RETAIN | Retaining Employment and Talent After Injury/Illness Network

Return to Work Coordinators CoP—Notes

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Session 3: Engaging Providers

August 4, 2022

The third Return to Work Coordinators (RWTC) CoP session opened with a brief welcome from the facilitators. The facilitators briefly introduced themselves, and then provided an overview of the agenda. The facilitator gave an overview of housekeeping and logistics items, and reviewed the RWTC CoP purpose and norms. She encouraged participants to turn their cameras on if possible to engage fully with the group. The facilitator briefly recapped the last CoP session and presented the topic of today's CoP, engaging providers.

Recap of RTWC CoP Session 2

The facilitator reviewed the Jamboard from the last session. Using the Jamboard, the group identified Return to Work competencies that 1) the coordinators are using already to successfully engage participants; and 2) competencies that coordinators want more support or practice in.

Competencies that are already being used successfully included:

- Having organizational and planning skills
- Being approachable and available
- Having listening skills
- Ability to communicate well verbally and in writing

Competencies that the group wanted additional support, practice, or resources for improvement included:

- Ability to instill trust and confidence in your role as the RTW coordinator
- Having patience with each stakeholder involved in the RTW process
- Being honest and frank in communications
- Ability to uncover and evaluate underlying problems affecting RTW

After the Jamboard session, session 2 shifted into breakout groups to discuss strategies for identifying participants; how to explain the RTWC role to participants; and how to fully engage participants.

RTWC Provider Engagement Strategies by State

After the recap of session 2, the group moved into the discussion for the current session on provider engagement. Each state gave a brief overview of how they engage with providers, including successes and challenges that they've experienced so far. This provided an opportunity to see similarities and differences among RWTCs across the states.

The facilitator first called on Minnesota to share how they engage and work with providers. A participant from MN stated that they're struggling with engaging with providers at this time. They are looking for guidance from other states in what has worked well for them. The state shares a postcard with providers that includes brief information on CME training. Provider engagement falls under research and clinical care team, and they have had some challenges with engagement. MN does not engage providers to recruit participants, and are focused on getting providers to take the CME training. MN had used other methods in phase 1 that they found to be less effective. One provider is very engaged but is one of the only providers they have right now. A priority for MN is to learn from the other states.

The facilitator then called on Kansas. The staff member from KS that was able to join this session is new to RETAIN, and has not yet participated in case management with providers yet. The one provider that the state has recruited so far went to the control group, and the state is working on finding other providers to engage.

Ohio then presented on their provider engagement efforts. The state recruits doctors and encourages them to take the CME class. Some types of providers, such as PAs and NPs, have been more engaged so far. The state does take referrals from providers, but it has been a struggle. Additionally, the state has seen varying levels of provider engagement based on which region they are from. OH has a lot of providers within RETAIN and have recruiters rather than RTWCs solely recruiting physicians because they have more contacts within the healthcare system. A goal is to get more referrals from providers, and the state is actively trying to facilitate participant recruitment from providers.

One of the participants from Kentucky shared that they are personally focused on recruiting providers and it has been challenging. Providers think the program is great but don't consistently provide referrals. The state is trying to get as many NPs, nurses, and PAs involved as possible. The state is now embedded in electronic medical records as of last week and have gotten two referrals so far. They want doctors to understand that RETAIN is there to help their patients. KY is focused on keeping referral sources updated with patient progress to encourage more referrals. They strive to give an overall big picture of RETAIN to providers so that

providers can give the best interventions. A lot of provider education is needed. The state has weekly case staffing with mental health professionals to provide feedback to RTWCs.

A participant from Vermont shared that their program is not referral-based and they use screeners to find participants. They do struggle with engaging clinical staff to get patients to complete the screeners. The state has been making more in-person clinic visits to promote RETAIN. Due to lots of healthcare/clinic staffing turnover, re-education of new provider staff is needed. The state is trying to spend more time physically in clinics and support the providers where they are. The state has implemented paper screener versions, screeners submitted using a tablet, and can add kiosks in waiting rooms by request of the providers. They have added posters with QR codes in exam rooms, so that patients can scan the QR code to be taken directly to a screening form for completion. VT's program uses a multidisciplinary case review, using trained trainers (similar role as RWTC) within the clinics. The state conducts case reviews with the trainers on Mondays to evaluate potential cases/program participants. The state also offers curbside consults around occupational health and promotion of RETAIN.

VT uses the provider CME as a program selling point for providers. The program's medical director goes in person to present CME (video recorded so it can be shared remotely). The state also communicates with providers to fill in gaps on the screeners they receive (e.g., if someone fills out paper screener illegibly). Lost contact letters get faxed to the providers and put in and put in the patient's chart so at the next visit the provider can engage with them about RETAIN. The state has access to patient medical records, which they use to identify potential participants. This approach takes the work off of the providers to refer participants. The state is mindful that the clinicians are very busy and wants to meet them where they are.

VT's medical director for RETAIN offers curbside consults. These are available by request (not on a set schedule). The medical director makes herself very available as needed to facilitate this. A SAW work plan is faxed to the clinic, which outlines the barriers and goals, and clarifies patient, health coach, and provider responsibilities. VT tries to be very responsive when visiting clinics, and clinics can request materials if needed (e.g., a provider requested writeup of a scenario where if a patient went out on SSDI what would that mean for their family). The state is trying to make themselves open to feedback on what would be helpful in educating their patients.

Discussion of Provider Types

In the next part of the CoP session, the co-facilitator discussed the different types of providers that may be engaged through RETAIN. These providers included the following list:

- Nurse Practitioners (NP)
- Physician Assistant (PA)

- Orthopedist
- Neurologist
- Physiatrist
- Primary Care Physician
- Orthopedist
- Occupational Medicine Specialist (OEM)

Additional provider types discussed included physiatrists, which is a growing field in occupational medicine. Other provider types that are engaged by the states but are not included on the above list are podiatrists, social workers, and other mental/behavioral health professionals.

VT shared that they have a clinic with a very engaged social worker who so far has been utilized for more of a referral-based method than has been typical so far for the state. The group then discussed preference for the use of the term "clinician" rather than "provider." One of the training videos on the ROC discussed this, so VT is trying to use the clinician term instead of "provider." The facilitator asked which verbiage states are using—one state is trying to use "clinician" only because provider is so broad. The facilitator mentioned that language matters so much. A concern with the term "clinician" is that it can leave off health care provider types that aren't in clinical role (e.g., social workers). U.S. HHS and CMS use "provider" but that isn't necessarily correct in all instances. Some doctors might prefer to be called "clinicians."

Other reflections from the ROC training is that providers are very busy so it is important to speak clearly and concisely when communicating with them. Which provider types are best-equipped to understand the RETAIN model? In one state, physical and occupational therapists and physical rehab clinicians have provided best referrals.

The facilitator asked states what information is given upfront to providers (e.g., CME and educational materials). In OH, a postcard gives an overview of the CME training modules. They offer providers a $100 incentive to take the training if they have someone in the intervention group. The state has mini trainings and then a refresher course that providers can take as needed. Specific practitioners have reached out to the HSCs and asked for more training. In those instances, the state sends an education team or has HSCs send messages to the providers. Providers can get as much training as needed.

The facilitator asked whether any states don't market to physical therapists. One state has been more focused on outpatient/ambulatory practices. Going forward, they will be focusing on rehab facilities, ERs, and other inpatient programs, because these are areas where they might find more patients who are struggling to return to work.

What might matter to certain providers over others? When clinicians hear about RETAIN matters. When seeing more success with one clinician over another, there can be differences in the provider workflow; the scope of the practice; the number of patients seen daily; whether the states connect directly with administrative staff vs. clinicians; wait time for appointments; incentives; and whether the clinician provides inpatient or outpatient services and in what type of setting (urban, suburban, or rural).

Breakout Room Discussions

The CoP participants were divided into three breakout rooms for 20-minute discussions where they were asked to consider the following questions:

- What have been your most successful provider interactions? What have been your less successful interactions? What did you learn from each?
- What are your best strategies for engaging providers? How do you shift your strategies depending on the type of providers you are working with?
- What challenges and questions do you still have?

After coming back together in the larger group, each breakout group provided a brief overview of their discussions.

In breakout 1, two states talked about sending RTW plans to the providers via fax or through the electronic medical records, because providers read patient-specific notes. The group discussed challenges with getting feedback from providers, and asked what can case managers do to have better interactions with providers. Other questions posed included: what is it like on the case management side? How are states getting provider feedback once a participant is enrolled?

In breakout 2, the consensus was that they are struggling to recruit providers. They discussed the importance of building strong relationships with providers. The facilitator who popped into this breakout room said that she enjoyed the discussion about relationship building. The participants also discussed challenges with providers not understanding RETAIN, and talked about challenges with workflow and time constraints when working with busy providers.

In breakout 3, one state mentioned that it has been hard to get direct contact with providers. They are looking to increase the incentive funding for providers but haven't decided yet what that looks like. One state has a recruiting team vs. just one recruiter, which may be helping with their success. Successful connections have been built for one state by attending festivals, races, job fairs, and similar events with a marketing table to get the word out about RETAIN. Handing out swag and engaging face-to-face with providers has helped to build knowledge about RETAIN in general. Another state mentioned that they'd like to hand out swag but are not sure if it is permissible within their grant funding. Consistent communication with providers is

challenging for all of the states. The facilitator mentioned that this group had a lot of co-learning. While structures are different across the states, strategies can be similar.

Closing

An optional Jamboard activity was planned for this session about how they support participants in navigating the health care system, if there was extra time. The activity will be pushed to the next RTWC CoP.

The facilitator closed out the session by urging all participants to complete the post-event survey. The feedback from the post-event surveys are an important way to hear from participants regarding the CoP. The participants were encouraged to identify additional topics for future discussions so that the CoPs continue to be valuable learning opportunities for everyone who participates.

Participants were reminded that the annual convening will take place on September 21-22, 2022.