you do need to give them kind of an overview of the general design of their program, who is going to do what, when, why, and how the parties and it has to be short though because they're not that interested, but they need to see where they fit in, then you need to briefly review the specific things you want the clinicians to do and why. You need to briefly review what they can expect from you and when. We're going to talk more about that later.

Succinctly provide the practical operational details, and we'll talk more about that later. Then, again, talk about the future course of this ongoing relationship. You want them to get really comfortable making referrals and depending on coordinators for help with multi-party communications with state work and return-to-work and individual case, and your network staff, if you may not have thought about this yet, but if you forecast, you're going to need people to nurture these relationships with you and they may not be return-to-work coordinators. In Washington State for example they have specific provider network staff that nurture the relationships as opposed to work on one-on-one cases.

And that network staff needs to be able to respond to the clinician's request for assistance with responsiveness or other relationship hiccups in the aggregate and not just one case at a time. The network staff is also going to provide them with periodic feedback with how much volume you guys have had in terms of how many workers you've been working on together, what kind of outcomes, what kind of quality is achieved, how closely they're adhering to what they said they were going to do, and request their feedback and suggestions. That's what the relationship really looks like.

And then as time goes on, I think you do want to forecast for them because they probably will be asked to take additional training and education. In Washington State that initial training by them is now only about 30 minutes, it's a minimum of 30 minutes, and over time they have realized that the operational part of the training is actually the part that is the most critical. Next slide.

>> MODERATOR: Dr. Christian, you're on slide 16 of 35 with 30 minutes left.

>> JENNIFER CHRISTIAN: Okay. Good. So then we want the training to be operationally oriented, and again the reason we want it operationally oriented is because we're launching a operation, and so you want to display a short list of the activities the clinician is supposed to carry out as part of their part of the program and the thing I think you want to do is keep an eye out for patients not recovery rapidly and who meet referral criteria and during clinical encounters, you want them to do the two best practices that occur then, make referrals after talking about it with the patient, and formulate and document the activity

prescription on a form and reinforce that with verbal instructions and reassurance to the patient.

And then on days when the patient is not in the office but when the employer or the coordinator or the insurer has a question, promptly respond to those questions about a patient you're working with together, about their ability to function and work. This is a particularly critical one because in the normal course of a medical office, if questions come in, I call it off cycle, they just stick it in the folder and they'll have the doctor answer the question next time the patient comes into the clinic if they notice the question then, right. So, by being willing, so call is the best practice, call it out, say we're going to pay you for the time to refamiliarize yourself with the case and answer the questions. That's an important best practice. And this is in the context of where to assess obstacles. You might have a different set of best practice, but in my mind, these are probably the best and closest. Next slide.

And then if it's operationally oriented, we need to go a level deeper and define the required elements for each of the best practices. You know, for you to do what we asked you to do, this is what it very specifically looks like, these are the people who can do each of the things that are the best practices, this is who can help you with them, this is when you can do them, and this is how frequently you can do them. So, for example, in Washington State they can do an activity prescription at every part where the patient's functional status has changed, and you need to describe the medical record documentation requirements each time a best practice is conducted, describe any additional data entry required by the grant, fee schedule billing instructions, assuming and I hope you will be paying for these, and that means they put a CPT code on assisted language as medical billing where you describe what the service was precisely, what supporting material needs to be attached, where to send the bill and to whom, and then describe on your end, the payment process, expected turnaround time, who to contact in case of questions, and explain the kind of issues they can ask the coordinator to handle.

Next slide.

And then if you really want people to remember what they learned in the training; you probably have to offer them in the way of handouts. When I was building a network, the provider that worked with me would refer to them as cheat sheets, cheat sheets that they can use as at the clinic. These are things that are going to make it easier for them to carry out some of the tasks. For example, if you want them to refer patient, you want to give a supply of printed referral forms and electronic template for them to use, you want to give brochures to hand to the workers to explain your service and the brochure needs to talk about how to contact you so

that the clinician doesn't need to be a expert in the program but they need to say, here is a brochure.

And then you want to give them things that are going to make it easier for them to remember to do these things, to keep these things front of mind, so this is where it really looks like a cheat sheet, a one-page sheet for the clinicians with a list of referral criteria, four best practices, billing codes, a one-page sheet for the billing office that lists the four best practices, the definition of them, the codes, the fee, the billing instructions, name, contact, billing questions, list of contact information for your program staff, and then this is the one I don't know the answer to at all. I haven't thought about this and it only occurred to me as I was doing this training, how are they going to figure out in the clinician office, which patients are participating in your service program? How are they going to do that? They don't know to do the best practice and they don't know to bill for it unless they recognize the patient as one who is participating on an ongoing basis.

And then thirdly, since all clinicians work in a business, the business office is going to want to know what kind of impact you are actually going to have on our practice. Are you going to hurt our practice or help our practice? So, what kind of volume are you expecting, how much clinician or staff time is this really going to add to each encounter? Is this going to save enough time for us that we can count on it, and what kind of revenue offset is this going to have? Because every minute in a medical office is the revenue-generating minute and every minute that doesn't generated revenue is potentially hurting the business.

Next slide. So, I was asked as I said, to look over a lot of the training materials that the states had put together. Some states also had some communication and website materials and I looked at all that I can find in October, and so here are some dos and don'ts that I picked up from what has already been submitted, and a lot of it will make sense to you based on what we've just been talking about. Next slide.

So, the things that I noticed, particularly were the appearance. A second go on the idea of terminology. Length and extent, scope and emphasis, whether or not inspired confidence, how talked about the four-best practice, and how it talked about money. Next slide.

I'm going to go fast through these because you're going to get all of these to look at. I go fast all the time, right, I know. So, thank you for listening fast.

So, appearance, this slide starts with a 44 font, the size of the font is important. Some of the slides I looked at had fonts really small and even if you were looking at a piece of paper, it was very small so these examples on the right-hand side, the second

bullet where it says don't use tiny font. This is 24, and 24 is usually the minimum size you will use for a projected presentation. When you're giving somebody something for self-paced instruction, you can use 22, and I actually on a couple of these slides, had some stuff at 20 because I was really trying to jam a lot of stuff on one slide. You can see the impacts of small font when you're trying to read along with me.

And the other thing that you don't want to do is allow the layout or the format of the text to go needlessly through the set. People like to predict where the slides lay out so they can predict where the message is going to appear, and it's visually fatiguing to keep finding the place where the main message is. The do here is to keep things graphically simple and clean so the flow of information is easy to follow, use a similar template, use fonts simple and large, and also I think it's a great idea to use photos that are relevant and create a positive emotional feel. Just like I was saying with the worker brochure, something that shows helping or Collaboration, for example, might be perfect for this. Next slide.

Terminology, one reason, other than just courtesy and gesture of respect, one reason you don't want to use the term healthcare provider or provider, is because these terms were invented by purchasers and payers and they do not imply a therapeutic relationship or alliance. They're discussions about payment, so you don't want to be seen as a payer. You do want to be seen as inside the tent as a collaborator for care. And in the sensitivity moment on the right, saying provider to physicians sends a subtle signal of disrespect, it's a failure to acknowledge their education and training because providers include people like nurses, lab techs, vendors, x-ray machines, wheelchairs, et cetera. To treating clinicians are in a different status, and so on the left here, the term physician, treating clinician, practitioner, clinical practice or medical office will not offend anybody and it will cover physician, physician assistant, nurse practitioner, psychologist, social workers and other licensed professionals recognized in the law for treating patients.

So in terms of diplomacy because we're building relationships with cross sectors of society, it is really probably important to remember that these people that we're talking with, the treating clinician, they are free to decide whether they like you or not, whether they want to team up with you, whether they want to send you referrals to do the best practices.

Physicians, in particular, have more volume of patients than all the other treating clinician types, the medical care in America is dominated by MDs and DOs. The science is the MDs and DOs have a lot of influence over what the patients think and do and how outcomes go, not just because they prescribe things but because they

talk to them. And doctors have very low tolerance for blah, blah, blah, and which is how they refer to bureaucratic talk.

So their willingness to make the effort to interact with you on a day to day basis in actual cases is going to be a major determination of your program's success, and so your staff's skill at diplomatic relations in the medical community is going to be one of the critical success factors in your program. Next slide.

One of the things I noticed in it the trainings is that often the purpose is not crystal clear and sometimes it is crystal clear but rather conceptual and theoretical but best practices in occupational health and if we look strategically, the purpose of the training, particularly at this stage in RETAIN and youth service program is to prepare them to work with you in your new service program and to prepare you guys to have a good working relationship.

As I say, they're able to do this in about 30 to 60 minutes, max, and if we -- part of what we're trying to do is to make it look easy, simple, like you're helping them in this, and actually, ideally, it will actually provide them a little more revenue. You want to partly embody that by keeping your training short and just doing a bare minimum to start. You can build it out over time, make it more sophisticated, deepen their skills, but in a way, you're forecasting the nature of your relationship with the way that you do these initial steps, including the training.

Next slide.

I think I've already just said this. Go get right down to the part that's going to be relevant to the clinician. A couple of the states have got slides with a lot of stuff at the beginning about grants and organizational administrative structure and other participants and relationships to benefit systems, and that's interesting to us people trying to do the administrative super structure of this program but it drives clinicians wild because it's not relevant in their world. They're working one-on-one with patients and what is going to make the difference in RETAIN is changing what happens in their interactions one-on-one with their patients and their willingness to get you involved.

Next slide.

So, again, this is a whole lot of words. This is one of the slides where I played with the font size and can you see how hard it is to read, but it's there for you to read later. You do want to ensure that by the end of the initial training, a clinician sees the difference between the purpose and intended outcomes of their Collaboration with you and your staff and service program versus the RETAIN research project, and that the service program, which is the part that actually cares for people and helps them have a better outcome is the part that is the most visible. You also want to make it clear how referring patients to your service program and doing their part in it is going to benefit both the doctor and the

patient, particularly if you're not paying, they have very little motivation to actually benefit if the patient if it's going to harm them.

Third thing as you want to have them understand the difference between their role in usual patient care and what they're doing when they're participating in your service delivery program, how is it going to be different very specifically, and then if there is a piece about the research project, how is that also different from their usual role in patient care. Make that crystal clear. What that means is, practically speaking, is they're clear about precise activities that count as best practices and precise documentation and work products they're supposed to produce and how they bill for them, and also know what they're going to get in return from your staff, is it really going to be less hassle, is it going to be practical help, are you going to take a load off them, are you going to make things feel more comfortable for them, are you going to get answers for them to their questions, et cetera?

Next slide.

>> MODERATOR: Dr. Christian, you're moving on to Slide 27 at the 45-minute mark.

>> JENNIFER CHRISTIAN: Thank you. So, if you're asking clinicians to entrust their patients to you, (Laughing), you have to look like you know what you're doing, and there were some materials that in my mind, seemed to create uncertainty about whether the program is going to make a difference. One state said that we're looking for ways to improve return-to-work outcomes, another one said it's a federally funded initiative exploring state work strategy, and like why would I make a referral to a program that I'm not sure whether it's going to make a difference?

So I don't think you want to -- uncertainty -- you also don't want to, right up front, before they refer, put a heavy pedal on the possibility that their patients may or may not be in the treatment group, so it's going to be hard to rationalize referring a patient to something that is not going to offer them any help whosoever at all, at all, at all.

So, you want to position your team as experts in working with the health and work interface and you want to create confidence in the design and by making it clear that the four best practices are and have been shown to improve patient outcomes and there have been a lot of studies that show outcomes with workers when they guide and support them this way. There is a rich evidence base underneath RETAIN and under the service program. It just isn't definitive yet at the state-wide level, but we don't need to emphasize that part. What we're just saying is it's got a rich evidence base. Next slide.

In terms of the four best practices, the close are you can get to the COHE's implementations the better because that's the stuff that's been actually shown to work, and it was a brilliant

piece the COHE did because the availability of fees and precise definitions draw attention to and reinforce the performance of some very specific clinician behaviors that are valued by other parties. And so by being willing to pay money and treat these as a reimbursable medical service, it sends a signal that you really mean it. You're not like treating it, you mean it.

The second brilliant part that the COHE did is by putting CPT billing codes, and asking them to bill for the services, this creates markers and datasets and so COHE was able to document how often the best practices were done and they were actually also able to document that the more often they were done, the more the case outcomes improved. And as I say, these four best practices and the billing and the CEs have been shown to improve outcomes in the COHE study.

And you don't want to be a sucker. You want to define precisely. You want to ensure that each bill, that the delivery of each service is verified by existence of a work product or medical record documentation, and you want to in terms of things to avoid, you want to not embed those four best practices in a much larger discussion. You want to have them obvious and really be a central part of your initial training for the doctors.

Next slide.

And then in terms of talking about money, I felt uncomfortable with some of the materials that I saw because they used the word incentives, and the it's the word used in the grant, but it often translates to bribe, right. We don't really mean that. What we mean is we want to create motivation. We want to create alignment of incentives between the clinicians and the program and the worker, so I would avoid the word, incentive at all because whenever a doctor has the slightest idea that somebody is trying to get them to do something which is not in the patient's best interest and paying them to do that thing which is the no in the patient's best interest, they're going to freak out. At the bottom of the right-hand column, most of us at the time we got our degree, took a sacred oath to put the patient's welfare above our own. If we ever feel like somebody is trying to get between us and a patient, like you could earn lots of money for pleasing us at the expense of your patient's wellbeing and that is just a run away, run away, and you also don't want to offer to pay for a particular outcome in a individual case like we'll pay you $50 for every release for return to work and that is going to feel like a bounty for scalps and same thing, has a very bad feeling.

And you want to keep the size of the payments relatively small. When I was first designing a physician incentive program, I went to a health plan medical director and asked for her input. What she said is, this is the equivalent -- well, I won't use that analogy. She said that you want to make sure that the payment is small enough that it keeps the focus on doing the best practice and

doesn't move the focus to the money. You don't want to have them be doing this in order to earn a lot of money. You want them to be doing this because now they're getting paid fairly for doing something, they would have liked to have done but they couldn't rationalize doing it because they weren't getting paid for it, right. This is on the left-hand side of this slide, you do need to find the right tone and balance because it really is critical. Clinicians earn a living with their time and expertise, so they deserve to be paid fairly and you can acknowledge that these four best practices typically aren't reimbursed today, they don't specifically benefit the doctors, see, they been fit others, so you have to be aware that clinicians have to generate a certain amount of billings per hour in order to have a sustainable practice and in today's world, productivity or billing per hour is often connected to their salary or their bonuses, either explicitly or in the background.

So if you ignore the issue of payment, that means you're asking physician practices to forfeit revenue by spending time doing the right thing instead of providing a one on one session

billable service, and so you may get the doctors to be willing to do it but the back office is going to work against it, and you would like to have the back office and the clinicians both thinking that this is a great program. Next slide.

So, yes, this was a rapid-fire review of the topics. We went over all these things, the slides are available for download, we aren't going to have 25 minutes of Q&A. I do invite you to set up a time to meet one-on-one with me. I would love to talk about this more in your settings, with your medical facility, how it's configured in your state, and now we do have a few minutes for Q&A and dialogue. Next slide. So, as I said, the real-world evidence of this success in communications with clinicians is are you getting more and more referrals, are they doing the best practices more and more, and does your program have a good reputation on the grapevine? Next slide.

If you didn't get these questions answered, that's another reason to schedule a session with me because I'll be very happy to enrich the way that I answered these questions for you. Next slide.

I think the third bullet here is I hope you find these materials useful in discussions with and trainings in your team, especially those who produce the written materials and those who are going to be interacting directly with the clinicians, and I hope that this is your awareness to have the necessity to have staff that are really nurturing and building and maintaining that relationship over time.

Next slide. Are we doing the Q&A yet? Yay! Okay. Anybody have a question before we must run away?

>> MODERATOR: We do have a couple of questions and we have

about 8 minutes to handle them. We'll handle as many as we can now and then follow up in writing.

So, the first one is, can you comment on how best to communicate workplace information between return-to-work coordinators and clinicians? For example, if return-to-work coordinator has good workplace information for job modifications but needs provider endorsement?

>> JENNIFER CHRISTIAN: Okay. Cool. I'll tell you the totally coolest best one is dear doctor, the worker and their supervisor have had a conversation, and this is what they think is he ready to do, this is the description of the job, is this okay? Check here, yes or no?

That's like the super best in the world. If the worker and the supervisor have already worked it out and all they're doing is having the doctor check that it's medically appropriate, that's the super best.

The next one is for -- the next best is for the employer to send a list of potential tasks they have available that they think the restrictions and limitations as the doctor has laid them out, are these medically okay with you, doctor, yes, no, I need more information. No more than one page in both situations.

I guess the worst solution is not to send any information from the employer. The next to worst is sending a written job description which is many pages long and not functional and not functionally oriented and described in functional terms.

The next best is for somebody to spend a few minutes looking at a functional job description and comparing that with the restrictions and limitations and pointing out that parts of the job that do or don't involve it -- you know, if somebody has a injury to their leg, and they do sedentary work there are really probably no tasks in that job that affect the work and it would just be the ability to get into and out of the office and to the bathroom and back, and so just being able to partition the information so that you're only asking the doctor to look at a page, somebody has done the work to boil it down.

The typical bad things that happen is that the employer says, can you release this person to work and the doctor has no idea what kind of work they normally do, and they know nothing about the employer's commitment. I think on the list of better than nothing is also a simple statement about what the employer's philosophy is, we will try and provide work within your restrictions and limitations, we will provide somebody that the worker can go to if they have questions, we will encourage the worker to see you again if there are any problems so that the employer is sending, basically, a statement of we're going to honor your restrictions and try and take care of this person and we'll be a safe place for you to send your worker back to. I hope that's helpful. I realize that's very

fast. Maybe we can talk more about it later.

>> MODERATOR: Great. Thanks for that answer. So, we have another one that is, how do you recommend setting up the operational system to support paying clinicians, i.e.., payment, receipts, billing, tracking denials, et cetera.

>> JENNIFER CHRISTIAN: That is a big question that I'm not prepared to answer in one second. I think I mentioned it because I wanted to alert you that you need to do that. There is a transactional piece to this project that I'm not sure people have really realized. There are accounts, billable accounts, payable, bill pay operations that need to be part of it. Among your partners, you may have somebody that has that capability and it's going to be a very state-specific solution.

I know, let's talk about that during your one-on-one session!

>> MODERATOR: Okay. Well, so I think it's 2:27 eastern time right now so let's take one more question and then we'll wrap it up. The last question we'll take is, if we aren't offering pay for referral model like COHE, what are other ways that clinicians generate revenue that might be thoughts to consider in the RETAIN model?

>> JENNIFER CHRISTIAN: I would not pay them for taking training. One of the states was paying a very large incentive for the doctors to take the training and I felt very uncomfortable about that because it really did start to feel on the inappropriate incentive side.

I think you need to find something that is the rule. One thing -- I think we should talk about that in your one-on-one session because I need to know more about what your exact design is. Sometimes what's happening is that clinicians will often export other clinicians to do things and they're all boy scouts and girl scouts and they all agree to do it and then the back office really gets in trouble, does not agree, and they don't modify the length of the patient appointments, they don't have the material available for them to do it, and so it's like we've asked you to do something but then you actually never really do it.

So, thinking, I'll be very happy to think that through with you. I am by nature an obstacle getter rounder and if for some reason you're unable to pay for the best practices, we will figure out something that will be in lieu of that. It just must be, again, the tone and the balance must be right. And you don't want to pay somebody for agreeing to sign a contract with you. You want to pay somebody for doing what they said.

>> MODERATOR: Okay, so I think that is the last question that we have right now and we are just about at time, so I am going to let everyone know about the evaluation survey that we would like you to take. The link is up there on the slide and I have also just put it in the Chat Box. You will also be receiving an email follow

up asking for you to complete our brief evaluation survey.

You can -- you'll be able to download the slides from the RETAIN online community at RETAIN.ta.org and that includes today's slides and last week's webinar slides as well.

As a reminder, if you wanted to set up a one-on-one with Dr. Christian, she has indicated to contact your FPO. Doctor, do you have anything to wrap up.

>> JENNIFER CHRISTIAN: This is Jennifer Christian I'm feeling bad about not having an answer for other incentive, so let me say if you manage to position your program as an honor for them to be part of, doctors are pretty much suckers for things that they think they got into it because they're good or cool or the best or something like that, so that is one strategy. And, for every program, if you can somehow have this be an honor and a recognition of their superior, blah, blah, blah in some way, that would be good. That's one idea.

>> MODERATOR: Okay. Great.

>> And I think -- this is Chris with ODEP and thank you Dr. Christian for a great webinar today. I think that was a good note to end on. And I know there will be opportunities for follow-ups that the states will have for you for one on within discussions. And as Mona mentioned earlier, please reach out to your state FPO to set that call up if you would like, and we'll be sending a reminder email out with some potential dates and times where Dr. Christian is available.

And I know that there was a lot of information today and I'm sure there is a lot more questions, and it would be great to follow up with that and there will be some additional TA on the topic, so we're all looking forward to continuing to work together on this RETAIN project, so thank you everybody.

>> MODERATOR: Thank you, everyone. Have a good afternoon.

>> JENNIFER CHRISTIAN: Bye-bye.

(session completed at 1:31 p.m. CST)