Propagating the New Work Disability Prevention Paradigm for Disability Benefits & Workers' Comp Systems Across North America

FINAL REPORT

Minnesota
Stay-at-Work & Return-to-Work
Stakeholder Summit

January 31 - February 1, 2008

University of Minnesota Continuing Education Center
St. Paul, MN

Report prepared by the
Minnesota SAW / RTW Summit Planning Committee
in collaboration with
The 60 Summits Project

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MINNESOTA STAY-AT-WORK & RETURN-TO-WORK SUMMIT

Executive Summary

In September, 2006, a group of 31 individuals from 20 organizations in Minnesota attended a meeting at the invitation of Dr. Jennifer Christian, founder and chair of The 60 Summits Project. She had sent an email asking them whether now is a good time to build a shared positive vision of how the stay-at-work and return-to-work process should function in Minnesota among those who participate in that process: employers, physicians and other healthcare providers, benefits payers, and several others.

At the meeting, the assembled individuals decided to form a group that would produce a Summit-type workshop. They did this after hearing about The 60 Summits Project, a grass-roots initiative to disseminate a new work disability paradigm for disability benefits and workers' compensation systems throughout North America. The new paradigm is embodied in a guideline issued by the American College of Occupational & Environmental Medicine (ACOEM) entitled "Preventing Needless Work Disability by Helping People Stay Employed." The basic idea of The 60 Summits Project is to use the ACOEM work disability prevention guideline as a framework for discussion in stakeholder summits in all 50 states and 10 Canadian provinces across North America and for those Summits to serve as catalysts for on-going multilateral efforts at positive system change.

The newly-formed Minnesota planning group envisioned the Summit as a first step in an overarching initiative to improve the well-being and productivity of Minnesota's workforce by uniting the stakeholders in a shared goal of preventing needless lost workdays and job loss (and its attendant misfortunes) due to illness, injury and aging. A key contribution to this broad social goal is to improve the timeliness, nature, and quality of services delivered to employees who are coping with the impact of injury, illness or aging on their daily lives and work -- as well as to their employers. The intended eventual result of their Summit and subsequent steps in this initiative will be an improvement in financial as well as human outcomes.

The planning of the Summit took almost a year and a half, culminating in a successful event with 87 carefully selected participants held on January 31 and February 1, 2008 in St. Paul at the University of Minnesota's Continuing Education Center.

The Summit planners themselves represented multiple stakeholder groups, with members who were employers, healthcare providers, insurers, and so on. (See list of planners at Appendix A.) They named their initiative MNWorkability and created a website: MNWorkability.com. They also chose to formally affiliate with The 60 Summits Project and Dr. Christian gave a keynote address and facilitated the Minnesota SAW / RTW Summit.

The Minnesota Summit received a matching grant from The 60 Summits Project and its charter North American sponsors, Prudential Financial and Webility Corporation. It was also sponsored by more than 23 Minnesota organizations who lent their names and provided financial support to the local event. (See list of sponsors at Appendix B.)

The actual Summit event lasted a day and a half, beginning with an early evening welcome reception and opening session on Thursday, January 31. The full-day workshop on February 1 began with a keynote presentation after which the 87 participants broke into 8 multi-stakeholder small groups to begin their deliberations. Each group was assigned one or more of the 16 specific recommendations made in the ACOEM work disability prevention guideline. Their charge was to decide whether the recommendation should be implemented, and if so, how to do so. Their challenge was to agree on strategies as well as on concrete first steps to take in order to start carrying out those strategies. Lastly, each participant was offered an opportunity to make personal commitments for action to themselves and asked to record them on paper.

The small groups reported their initial findings and described their preliminary action plans in a general session, and then received suggestions for improvement from Dr. Christian. They returned to their small groups, refined and further developed their plans, and re-presented them to the general session. What emerged from this process was many plans with a remarkable level of specificity and concreteness -- as well as a very high level of excitement and a collaborative spirit. Many small teams spontaneously formed to take on specific projects together.

All of the work groups thought the individual recommendations they that had been assigned were worthwhile (although they reworded some phrases). Therefore, all of them developed action plans to implement them. Commonalities among the plans became apparent as the small groups gave their reports. The major domains in which many of the action plans focused were:

1. **Continued propagation of the new paradigm.** Many of the action plans involve disseminating key precepts of the new work disability prevention model to a wide array of audiences using a variety of media through several channels.

2. **Engaging others.** Many of the action plans involved outreach, liaison, building relationships and collaboration with specific people, organizations and groups, especially the Summit's own follow-on action group.

3. **Development and testing of better tools and methods -- and advocacy for their widespread adoption.**.

4. **Operationalizing the recommendations.** Many people saw ways to put them into everyday practice.

This list includes only the most prevalent domains; many action plans touched more than one domain. Other domains in which there were several action plans include legislative/regulatory action (though not as many as some might have expected) and personal development (the deepening of one's own knowledge or expertise).

At the end of the day, participants were asked to complete evaluations and indicate the extent of their desire for on-going involvement with MNWorkability. More than 90% of those who completed evaluations said the day had been a good use of their time and they feel confident

that the event will bear fruit in the future. Whole small groups signed up en masse to become part of a follow-on action group. In fact, the 87 participants indicated a strong interest in on-going engagement:

- 54 (62%) signed up to be part of the follow-on action group
- 63 (72%) signed up to be notified of up-coming events
- 68 (78%) signed up to be on the mailing list

The successful planning and conduct of the Minnesota SAW / RTW Summit is a strong first step in a truly innovative grass-roots initiative. The relationships that were established and the action plans and personal commitments that were made during the Summit must now go out into the real world and be carried out. The group is now entering uncharted territory. The next step for the Minnesota group is to develop a structure for the fulfillment of the plans that came out of the Summit -- some sort of multi-stakeholder action coalition, consortium or similar organization. People will need support in order to make their commitments into realities. The first follow-up meeting will occur on February 29, 2008 in Minneapolis.

Acknowledgements

Members of the Minnesota Summit Planning Committee. The membership of this all volunteer committee is itself an example of the multi-stakeholder approach. Employers, physicians and other healthcare providers, insurers, and intermediaries worked together to plan this event. A list of committee members appears as Appendix A.

60 Summits Project staff. We appreciate the support of Diana Cline, David Siktberg, Anita Nyyssonen, and Jennifer Christian, MD, of the 60 Summits Project who assisted us throughout the planning process as well as our Summit event, and then prepared this report.

Sponsors. Without the generous support of our sponsors, this Summit would not have been possible: A list of our sponsors appears as Appendix B.

Introduction and Background

The American College of Occupational & Environmental Medicine adopted its guideline entitled "Preventing Needless Work Disability by Helping People Stay Employed" in May 2006. Dr. Jennifer Christian led the committee of 21 U.S. and Canadian physicians who developed the guideline. She founded The 60 Summits Project shortly thereafter for the purpose of propagating the ideas in the Guideline -- which embodies a new model for work disability prevention -- throughout the 50 US states and Canada. The basic idea is to convene multi-stakeholder summits in which participants learn about the concepts in the guideline and decide if they want to implement them in their locality. If so, they agree on a strategy for how to do it, start making concrete plans for action to accomplish that strategy, and then decide whether to form a multi-stakeholder follow-on action group to continue propagating the work disability prevention paradigm to every corner of their states while supporting themselves in making program and system changes.

Minnesota was among the earliest states to get engaged with The 60 Summits Project, and the first to have an ad hoc volunteer multi-stakeholder Summit planning committee. Dr. Christian had sent emails to 14 people in Minnesota asking them whether the time was right to build a shared positive vision of the SAW/RTW process based on the ACOEM guideline, and whether

they might want to participate in the 60 Summits Project. She suggested they route the email to others who might also be interested. By the time she arrived in Minneapolis in September 2006, 31 people representing 20 different organizations were in the room! They came in for a breakfast meeting, not just from the Twin Cities, but also from Marshall, and Rochester. They wanted to hear more about the possibilities the ACOEM guideline offered them on addressing the gaps and breakdowns that lead to needless work disability and job loss. With a resounding "yes!" this group decided that the time was right to spread the news about the ACOEM work disability prevention guideline by means of a stakeholder summit. The desired outcome was to build a consensus among the involved parties that the ACOEM guideline's recommendations should be implemented, and then to make it happen.

At first, the group agreed on a roughly 13 month planning cycle and initially scheduled their Summit for November, 2007. Momentum dropped off midway, partly due to long intervals between meetings and partly due to distraction by intervening events. By mid-summer 2007, it was clear that the November event would have to be postponed and new leadership recruited. Scott Sexton, JD from CorVel Corporation and Michael Goertz, MD from Park Nicollet Clinic stepped into the breach and agreed to co-chair. The planning committee reconstituted itself, recharged its batteries, and proceeded full speed ahead with planning for a Stay at Work / Return to Work Summit 2008 on January 31-February 1 in Minneapolis.

As part of their planning efforts, the committee developed its own website, www.MNWorkability.com to share not only their Summit planning information but to provide an ongoing resource for future follow-up activities.

Key Definitions

ACOEM Guidelines: The American College of Environmental Medicine has issued a variety of guidelines, policies, and position statements over time.

- The most well-known of its guidelines are the *Occupational Medicine Practice Guidelines* for diagnosis and treatment of occupational conditions, adopted in 2002. This several hundred page document is available for sale from ACOEM. The Practice Guidelines were adopted as the presumptively correct standard of care by the California workers' compensation system. Those guidelines **were not** the topic of the Minnesota SAW/RTW Summit.
- The work disability prevention guideline which **was** the focus of the Minnesota SAW/RTW Summit is the most recent guideline that ACOEM has issued, entitled *Preventing Needless Work Disability by Helping People Stay Employed*. It was adopted in May 2006. It is 27 pages long, and is free on ACOEM's website (www.acoem.org) under Policies and Position Statements. The work disability prevention guideline is addressed to all participants in the stay-at-work and return-to-work process. It makes general and systemic recommendations to improve how the process functions in order to improve service to workers and their supervisors, and to improve outcomes of injury-, illness- or aging-related employment predicaments.

The Stay-At-Work and Return-To-Work (SAW / RTW) process occurs whenever an employed person becomes injured, ill, or has had a change in their ability to function. It consists of a sequence of questions, actions and decisions made separately by several parties that, taken as a whole, determine whether, when and how an injured or ill person stays or returns to work. Thus, the SAW/RTW process is an outcome-generating process. However, it often

becomes derailed because the focus is instead on certifying, corroborating, justifying, evaluating, or measuring the extent of the disability rather than preventing it.

Work disability. It is important to note that the term "disability" or "work disability" here means time either away from work or working at less than full productive capacity attributed to a medical condition. Work disability ***does not*** mean an impairment, because many people with substantial impairments work full time and full duty. Needless work disability (absence or withdrawal from work) is harmful, disruptive, and costly both to the employee and the employer.

The Summit Planning Process

The core Minnesota Summit planning group also known as "the Summit planners" consisted of ten volunteer members. They worked together to plan the Summit by email, on the phone, and in face-to-face meetings. They engaged the 60 Summits Project staff to assist with planning and delivery of their day and a half Summit workshop, as well as providing speaking and leadership services. The planning process involved clarifying the goals, purposes, design and agenda of the workshop, identifying invitees within each of the stakeholder groups, designing the invitations, conducting the invitation process, arranging the facility logistics and developing the associated materials that would be used during the workshop. It also involved developing a budget, developing informational materials for potential sponsors, and raising money from local organizations.

Goals and Intended Outcomes of the Summit

The goals of the planning committee were to:

- Provide an arena in which stakeholders can both speak and listen to one another's point of view.
- Explore the feasibility of implementing 16 specific recommendations made in a widely-acclaimed and common sense guideline entitled "Preventing Needless Work Disability by Helping People Stay Employed" issued by the American College of Occupational & Environmental Medicine (ACOEM).

INTENDED OUTCOMES FOR SUMMIT PARTICIPANTS

- New relationships and collaborators
- Greater awareness of and respect for:
  - the outcomes created by the Stay-at-Work and Return-to-Work (SAW/RTW) process
  - other SAW/RTW participants' concerns and perspectives.
- Several new ideas and concrete steps to take that will improve results

In the invitation, the Summit planning group promised that participants would learn how communication -- or the lack of it -- among employers, workers, healthcare providers and insurers during the treatment and recovery of an injured employee affects medical and employment outcomes; and techniques and tips for better communication that reduce hassles, improve medical outcomes, protect jobs and improve business productivity. Participants were also told that they would leave with (a) new relationships with people in other sectors, and colleagues to collaborate with in the future, (b) a greater awareness of the SAW/RTW process and other participants' concerns and perspectives, which will allow the participants to communicate with them more effectively; and (c) several concrete ideas and strategies to

improve the stay-at-work and return-to-work process in their own organizations, communities, and Minnesota as a whole.

In the opening session, Dr. Christian declared the intention that this Summit would become a historic milestone, signal a beginning, and cause the creation a group of inspired and energized people who will gradually transform Minnesota into a state that prevents needless work disability by actively helping people stay employed

INTENDED OUTCOMES
OF THE SUMMIT EVENT

- Become a historic milestone
- Signal a beginning
- Cause the creation of a group of inspired and energized people who will gradually transform Minnesota into a state that prevents needless work disability by actively helping people stay employed.

Summit Participants

The 87 Summit attendees were a representative group of people from nine stakeholder groups who had been thoughtfully selected and personally invited by the Minnesota Summit planning group. Appendix E is entitled A List of Summit Participants. The stakeholder groups consisted of representatives from employers, physicians, labor, insurers, case managers, occupational and physical therapists, return-to-work specialists, associations, government, mental health, legal, and managed care. They accepted the invitation knowing that they would work within the framework of the ACOEM guideline in joint pursuit of creating a milestone event for Minnesota and a better stay-at-work and return-to-work process to benefit both employees and employers. The intended outcomes for participants were: It was inspiring to see them deeply engaged in conversations with other stakeholders in their small groups, listening carefully to each other with respect, good will, and real enthusiasm.

Description of the Summit Workshop

The Minnesota SAW/RTW Summit was the first of the 60 Summits events nationwide to employ a day and a half delivery format. This format worked very well because it allowed participants to form cohesive multi-stakeholder working groups in a relaxed half day session before the more difficult assignment of coming up with strategies and concrete next steps the following day. See the summary agenda in the box.

AGENDA

<u>January 31 - Early Evening Event</u>

Opening session, welcoming remarks
Dinner and introductions
Presentation by Dr. McGrail
Prepare for tomorrow

<u>February 1 - Full Day Event</u>

Keynote presentation by Dr. Christian
First round of small group work sessions
Lunch
Second round of small group work sessions
Panel discussion
General session & adjournment

<u>Welcome reception and opening session</u>. The Summit began with a welcome reception on Thursday afternoon. Attendees were then guided by their group facilitators to their assigned tables. The facilitators were members of the Minnesota Summit planning group whom Dr. Christian had trained in a single session prior to the Summit. The facilitators worked with their groups for the duration of the Summit and were responsible for keeping the discussion in their groups focused on the issues and on producing their small group reports.

Brief opening remarks were made by the local Summit planning committee chair followed by Dr. Christian's short orientation. One thing stood out from the beginning of this Summit. *With a show of hands, more than 90% of the room indicated that they had already read and were familiar with the ACOEM SAW-RTW guideline!* This is due to the Minnesota Summit planning group's preparatory work. They had made sure that all attendees had a copy of the guide in advance and had successfully communicated how important it would be to come prepared.

During an informal working dinner, the participants received their group assignments. Each joined a small group composed of 10-12 people from multiple stakeholder types. In turn, each group was assigned different ACOEM recommendations, varying from one to three recommendations per group. After that, the participants got to know one another, and prepared for their work the next day. Dr. Michael McGrail also delivered a keynote address. He is a local physician who was part of the committee that developed the ACOEM work disability prevention guideline, and a well-known longtime local champion of work disability prevention.

The Summit workshop. Friday's events consisted of a keynote address by Dr. Christian that provided an overview of the 60 Summits Project, stressed the importance of preventing needless disability, outlined key concepts in the ACOEM Guideline and briefly reviewed each of the 16 recommendations in the guideline. Small group break-out sessions were held in both the morning and afternoon, then a panel discussion delivered by a variety of stakeholders, and finally a brief closing general session.

TASKS ASSIGNED TO EACH MULTI-STAKEHOLDER SMALL GROUP:

1. Decide which portion(s) to focus on of the ACOEM guideline you were assigned.
2. Decide if you agree with the recommendation. If not, solve that problem another way.
3. If so, devise a strategy to make it happen in your own practice, organization or community.
4. Identify a concrete first step to get started.
5. Describe what you are going to do starting tomorrow.

The eight small groups, each composed of multiple stakeholders, were challenged to decide whether they agreed with the ACOEM recommendation(s) they had been assigned. If so, they were asked to come up with strategies for making them into realities, as well as concrete first steps, and commitments for action to take "tomorrow".

Following the morning work session each small group presented their initial reports, received feedback from Dr. Christian, and then were given time to further develop and refine their concrete action steps. In another general session, they presented their final reports. The design of the afternoon session presumed that the small groups had learned how to work together in producing concrete plans, so it consisted of only one round of small group work session and reports.

After the presentations, a panel comprised of employers, physicians and labor attendees gave their reaction to the small groups' proposals and commented on the practicality of implementing the ideas in the Guideline for the SAW/RTW process in Minnesota. All of the small groups indicated they agreed with the recommendations although some did revise some of the wording of the particular recommendations they had been assigned. The action plans developed by the small groups is remarkable for its variety, breadth, depth, and specificity, including dates by which certain activities will be complete! This practical "to do list" for the future appears in Appendix D, a comprehensive list of all of the action plans developed by the multi-stakeholder small groups.

In addition, each individual participant was asked to complete a personal commitment sheet that they could take home and use as a reminder of the promises they had made to themselves and in some cases, to each other. Each participant in the Minnesota SAW/RTW Summit was asked to write down his or her own personal insights, plans, and commitments they had made to themselves during the Summit. (According to social scientists, people are more likely to actually do things if they have made a formal written or oral commitment to do so.) The Personal Commitment forms were copied towards the end of the event so that the ideas that were arising during the Summit could be captured and consolidated for inclusion in this report. The original forms were returned to the participants so they could take them home. Appendix E is a list of personal commitments made by participants. Personally identifying information has been removed.

STATEMENTS COMPLETED BY EACH PARTICIPANT ON THEIR PERSONAL COMMITMENT FORM

1. The main things I see that I can actually do to improve MY OWN practice or organization are: _____.
2. The main opportunity where I can actually do something to improve how things work in my community or state is: _____.
3. Here's what I personally intend to do about this tomorrow or this week: _____.

After a brief summary wrap-up in which Dr. Christian summarized the general themes that had appeared throughout the day, the Summit was complete. Attendees completed evaluations of the event, and were given the opportunity to state their desire as to which activities they would like to be involved with going forward, such as whether they want to receive follow-up emails, be invited to future events or be part of the follow-on action group. *Of note, more than 60% of the attendees signed up to be part of the Minnesota Summit Follow-on Action Group!*

Summary of Action Plans and Personal Commitments

All of the work groups thought the individual recommendations that they had been assigned were worthwhile (although a few groups reworded some phrases). Therefore, all of the small groups developed action plans to implement them. Commonalities among the plans became apparent as the small groups gave their reports. Commonalities were also obvious after a review of the personal commitment sheets that were completed by participants and submitted for copying. The major domains in which their plans and commitments exist are:

1. **Propagating (or disseminating) the new paradigm.** Many of the action plans involve disseminating key precepts of the new work disability prevention model to a wide array of audiences using a variety of media through several channels. The media ranged from conversations to presentations, from simple brochures to formal educational courses and systematic training programs. Examples of these plans included the development of materials: advertising campaigns, informational brochures and packets, and continuing education courses. Other plans focused on the delivery of the message (e.g., forming a speaker's bureau, volunteering to give presentations at meetings of local organizations, incorporating it into existing company training materials and courses, etc.). Among the audiences at which these messages are to be aimed are employers, workers/ unions, physicians, claims/case managers.

2. **Engaging others -- building an ever-larger community of interest.** Many of the action plans involved outreach, liaison, building relationships and collaboration with specific people, organizations and groups, especially the Summit's own follow-on action group. The purpose of this engagement is more than dissemination of the ACOEM

guideline and includes invitations to collaborate on an everyday basis or to participate in the projects arising out of the 60 Summits' multilateral approach to process improvement and system change.

3. **Developing and testing better tools and methods -- and facilitating their widespread adoption.**. Examples of action plans in this domain include: (a) designing a better form for employers to use in describing job demands; (b) designing a reimbursement and privileging method that will reward physicians for developing and demonstrating expertise in work disability prevention; (c) researching existing tools to select one to use in screening programs to identify employees at increased risk for prolonged disability so they can receive special support, (d) putting together "toolboxes" for employees and employers that are ready when needed; (e) creating a self-assessment tool for employers to determine how their programs match up against current best practices.

4. **Operationalizing the ACOEM guideline's recommendations by putting them into everyday practice.** Examples of action plans in this domain include commitments to: (a) revise routine charting and documentation practices; (b) add information about disability program to new hire training; (c) establish a procedure to ensure that a functional job description is always provided to the treating physician; (d) develop a process to regularly utilize the Guideline in communications with physicians during the claim process; (e) change the language routinely used in the workplace to reflect the Guideline's philosophy.

This list includes only those domains in which the bulk of action plans lay. Many action plans touched more than one domain. Other domains in which there were also several action plans include legislative/regulatory action (though not as many as some might have expected) and personal development (the deepening of one's own knowledge or expertise).

Next Steps

The intention of the Minnesota SAW/RTW Summit planning team was for this event to be a milestone, and the day when the paradigm began to shift towards work disability prevention throughout Minnesota. During the planning of the Minnesota Summit, committee members acknowledged that work had already begun on some of the topics addressed in the ACOEM guidelines. This was not the first time that some of the attendees had come together to try to make breakthroughs in some areas. So what was different this time?

The shift begins with getting as many of the right people as possible in the room to take on actually finding a way to implement the 16 ACOEM recommendations. The Summit starts with asking attendees to identify what is possible through communication and collaboration across multi-stakeholder groups. The 60 Summits Project supports a structure for fulfillment that starts with the workshop structure offered during the Summit and continues with the Follow-On Action Group. Having a structure to support attendees who have made personal commitments to action is key.

More than 60% of the attendees at the Minnesota Summit expressed an intention to participate in the follow-up action group. The co-chairs of the Minnesota Summit planning committee offered to launch that group for Minnesota Workability on February 29th and to take the

preliminary steps towards development of a structure that will help people refine and fulfill the preliminary plans and commitments they made during the Summit. Minnesota Workability will continue to update its website.

The 60Summits website will link to the MNWorkability.com website and provide a central clearinghouse for all the other state groups participating in The 60 Summits Project. The 60Summits Project is also developing a guide to assist local groups with developing the structure, methods and tools needed to support the ongoing work of their newly-created local group. In addition, the first national conference of The 60 Summits Project is scheduled for November 2008. The goal of the national conference is to provide a venue in which all local groups can meet, share their experiences, successes and challenges, and collaborate on joint projects. While each jurisdiction and planning group has unique characteristics, they also have many issues and challenges in common. The local groups are enthusiastically supporting the idea of working together, since they see little need to "re-invent the wheel" and have already grasped the advantages of cross-fertilization of ideas and sharing of solutions.

Appendix A
MINNESOTA SAW / RTW SUMMIT
List of Planning Committee Members

CO-CHAIRS:

Michael Goertz MD, MPH is the Medical Director of Employee Health Services, Park Nicollet Clinic. He is also contributing editor to Cornerstones of Disability Prevention and Management (Chapter 5. Occupational Medicine Practice Guidelines) and is a member of the ACOEM committees on Disability Prevention and Management and the Low Back Treatment Guidelines.

Scott Sexton, J.D., is an Account Executive with CorVel Corporation, as well as a licensed attorney in the State of Minnesota. Mr. Sexton works with employers and insurance companies in Minnesota and throughout the country to develop cost effective and comprehensive medical and disability management programs. Mr. Sexton has over 18 years of industry experience and has won CorVel's Circle of Excellence award for the past four years, including Inner Circle of Excellence for the past two years.

MEMBERS:

Dave Fuecker is the Associate Director of Disability Services/UReturn at the University of Minnesota. UReturn is an integrated internal case management program that serves all employees of the University of Minnesota. David has been at the University of Minnesota since 1996. Prior to his position at the University of Minnesota, David worked as a Qualified Rehabilitation Consultant for VanWagner & Associates. David earned a masters degree in Rehabilitation Counseling from Mankato State University, Mankato, MN in 1994.

Susan Isernhagen PT is C.O.O. of DSI Work Solutions, Inc., a consulting company to industry and healthcare. She specializes in implementing processes to reduce work injury and related lost time for employers and workers. She has presented internationally and published numerous articles on early return to work and injury prevention. Downloads can be found on www.dsiworksolutions.com.

Laurie Johnson is the Manager of the WorkWell Quality Provider Network. Ms Johnson provides clinical support, consultation and documentation feedback to its members. She also provides information to payers, employers and other referrers about the Provider Network Services and about WorkWell's Work Injury Prevention and Management Programs. Ms. Johnson has experience in implementing, as well as teaching the protocols and principles of,

WorkWell's FCE, FJA, PWS and WR programs. She is a member of the American Physical Therapy Association, Orthopedic Section and Industrial Rehabilitation Special Interest Group.

Brian Konowalchuk MD is a practicing occupational medicine physician at the Duluth Clinic. He also serves as the Saint Mary's Duluth Clinic (SMDC) Health System Program Director for regional disability management and is the Medical Director for SMDC Employee Health. Dr. Konowalchuk had been successful in improving employee access and reducing unnecessary lost work time with innovative solutions in the SMDC Health System, and he continues to work to improve employee injury and illness care across Northern Minnesota and Wisconsin.

Peggy Mann Rinehart is the Associate Director for Access Programs and Special Projects in Disability Services at the University of Minnesota. She is responsible for the areas of document conversion, testing accommodations, access assistants, computer accommodations and access to information technology. In addition, she is responsible for developing special programs and projects. Prior to joining DS staff, Ms. Mann Rinehart was the executive director of the KDWB Variety Family Center in the Department of Pediatrics at the University of Minnesota working with families who have children with chronic illness or disabilities.

Rob Otos is the Director of Operations for The ALARIS Group, Inc. Mr. Otos is a Qualified Rehabilitation Consultant and a Certified Disability Management Specialist. He specializes in medical and vocational case management, ergonomic assessment, job analysis and job modification. The ALARIS Group is the leading resource for insurance carriers, attorneys and employers striving to maximize the recovery of injured employees – and minimize the financial impact.

Betty Post, RN, COHN-S, CPDM is the Supervisor of the Disability Case Management at Xcel Energy in Minneapolis. Her area of responsibility is case management and return to work processes for both occupational and non-occupational injuries and illnesses for employees in all Xcel Energy jurisdictions. She has worked from both the medical provider and the employer sides in regards to absence and disability management. She is the current President of the Minnesota Association of Occupational Health Nurses. Betty is a board member, past President and current Program Chair of the Minnesota Chapter of Disability Management Employer Coalition.

Jane Ryan is Return to Work Section Head at Mayo Clinic in Rochester, MN. She was instrumental in the development of Mayo's return to work and accommodation practice that has achieved national recognition and awards as a best practice program. Previous experience includes work as a Qualified Rehabilitation Consultant in the private rehabilitation sector, program coordinator of a pain management program, nurse therapist in inpatient chemical dependency and psychiatric programs and counselor in a private marriage counseling practice. Ms. Ryan is a charter member of the Minnesota Disability Management Employer Coalition (DMEC) chapter board, past president and currently serves as secretary for the chapter. She received the Chester Miller Leadership Award from DMEC in 2005.

Appendix B
MINNESOTA SAW / RTW SUMMIT
List of Sponsors

North American Sponsors

The 60 Summits Project

Prudential Financial

Webility Corporation

Local Sponsors

The Alaris Group, Inc.

BMI - Behavioral Medical Interventions

CCMSI

CorVel

DSI Work Solutions, Inc.

Duluth Clinic
an affiliate of SMDC Health System

Encore Unlimited, LLC

Graco

HealthPartners

Mayo Clinic

Minnesota Association of
Occupational Health Nurses

Minnesota Association of
Rehabilitation Providers

Physicians Neck & Back Clinics

RTW, Inc.

The Schwan Food Company

SFM Mutual Insurance

The Standard Insurance Company

Union Construction
Workers Compensation Program

University of Minnesota Disability Services

Workwell Systems, Inc.

WCRA - The Minnesota Workers'
Compensation Reinsurance Association

Xcel Energy

Appendix C
MINNESOTA SAW / RTW SUMMIT
List of Participants

Name	Primary organization
Debra Anger	Berkley Risk Admin / League of MN Cities
Jeanne Ayers, MD	U of MN - Boynton Health Service
Ross Azevedo	U of MN - Carlson Industrial Relations Center
Beth Baker, MD	Health Partners / SFM Mutual Insurance
Kim Beck	Graco
Mary Beck	CCMSI
Neal Binsfeld	U of MN - Disability Services
Ellen Bleck	Assurant Employee Benefits
Sandra Bodensteiner	City of St. Paul
Rhonda Bosworth	Sedgwick CMS
Kathy Bray	Lynn, Scharfenberg & Assoc.
Connie Brown	SFM Mutual Insurance
Jane Brownlee	Fairview University Medical Center - MESABI
Dave Carpenter	PNBC
Kristi Carrington	Mayo Clinic / MARP
Cathy Cato	BMI
Tim Collin	Comp Rehab
Greg Couser, MD	Mayo Clinic
Terri Dolan	PNBC
David Dubovich	Allina Hospital & Clinics
Tanya Dunagan	Star Tribune
Catherine Ellis	University of Minnesota
David Fuecker	University of Minnesota
Todd Ginkel	Physicians' Diagnostics & Rehabilitation
Michael Goertz, MD	Park Nicollet Airport Clinic
Tawnya Goertzen	The Hartford
Kathy Goldblatt	Prudential Financial

Name	Primary organization
Robert Gorman, MD	Park Nicollet Clinic
Marty Haefner	University of Minnesota
Natalie Haefner	WCRA
Julia Halberg, MD	General Mills
Linda Hanson	L. Hanson Consulting Group, Inc.
Carline Harris	Continental Western Group
Rose Hatmaker	SFM Mutual Insurance
Gari Hayden	RTW, Inc.
Barbara Herke-Smith	Workwell Systems, Inc.
Elliot Herland	UCWCP
Tom Hesse	MN Chamber of Commerce
Julie Horak	CorVel Corporation
Philip Hoversten, MD	Allina Medical Clinic
Susan Isernhagen, PT	DSI Work Solutions
Gary Johnson, MD	North Memorial Health Care
Laurie Johnson	Workwell Systems, Inc.
Joe Kapaun	North Country Health Services
Meg Kasting	SFM Mutual Insurance
Connie Klein	Metropolitan Council
Kathryn Koch	Allete Inc.
Brian Konowalchuk, MD	Duluth Clinic (SMDC)
Kelsy Kuehn	St. Lukes Hospital
Nancy Kuntz	The Alaris Group, Inc.
Bradley Lehto	Minnesota AFL-CIO
Peter Lewon	MN Nurses Association
Peggy Mann Rinehart	University of Minnesota
Michael McCallum	Xcel Energy
Michael McGrail, MD	HealthPartners Medical Group
Margot Miller	Workwell Systems, Inc.
Lisa Mitchell	Graco
Rob Otos	The Alaris Group, Inc.
Robin Peterson	OSI Physical Therapy
Marie Petsinger	Hutchinson Technology

Name	Primary organization
Diane Polman	The Hartford
Betty Post	Xcel Energy
Patty Prentice	League of MN Cities
Mark Radersdorf	Behavioral Medical Interventions
Philip Rodgers	CCMSI
Dotti Rottier	Encore Unlimited, LLC
Jane Ryan	Mayo Clinic
Jeanne Sample	Flint Hill Resources
Jennifer Schaubach	Minnesota AFL-CIO
Cindy Sesolak	Jenny-O-Turkey Store
Scott Sexton	CorVel Corporation
Pat Sheveland	RTW Inc.
Elizabeth Shogren	Minnesota Nurses Association
Dawn Soleta	The Toro Company
Scott Sonstegard	TEAM Industries
James Stanfield	The Standard Insurance
Maureen Stanley	Boynton Health Service
Linda Suzuki	Standard Insurance Company
Dave Thoreson	Health Fitness Corp.
N. Marcus Thygeson	HealthPartners
Patricia Todd	Minnesota Department of Labor & Industry
Lisa Triplett	Visant Corp./Jostens
Sue Verbrugge	Target Corporation
Joe Wegner, MD	PNBC
Jana Williams	Minnesota Department of Labor & Industry

Appendix D
MINNESOTA SAW / RTW SUMMIT
Action Plans Developed by
Multi-Stakeholder Small Groups

The 90 participants in the Minnesota Stay-at-Work and Return-to-Work Summit on January 31 and February 1, 2008 were divided into 8 small groups. Each group had 10 - 12 members representing all the stakeholder groups attending the Summit.

The 16 recommendations made in the ACOEM work disability prevention guideline were divided up among the groups. Most groups discussed two or three recommendations. However Group D was assigned only the one recommendation that suggests paying physicians for disability management. A closely-related issue, known in Minnesota as "pay for performance," had already received considerable attention. The conference planners viewed the Summit as an ideal opportunity to get all the necessary parties together and spend enough time to make significant progress in this area.

Most groups addressed their recommendations separately, one in the morning, and the other(s) in the afternoon. As a result, there are two reports below from all Groups except Group F. They issued a consolidated report about all three of the recommendations they had been assigned. Despite being assigned only one recommendation, Group D has two reports below because they took on a special topic in the afternoon.

Group	ACOEM SAW/RTW Recommendations Discussed
A	2, 9
B	3 (also assigned to Group C), 4
C	3 (also assigned to Group B), 5
D	7 (and a voluntary Special Topic)
E	6, 10, 11
F	8, 12, 13b
G	14, 15
H	1, 13a, 16

In their deliberations, the groups were assisted by facilitators who were all members of the Summit planning group and who had been trained by 60 Summits Project staff.

The groups were instructed to use a standardized format to prepare their findings. They were asked to:

1. Identify the members of their group
2. Specify the recommendation they were addressing and the specific parts of the recommendation they focused on.
3. Lay out the strategy they believe is best for making this (the things called for in the recommendation) actually happen.
4. Describe their concrete first steps towards implementing this recommendation.

5. Share examples from their Personal Commitment sheets about what they intend to do starting tomorrow (the day after the Summit).

Following their deliberations, each group appointed its own spokesperson who had about 2 minutes to present their findings in a general session. They used a pre-printed form to prepare and deliver their reports, which were turned into 60 Summits Project staff for incorporation in this Report. A couple of groups took notes on computers as they worked. As the spokespeople presented, 60 Summits staff took notes and a tape recording was made of the afternoon session. Thus, the report summaries below are based on all four sources as available: the hand-written paper forms, computer files, notes, and the recording.

Group A – Minnesota Small Group Report
Section I, Recommendations 2 and 9

Group Members

Name	Company
David Dubovich	Allina Hospitals & Clinics
Marty Haefner	University of Minnesota
Linda Hanson	L. Hanson Consulting, Inc.
Geri Hayden	RTW, Inc.
Elliott Herland	UCWCP
Diane Polman	The Hartford
Rob Otos	The Alaris Group, Inc.
Phillip Rodgers	CCMSI
Dave Thoreson	Health Fitness Corp.
Joe Wegner	Physicians Neck & Back Clinic

GROUP A - Recommendation 2

Text of Assigned Recommendation(s) from ACOEM Guideline

I. ADOPT A DISABILITY PREVENTION MODEL

2. Urgency is Required Because Prolonged Time Away from Work is Harmful

Sub-recommendations:

a. Shift the focus from "managing" disability to "preventing" it and shorten the response time.

b. Revamp disability benefits systems to reflect the reality that resolving disability episodes is an urgent matter, given the short window of opportunity to re-normalize life.

c. Emphasize prevention or immediately ending unnecessary time away from work, thus preventing development of the disabled mindset, and disseminate an educational campaign supporting this position.

d. Whenever possible, incorporate mechanisms into the SAW/RTW process that prevent or minimize withdrawal from work.

e. On the individual level, the health care team should keep patients' lives as normal as possible during illness and recovery while establishing treatments that allow for the fastest possible return to function and resumption of the fullest possible participation in life.

1. The part(s) of the Recommendation we focused on are:

The urgency and education components. We changed the wording from "Urgency is required because prolonged time away from work is harmful." to "Urgency is required because prolonged time away from work is important to all parties, especially those who are being harmed."

2. **The strategy we believe is best for making this actually happen is:**
   a. Define "urgency" for each party. "Urgency" mostly impacts financials for most parties
   b. Define a group of educators w/curriculum and educate all parties
   c. Shorten the time for when injured or ill employees are seen by providers
   d. Through league of educators, arm them with protocols so the medical and employer part of the team are prepared
   e. Take away the risk for insurance to pay even before they pay; pay the bill up front, don't wait – it's the opposite of subrogation
   f. Identify and use qualified providers to educate other providers
   g. Use occupational medicine physicians and medical schools to teach SAW/RTW
   h. Ask networks to educate their providers
   i. Provide education to employees on their responsibilities
   j. Make contacts as assigned
3. **Our concrete first steps towards implementing this recommendation are:**
   a. Our committee to develop curriculum for each group after commitment of stakeholders
   b. Educators will be specific to group- stakeholder specific
   c. Ongoing education for case managers.
4. **Here's what we intend to do starting tomorrow: (Examples from the group's Personal Commitment Sheets):**
   a. MSIA – SAW/RTW – Phillip Rodgers - June? – subcommittee rep.
   b. MSRB/DOLI MD's, PT, ortho, union – Beth Baker – include DOLI – subcommittee rep. 2-15-2008
   c. MARP/MASPAR/MRCA – Linda Hanson – 3-1-2008-subcommittee rep.
   d. DMEC- David Dubovich – June meeting- subcommittee rep.
   e. AFLCIO – Betty Shogren
   f. WCAC – Tom Bakk – Rob Otos
   g. Union construction board –union and union contractor support mtg 2-12-2008 Kevin Gregerson

GROUP A - Recommendation 9

Text of Assigned Recommendation from ACOEM Guideline

> ***III. ACKNOWLEDGE THE POWERFUL CONTRIBUTION THAT MOTIVATION MAKES TO OUTCOMES, AND MAKE CHANGES TO IMPROVE INCENTIVEALIGNMENT***
>
> ***9. Increase "Real-Time" Availability of On-the-job Recovery, Transitional Work Programs, and Permanent Job Modifications***
>
> *Sub-recommendations:*
>
> *a. Encourage or require employers to use transitional work programs;*
>
> *b. Adopt clearly written policies and procedures that instruct and direct people in carrying out their responsibilities;*

c. Hold supervisors accountable for the cost of benefits if temporarytransitional work is not available to their injured/ill employees;

d. Consult with unions to design on-the-job recovery programs;

e. Require worker participation with ombudsman services available to guard against abuse;

f. Make ongoing expert resources available to employers to help them implement and manage these programs.

1. The part(s) of the Recommendation we focused on are:

Employer is the key player

Replace the phrase "real time" with awareness and immediate.

2. The strategy we believe is best for making this actually happen is:

a. Need insurers and unions to be key players.

b. Review incentives to keep employees at work versus not

c. Get info out to employers on RTW programs.

3. The concrete first step towards implementing this recommendation is:

a. EDUCATE – USE current groups to share what's working in transitional RTW programs, for large and small employers – metro and non-metro. Encourage designated local on site contact.

b. Suggest incentives, lists of LOT, and identification of successful and unsuccessful program

4. Here's what we intend to do starting tomorrow: (Examples from the group's Personal Commitment Sheets):

a. Contact to share with the 2 largest employer based organizations – DMEC and MSIA to tap into their resources and network. – Rob

b. Phillip plans to email brokers, clients, MD's and chiropractors to increase awareness of SAW/RTW process by 2/14/08.

c. Elliot will present the SAW/RTW concepts to the UCWCP Board of Trustees on 2/12/08

Group B – Minnesota Small Group Report – Section II, Recommendations 3 and 4

Group Members

Name	Company
Ross Azevedo	U of M – Carlson Industrial Relations Ctr.
Mary Beck	CCMSI
Neil Binsfeld	U of M – Disability Services
Jane Brownlee	Fairview University Medical Center
Cathy Cato	BMI
Todd Ginkel	Physicians' Diagnostics & Rehabilitation
Tawyna Goertzen	The Hartford
Carline Harris	Continental Western Group
Susan Isernhagen	DSI Work Solutions, Inc.
Mike McCallum	Xcel Energy
Lisa Mitchell	Graco
Dotti Rottier	Encore Unlimited, LLC

GROUP B- Recommendation 3

Text of Assigned Recommendation(s) from ACOEM Guideline

> ***II. ADDRESS BEHAVIORAL AND CIRCUMSTANTIAL REALITIES THAT CREATE OR PROLONG WORK DISABILITY***
>
> ***3. Acknowledge and Deal with Normal Human Reactions***
>
> *Sub-recommendations:*
>
> *a. Encourage all participants to expand their SAW/RTW model to include appropriate handling of the normal human emotional reactions that accompany temporary disability to prevent it becoming permanent.*
>
> *b. Encourage payers to devise methods to provide these services or pay for them.*

1. The part(s) of the Recommendation we focused on are:

The worker's normal reaction to injury/illness that is affecting them.

2. The strategy we believe is best for making this actually happen is:

[No answer provided.]

3. The concrete first step towards implementing this recommendation is:

a. To avoid worker fear and uncertainty – all of a. needs to be done upfront and put to work at first report
   i. Toolbox for employees (employer responsibility)
      - At hire
      - Regular updates

- At time of presenting problem

ii. Toolbox for employers (insurer responsibility)

- Covers forms/reports/FMLA – need to be familiar with the process so they can answer employee questions
- Covers processes

b. To assist workers in understanding professional roles, each professional group to develop declarations and questions for worker. Each group commits to meeting with others for overall understanding

c. How to keep worker in worker mode

i. Employers select and train supervisors in

- managing workers with work limitations and
- balancing productivity with SAW/RTW issues
- better interpersonal relationship skills

ii. Through

- consultants
- training modules

4. Here's what we intend to do starting tomorrow: (Examples from the group's Personal Commitment Sheets)

[No answer provided.]

GROUP B - Recommendation 4

Text of Assigned Recommendation(s) from ACOEM Guideline

> ***II. ADDRESS BEHAVIORAL AND CIRCUMSTANTIAL REALITIES THAT CREATE OR PROLONG WORK DISABILITY***
>
> ***4. Investigate and Address Social and Workplace Realities***
>
> *Sub-recommendations:*
>
> *a. The SAW/RTW process should routinely involve inquiry into and articulation of workplace and social realities;*
>
> *b. Establish better communication between SAW/RTW parties;*
>
> *c. Develop and disseminate screening instruments that flag workplace and social issues for investigation; and*
>
> *d. Conduct pilot programs to discover the effectiveness of various interventions.*

1. The part(s) of the Recommendation we focused on are:

Investigate and address social and workplace realities

2. The strategy we believe is best for making this actually happen is:

a. Investigate screening tools to identify social and workplace issues

b. Review literature – by 3-15-08 Dottie Rottier and Cathy Cato will complete literature review

c. Carline Harris via email will ask employers, insurers, providers, QRC, case managers to send in form(s) and/or tool(s) that they have used to screen by 3-15-08. Carline will ask for community volunteer

3. The concrete first step towards implementing this recommendation is:

a. The community will choose and develop best in class screening tools

b. The community will solicit payers, insurers and employers to participate

4. Here's what we intend to do starting tomorrow: (Examples from the group's Personal Commitment Sheets)

The community will evaluate the pilot study within 6 month timeframe

Group C – Minnesota Small Group Report
Section II, Recommendation 3 (duplicate) and 5

Group Members

Name	Company
Ellen Bleck	Assurant Employee Benefits
Greg Couser	Mayo Clinic
Catherine Ellis	University of Minnesota
Julie Horak	CorVel Corporation
Connie Klein	Metropolitan Council
Peter Lewon	MN Nurses Association
Mark Raderstorf	BMI
Jane Ryan	Mayo Clinic
Pat Sheveland	RTW Inc.

GROUP C - Recommendation 3

Text of Assigned Recommendation(s) from ACOEM Guideline

> ***II. ADDRESS BEHAVIORAL AND CIRCUMSTANTIAL REALITIES THAT CREATE OR PROLONG WORK DISABILITY***
>
> ***3. Acknowledge and Deal with Normal Human Reactions***
>
> *Sub-recommendations:*
>
> *a. Encourage all participants to expand their SAW/RTW model to include appropriate handling of the normal human emotional reactions that accompany temporary disability to prevent it becoming permanent.*
>
> *b. Encourage payers to devise methods to provide these services or pay for them.*

1. The part(s) of the Recommendation we focused on are:

[No answer provided.]

2. The strategy we believe is best for making this actually happen is:

a. Develop educational brochure addressing what to expect when you're injured/ill for employees and make available to them by providers and employers

b. Educational brochure to assist injured worker with maximizing physician visit

c. Ad Campaign

i. "Don't let pain consume your life – we can still lead productive lives!"

ii. "Got Pain?" with a pain mustache

iii. "Work a day keeps the doctor away"

iv. "If I have to work so do you"

v. "Work is therapy!"

vi. "Work to cure what ails you"

vii. "Depressed or blue, join the _____"

3. **The concrete first step towards implementing this recommendation is:**
   a. Contact U of Minnesota School of Public Health to take on the ad campaign through an internship or plan B paper (include recommended funding sources as part of the research)
4. **Here's what we intend to do starting tomorrow: (Examples from the group's Personal Commitment Sheets):**
   a. Short term - Each member will review their educational materials for appropriateness and revisions. Connie will contact Deb Olson with U of M's School of Public Health.
   b. Get that student from the U.
   c. Long term – Statewide ad campaign and materials for provider, patients, workers, employers, insurers, labor, DOL-WC, MDH etc.

GROUP C - Recommendation 5

Text of Assigned Recommendation(s) from ACOEM Guideline

> ***II. ADDRESS BEHAVIORAL AND CIRCUMSTANTIAL REALITIES THAT CREATE OR PROLONG WORK DISABILITY***
>
> ***5. Find a Way to Effectively Address Psychiatric Conditions***
>
> *Sub-recommendations:*
>
> *a. Adopt effective means to acknowledge and treat psychiatric co-morbidities*
> *b. Teach SAW/RTW participants about the interaction of psychiatric and physical problems and better prepare them to deal with these problems*
> *c. Perform psychiatric assessments of people with slower-than-expected recoveries routine*
> *d. Make payment for psychiatric treatment dependent on evidence-based,cost-effective treatments of demonstrated effectiveness.*

1. **The part(s) of the Recommendation we focused on are:**
   To perform psychiatric assessments of people with slower than expected recoveries, our group suggested the revised wording
   a. Add new first bullet "Provide early screening to identify red flags for delayed recovery"
   b. Revise 3rd bullet – "For people with slower than expected recovery, perform reassessment of psychiatric condition which be contributing to delayed recovery"
2. **The strategy we believe is best for making this actually happen is:**
   a. Develop screening/triage tools to assist with identifying individuals who may have predisposition to delayed recovery
   b. Develop easy access to self-directed support and psychiatric assistance that doesn't have stigma of full blown psychiatric care (e.g., EAP)

3. **The concrete first step towards implementing this recommendation is:**
   Identify existing resources/tools (e.g., APA – workplace mentalhealth.org)
4. **Here's what we intend to do starting tomorrow (Examples from the group's Personal Commitment Sheets):**
   a. Meet 3-15-08 with goal of developing assessment tool
   b. Mark will call Claire Miler re: APA assessment tool
   c. Greg and Jane will explore Mayo assessment tools
   d. Catherine and Julie will investigate foundations for assessment tools (brain injury, lupus, MS, blind etc.)
   e. Mark will coordinate meeting location
   f. Julie will meet with DOLI to discuss employee brochure development by 3-15-08
   g. Connie will develop email distribution list
   h. Education
      i. MN DMEC – June 08 and October 08 conferences – Mark will approach program committee to offer as topic
      ii. Behavioral Health Conference – April 08 – Mark will introduce assessment tool
      iii. Park Nicollet/SMDC and Mayo are offering disability prevention, disability management education conferences to providers, employers, case managers, insurers – Greg will offer topic on agenda

Group D – Minnesota Small Group Report
Section III, Recommendation #7

Group Members (Group D did not list their members, so this list is from the Summit notebook)

Name	Company
Debra Anger	Berkley Risk Admin/League of MN Cities
Tom Hesse	MN Chamber of Commerce
Phillip Hoversten, MD	Allina Medical Clinic
Bonnie Skuya	The Schwan Food Company
Meg Kasting	SFM Insurance
Peggy Mann Rinehart	University of Minnesota
Cindy Sesolak	Jenni-O Turkey Store
Scott Sexton	CorVel Corp.
Linda Suzuki	The Standard Insurance Company
Patricia Todd	MN Dept. of Labor & Industry

GROUP D - Recommendation 7

Text of Assigned Recommendation from ACOEM Guideline

III. ACKNOWLEDGE THE POWERFUL CONTRIBUTION THAT MOTIVATION MAKES TO OUTCOMES, AND MAKE CHANGES TO IMPROVE INCENTIVE ALIGNMENT

7. Pay Physicians for Disability Prevention Work to Increase Their Professional Commitment

Sub-recommendations:

a. Develop ways to compensate physicians for the cognitive work and time spent evaluating patients and providing needed information to employer and insurers as well as on resolving SAW/RTW issues. ACOEM developed a proposal for new multilevel CPT codes for disability management that reveals the variety and extent of the intellectual work physicians must do in performing this task. Adopting a new CPT code (and payment schema) for functionally assessing and triaging patients could achieve similar goals. Payers may be understandably reluctant to pay all physicians new fees for disability management because of reasonable concerns about billing abuses – extra costs without improvement in outcomes.

b. Make billing for these services a privilege, not a right, for providers and make that privilege contingent on completion of training and an ongoing pattern of evidence-based care and good-faith effort to achieve optimal functional outcomes.

1. The part(s) of the Recommendation we focused on are:

Compensating physicians/treating providers for time spent on cognitive work

2. **The strategy we believe is best for making this actually happen is:**
    a. Pay for phone calls requested by insurers, conference time, answering questions
    b. Standardize channeling method (referrals, delivery of care and compensation)
    c. Bridge disability with MN Community Measurement Project and think about pay for performance concept
    d. Maintain registries, get data submitted (like the guidelines for diabetic care)
    e. Use ACOEM Guidelines for Care (Practice Guidelines) which will lead to measurable outcomes – can we use these guidelines to support pay for performance?
3. **The concrete first step towards implementing this recommendation is:**
    a. Support ACOEM CPT codes
    b. Training packages online
    c. Develop proposal for new CPT codes in order to compensate for physician communication on SAW-RTW
    d. Would need to work through MSRB to develop new CPT code
    e. DLI required to sign and/or approve training as it relates to the ACOEM guideline – would need MSRB involvement – tie to a CME course – potentially partial reimbursement for taking the course
    f. DMSE certification – Insurance Educators Association
    g. Accountability – limit abuse & document note in chart
    h. Channel to good providers – reimburse at a different level
    i. Train and/or acknowledge through extra reimbursement for doctors that have more experience
    j. Develop a certifying body in order to generate on-line training
    k. Motivate awareness in the community
    l. Find ways to fund training to improve and enlarge channel
    m. Piggy back on ICSI in regard to quality measurement approach
    n. P4P based upon outcomes
    o. Identify unbiased doctors to look at/or review cases
    p. Include in the new adjuster training a section on communication with medical professionals and SAW/ RTW principles
    q. Certification through Insurer Association on a National Level as it relates to doctor rehabilitation training
    r. Look at ACOEM for a leadership role in developing training – they could approve the training
    s. Certification of docs similar to IME docs through their training
    t. Certified doc list will be listed on DLI website or avail. through professional assn. – insurer assn.
    u. The workability form would still be needed
    v. Train physicians in disability management utilizing on-line training
    w. DLI certify the training package for doctors through Dr. Bill Lohman - it will include information on ADA – FMLA – RTW – SAW

4. **Here's what we intend to do starting tomorrow (Examples from the group's Personal Commitment Sheets):**
    a. Tom completed by contacting the healthcare lobbyist w/in the Chamber re: ICSI
    b. Deb, Meg, Scott and Tom – develop a subteam and plan F/U meeting for 2/29/08
    c. Phil will talk to Medical Director at ICSI about the ACOEM Guideline and how to fit into MN P4P (pay for performance), outcomes
    d. DLI certify the training package for doctors through Dr. Bill Lohman - it will include information on ADA – FMLA – RTW – SAW
    e. Develop proposal for new CPT codes in order to compensate for communicate – through team discussion
        i. Utilize an unused CPT code for our state
        ii. The list of certified doctors will be listed on DLI web-site or available through a professional association – insurer association
        iii. Would need to work through MSRB to develop and weigh a new CPT code
        iv. DLI required to sign and/or approve training as it relates to the ACOME guideline – would need MSRB involvement – tie to a CME course – potentially partial reimbursement for taking the course
    f. Add as agenda item on the MSRB to discuss this issue
        i. New CPT code or utilize non-used code to compensate for communication
        ii. Document the treatment criteria in regard to specific CPT
        iii. List of doctors
        iv. DLI maintain the list of certified doctor
        v. Best practices to deal with disability management

GROUP D - Special Topic: Summit Follow Up Activities

> **NOTE**: This topic is not one of the 16 ACOEM recommendations, but instead is a special topic that Group D elected to address.

1. **What we focused on:**

We focused on Summit Follow-Up Activities to stress the importance of the next steps beyond today's Summit.

2. **The strategy we believe is best for making this actually happen is:**
    a. Today's Summit is just the first step in propagating a new way of thinking about the SAW-RTW process.
    b. We specifically addressed how to facilitate the ongoing structure and development of the SAW-RTW process.
3. **The concrete first step(s) towards implementing this recommendation are:**
    a. Summit draft Final Report due by 2/25/2008

b. Hold Summit Follow-Up Meeting – 2/29/2008, 8 a.m.-10 a.m.
c. Create Action Leadership Group based on Summit recommendations
    i. Outreach
        1. Government
            a. Legislative
            b. Regulatory
                i. Pay for Performance
                ii. Physician certification for additional reimbursement
        2. Associations
            a. DMEC, MSIA, RIMS, MSBA
            b. Unions
            e. MMA
        3. Education/Communication
            a. ACOEM Guideline dissemination
                i. Providers
                ii. Employers
                iii. Unions
                iv. Payers
            b. Training
                i. Online training for employers, physicians, employees
                ii. "just in time training" – at the point of injury or illness
            c.. Website – www.mnworkability.com
                i. Links
                ii. Resources
        4. Best Practices
            a. RTW Programs
            b. Measuring Success
                i. Report Cards for all (employers, physicians, QRCs, insurers, attorneys etc.)
                i. Empaq
        5. Membership/Recruitment
        6. Administration
            a. Database management
            b. Meeting coordination
            c. Project coordination
        7. Funding
            a. Grants
                i. Robert Wood Johnson
                ii. Medicaid

b. Sponsors
c. Membership Dues

d. Follow-up Summit
   1. All Committees establish 1 year program goals & concrete plans
   2. Review program success in one year

Group E – Minnesota Small Group Report
Section II, Recommendations 6, 10 and 11

Group Members

Name	Company
Sandra Bodensteiner	City of Saint Paul
Connie Brown	SFM
Tim Collin	Comp Rehab
Dave Fuecker	University of Minnesota
Nancy Kuntz	Alaris Group
Brad Lehto	Minnesota AFL-CIO
Marie Petsinger	Hutchinson Technology
Scott Sonstegard	TEAM Industries
Jim Stanfield	The Standard Insurance

GROUP E - Recommendation 6

Text of Assigned Recommendation(s) from ACOEM Guideline

> ***II. ADDRESS BEHAVIORAL AND CIRCUMSTANTIAL REALITIES THAT CREATE OR PROLONG WORK DISABILITY***
>
> ***6. Reduce Distortion of the Medical Treatment Process by Hidden Financial Agendas***
>
> *Sub-recommendations:*
>
> *a. Develop effective ways and best practices for dealing with these situations.*
> *b. Instruct clinicians on how to respond when they sense hidden agendas.*
> *c. Educate providers about financial aspects that could distort the process.*
> *d. Procedures meant to ensure independence of medical caregivers should not keep the physician "above it all" and in the dark about the actual factors at work.*
> *e. Limited, non-adversarial participation by impartial physicians may be helpful. For example, ask an occupational medicine physician to brief the treating clinician.*

1. **The part(s) of the Recommendation we focused on are:**
   Medical provider instruction and education regarding financial agendas
2. **The strategy we believe is best for making this actually happen is:**
   a. Utilize willing and qualified providers to educate other providers re: financial hidden agendas.
3. **The concrete first step towards implementing this recommendation is:**
   a. Identify medical providers to be used to educate other providers re: financial incentives affecting the RTW/SAW process
   b. Use occ med docs and medical schools to teach SAW RTW
   c. Ask networks to educate on the guideline

d. Provide education to employees on their responsibilities
e. Partner with other MN Summit groups (Groups D, F and H) when delivering education to medical providers to "sign them up" as a RTW/SAW educator.
f. Send out list of medical providers and the ACOEM Guidelines that would be willing to assist providers with RTW/SAW issues. Send this list out with license renewal applications

4. Here's what we intend to do starting tomorrow (Examples from the group's Personal Commitment Sheets):

a. Nancy will send out an email to Summit participants asking for recommendations on docs who you have worked with on SAW/RTW to create large data base.
b. Compile list and follow-up to ask if they are willing to be "experts"
c. Dave will contact MN Medical Board re: opportunity to deliver letter with license renewal.
d. Can we send ACOEM guideline from the Board with licensures – would these docs be willing to contact the expert docs?
e. Dave will start with U of MN – email list of participants to identify providers who can educate other providers
f. Contact and work with Groups D, F & H to ensure that RTW/SAW education about guidelines goes out

GROUP E - Recommendation 10 and 11

Text of Assigned Recommendation(s) from ACOEM Guideline

III. ACKNOWLEDGE THE POWERFUL CONTRIBUTION THAT MOTIVATION MAKES TO OUTCOMES, AND MAKE CHANGES TO IMPROVE INCENTIVE ALIGNMENT

10. Be Rigorous, Yet Fair in Order to Reduce Minor Abuses and Cynicism

Sub-recommendations:

a. Encourage programs that allow employees take time off without requiring a medical excuse;
b. Learn more about the negative effect of ignoring inappropriate use of disability benefit programs;
c. Discourage petty corruption by consistent, rigorous program administration;
d. Develop and use methods to reduce management and worker cynicism for disability benefit programs;

11. Devise Better Strategies to Deal with Bad-Faith Behavior

Sub-recommendations:

a. Devote more effort to identifying and dealing with employers or insurers that use SAW/RTW efforts unfairly and show no respect for the legitimate needs of employees with a medical condition;
b. Make a complaint investigation and resolution service – an ombudsman, for example – available to employees who feel they received poor service or unfair treatment.

1. **The part(s) of the Recommendation we focused on are:**
   [No answer provided.]
2. **The strategy we believe is best for making this actually happen is:**
   a. Communicate, Inform and educate all involved parties re: benefit programs.
   b. Don't withhold info regarding disability benefit programs.
   c. Involve employee, employer supervisor, manager, union reps, HR – get all together
   d. Establish feedback mechanisms to determine what's working
   e. Be open and honest with communication
   f. Model accountability
3. **The concrete first step towards implementing this recommendation is:**
   a. Jim will contact broker's group to determine what tools, assessments are already
   b. available for identifying whether an employer uses best practices for disability management
   c. Our team will meet, evaluate and compile self assessment tools to create a new audit tool
   d. Tool will be used to help employers determine where they stand with best practices
4. **Here's what we intend to do starting tomorrow (Examples from the group's Personal Commitment Sheets):**
   a. Nancy will send out an email to Summit participants asking for recommendations
   b. Compile list and follow-up to ask if they will be "experts"
   c. Dave will contact MN Medical Board re: opportunity to deliver letter with license renewal
   d. Contact and work with Groups D, F & H to ensure that RTW/SAW education about Guidelines go out

Group F– Minnesota Small Group Report
Section III and IV, Recommendations # 8, 12 and 13b.

Group Members

Name	Company
Michael Goertz	Park Nicollet Airport Clinic
Rose Hatmaker	SFM Mutual Insurance
Gary Johnson	North Memorial Health Care
Robin Peterson	OSI Physical Therapy
Betty Post	Xcel Energy
Jeanne Sample	MAOHN/FHR
Elizabeth Shogren	MN Nurses Association
Susan Verbrugge	Target

GROUP F - Recommendation 8, 12, and 13b consolidated

Text of Assigned Recommendation(s) from ACOEM Guideline

III. ACKNOWLEDGE THE POWERFUL CONTRIBUTION THAT MOTIVATION MAKES TO OUTCOMES, AND MAKE CHANGES TO IMPROVE INCENTIVE ALIGNMENT

8. Support Appropriate Patient Advocacy by Getting Treating Physicians Out of a Loyalties Bind

Sub-recommendations:

The SAW/RTW process should:

a. recognize the treating physician's allegiance;

b. reinforce the primary commitment to the patient/employee's health and safety and avoid putting the treating physician in a conflict-of-interest situation;

c. focus on reducing split loyalties and avoid breaches of confidentiality;

d. use simpler, less adversarial means to obtain corroborative information;

e. and develop creative ways for treating physicians to participate in SAW/RTW without compromising their loyalty to their patients.

IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS

12. Educate Physicians on "Why" and "How" to Play a Role in Preventing Disability

Sub-recommendations:

a. Educate all treating physicians in basic disability prevention/management and their role in the SAW/RTW process; provide advanced training using the most effective methods;

b. Make appropriate privileges and reimbursements available to trained physicians;

c. Focus attention on treatment guidelines where adequate supporting medical evidence exists;

d. Make the knowledge and skills to be taught consistent with current recommendations that medicine shift to a proactive health-oriented paradigm from a reactive, disease-oriented paradigm.

13. Disseminate Medical Evidence Regarding Recovery Benefits of Staying at Work and Being Active

Sub-recommendations:

a. Specify that medical care must be consistent with current medical best practices.

b. Or preferably, adopt an evidence-based guideline as the standard of care.

3. The part(s) of the Recommendations we focused on is:

Getting physicians out of the loyalty bind and educating clinicians and others

4. The strategy we believe is best for making this actually happen is:

a. Education re: RTW/SAW Guidelines and why it matters to the participant (Primary Curriculum Overview and breakout curriculum for groups)

b. Education re: RTW/SAW Guidelines and why it matters to the participant (Primary Curriculum Overview and breakout curriculum for groups)

c. Form a group within MSRB to develop a plan to educate clinicians, unions, employers, employees, insurers, and the health system on the ACOEM SAW/RTW Guidelines

5. The concrete first step towards implementing this recommendation is:

a. Identify industry leaders (DOLI, employer groups, employee reps) as an overall outcome of this Summit and all groups

b. Develop a plan to coordinate activities with all groups

c. Implement ACOEM Guidelines (evidence-based) and Disability Duration Guidelines

6. Here's what we intend to do starting tomorrow (Examples from the group's Personal Commitment Sheets):

a. Elizabeth, Dr. Goertz and Rose to bring physician education needs to next MSRB meeting by 3/1/08

b. Betty, by 2/7/08, to work with DMEC Minnesota to develop programs to educate attendees on the ACOEM recommendations

c. Elizabeth to work with Labor Education Services to develop programs

Group G – Minnesota Small Group Report
Section IV, Recommendations 14 and 15

Group Members

Name	Company
Kim Beck	Graco
Rhonda Bosworth	Sedgwick CMS
Sue Carlson	SMDC
Kristi Carrington	Mayo Clinic
Tonya Dunagan	Star Tribune
Robert Gorman	Park Nicollet Clinic
Natalie Haefner	WCRA
Laurie Johnson	Workwell Systems, Inc.
Kelsey Kuehn	St. Lukes Hospital
Margot Miller	Workwell Systems, Inc.
Maureen Stanley	Boynton Health Service

GROUP G - Recommendation 14

Text of Assigned Recommendation(s) from ACOEM Guideline

> ***IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS***
>
> ***14. Simplify/Standardize Information Exchange Methods between Employers/Payers and Medical Offices***
>
> *Sub-recommendations:*
>
> *a. Encourage employers, insurers, and benefits administrators to use communication methods that respect physicians' time;*
>
> *b. Spend time digesting, excerpting and highlighting key information so physicians can quickly spot the most important issues and meet the need for prompt, pertinent information;*
>
> *c. Encourage all parties to learn to (a) discuss the issues – verbally and in writing – in functional terms and to (b) mutually seek ways to eliminate obstacles.*

1. **The part(s) of the Recommendation we focused on are:**
   Communication methods and packet
2. **The strategy we believe is best for making this actually happen is:**
   a. The company's philosophy and transitional work program is written and given to employees during orientation at time of hire
   b. Then annually and ongoing thru supervisor training with employees
   c. Worker brings this form to physician visit
3. **The concrete first step towards implementing this recommendation is:**
   a. Look at your forms for work ability – providing info on abilities and restrictions

b. Collaborate with other medical facilities for education
c. Small groups from this Summit to speak at Self Insured Conference, Small Business Association and Chamber of Commerce
d. Identify employers who don't have transitional work programs
e. Online training for education
f. Sample packet on Dept. of Labor website
g. Hold mini Summits

4. Here's what we intend to do starting tomorrow: (Examples from the group's Personal Commitment Sheets):

a. Check on feasibility. Educate employers thru MARP conference
b. Dept. of Labor put a link on website and endorses ACOEM Guidelines and potential email distribution
c. Star Tribune is going to develop a document describing their commitment to transitional duty
d. MN Safety Conference and other conferences – educate on ACOEM Guidelines
e. Sign the form today to be part of ongoing work (referring to the Follow Up Activities Sign-Up Sheet from today's Summit)
f. Check with physician assistants and other groups to be an "endorsed" document (ACOEM Guidelines) such as ICSI as a practice guideline
g. Document your disability program for employees
h. Document your disability program for employees and supervisors – who to contact (STD, LTD, FMLA)

GROUP G - Recommendation 15

Text of Assigned Recommendation(s) from ACOEM Guideline

IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS

15. Improve/Standardize Methods and Tools that Provide Data for SAW-RTW Decision-Making

Sub-recommendations:

a. Help physicians participate more effectively in the SAW/RTW process by standardizing key information and processes;
b. Persuade employers to prepare accurate, up-to-date functional job descriptions (focused on the job's maximum demands) in advance and keep them at the benefits administrator's facility; and send them to physicians at the onset of disability;
c. Teach physicians practical methods to determine and document functional capacity;
d. Require purveyors of functional capacity evaluation methods and machines to provide published evidence in high-quality, peer-reviewed trials comparing their adequacy to other methods.

1. **The part(s) of the Recommendation we focused on are:**

   Standardizing methods and tools for RTW.

2. **The strategy we believe is best for making this actually happen is:**
   a. R32 or functional job description (FJD) template for identifying the physical job demands.
   b. Conversation starts with 1st visit with MD.

3. **The concrete first step towards implementing this recommendation is:**
   a. Jana (DOL) - bring back the R32 as a FJD template
   b. Employer thru employee/HR/supervisor should complete a FJD form and bring to physician
   c. Educate employers on benefit (thru our small groups and speaking on importance of having job descriptions, even starting with the R32 (FJD template)
   d. Jana (DOL) – bring back the R32 as a Functional Job Description template

4. **Here's what we intend to do starting tomorrow: (Examples from the group's Personal Commitment Sheets):**

   Emphasize all of our responsibilities in educating one-on-one with those physicians that take workers off work if transitional work is available

Group H – Minnesota Small Group Report
Section I and IV, Recommendations 1, 13a, and 16

Group Members

Name	Company
Jeanne Ayers	Boynton Health Service
Kathy Bray	Lynn Scharfenberg & Associates (Duluth)
Kathy Goldblatt	Prudential Financial
Barb Herke-Smith	Workwell Systems
Joe Kapaun	North Country Health Services
Kathryn Koch	Allete/MN Power
Brian Konowalchuk	Duluth Clinic
Patty Prentice	League of MN Cities
Jennifer Schaubach	MN AFL-CIO
Dawn Soleta	The Toro Company
Lisa Triplett	Visant/Jostens

GROUP H - Recommendation 1

Text of Assigned Recommendation from ACOEM Guideline

I. ADOPT A DISABILITY PREVENTION MODEL

1. Increase Awareness of How Rarely Disability is Medically Required

Sub-recommendations

a. *Stop assuming that absence from work is medically required and that only correct medical diagnosis and treatment can reduce disability.*

b. *Pay attention to the non-medical causes that underlie discretionary and unnecessary disability.*
Reduce discretionary disability by increasing the likelihood that employers will provide on-the-job recovery.

c. *Reduce unnecessary disability by removing administrative delays and bureaucratic obstacles, strengthening flabby management, and by following other recommendations in this report.*

d. *Instruct all participants about the nature and extent of preventable disability.*

e. *Educate employers about their powerful role in determining SAW/RTW results.*

1. The part(s) of the Recommendation we focused on are:
Increasing awareness (sub-recommendations e.and f.)

2. **The strategy we believe is best for making this actually happen is:**
   a. Education for different stakeholder groups, employees, employers, medical providers, insurers and payers and a task force charged with finding ways to bring them together
3. **The concrete first step towards implementing this recommendation is:**
   a. Create a task force by 3 regions to create standardized materials and a uniform message for further stakeholder education with website portal on mnworkability.com so that others can track events and developments
   b. Bring the guideline to stakeholder groups; union meetings, safety councils, insurance associations etc.
   c. Make a personal commitment to your own organization to share the guideline
4. **Here's what we intend to do starting tomorrow (Examples from the group's Personal Commitment Sheets):**
   a. Sign up sheet today at lunch by region
   b. Representatives of "parent" group to meet by 3-15-08 w/charge of creating a work plan, timelines and materials by June perhaps and identify strategies that regional task forces can use to disseminate the materials and create a speaker's bureau
   c. Planning multi-institutional national meeting – providers and other stakeholders – focused on the guideline
   d. Take to the local communities and work it into the conversations

GROUP H - Recommendation 13a and 16

Text of Assigned Recommendation(s) from ACOEM Guideline

IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS

13. Disseminate Medical Evidence Regarding Recovery Benefits of Staying at Work and Being Active

Sub-recommendations:

a. Undertake large-scale educational efforts so that activity recommendations become a routine part of medical treatment plans and treating clinicians prescribe inactivity only when medically required;

16. Increase the Study of and Knowledge about SAW/RTW

Sub-recommendations:

a. Complete and distribute a description of the SAW/RTW process with recommendations on how best to achieve desired results in disability outcomes;

b. Establish and fund industry-specific, broad-based research programs, perhaps in the form of independent institutes or as enhanced university programs;

c. Collect, analyze, and publish existing research;

1. **The part(s) of the Recommendation we focused on are:**
   Increasing the study and knowledge about SAW/RTW

2. **The strategy we believe is best for making this actually happen is:**
    a. Collaborate with all 60 Summit groups for purposes of funding and coordinating data collection and analysis.
3. **The concrete first step towards implementing this recommendation is:**
    a. Facilitator suggests at 2-29-08 mtg. that Pat McGovern (612) 625-7429, Director of Occupational Health Nursing, Dept. Of Occ. Health/NIOSH, and Bill Lohman, Medical Director of DOLI be at the table to discuss what is needed to seed group for national level research and data collection.
    b. Have other Summits identify comparable contacts in their states for purposes of coordinating the efforts with goal of seeding national research program.
4. **Here's what we intend to do starting tomorrow: (Examples from the group's Personal Commitment Sheets):**
    a. see above

Appendix E
MINNESOTA SAW / RTW SUMMIT
Personal Commitment Forms
Completed by Summit Participants

Each participant in the Minnesota SAW/RTW Summit on January 31 - February 1, 2008 was asked to write down his or her own personal insights, plans, and commitments made during the Summit. (According to social scientists, people are more likely to actually do things if they have made a formal written or oral commitment to do so.) The Personal Commitment forms were turned in and copied towards the end of the event so that the ideas that were arising during the Summit could be captured and consolidated for inclusion in this Report. Participants were assured that the aggregate list of commitments would not include any names. The original forms were returned to the participants so they could take them home.

The table below is a compilation of the 53 Personal Commitment forms that were turned in. Individual names have been removed. Each row in the table is one respondent's answers. The forms asked the participant to specify their name and the small group of which they were part, and then asked them to complete these statements:

1. *"The main things I see that I can actually do to improve MY OWN practice or organization are: _____."* Responses to this issue are listed in the "Internal Opportunity" column in the table below.
2. *"The main opportunity where I can actually do something to improve how things work in my community or state is:* _____." Responses appear in the "External Opportunity" column below.
3. *"Here's what I personally intend to do about this tomorrow or this week:* _____*."* Responses appear in the "Immediate Action" column.

Person	***Internal Opportunity***	***External Opportunity***	***Immediate Action***
1	• Educate & encourage accommodation	• Discuss with front line personnel: nurses, supervisors, HR	• Assign union to define light duty work with nurse
2	• Physician urgency and RTW focus: figure out how to impact this	• Leader: impress this initiative on others	• Sign up to continue involvement in this project
3	• Become more familiar with guidelines and SHARING with medical providers	• I am a QRC and can continue to mediate / educate /advocate SAW / RTW with all team members	• Continue to encourage employees to have specific job descriptions, develop & maintain policies on SAW / RTW
4	• To convey the Summit information to the	• Use my role as Program Dispute Facilitator as a	• Make a presentation to our Board of Trustees on

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
	Program's, B.O. Trustees, participants (unions & contractors), & our own QRC panel. The Exclusive Provider Organization will be gearing from CorVel.	platform to educate the Union Construction Workers' Compensation Program.	the SAW / RTW concepts.
5	• Get the ACOEM guidelines out to my CM staff.	• Because case managers tend to "touch" all stakeholders, they are a good avenue to continue to talk and keep the "buzz" going.	• Send ACOEM guidelines to all staff.
6	• Distribute and review the ACOEM Guidelines within the clerical staff that supports the STD-LTD RTW program.	• Communication with policy holders to assist them with developing SAW/RTW programs to reduce lost time for STD-LTD policies.	• Develop a process to utilize the Guideline in our communications with physicians to educate them on RTW as we contact them on claim questions.
7	• Train my staff, clients and various stakeholders on preventing time from work starting 2/5/08.	• Educate staff and require sending ACOEM guidelines to employers, clients and physicians, chiropractors, clinics, hospitals on 2-5-08. MNworkability.com send to all chiro web sites by 2-20-08.	• Contact MSIA to put ACOEM on meeting agenda for June. Go on website and email to Joanne by 2-8-08 for 6-08 meeting.
8	• Establish more precise contractual components of work disability prevention strategies. • Enhance education standards with clients, employers, MD's, payors, etc	• Actively participate in the MN Summit Advisory Group to review, analyze and develop strategies and action plans to move the SAW/RTW process forward.	• Volunteer to be action on the MN Summit Taskforce • Identify major barriers that need to be resolved to effectively achieve desired outcomes
9	• Train and monitor work comp adjusters to promote effective and frequent communication to the injured worker and employer that will identify and address concerns through the WC process.	• Research with industry contacts to provide any screening instruments they use to identify at risk employees early on in the disability process – or otherwise.	• Email employers I work with and ask them if they should share screening tools they have found useful to identify at risk employers for workplace and social issues. • Provide this info to committee members to compile.

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
10	• Educate players: HR, MD's, WC / CM, Employees • Implement program suggestions.	• Continue involvement with 60 Summits • Actively participate in requests for information.	• Share with my peer group at work. • Bring information to professional group meeting for discussion • Think about tools to share with committees
11	• Better understand others' roles and paradigms through dialog – Listen • At work – Look for methods to partner with a different role/partner with regard to RTW/SAW eg. physician or insurance company.	• As above – utilize evidence based criteria to ID claimants/employees who may be at risk for non-medically necessary disability (in own company – focus on psych).	• Literature search psych yellow flags
12	• Focus on understanding what the barriers are for both physical and psych that are inhibiting RTW.	• Focus on increasing communication with payers, QRC, employers; • Think about how I write work restrictions.	• Call insurance adjusters and QRC. Look for ways to keep people working. Get involved. Make a Difference.
13	• Meet with HR to discuss creating a Toolbox that gives employees info as to what to do if they experience or disabling condition. Contacts, numbers, EAP, who to contact in payroll. To help eliminate employee's fears and concerns.	• Take committee findings and encourage my employer to support and implement. • Forward copy of guidelines across the company network.	• Talk with HR • Look at screening tools for my project to forward to committee.
14	• Providing comprehensive information to the employees via all insureds. • Provide empathetic practices for our claim handlers. • Promote claim handlers coordinating efforts with all the other "players".	• Initiate mini-Summits with our insureds and medical providers in each state we do business in.	• Create an educational module for my claims staff.
15	• Provide training to supervisors/managers obtaining positive outcomes in managing	• Provide information to MN Self Insurers Association on Summit and cascade knowledge to other	• Develop a manager training module on workers' compensation issues.

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
	employees with work disability issues.	employers.	
16	• With initial meetings with injured workers, explain my role in more detail and address fears/concerns of injured worker • Address SAW/RTW guidelines with employers.	• Continue contact with Summit members.	• Discuss Summit with my supervisor. • Distribute info to workers • Organize speaking time at next company staff meeting to review SAW/RTW guidelines. • Begin review of literature for social/workplace issues and screening instruments.
17	• Develop screening tools for early intervention on cases that may need psychiatric treatment.	• Pull appropriate parties together to develop tools.	• Contact APA - re: tools • Convene meeting by 3-15-08 • Approach DMEC about education opportunities
18	• Include question of "was behavioral reaction to illness/injury addressed during office visit" in my letters to providers. • Discuss adding this with our documentation committee to formally add on our template.	• Attend and participate in any local meetings on SAW/RTW. • Spread the "news" to the health care providers I work with.	• Share the information learned with my supervisor, our medical director and prepare a newsletter to distribute to my coworkers in 3 offices sharing the 60 summit purpose. • Check with 2 Behavior Health Specialists at our company to see if they are interested in being on a committee.
19	• Look at our brochures and materials to see how we can better inform employers about SAW/RTW process and how to talk with medical providers.	• Continue to educate all stakeholders. • Change our materials to reflect work is therapy. • Work with other stakeholders in my group to identify resources to address psychological issues.	• Call disability associations to find out about psychological resources for various medical conditions (i.e. Lupus, Foundations, MS Society, Cancer Assn.)
20	• Educate our staff • Modify our usual initial screening tools – follow development of new tools. • Look at our MCO _____	• Advocate for psych recognition / care with insurers • Serve on committees • F/ U on agreed upon	• Pull existing resources/review – work with [person] • Stay involved – 3-15-08 F/U meeting

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
	What are they doing?	duties	• F/U DOLI – existing psych care
21	• Revise disability management procedures and restricted duty program. • Educate our supervisors and managers.	• Stay involved with team and summit follow-up	• Call School of Public Health about Masters project ad campaign
22	• Educational materials • Expand communications to management and employees • Research assessment tool	• Change communication brochures re: disability management to reinforce SAW/RTW principles. • Participate in SAW/RTW initiative.	• Check assessment tools available in our organization. • Talk to Communications Committee and draft revisions of materials. • F/U with Feb 29th and March 15th meetings – schedule on my calendar.
23	• Relookat “Rights and Responsibilities” in “Hello” Packets to incorporate more “what can you expect “ re: normal human reactions- to set the framework/ expectations for employee	•	• Next week (since it’s Friday today) - look at possibly revising employee packet by 2/7/2008. 2. Research “free” initial screening tools – early interventions – EAP’s, questionnaires, psychiatric red flags • Model sign up for unemployment online /telephone – gives instructions and expectations • Why not the same for work comp or STD? or even when signing up for benefits???
24	• Increase awareness / training for claims staff on importance of communication with doctors • Express willingness to pay additional $ to doctor for a conference to facilitate RTW.	• Cooperation with fellow industry professionals.	• Meet with [2 people's names] to follow up with legislative contact identified by [person] at Chamber of Commerce. This meeting will take place prior to 2/29/08.

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
25	•	• Try to make the connection between the ongoing pay-for-performance efforts and 60 Summits/ SAW/ RTW.	• I plan to contact people involved in the pay for performance debate for major medical and determine who is the appropriate person/people to discuss adding workers' compensation /disability to the agenda.
26	• Structure the discussion I have within my workplace in the language of the Guideline. • Discuss guideline and principles with the team at work that manages disability, HR, and employee occ health.	• Discuss guideline with Institute for Clinical and System Improvement – Medical Director • Explore where disability data resides in our organization. Is this a burning platform?	• See above • Talk to Chair of MMA-QI Committee • How this may be helpful in the healthcare reform initiatives discussion • In 1 year: • Training calendar and products available up and running • ACOEM Guideline well known to all relevant constituencies. • EMPAQ standard knowledge promulgated to all parties. • Payment mechanism in place for MDs for disability management • How many docs and insurers are trained and certified • WCRI - Data Service NWCNA • Steering Committee: • Training • P4P and payment CPT • Have best practices www.mnworkability.com • Review plaintiff attorney fee mechanism • Report card for companies and doctors • Government and other associations • Communication management

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
27	• Increase awareness and application of ACOEM Guideline within my company	• Use the ACOEM guideline when I am reviewing and analyzing work on cases.	• Lead the F/U • Discuss with my staff • Look and plan to train my own staff as appropriate
28	• Increase training in our organization. Include specific training on ACOEM guidelines.	• Support staff participation in MNWorkability.	•
29	• Develop a Provider Certification w/ Disability Management Training • Review ACOEM guideline with nurse case Managers • Develop pay for performance mechanism for provider network	• Chair the F/U Meeting. • Develop on-going leadership to continue the Summit recommendations	• Schedule F/U meeting. Develop new action leadership • Work with 3 people on P4P with MN Community Measurement and ICSI
30	• Create voluntary pay model ? - for physicians – explore and champion ideas and change	• In presentations (I do) I can use this information to help educate employers. • On Board of DMEC local, I can explore ways to integrate concepts of guidelines at conferences.	• Work on developing a communications plan for paying physicians for their time in talking about RTW. Way to approach – budget impact. • Talk to Director of Medical Services • Talk to Management
31	• Education to organization • Distribute guidelines	• Distribute through organizations I am involved in: MSIA, MN RIMS, MN PRIMA, Safety Groups	• Education among my organization • Distribute guidelines • Distribute information among professional organization
32	• Implement the recommendation discussed – be involved on task team to disseminate the info and guidelines. • Educate staff/team re: guidelines	• Volunteer to be part of task team – proactively implement the various tools and techniques learned. • Work to develop partnerships with employers, physicians, employees, more proactively toward SAW/RTW	• Educate team/staff re: SAW/RTW • Get involved with ongoing work toward improvement of current processes.
33	• Research and implement an educational module	• Stay involved with 60 Summits/MN SAW/RTW	• Begin to research medical provider training

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
	focused on university culture (SAW/RTW culture) for provider networks • Work with 60 Summits Group Member to develop a SAW/RTW employer rating tool	Summit work activities in the future.	mechanisms as well as employer rating tools.
34	• Present guidelines to General and Executive Board and explore the possibility of resolutions of support. • Speak with other labor organizations about the guidelines to get support and have them work at implementing.	• Work with the Workers' Compensation Advisory Council and the Dept. of Labor and Industry	• Speak with Executive Officers of my organization to clear presenting to General and Executive Boards.
35	•	• Meet with local medical providers and share with them ACOEM's guidelines. Ask and listen to them re: feedback.	• Discuss RTW/SAW with my manager and review opportunities to improve my company's practices and culture -short and long term goals .
36	• Get supervisors and employees trained in work comp.	• Talk to the Work Comp Advisory Board.	• Call 1 person at DOLI.
37	• Use the SAW/RTW report to guide/teach the 10 MDs/Urgent Care MDs in my system (one of my work goals anyway)	• I'll continue to serve on the local Occ Med Residency Advisory Committee with renewed enthusiasm and ideas. • Likewise, I'll continue to train FP residents in our clinic – again with renewed enthusiasm and ideas. • I'll continue to serve as a leader in our community (professional org – ACOEM local affiliate and a contributor to conferences and seminars.	•
38	• Train therapists at my company on the	• Contact the MNAPTA re: training on the RTW/SAW	• Schedule training at my company.

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
	RTW/SAW guidelines.	guideline. • As MSRB PT alternate member, support initiative for DLI overseeing.	
39	• Encourage RTW/Return to Productivity • Educate managers/ employees and upper management.	• Continue to discuss and encourage RTW	• Continue to find resources to educate doctors on RTW. • Continue to build employee communi-cations in "real time" • Continue to build on integration with other vendors/resources • Continue to set expectations and measurements
40	• Report to MAOHN to increase awareness as well as education with HR-management.	• Participate in one of the action groups in the state	• Bring information back to my employer and corporate wide – which would cross several state lines.
41	• Provide member education on benefits of RTW	• I am on the Med Services Review Board and Work Comp Advisory Council and on staff of a major health care union	• Write a report on summit for all year Association newsletter and • Give it to the Board of Directors of MNA • Bring concept to MNA Health and Services Steering Committee • Take action and develop employee Tool Kit and resource material • Possible Summer ABUL Conference topic • Also possible topic for State AFL-CIO Convention • L.E.S. developed program
42	• Continue to promote and encourage return to work and stay at work practices .	• Within my role as a return to work consultant in our organization • As a MARP board member	• Locate old R-31, R-32, R-33 forms • Share information with Northern and Southern MN MARP representa-tives re: seminar idea re: RTW/SAW Summit and

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
			Guideline • Continue to enhance my own communication tools in my role as RTW consultant
43	• Create a package of work comp related info that will be given to newly hired employees. • Send reminders to supervisors about work comp procedures within our organization • Create transition work document that injured worker can take to the doctor	•	• Create transition duty documents • Review job descriptions • Upgrade WC package information • Talk to HR about initial orientation and employee book materials that pertain to WC issues
44	• Communicate the how/why to use some of the "recommendations" to the other medical providers I work with from around the country.	• Continue to work w/the Summit group – hold small group meetings in my community with employers and medical care givers.	• Speak with the medical care givers I know about how/where to find the guidelines.
45	• Make sure any transitional duty opportunity is spelled out for each new client. • Make contact with each primary care provider from whom I inherit a patient when they have been taken off work.	• Educate primary care providers on the benefits of transitional duty and how to write restrictions.	• Contact Minnesota PA organization offering education – Newsletter article? Conference presentation?
46	• Implementing this Guideline into our presentations to employers nationwide • Implement this approach with employers	• Actively commit to being part of the dissemination of knowledge	• Use ACOEM guidelines to rework our current Work Rehab program
47	• Develop a toolkit/packet for employees who are injured to take with them to doctor. Packet would contain contact information and instructional information for employee.	• Help educate others (physicians, employers, employees) about ACOEM guidelines.	• Assess injuries for past year in my organization • Develop packet

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
48	• Continue to keep in mind the overlapping interests of the various stakeholders and practical ways to use the guidelines in my day-to-day practice.	• Incorporate reference to the Guidelines in working with QRCs, employers, etc in the RTW process.	• The next employer/ industry group or attorney presentation touching on RTW issues, work in resource links and overview of ACOEM Guidelines • Include blurb on the Guidelines in my next employee newsletter.
49	• Be a link to 60 Summit org and share information with our group insurance organization • Identify opportunities for partnering with Summit participants.	• Encourage a Summit in other states	
50	• Increase awareness of 60 Summits among network of professionals working w/in industry.	• Increase awareness that disability – time off work is rarely medically required.	• Raise awareness for network of providers on ACOEM Guidelines. • Distribute ACOEM Guidelines to network (newsletter) • Link to ACOEM website
51	• Increase awareness of the guideline and education different players.	• Work with large employers, MDs and carry out task force education.	• Talk to CRI at _____ State to present on guidelines (employers).
52	• Work on a coordinated RTW program engaging line supervisors to identify light duty work • Work with employees out of work on the “feel good” issues.	• Present the ACOEM Guidelines at the Local Northland Human Resources Association Monthly Chapter Meeting.	• Serve on a Task Force that is committed to bring this message/initiative forward
53	• Educate company areas – make them aware of ACOEM guideline • Incorporate key pieces of guidelines into our SAW/RTW program	• Share guidelines with professional organizations – my company is involved with /members of. • Look at ways to be involved in legislative changes needed to incorporate guidelines into current work comp disability management	• Take information back to my company and start discussion/work on where we want to go with the ACOEM guidelines.

Person	***Internal Opportunity***	***External Opportunity***	***Immediate Action***
		regulations and statutes.	

Appendix F
MINNESOTA SAW / RTW SUMMIT
Summary of Evaluation & Sign-Up Sheet Results

Participant Evaluation and Sign-Up Sheet

Overall, participants who completed the evaluation were very satisfied with the Summit event. A total of 47 out of 87 participants (54%) returned their evaluations.

The evaluation form asked the participants to identify their stakeholder group, and then to address 21 issues. The first 15 items concerned meeting preparation, logistics and venue, design and flow of meeting, and meeting events, and were rated as "not-acceptable," "acceptable/OK," "good to great" or "N/A." The last 5 items were statements that explored the participants' perceptions about the value of the meeting to them, and were rated as "agree" "neutral", "disagree" or "N/A".

In addition, participants were asked to complete a sign-up sheet that offered three ways to continue engagement with each other going forward: (1) be on the mailing list (2) be notified of upcoming events or (3) join the follow up action group.

Role of Respondents:

Employers	23%
Clinicians	21%
Payer	14%
Other	14%
Case Managers/QRC	10%
Labor	10%
Legal	4%
Government	4%

Items # 1-3 addressed meeting preparation.

1. Invitation and conference brochure (43 responses)
    - 91% good to great
    - 9% acceptable/OK.
2. Invitation from Summit Planning Committee -phone call / personal invitation (34 responses)
    - 91% good to great
    - 9% acceptable/OK.
3. Reading materials sent prior to the meeting (44 responses)
    - 93% good to great
    - 7% acceptable/OK

Item #4 addressed logistics and venue.

4. Location and facility, meeting room, meal (47 responses)
    - 91% good to great
    - 9% acceptable/OK

Items # 5 through #9 addressed design and flow of meeting.

5. Plan for the meeting; what was on the agenda (42 responses)
    - 81% good to great
    - 19% acceptable/OK

6. Flow of the meeting/keeping to the plan (41 responses)
    - 79% good to great
    - 16% acceptable/OK
    - 5% not acceptable

7. Interactions between audience, panelists and speaker (42 responses)
    - 81% good to great
    - 19% acceptable/OK

8. Management of any differences/disagreements (31 responses)
    - 84% good to great
    - 16% acceptable/OK

Items # 9 through #15 addressed meeting events.

9. Thursday p.m. welcome session, reception (45 responses)
    - 93% rated as “good to great”
    - 7% acceptable/OK

10. Thursday p.m. presentation by Dr. Michael McGrail (41 responses)
    - 83% good to great
    - 17% acceptable/OK

11. Friday a.m. presentation by Dr. Jennifer Christian (44 responses)
    - 95% good to great
    - 5% acceptable/OK

12. Small group work sessions (45 responses)
    - 78% good to great

- 20% acceptable/OK
- 2% not acceptable

13. Presentations by small groups (45 responses)
    - 80% good to great
    - 18% acceptable/OK
    - 2% not acceptable

14. Panel discussion (35 responses)
    - 57% good to great
    - 31% acceptable/OK
    - 12% not acceptable

15. Wrap-up session (29 responses)
    - 69% good to great
    - 31% acceptable OK

Items # 16 through # 21 explored the participants' perceptions of the overall value of the meeting to them. Participants were asked to respond whether they disagreed, agreed, were neutral or N/A.

16. The information presented was very interesting to me (47 responses)
    - 96% agreed
    - 4% neutral.

17. Having met the people here will help me in the future (47 responses)
    - 94% agreed
    - 6% neutral.

18. This new angle or approach has made me think differently about some important things. (45 responses)
    - 71% agreed
    - 16% neutral.
    - 13% disagree

19. I have a list of some practical next steps I can take to improve my participation in the SAW/RTW process (44 responses)
    - 91% agreed
    - 7% neutral
    - 2% disagree

20. This workshop was a good use of my time and effort (46 responses)
    - 91% agreed

- 9% neutral.

21. I think this workshop will really bear fruit in the future (47 responses)
    - 91% agreed
    - 9% neutral

Minnesota Follow-Up Activities Sign-Up Sheet

All participants were provided with a copy of the Follow-Up Activities Sign-Up Sheet. Participants were invited to sign up individually or as a group for any or all of the three activities: mailing list, events, or action group.

In several groups *the entire group* signed up for all three activities. In the other groups the majority of the group signed up for all three activities. Out of 87 participants, 68 (78%) signed up for at least one of the follow-up activities.

Out of 87 participants:

- 54 (62%) chose to join the follow-on action group;
- 63 (72%) chose to be notified of up-coming events;
- 68 (78%) chose to be on the mailing list.