Sample RETAIN Letter to Providers

Purpose of This Template

This template will help you when communicating with providers about RETAIN participants. It includes tips, guidance, and recommendations on messaging. The template may be used to guide and customize the structure of your letter to accommodate variations in provider audiences (e.g., medical directors, physicians, health care administrative staff), participant scenarios, and communication goals—for example, what you want the provider to do after reading your letter.

Heading:

- Consider using RETAIN letterhead or state-specific RETAIN branding in all correspondence and tailoring your letter to state-specific needs and resources.
- Use a formal heading and include: To (*recipient*), Cc (*if applicable*), Date, and Subject (*Participant Name/Date of Birth [DOB]*).
- Edit or add other information as needed (*e.g., Name of Practice, Mailing Address*).

Greeting:

- Use formal titles regardless of your personal relationship with the recipient(s).

Sample:	
To:	Dr. Susan Jones
Cc:	Ms. Ann Clarke
Subject:	Ms. Jane Doe; DOB 12/01/1980
Date:	7/7/2021
Dear Dr. Jones:	

Paragraph one:

- Indicate that you are authorized to communicate with the provider on behalf of the participant.
- Identify the participant's diagnosis.
- Note the date and reference any previous correspondence.
- State that the patient is now in your RETAIN program and include the goal of RETAIN.
- Summarize the patient's generic goals.

Sample:

Jane Doe has authorized me to write to you on her behalf to ask for your collaboration and support. You have been treating her for degenerative joint disease (DJD), which is now significantly disrupting her work. As you recall during our conversation on 6/30/21, she is enrolled in our RETAIN program to reduce the negative impact of her DJD on her ability to function and participate fully in life—and, especially, to keep working. She wants to find a way to stay employed so she can continue being productive and maintain her economic independence.

Paragraph two:

- Specify the purpose of your letter.
- Reference the goal of communication or coordination with the health care provider.
- Identify immediate next steps.

Sample:

The purpose of this letter is to ask you to do three quick things. Please:

1. Help us understand Jane's current and anticipated functional status by checking the boxes that apply on the enclosed "Participant Status Form" and signing it.
2. Review and comment on or approve the enclosed "Return-to-Work Plan" for Jane that she developed with our assistance. Her employer has already seen and approved the plan.
3. Return the "Participant Status Form" and the "Return-to-Work Plan" within 7 business days.

Paragraph three:

- Invite the provider to give you input and feedback.
- State RETAIN's commitment to collaboration.

Sample:

We welcome your input as we work together to help Ms. Doe improve her health and return to work. We want to keep our goals aligned with your view of her situation as well as her hopes for returning to work. Please feel free to reach out with any questions you may have regarding Jane's plan or the RETAIN program.

Closing section:

- Close with a standard signature block including your name, your title and/or RETAIN role, your direct phone number, your email address, and the URL for your RETAIN website.
- Include the standard RETAIN boilerplate language/description of the program.
  - Edit the boilerplate as needed for state-specific programming.
  - Keep this section as brief as possible.

Sample:

John Smith
RETAIN Coordinator
202-555-1212
jsmith@retain.dc.gov
www.retain.dc.gov

About RETAIN:
The Retaining Employment and Talent after Injury/Illness Network (RETAIN) is a program focused on using Stay-at-Work/Return-to-Work (SAW/RTW) strategies to reduce long-term work disability. The program is funded by the U.S. Department of Labor's Office of Disability Employment Policy (ODEP) in partnership with the Employment and Training Administration and Social Security Administration. RETAIN is supporting teams in five states as they demonstrate the value of active assistance in helping workers stay at or return to the workforce following a recent illness or injury. To learn more about RETAIN, visit the website: https://www.dol.gov/agencies/odep/initiatives/saw-rtw/retain

[TEMPLATE BEGINS IN NEXT SECTION]

To use the following letter template and Participant Status Form, copy and paste these pages into a new document, populate the bracketed sections as required, and edit any other sections as needed.

To: [*Dr. Full Name*]

Cc: [*Mr./Ms. Full Name*]

Subject [*Mr./Ms. Patient's Full Name; DOB: MM/DD/YYYY]*

Date: [*Date*]

[*Greeting*],

[*Insert patient's full name*] has authorized me to write to you on [*her/his*] behalf to ask for your collaboration and support. You have been treating [*her/him*] for [*insert diagnosis or most relevant diagnoses*], which is now significantly disrupting [*her/his*] work. As you recall during our conversation on [*date*], [*s/he*] is enrolled in our RETAIN program to reduce the negative impact of [*her/his*] [*insert diagnosis or most relevant diagnoses*] on [*her/his*] ability to function and participate fully in life—and, especially, to keep working. [*S/he*] wants to find a way to stay employed so [*s/he*] can continue being productive and maintain [*her/his*] economic independence.

The purpose of this letter is to ask you to do three quick things. Please:

1. Help us understand [*patient's name*] current and anticipated functional status by checking the boxes that apply on the enclosed "Participant Status Form" and signing it.
2. Review and comment on or approve the enclosed "Return-to-Work Plan" for [*patient's name*] that [*s/he*] developed with our assistance. [*Her/his*] employer has already seen and approved the plan.
3. Return the "Participant Status Form" and the "Return-to-Work Plan" within 7 business days.

We look forward to collaborating with you to align our goals with your treatment plan. We welcome your input as we work together to help [*patient's name*] improve [*her/his*] health and [*stay at work/return to work*]. Please feel free to reach out with any questions you may have regarding the RETAIN program.

[*Sender's name*]

[*Sender's role*]
[*Sender's phone number*]
[*Sender's email address*]
[*Sender's organizational website*]

About RETAIN:

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Participant Status Form

Patient Name:
Date of Birth:

In your role as a ☐ treating clinician or a ☐ specialist consultant/one-time evaluator in this person's case, indicate below your determinations of this person's current ability to function and work.

A. FUNCTIONAL EXPECTATIONS

Your patient and [*her/his*] *employer are uncertain about whether it is medically safe, possible, or humane to expect your patient to perform some specific activities or job tasks at work. Please provide guidance regarding the safety, capacity, and tolerance of these tasks for your patient at this time, with or without accommodations.*

1. RISKS: Please state your opinion as to whether the following activity(ies)/job task(s) pose unacceptable safety or medical risks to your patient:

   [Insert list of any activities/tasks that are in question—ones known to be potential risks or that the worker or her/his employer has identified as potential risks. Option: List the usual activity/job task **along with** *a version that has proposed protective restrictions.]*

   ☐ Yes, it is medically safe and appropriate for [*patient's name*] to do [that activity/those activities].
   ☐ No, it would be medically risky or harmful for [*patient's name*] to do [that activity/those activities].
   ☐ Unclear. To help me make this determination, please provide historical information, evidence, scientific literature, and/or objective data to help determine whether [*s/he*] will be able to do [that activity/those activities] without harm.

   Duration: Any risks described above are expected to ☐ be long term or ☐ last until _____

   Comments: _____

2. CAPACITY: Your estimate of this person's current capacity (or lack of capacity) to perform these proposed activity(ies)/job task(s):

   [Insert list of any activities/tasks that are now in question—ones that the worker or her/his employer has identified as critical. Option: List the usual activity/job task **along with** *a version that has proposed accommodations.]*

   ☐ Yes, at this point the patient is fully physically capable to do [that activity/those activities].
   ☐ Yes, on a limited basis. With an accommodation, the patient can do some of [that activity/those activities].
   ☐ No, at this point the patient is not physically capable of doing [that activity/those activities].
   ☐ Unclear. [*patient's name*] may need to start slowly, begin doing [it/each one] gradually and cautiously, under controlled conditions to see how much [*s/he*] can do. Other than short-lived discomfort and fatigue due to overexertion, the likelihood of risk to [*her/him*] from attempting this activity/task is low.

Duration: The capacity limitation(s) above are expected to ☐ be long term or ☐ last until ____

Comments: _____

_____

3. TOLERANCE: [Note: Tolerance is a comfort issue, not a medical one.] Provide your prediction of the patient's tolerance/comfort level for performing the/these proposed activity(ies)/job tasks(s):

   [Insert list of any activities/tasks that are now in question—ones that the worker or her/his employer has identified as critical. Option: List the usual activity/job task **along with** *a version that has proposed comfort accommodations.]*

   ☐ Yes, [*patient's name*] says [*s/he*] can tolerate the effort/discomfort of this activity/these activities.
   ☐ Yes, on a limited basis. [*patient's name*] can tolerate some of that activity.
   ☐ No, [*patient's name*] says [*s/he*] cannot tolerate the effort/discomfort of this activity/these activities as shown above.
   ☐ Unclear. [*patient's name*] may need to start this activity slowly and see how it goes.

B. PROPOSED PLAN OF ACTION

Please check the box beside the statements you agree with. If you feel uncomfortable or disagree with any part of this plan, please tell us why. Make revisions, comments, or suggestions in the space below. Our goal is to align our work with yours for the long-term benefit of this patient.

☐ This patient's overall quality of life and total well-being will be better in the long run if [*s/he*] is able to stay healthy and functional enough to keep earning a living.

☐ I will encourage this patient to continue working with the RETAIN team and

- Establish short- and long-term life goals regarding health, function, and employment;
- Take advantage of the RETAIN program's support structure and pursue [*her/his*] step-by-step plan so that [*s/he*] can fulfill those goals; and
- Resume work as soon as medically safe and appropriate work can be arranged that is also within this person's current capabilities and tolerance.

☐ Please keep me updated on [*her/his*] progress with this plan.

☐ If any medically related uncertainties or obstacles arise, let me know and I will try to help.

[OPTIONAL] In addition, I will support this person and collaborate with RETAIN to help this patient resume work by: _____

ADDITIONAL COMMENTS:

_____

_____

_____

_____
Practitioner Signature

_____ _____
Printed Name and Title Date