RETAIN Webinar

Puzzling Together the Pieces of a Return-to-Work Team

Facilitators: Leslie Dawson, MA, Jennifer Christian, MD, MPH, and Latha Brubaker, MD

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>> MONA KILANY: Hi everyone, welcome to today's webinar, Puzzling Together the Pieces of a RETAIN Return-to-Work Team. As we connect, if you are having any problems with Adobe Connect, please put a message in the chat box or email the RETAIN TA email box at RETAINTA@air.org. Please mute your line when you are not speaking by pressing the far-left green button that you see in the picture on the screen. We recommend that you connect via audio by having the Adobe Connect system call you. If you did not do that before, you can do that by clicking on the phone button at the top of the screen and having the system call you. If you have any questions, you can put it in the chat box or use the raise the hand button. At the end of today's webinar, we will provide a link to an evaluation. We use your feedback to determine what type of TA resources are helpful and which to SMEs to engage

>> -- in supporting a worker. We'll then wrap up with key takeaways you should consider for your RETAIN program with takeaways presented by each panelist. As always, please feel free to ask questions of the panelists throughout by raising your hand or typing in the chat box.

>> MONA KILANY: Please also mute your line if you're not speaking.

Today's panelists, I'm excited to introduce are Leslie Dawson, the state administrator for vocational rehabilitation division in the Alabama Department of Rehabilitative Services. Dr. Jennifer Christian, Senior Consultant for ODEP and Dr. Latha Brubaker, the Vice-President of Medical Operations for Concentra Northeast Region.

Each player in the return-to-work/stay at work process has a vital role in assisting the injured or ill worker in retaining their job. However, the players' role is very specific to their specialization. We know from prior work on COHE and other model programs that are using an approach like this where we are coordinating across each of the parts can, in the short term, decrease medical costs and decrease the likelihood of being out of work and on disability one year after injury.

For example, we saw in the evaluation of COHE where there was a 21 % reduction in likelihood of being out of work and on disability one year after injury. We also know in the long term, this can result in fewer disability days while for businesses, it can reduce their claim and medical costs, return valued experienced employees to work, retain more workers on the job, and improve productivity years and disability avoided per 10,000 workers. In the case scenarios that follow, we'll look at what resources are needed at each stage of the case. Our panelists will highlight various aspects of the stay at work/return-to-work process. In order for RETAIN programs to gauge their components and to see if additional elements are needed for their program.

So now I'm going to turn it over to Leslie Dawson to briefly talk about who's looking out for Joe.

>> LESLIE DAWSON: Thank you, Mona. I wanted to bring us back to a diagram we had in an earlier webinar. It was talking about Joe the Worker. Joe is the worker injured either on or off the job. He has a lot to deal with. He may have to deal with human resources, dealing with a supervisor or manager, managing employee benefits or if they're short-term or long-term disability third-party providers. So, he has a lot that he has to keep up with. It comes to the point where the question is asked: Who is looking out for Joe? Who is trying to help Joe coordinate all of these additional things that he has to focus on in addition to having to focus on the injury that he now has? As part of the RETAIN program and the RETAIN team, what we want to be able to assist Joe in managing all of those aspects of human resources, employee benefits, manager, supervisor needs, third-party providers, but we also want to be able to add in additional supports for Joe.

It's the return-to-work coordinators' responsibility as well as the entire RETAIN programs responsibility to make sure all of these things are coordinated. So we're going to look at what are those auxiliary supports that the RETAIN program with bring. What are the other government resources that might be available in terms of maybe transferable skills or retraining That's kind of what we'll be focusing on with the scenarios as well

>> We sent out a copy in advance. If you're unable to see a screen, you can at least follow along with the Word document that we sent ahead of for the webinar. As always, the slides and the cases and the recording will be posted on the RETAIN online community after today's webinar.

So, the first case is Julie. She's a 47-year-old female who was referred for return-to-work services by her employer. She's worked for her employer for four years. She works as a program coordinator as an ultrasound tech. She had a C5 and 6 and C6 and 7 neck fusion with plates two months earlier. This injury may have been work related, but she does not have proof that it was for certain work related.

Some of the problems she has in performing her job duties include research tasks that are related to the protocols. So, things like checking blood pressure, performing ultrasounds, using the mouse and the phone. She has used all of her sick leave, and if she is off work, she has to go on leave without pay.

So, our first question for this case scenario mentions that the injury could possibly be work related. So, there's no proof. Assuming Julie mentions this possibility, what should a return-to-work coordinator do to address Julie's concern?

Leslie, would you like to start?

>> LESLIE DAWSON: Sure. I would be glad to address this. This does happen often when we're dealing with return-to-work cases. Chances are that Julie, in this scenario, has probably already inquired about worker's comp and has probably been given an answer by her employer. It's very important that, as a return-to-work coordinator that we basically stick with what our intent is. If the intent is to return to work, we want to redirect and focus Julie on how do we keep you in the current job. Of course, Julie is going to have stressors. She's very limited in her leave with pay. She's probably looking for some additional resources to assist her economically and so forth. We can acknowledge she has these concerns, but we need to refocus her on retaining the job.

Also, case in point, most employers are going to have the policy that if you didn't make the worker's comp claim immediately after the injury, then the statute of limitations has passed on that. I would recommend steering clear if she continues in this direction and continues making these comments. I would definitely just refer her back over to the human resources or the benefits office for additional guidance on that.

>> MONA KILANY: Great. Thank you. Dr. Christian or Brubaker, is there anything else you would add?

>> DR. CHRISTIAN: I have two comments. One is some employers don't actually really know what the rules are of worker's compensation. The place someone like Julie should go is to her State Worker's Compensation Agency and ask them those questions.

Secondly, I want to affirm what Leslie is saying. Although Julie may decide she wants to pursue a claim for worker's compensation, what we need to do is focus on getting her -- keeping her job, keeping her livelihood, and focusing on her recovery. There is some evidence that people who have what they call perceived injustice who think they've gotten a raw deal have more trouble recovering, have more trouble achieving a good recovery; and people who think their work caused something, they also have more difficulty. The focus we're trying to do, if we're trying to have Julie have the best outcome, it's to realize that many people have neck problems for a lot of reasons, and there's really no evidence that in the absence of a trauma, a relatively young person who's doing routine movement of the head is going to have trouble. Don't try to get in the way of her making the work comp claim, but our job is to focus her on recovery.

Dr. Brubaker, did I cover what you would say?

>> DR. BRUBAKER: It's the key focus of keeping her focused. The goal is to see Julie return to work. There's a couple of other questions coming up. I will elaborate with some of the questions that can be asked, but I totally agree with keeping her focused. It's very easy to start going down the road of who did this, there's some sort of injustice here, and it doesn't mean that things don't need to be addressed, but keeping it positive, keeping her focused, and maybe resourcing, like you said, to the State's worker comp team and getting more information that way.

>> MONA KILANY: Great. Thank you. It looks like we have a comment from one of our participants who says that they would refer her to the worker's comp division at the state Department of Labor to provide her with State worker compensation claims that's in line with what everybody has been saying at this point.

So, let us go on to the next question about Julie's case. That is: How likely is it that Julie has already reached maximum symptomatic recovery after her surgery.

Let's start with Dr. Christian.

>> DR. CHRISTIAN: Seems like whenever we get a referral of a new case, we need to ask ourselves: Is this as stable as it's going to get? Is it likely to improve, these symptomatic and functional problems? If we think there's the possibility of further recovery and it's not complicated, it's a routine recovery from a fractured arm or knee sprain, then we can just let the biology heal it, and we'll maybe arrange temporary adjustments to the job in order to allow the patient to work during recovery.

For people like Julie who have had surgery, and it wasn't a miracle cure, and she's still symptomatic, we have to say, well, first, is it reasonable to believe she would be symptom-free and should be better by now. There's ODG [Official Disability Guidelines] that have predicted durations of work disability that are based on large populations of data and that have been clinically adjusted by experts.

I looked up neck fusion surgery. They only had it listed for one level, not two. I don't think it would make a giant difference. She is -- I think her job would probably be called light rather than medium, but we don't really have a job classification yet. It looks like she's just about

at the maximum of what would normally be expected for somebody who has had a neck fusion. So, I think she's on the cusp. It doesn't seem like she's achieved a particularly good recovery. So, then I think the second question is: Has her rehabilitation services been adequate so far, and is there a possibility that psychosocial factors are making things harder for her?

I mean, does she think that pain is a sign of a problem? Is she worrying that there's something dangerously wrong with her because there's something going on in her neck? Or does she not have the skills that are needed in order to cope successfully and live with chronic pain? So, she's unable to tolerate the discomfort of her job? So I think there's the question of the occupational physician on the team could help the return-to-work coordinator size that up in this case to figure out if there's going to be any attempts to improve the quality or the extent or the adequacy of the rehabilitation efforts so far.

If she's stable, then what she has to do is learn to live with what's going on. The same question, to some degree, applies, which is: Are there resources available for people with chronic pain that would enable her to tolerate her discomfort more and be less functionally disabled by it?

>> MONA KILANY: Great, thank you, Dr. Christian. Leslie or Dr. Brubaker, would you like to add anything?

>> DR. BRUBAKER: I was just going to add to that. The question is maximum, symptomatic functional recovery. The pain may be such a focus or outweigh the focus on functional recovery. A good approach, even on the clinical side -- well, I wouldn't say some. Many savvy practices are looking at focusing on function. Let's get, again, refocused. We talked about that earlier. It's really keeping this patient or Julie focused on return-to-work. So that function, what can she do, what are the barriers, and certainly pain can be a significant barrier, but, you know, more of a rounded approach to refocus, maybe combine, like Dr. Christian was saying, and get to rehab to get Julie back to work, and maybe it's in a different capacity.

>> MONA KILANY: So, we've had two comments come in really quick, Dr. Christian. So, a state participant said this is a value as we can help coach Julie to what her new normal can be.

Another RETAIN participant has a question on neurosis and whether or not it's chronic neuropathic pain and the compression, solid fusion, and intact hardware in alignment.

>> DR. CHRISTIAN: In RETAIN, we're dealing with people who have a new and probably often still evolving medical condition. It would be kind of inappropriate and sad if what we're doing is consigning people to a future of living with something that was inappropriately treated, and we could have made a difference. That's part of why all the Retain teams have been encouraged to have medical directors who can serve as a backstop to the return coordinators and size them up.

As the medical director for many cities, we look at people who have been out of work for up to eight weeks. So, it's sort of similar to RETAIN. I find my role is to try to alert the non-medical people to the exact kind of issues we're talking about right now.

>> LESLIE DAWSON: I just wanted to add that this is excellent discussion, especially as Dr. Christian was mentioning -- and Dr. Brubaker, are you at the symptomatic recovery because when you're looking at assisting people with limitations, you have to look at is the accommodation there to help the ongoing long-term limitation or is the accommodation only going to help midway while the person continues to recover?

I think, also, one thing I want to throw in that's very important for the return-to-work coordinator is to keep in mind, or the programs, if you don't have a business relations person on your staff, to remember that you have to think about what the employer is looking at as well. Personal healing, injury healing, absolutely, bar none, very important. If that employer has already been patiently waiting for this person to come back to work. This is a research study. This is money lost if she's not back and functional in the job.

So, we don't want to compromise anyone's health, but you have to keep that in mind, is the employer getting impatient? Can they see we're trying to move ahead and make differences in this situation? Therefore, they might be willing to work with us a little bit longer in keeping the person on the job and trying to keep her working.

>> Great. I think that's a good point to move on to the next question. Thank you, Leslie.

So, the next question we have is: What information would help a return-to-work coordinator determine if Julie is a candidate to return to work for modified duty or retraining.

We'll start with Dr. Brubaker at this time.

>> DR. BRUBAKER: My perspective, just to give you a background, I'm often interacting with people who have been through an acute injury. A lot of times, when a patient reaches the RETAIN, perhaps there's some failure in what was initial treatment or interaction with the patient. That's why they get there. There could be several other reasons, as you know. So that's why, again, some of my focus is really asking a little bit more about -- and without getting off focus, maybe ask some questions about the specific injury or incident that may have precipitated her symptoms. I know it's tricky to decide if this is work related or if it happened outside of work. It's important to ask, even for Julie. She might even appreciate the question. Again, it might reveal some underlying frustrations that she may have in terms of barriers that could be uncovered in terms of return-to-work.

Another question I would ask as well is participation in a really good rehab program. As you know, with musculoskeletal injuries, there are rehab programs. Asking what she has, if so, how long; what was her experience.

Another one is time away from work. That could be a discouragement. Another possible thing to ask and inquire about is her employer. Does she have any options for a return-to-work in a modified format? Is there an option for job retraining? Could she even benefit from other types of -- like cognitive behavioral therapy, some of these would be asked of Julie. It's also important to connect with her employer or the health care clinician who took care of her. You want to get those questions answered, whether it's clinical barriers, psychosocial barriers of whether or not to return to work. It will help in providing guidance for Julie in getting her back to work.

>> Great. Thank you.

Leslie, do you have anything to add?

>> LESLIE: No. I think that's spot on as well. Yeah.

>> Dr. Christian, is there anything you would add?

>> DR. CHRISTIAN: Well, just to sort of sum up what we're saying, I think one of them is: Is Julie as good as she's going to get? If she's not, is there anything we can do to get her better? When I mean better, I mean coping better with her pain or even reducing her pain, making sure she's getting the right medical care. If she's going to be stuck with chronic pain, helping her learn how to live with it, I'm finding I think we're going to run across a lot of people whose doctors say, You have to learn how to live with this. Yet, they do not get anything,

instruction, on how to live with it.

One of the interventions we may end up realizing is a big opportunity for us, and that's to point people to resources on how to live a good life despite chronic pain.

I think the second big thing the return-to-work coordinator needs to know is: Am I arranging a temporary solution or a long-term, permanent one. I'm going to encourage us not to use the words accommodations when we're talking about temporary. Many times, employers are willing to go beyond what the requirements are of reasonable accommodation and provide work which eliminates essential function and reduces productivity expectations. They do that in disability programs.

My personal recommendation is we make distinctions between reasonable adjustments and accommodations. Sometimes you can do a reasonable accommodation in short term. In the working population, the problem is that they use that body part in their work. So, the reduction of essential functions and reduction of productivity may be part of these temporary adjustments. We need to know that in virtually every case.

And then the last case, in the case of Julie, if you look at it practically and realistically, I think the market for ultrasound technicians is very good. I'm not sure she needs help retaining. I think she needs help getting a job. Can we send in an ergonomist that can show her different ways to position herself so she's not straining her neck?

>> I really like what you were saying about looking at if there's a temporary reduction in productivity or something like that while the person is still recovering and using that terminology instead of reasonable accommodation. That's more of a permanent fixture. Of course, all are time limited, but that's going to be a permanent change. That's an important point to bring out.

>> I'm so glad you agree. In my work with employers, they're so afraid of light duty because they fear it's going to go on forever. If we mention temporary when that's what we mean and we talk about it for a defined period on the calendar, rather than with a fuzzy endpoint, I think we'll get a heck of a lot more buy-in.

>> And many of your clinicians have that focus, and that's what you should expect of them. When we're approaching it, too, we're looking at it as temporary. Just thinking back -- I love what you said, Dr. Christian, Julie may have every desire to get back to what she's doing. If an ergonomic evaluation can come in and show her how to do things, she may be elated. Help her enjoy what she's doing and get back to something different. Sometimes we ensue with this patient population, whether it's chronic pain, they may not want to do it. They're not motivated. I think in some cases they are. It's about getting them the right resources.

>> Totally right. There are people who -- including my grandmother -- her arthritis always bothered her more when she was mad at my great aunt. Pain is affected by stress and old memories. If we really pay attention to Julie and her feelings about the possibility that her stress is being manifested as pain and help her address whatever stress she's got -- this is what I mean, learning to live with chronic pain, learning how to take the stress out of your pain, can be a huge thing.

The ACPA, their motto is: From patient to person. Their idea is stop having your medical problem and your pain be the center of your life.

>> Thank you, Dr. Christian. We had a comment come in. If post-op imaging, including (indiscernible) shows no instability or ongoing compression and there are no clinical

red flags, then education, rehab, and appropriate non-opioid management are the next steps as well as reviewing the job description. Do we have a job description?

>> Not yet. We have not had anybody give us a job description. We don't have a formal job description. Right now, it doesn't seem as though the doctor is too involved in this case. To some degree, some of these processes where it might be a good idea to encourage a conversation between the doctor and Julie -- and I think to tee it up, this suggestion about a job description is great.

You know, is there any risk in Julie performing any of those tasks? Is she physically capable of performing these tasks safely? Thirdly, is the problem fundamentally her lack of ability to tolerate the pain? It's most likely all going to be in column C, her inability to tolerate because there's no physical evidence that she's not able to do anything.

All my prior comments stand but getting the doctor to tell her it's safe is good, once she has a safe fusion. And it is only two months. It is only two months. Many people who have surgery, it takes six months for the whole thing to really stabilize. Sometimes it takes a year for it to stabilize, for sure.

(Overlapping speakers)

>> Just a quick comment, depending on who was in care of this patient -- like we said, we don't know if this is return-to-work or is it. Surgeons, clinicians who are not aware of these sorts of injuries on their work, it may not have even been addressed. They may not be thinking in terms of work. My work before this is family medicine. I certainly had a skill set of looking at the clinical side of it, the medical side of it, how to address things, but sometimes we're not thinking about it. Sometimes just a simple conversation with the person taking care of the patient, it would be good to walk through this.

Just a thought.

>> Great. Thank you, Dr. Brubaker.

Leslie, I would ask if you have any other comments before wrapping up Julie's case and moving on to Jack's.

>> LESLIE: I would move to Karen's comment, do we have a job description. It's important to get a job description immediately. That way the return-to-work coordinator can share that with the health care professionals. Then you're also making sure that you're covering all aspects of the job performance issue, and there may be things that the person was not disclosing or saying was needed but that the employer feels is very important for that person to be doing as well.

>> Excellent. Thank you for all of the great discussion around Julie's case.

>> DR. CHRISTIAN: Leslie's comment, this is the perfect reason to have a video of her doing her job. The description is not going to show how she's moving her head.

>> Thank you, Dr. Christian.

Looking at the time, I want to make sure we have time for Jack's case. I'm going to move on to our case scenario number two.

Here we have Jack who's 45. He was referred to return-to-work services by his health care provider. He has a high school degree and began working for his employer back when he was 21 years old. There was an apprenticeship but has no other education and training. He fell

off a ladder at his house and injured his back. At the time of the injury, he was told he had several herniated disks that were pressing against his sciatic nerve as well as nerves leading into his legs. He tried to return to work, but his pain was too severe, and he could not perform his job tasks to the necessary levels.

His company offered him short-term disability as an employee benefit. He decided he needed to access those services while he continued to receive medical treatment.

After another six months, he tried to return to work, but the pain continued. He had to go back on short-term disability and have another surgery. He also had a post-knee replacement that prevents him from moving toward squatting on a single knee and making it difficult to get into lower places.

Jack would like to be able to return to work, but there are concerns on his part and his employer's part about his personal safety, safety to others, and his ability to perform the required job tasks.

So, our first question is: When you see a scenario like Jack's when a back fusion has been performed -- I'm sorry. I think I might have -- we might have the wrong question.

>> You're right.

>> It is right? I'm sorry.
What are your first thoughts subsequent to the discussion with the individual?
I will start with Leslie.

>> LESLIE: So, Mona, in this situation, what I'm going to be wondering are several things. If he's referred by the health care provider, are you wanting to go to work with your previous employer, have you talked to them about going back to work? Have you talked about going on long-term disability? We need to make sure if he's looking at long-term disability through the employer's policy, that he is aware of any policy requirements that, perhaps, take him off the payroll and he's no longer employed by the employer. I'm trying to get at is he still technically employed by the employer because he's just on short-term disability? Or has that relationship been severed?

The other thing I'm looking at is a RETAIN program is looking at what transferable skills does he have? Since he ceased being a plumber, he could be looking at a program manager or retraining into a different job.

My experience with a low-back fusion, the responsibilities of doing the duties of a plumber are going to be very difficult. But I'm going to research plumbing jobs. I've never worked in that field. I may go out and see what he's required to do. I may look at the job description again. I want to see it in action so I can see if there's a possibility of accommodating a lot of these activities that are associated with this job because that is going to entail a tremendous amount of accommodations. In the case of a lumbar fusion, there's going to be some definite, permanent restrictions coming into play with the bending and getting into awkward spaces. That's one of the first thoughts I'm thinking when I get a referral like this.

What are his transferable skills? Is he able to do additional education? Are there resources out there for additional education? Could he go through a career center for an individualized training? All of these things are going to be running through my mind when I get a referral like this.

>> Great.
Dr. Christian, would you like to add anything?

>> DR. CHRISTIAN: I agree odds are unfavorable for him to stay at work as a plumber. I think one of the things that was taught to me was to ask if you know anybody who has had the same surgery and is still working as a plumber. The answer is I don't know personally, but I do know a person working as an aid in a developmentally disabled classroom who's had three back fusions, and we think she's kind of unwise to be doing it because of the likelihood of her fusion breaking down.

I think encouraging somebody to persist at a heavy job when it may not be fair to them -- I'm wondering, when I'm seeing this, why he wants to return to that job so much and if we could understand why it's so important to him -- maybe part of the plan we're going to come up with is to help him accomplish what is really important to him and channel that energy in a new way. If it's strictly money, that's going to be a different issue.

>> And Dr. Brubaker, would you like to add anything?

>> DR. BRUBAKER: Sure. I agree with what has been said. You see somebody like Jack who has been in this job for 20 years -- it started when he was in his 20s -- well, graduated from high school and started working. He's probably emotionally connected to this job. It seems like, in this case, that's all he knows. So, first, applauding him that he wants to keep doing it -- I think you can really capitalize on that and say, you know, that's wonderful he wants to do this.

I agree that the likelihood of what's gone on, it may not be possible, but really exploring what his thoughts are, what he desires. Like Dr. Christian is saying, there may be a way to redirect things, but first and foremost, applauding him for wanting to return. The motivations could be caring. It could be financial, but it seems that the person involved in this, there could be a family feel. May not want to leave. That's why we're trying to dig in and find out more information.

>> Absolutely.

So, let us go on to the next question. Should a professional who is familiar with or creative at finding alternative ways, could adaptive tools be involved in a case like that?

Let's start with Dr. Christian.

>> DR. CHRISTIAN: I've asked this question. Even though I've said I think the odds are against it, I think we too rarely actually get somebody who is familiar with improvising and finding adaptive tools and ways of doing things involved in cases. I think it would mean a lot to somebody like Jack to have somebody really engage with him who is an expert at that stuff and help him come to see that there is or there is not a way to do it.

I was thinking about this because I think we shouldn't jump to assuming that the employer knows all the creative solutions or where to find them. Nor should we assume the worker knows them. And there are some professionals that are experts at this. They're kind of hard to find, but when I used to be the medical director of a shipyard, I knew enough to know when somebody had a hand problem, because of vibration, that we needed to find vibration dampening tools, but I didn't know where to find a vibration dampening tool. Many employees wouldn't know there is a vibration dampening tool.

In most cases, it's important to make Jack believe that we've done everything to try to help him. This is a perfect example of people ending up on SSDI now. These men with relatively low education who have been earning good money in something that required them to have a good body, these are the ones that are the ones we really need to get good at helping.

Part of the help may involve helping him change his identity and accept the loss. Something has happened. In your case, it looks like it was mostly age. You still have 20 years of

good life ahead of you. How are we going to have you have a good life going forward instead of putting you on the waste basket of people on SSDI?

I think getting him enrolled in the idea of creating a good future for himself, everybody though it may not have as much money or status, but he'll be doing something he likes.

>> Thanks, Dr. Christian.

Dr. Brubaker, would you like to respond?

>> DR. BRUBAKER: Nothing to add. I think what Dr. Christian said is great.

>> How about you, Leslie?

>> LESLIE: I would absolutely agree with bringing in specialists who make the evaluation. I think it's important for Jack to also know that it has been investigated. His ability to go back and do some of those tasks has been investigated. I think, as Dr. Christian was pointing out, it will help to see we tried. It's not going to work. Let's look at some alternative options for you.

>> Great. Thank you.

Just a reminder to everybody who's listening, if you have comments or questions, feel free to raise your hand or put your comments and questions in the chat box, and we'll respond to them as we go along.

So, the next question is: What would be the benefit for Jack to participate in a physical rehabilitation or therapy program?

So, let's go ahead and start with Dr. Brubaker on this one.

>> DR. BRUBAKER: Activity with clinical guidance on how to lift, push, pull, again, specific to Jack, is so important. That need to continue and sometimes on an intermittent basis. If there's a consideration of job retraining, rehab is a significant component. Some of your strong rehab specialists can focus on whether it's work conditioning, work hardening, work retraining. They're a key partner.

A rehab specialist will be tuned in to other things that may be present. They can be a strong part of the team in providing valuable feedback on return-to-work and job retraining. Of course, you want a partner with someone who has a strong understanding. Kind of going back to a previous case, when you have a clinical team that's on board and understands it, that feedback is welcome. I think, again, it is just promoting the activity for Jack. He's 45. We don't have someone at 45 to go down the pathway of disability and inactivity. We want them to remain active. It may be a difficult sort of activity or a different way of doing the same activity, but that is incredibly important.

>> Absolutely. Dr. Christian, would you like to weigh in?

>> DR. CHRISTIAN: Basically, ditto on the physical rehabilitation. Looking at his lifestyle habits, which we haven't really heard anything about, the physical rehabilitation may be part of a lifestyle/behavioral change that may prepare him to have a much more vital future.

The second thing I wanted to mention is sometimes -- and we don't know the fraction -- repeated back surgeries is an indication that the real problem is what we call brain-generated pain. You can do as many surgeries as you want, but if it's learned pain, I think he may be a good candidate for cognitive therapy in a way to reduce pain and teach him

self-management in whatever job it's going to be.

>> Great.

Before I let Leslie weigh in, a comment came in.

I would add (indiscernible) in my experience, some have entered blue collar (indiscernible) these would need to be taken into consideration for in-office-type transitional duty.

>> Great comment.

>> Yeah.

>> So, Leslie, would you also like to weigh in on this?

>> LESLIE: I definitely agree with Dr. Brubaker for the need for physical rehabilitation and continually staying active. I think that's definitely important. I would like to add that is very crucial. You do have testing done to see what their ability is in getting additional training, retraining, or even with transitional work opportunities that may come available. How would they do with that?

Also looking for short-term training, if the person is able to benefit from the training, so that we get them back into physical activity with physical therapy but also a routine of learning and feeling like they're contributing as well.

>> Great. Thank you.

I think I've heard all of you acknowledge in some way the one piece that I didn't mention in the description of the case, the mental health side and the importance of really hitting on both the physical health and the mental health needs of Jack's situation.

>> Absolutely. We should have talked about that more. Depression intensifies pain, and pain intensifies depression. So, the two are tightly related. So, the cognitive therapy suggestion I made would help, potentially, with both of them.

But, you know, also, there are people -- we'll talk about this, I'm sure, in the future. There were people who had very difficult childhoods and have a high ACES score, a high adverse childhood experiences score. They often end up with poor recoveries from medical conditions and chronic pain and medically unexplained physical symptoms. What I've discovered in working with people like that, they often have weak life skills. Their parents didn't teach them to deal with adversity.

Many plumbers may have found a job quicker than Jack has. They may have been more flexible and adapting to what has happened. I think one question, if you were the vocational rehabilitation person working with them would be to start figuring out if he's weak on some life skills and coping skills, and what is his resilience level so we can potentially help find resources to strengthen him so he can create a good future for himself.

>> Great. Any last points that Dr. Brubaker or Leslie, that you would like to comment on for Jack's case?

>> I'm good.

>> I'm good. I would just re-emphasize what Dr. Christian was just saying about using some counseling to get additional factors.

>> Excellent.

As I said, if you have any other last questions about the case or any broader questions, go ahead and put them in the chat box.

Right now, we're going to shift into a few minutes of key takeaways from each of our panelists. I will give it back to Leslie to share her takeaways.

>> LESLIE: I think that one of my biggest takeaways that I can leave with everybody is being sure to involve the employer at the beginning, middle, and end of a retention or return-to-work case. When I say involve -- well, if you've got an individual, an employee you're working with, and they don't want you to contact their employer, I think it's still very crucial for the return-to-work coordinator to be able to guide that employee on having beneficial conversations with their employer. So still knowing what goes on is very important for that return-to-work coordinator to help guide the individual. If you're able to communicate with the business, I think it's important to find out what their thoughts and feelings are, where their stand is on returning to work or staying at work, so that you can help facilitate that on both ends, the employer and the employee end.

I think it's very important to also bring in experts to evaluate and to recommend reasonable accommodations when the time comes. They would also be helpful to recommend short-term fixes during a recovery period, but they're beneficial in recommending long-term fixes that would enable an employee to perform existential function.

Last, I would be sure to say to create a plan in moving forward in your return or retain case. Make sure you have clear roles and responsibilities during time frames. I think this is very beneficial for the employee. They will know what to expect and what is going to come next. They will know what they're responsible for participating in their return-to-work plan. I think it's important for the employer to know what your next steps will be. Again, that could be communicated by the individual or by you, straight to the employer. It lets that employer know that, hey, these things are moving along. They're going to be more than willing to step back and give some time to allow you guys to come in and help this person retain their job as long as you're communicating with them and letting them know what those next steps are.

Then I think ultimately, as long as you've got that plan, you've got the time frame, you're going to have better retention from that individual. They're going to know, okay, this is the next step. I'm going to hang in here. I'm going to wait for the next step to happen before I check out. If you're not following up with people on a consistent basis, they're going to say, Well, I guess this isn't for me. I'm not going to be able to retain my job. But then they go back to work, and they don't let you know as well. I think that's important when you sit down with a plan. You have the open communication, and that person is ready to sit down with you. Those would be my key takeaways.

>> Great. Thank you, Leslie.

I will turn it over to Dr. Christian.

>> DR. CHRISTIAN: We need to assess all parts of the decision before we do the plan. We need a multi-dimensional assessment. What's going on in the mental health side? What is going on in the physical side? What's going on with the employer? We need to be looking for potential opportunities to improve the outcome as we're looking. So, we're looking for the potential for additional medical or functional recovery and what might accomplish that and whether we can intervene. We're clarifying whether the functional loss is temporary, established but potentially remediable. It could be left disabling or irrevocable. That's an incredibly important point. That will help us clarify whether to stay at work or return to work.

By the way, I'm a preacher of the acronym stay or return-to-work rather than the

other way around. Helping somebody stay at work is preferable to have them return to work after a big interruption. So, we want to clarify whether we're talking about temporary adjustments or long-term reasonable accommodation, or one to follow the other is a reasonable possibility.

In order to do this multi-dimensional work, that's why we developed the team concept. They need clinical expertise. They need rehab expertise. They need vocational expertise. They need expertise.

Sit around the table and request input from the clinician from the people that know rehab from the people that know workplaces. Make sure the assessment is accurate before we work on the plan.

Then, what I've learned from watching this now over the last couple of months, as soon as you start figuring out these situations, you start seeing you need an intervener. We need somebody who knows how to go to a workplace and take the cell phone video and make potential adjustments to how she does her job.

You can't sit on your telephone as a return-to-work coordinator and -- what will become obvious is the need for interveners and the fact that we often won't have them and will feel impotent. That's what happened to me in my group. So, you end up pressing someone else into service.

Once you figure out what the intervention is and the closest approximation you can come to an intervener -- I'm just forecasting for you what's going to happen. That's what happened for us. You realize somebody needs to be orchestrating the delivery of all of these dimensions. Unless somebody is driving it forward, something could get lost.

>> Great. Thank you.

So, I will turn it over to Dr. Brubaker for her takeaways

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>> DR. BRUBAKER: All right. I want to emphasize what Dr. Christian said about understanding the whole picture. That's where your role is key in understanding all of those different aspects, kind of going back to who is taking care of Joe. This is a good multi-disciplinary understanding of what's going on is going to really help take care of Joe.

Just some key takeaways from my perspective, I say early return-to-work. Again, I agree with Dr. Christian. Stay at work would be even better. My perspective, I see a lot of patients on the acute care side. On the other side, where you have chronic pain, the earlier we return a patient or someone to work will produce favorable outcomes for both the employee, the employer, and everyone all around. It's great physically, mentally, emotionally. We know unemployment is unhealthy. Even if a person cannot return to their original job, there should be consideration of job retraining. I think of even the retired individual, it's great someone gets to retirement. When you look at those retired, if they don't have the perspective of, Hey, I'm going to travel. I'm going to do this or have certain interactions or activities, that's often where depression can set in when we look at some of our seniors.

It's important to look at who is still working and keeping them employed is important.

Here I put employer or supervisor support of the employee. I would say everyone involved in the care of these patients, it's so important that they are involved, that they're addressing injury, that we're addressing not just all around but like what we've already talked about, all the needs of the particular patient. That produces positive results in most cases and can promote an earlier return-to-work, or a quicker return-to-work -- or even a stay-at-home work.

>> Those are all great and very important takeaway points from all of our panelists.

So, we're slightly out of time, but I want to thank all of our panelists for the excellent conversation that we have had. We do have some time for some questions if anybody from the

audience wants to ask any last set of questions or make any comments.

I'm starting to see some typing. We can hold on a minute.

I wanted to thank all of our panelists today for this very informative. I think there's a lot to learn from your perspectives on the two cases as well as your overarching considerations if somebody is trying to stay at work or return to work.

So, I am going to shift over to our next points. If you have comments, feel free to type them in.

So, I want to mention a couple of activities or events that we have coming up. Save the date for the Job Retention Series-the Communities of Practice. Case management for TIPS, tools, insights, processes, and strategies for return-to-work coordinators.

The next community of practice is from the same period, how the ADA and reasonable accommodations can make or break a RETAIN case.

So, we had a question/comment saying, I thought that RETAIN was originally designed to be low-touch, high volume.

>> Teacher, teacher, let me answer that question.

>> Okay. We can start with you, Dr. Christian, and then shift to Leslie.

>> I love the question. It is a perfect question. I think the question is low-touch, high-volume compared to what? If normal rehabilitation plans take a year and thousands of dollars, sending a person out to do a video job description and help somebody stay at work is a teeny intervention compared to that.

I looked at the data from COHE very carefully. They actually sent out -- I will share it with anybody who wants it -- an assessment on how many hours they would be working on cases. They located 70% of cases, it was going to be like an hour. For some fraction, it would be more than that. As you recall, COHE stops at 12 weeks. RETAIN is going to take cases out 26 weeks. You're going to have where it's really worth putting in a couple of days of effort on that case to help that person keep their job.

>> Thank you.

>> Leslie, go ahead.

>> I would reiterate that. Probably the majority of your cases are going to be low touch, but you're going to have some that are going to require that more one-on-one, out there with the individual, type.

I have actually been at a company where their HR people videotaped someone performing the job in order to take it with them when they went to meet with the worker's comp doctor so the doctor could clearly see what they were required to do and see if the recommended accommodation would be suitable for the person in light of their injury.

So, I think just a video can come into play a lot of different ways. Today, with technology and our cell phones and iPads, that is a very easy thing to be able to do. So, don't be surprised if you do have to go out and do a little bit more deeper interaction, especially if these are supposed to be quick cases.

RETAIN cases typically are. You need to move it along as quickly as possible because of those employer expectations. So that's a good question.

>> So, we have another question come in. The initial information stated 21% decrease

and out of work with COHE. Is this absolute or relative? What I read; this is relative. This seems very low compared to the effects of retained intervention. Do any of the speakers have thoughts on this?

Since that was the piece I was talking to, it was relative. So, you did have that read right.

Leslie, Dr. Christian, Dr. Brubaker, do you have any thoughts on that?

>> LESLIE: If I'm not mistaken, it was worker's comp. Am I correct?

>> That is correct.

>> LESLIE: Okay. I think with that situation, you're going to have a little bit longer time, maybe a little less result because, unfortunately, there are some additional benefits of a worker's comp injury because the person is still getting paid and getting medical care and so forth. When you have off-the-job injury that's occurred and is not related to that work being done, then you're going to have somebody way more motivated to get back to work and to follow through and to participate in a retention program.

>> Dr. Christian or Dr. Brubaker, go ahead.

>> That's a very complicated question to answer because part of the results in COHE had to do with the fact that it was -- the community physicians were not 100% complying with the program. I think I sent out a spreadsheet showing all of the details, and I think the percentage of doctors doing the best practices, for example, was quite low at the beginning and grew over time. I think there's a question about adherence. Probably you don't have that much volume. Everyone is swamped right now.

Also, we have to remember that COHE was only lasting 12 weeks. So, the sort of substantive and serious cases that you're making were not part of the COHE program. They were doing the simple cases like we did not look at today. I would like to have one straightforward, easy one where a quick intervention cut a up couple of days off and prevented someone from even thinking they wouldn't be able to work. That's the heart of the program.

>> Great. Thank you.

So, Jayme is from Washington, I think. She has just further info.

(Reading document)

>> This is the same info that Dr. Christian just mentioned now.

Karen also noted that this is helpful. We're getting complex cases referred.

So, we have one-minute left -- go ahead, Leslie, quick.

>> LESLIE: I was going to respond to Karen's comment. When people start hearing about this, they're going to refer cases because they're at a loss. You will get complex cases. Then they will realize they need to do early intervention. Then they will send you more.

>> Let's say that again and again louder, Leslie. The low-touch/high-volume approach is the approach. We have to woo them to show them what we can do and then do more and more of getting people on the right path instead of trying to risk it later.

>> On that note, it's 3:15. I thank you all for your time. I thank all of our panelists. We

have put the link for the survey up in the chat box and on the screen. Please take a moment to fill out the feedback and let us know your comments about today's session and any other resources and events that might be helpful. Thank you, again. Have a good afternoon.

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