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

FINAL REPORT

Preventing Needless Work Disability of Ohioans

Stay-at-Work/Return-to-Work Leadership Summit

Held March 14, 2008

Quest Business Conference Center
Columbus, Ohio

Report prepared by

The Ohio Chapter of The 60 Summits Project

in collaboration with

The 60 Summits Project

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Executive Summary

In mid March of 2007, a group of 30 individuals from 16 organizations in Ohio attended an unusual meeting in central Ohio. They met to consider 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 Ohio among those who participate in that process -- employers, physicians and other healthcare providers, benefits payers, and several others. They came together because their familiarity with how that process works today had made them uncomfortable. They were interesting in finding ways to stop wasting money and hurting the people that the workers' compensation and disability benefits systems are designed to help.

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 (www.60summits.org), 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 Ohio planning group envisioned the Summit as a first step in an overarching initiative to improve the well-being and productivity of Ohio'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 a year culminating in a successful event with 130 participants held on March 14, 2008 at the Quest Business Conference Center in Columbus, Ohio.

The Summit planners themselves represented multiple stakeholder groups, with members who were employers, industrial therapists and case managers, the state insurance fund, and so on. (See list of planners at Appendix A.) They named their initiative *Preventing Needless Work Disability of Ohioans* and shared their information through The 60 Summits Project website (www.60Summits.org).They chose to formally affiliate with The 60 Summits Project and Dr. Jennifer Christian, chair of The 60 Summits Project, gave a keynote address and facilitated the Ohio SAW / RTW Summit.

The Ohio Summit received a matching grant from The 60 Summits Project and its charter North American sponsors, Prudential Financial and Webility Corporation. The Summit was also sponsored by 28 other organizations who lent their names and provided financial and in-kind support to the local event, nine of whom exhibited at the event. (See list of sponsors at Appendix B.).

The actual Summit event was a full-day workshop beginning in the morning with registration and continental breakfast in the exhibit area, followed by a keynote presentation by Dr. Christian. Participants broke into 11 mixed work groups to begin their deliberations. Each group was assigned one to three 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. The mixed groups reported their initial findings and described their preliminary action plans to all attendees, and then received suggestions for improvement from Dr. Christian.

After the initial mixed groups gave their reports, attendees were placed into a second set of groups that contained individuals all from the same stakeholder group (all the employers together, all the payers together, and so forth). These stakeholder groups met to determine what they needed and what they could contribute to make a successful transition to the work disability prevention paradigm. Spokespersons for the stakeholder groups presented their reports in panel fashion. The mixed groups from the morning then re-convened to revise their action plans based on the new information they had learned from hearing each other's reports and from the stakeholder panel presentations. The mixed groups presented their revised plans to all attendees. In addition, each participant was offered an opportunity throughout the day to make personal commitments to themselves for what actions they were going to take, and asked to record them on paper.

All of the work groups thought the individual ACOEM recommendations they had been assigned should be implemented, sometimes with minor modifications. They all made action plans to do so.

The plans they produced had a remarkable level of specificity and concreteness -- and reflected a very high level of excitement and a collaborative spirit. Several teams indicated that they wanted to continue to work together beyond the Summit. Teams indicated support for other teams' ideas, and agreed to cooperate on some joint initiatives.

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. **Education – to make sure that everyone is aware of the ACOEM work disability prevention guideline, and to continue to propagate 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. As an example, one group came up with a plan for creating a cadre of "disability detail reps" (analogous to drug detail representatives routinely sent out by pharmaceutical companies to visit doctors in their offices and educate them about medications).

2. **Communicating and collaborating with 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. Three of the multi-stakeholder groups made plans to stick together and carry out the projects they had come up with during the Summit.

3. **Development and testing of better tools and methods -- and advocacy for their widespread adoption.** As an example, one small group came up with the unique idea of producing a "SAW/RTW Guide for Dummies." After other groups heard that idea, several of them volunteered to write specific portions of the Guide, for example the section on mental health.

4. **Operationalizing the ACOEM guideline recommendations.** Many people saw ways to put particular recommendations into everyday practice, and made plans to do so.

Some action plans covered more than one of the above domains, and some touched additional domains. For example, there were several action plans regarding 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 Preventing Needless Work Disability of Ohioans. Overall, the attendees were extremely satisfied with their experience at the Ohio Summit. More than half of them asked to stay on the Ohio group's mailing list, and more than 40% intend to participate in the follow-up Ohio action group.

More than 90% of the attendees reported that:

- the workshop was a good use of their time and effort,
- the information presented was very interesting,
- having met the other attendees will help them in the future, and
- the event had made them think differently about some important things.

More than 87% of attendees reported that:

- they left with a list of practical next steps they can take to improve their participation in the SAW/RTW process, and

- they think this workshop will really bear fruit in the future.

The successful planning and conduct of the Ohio 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 be transferred to the real world and be carried out. The group is now entering uncharted territory. The next step for the Ohio 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 turn their commitments into realities. The first follow-up meeting will occur on May 1 in Columbus with the main agenda item being the establishment of an ongoing action group.

Acknowledgements

Members of the Ohio 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, state fund, insurers, and intermediaries worked together to plan and produce this event. A list of committee members appears at 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 the draft of this report.

The Facilitators. Facilitators who had been specially trained by The 60 Summits staff supported the deliberations of all of the small group sessions. Due to the size of the Ohio meeting -- the largest Summit to date -- many facilitators were required. The Ohio Bureau of Workers' Compensation agreed to orient, train, and send eight expert staff members to augment several volunteers previously recruited by the Summit planning committee.

Sponsors. Without the generous support of our sponsors, this Summit would not have been possible: A list of sponsors, some of whom provided services in kind, appears at 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 each other in making program and system changes.

Ohioans were invited to participate in a Summit feasibility planning meeting in mid March of 2007. Dr. Christian sent emails to individuals in Ohio 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.

The central Ohio feasibility meeting was hosted by The Ohio State University's Integrated Disability/Unemployment Benefits Department of The Office of Human Resources. Thirty people representing employers, transitional work providers, physical therapists, physicians, case management companies, MCOs and The Ohio Bureau of Workers' Compensation attended. During this meeting, participants agreed that Ohioans would benefit from the possibilities the ACOEM guideline offered them on addressing the gaps and breakdowns that lead to needless work disability and job loss. In fact, several indicated that Ohio needs this new way of thinking now more than ever.

Major employers who attended the feasibility sessions observed that 80% of the work days lost to illness and injury in their organizations are covered by their sick leave and disability benefits programs rather than their workers' compensation programs. The group thought that it would be important for a Summit to address solutions to prevent needless work disability in all types of benefit programs, which is the approach taken by the ACOEM work disability prevention guideline.

The central Ohio group formed a team to begin planning a Summit in Ohio, and decided to affiliate with The 60 Summits Project. They committed to a 12 month planning cycle with two co-chairs, Terry Driscoll and Chris Moranda, and Rick Wickstrom played a major supporting role as sponsorship team chair. Terry is President of Working Options, Inc., an independently owned case management company and Chris Moranda is Manager of Disability Programs within the internal Associate Health and Wellness program for Ohio Health, a large health care system in Ohio. Rick Wickstrom is a physical therapist and operates the WorkAbility Network.

Like most of the groups working within The 60 Summits initiative, the planning of the central Ohio event was led by a small group of volunteer professionals. They all work full time in some part of the absence management, workers' compensation or disability benefits systems and are uncomfortable with the harm that is currently being done by the gaps that create delays in functional recovery.

The large initial planning group began with great enthusiasm, but went through a difficult period when their team shrank in size and momentum was lost. In early January, about 10 weeks before their event, they had raised very little sponsor money and had only 12 confirmed conference registrations. The demands of their normal jobs loomed large. Faced with the prospect of failure and tempted to quit, the leaders asked for help from the 60 Summits Project staff who led them through an exercise to rediscover their initial commitments and intentions and get better organized.

Again inspired and energized, and now with clearer accountabilities and specific goals, the core team reached out to re-engage their colleagues on the original larger committee, and

redoubled their efforts to plan a milestone of an event for Ohio. As a result, this very determined and committed team of individuals delivered the largest 60 Summits Project event attendance and the largest number of local sponsors to date on March 14, 2008 at Quest's Business Conference Center in Columbus, Ohio -- and created a very strong level of commitment in the attendees for on-going action together.

[NOTE: Earlier, the northern Ohio area decided to hold their own version of a summit-type event, and chose to work independently from The 60 Summits Project. Their event was held in Cleveland in November, 2007 and was deemed a success. Some of the planners and attendees at that event also participated in the central Ohio Summit.]

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 -- which cover the *medical treatment* given to injured or ill individuals -- **were not** the topic of the Ohio SAW/RTW Summit. The guideline used in the Summit is a completely different document covering a very different set of topics.
- The work disability prevention paper which **was** the focus of the Ohio 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, or at www.60summits.org. 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 moves to 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 "having 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 Ohio Summit planning group, also known as The Ohio Chapter of The 60 Summits Project, worked together to plan the Summit by phone, email and through face-to-face meetings. They elected to call their initiative "Preventing Needless Work Disability of Ohioans." After their first few independent meetings, they decided to engage the 60 Summits Project staff to assist with planning and delivery of their all day Summit workshop, as well as providing administrative, 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 and registration process, facility logistics and developing the associated materials to 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 could 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 sent to prospective attendees, 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 Ohio 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 Ohio into a state that prevents needless work

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.

disability by actively helping people stay employed

Summit Participants

The 130 Summit attendees were distributed across the key stakeholder groups in the stay-at-work / return-to-work process. The Ohio Summit Planning team selected and personally invited many of the attendees but they also wanted to spread their information to as many people as possible so they also employed an open invitation. Participants accepted the invitation knowing that they would work within the framework of the ACOEM guideline in joint pursuit of creating a milestone event for Ohio and a better stay-at-work and return-to-work process to benefit both employees and employers.

Appendix C contains a list of all Summit participants. This was the largest Summit held to date and was truly a groundbreaking event for Ohio. This is the first time that such a large and diverse group has come together to address preventing needless work disability for all Ohioans. The stakeholder groups consisted of representatives from employers, medical practices, labor, insurers, case managers, occupational and physical therapists, return-to-work specialists, associations, government, mental health, legal, judicial, regulator, pharmaceutical and managed care. The number of participants from some of the stakeholder groups were larger than others. For example, the employer, payer and industrial therapist groups were the largest while the labor, legal and judicial groups were the smallest. Even though some groups were small, the quality of the representation was very high. Everyone acknowledged that they must work harder to spread the word to these underrepresented groups.

Summit Facilitators

The facilitators for the day were provided by The Ohio Bureau of Workers' Compensation (OBWC) and the Summit Planning Committee. Facilitators from OBWC were trained internally where they received the basics of "Facilitation 101". Dr. Christian then followed up with special Summit-specific training for all facilitators via teleconference to cover the specifics needed for the Summit day. The facilitators worked with both the mixed groups and the stakeholder groups throughout the Summit and were responsible for managing the considerable logistics of the day, keeping the discussion in their groups focused on the issues, and on producing their small group reports.

Description of the Summit Workshop

The agenda for the day appears in the ruled box to the right.

AGENDA

March 14 – Full Day Event

- Opening session, welcoming remarks
- Keynote presentation by Dr. Christian
- Mixed groups' work sessions
- Groups present preliminary action plans
- Lunch
- Stakeholder groups' work session
- Stakeholder groups' panel session & Q&A
- Mixed groups' refinement of action plans
- Mixed groups' final reports on action plans
- Closing session and adjourn

Welcome reception and opening session

The Summit was held at Quest Business Conference Center on the North side of Columbus. The Summit began early in the morning with registration, continental breakfast and the opportunity to visit with exhibitors who had set up tables in the assembly area. Attendees were then guided to the large

conference room on the second floor for the opening session conducted by Dr. Christian.

The Summit workshop

Brief opening remarks were made by the Ohio Summit planning committee followed by Dr. Christian's short orientation to the day. A show of hands in the room indicated that less than 30% of the room had read or were familiar with the ACOEM SAW-RTW guideline. This "read of the room" has varied from Summit to Summit with the highest being Minnesota's Summit at 90%.

The keynote address by Dr. Christian provided an overview of the 60 Summits Project, stressed the importance of preventing needless work disability, outlined key concepts in the ACOEM Guideline and briefly reviewed each of the 16 recommendations in the guideline. It concluded with instructions on how to conduct the multi-stakeholder group sessions. (See the ruled text box at right for details.)

TASKS ASSIGNED TO EACH MIXED STAKEHOLDER WORK GROUP:

1. Decide which portion(s) of the assigned ACOEM guideline to focus on.
2. Decide if you agree with the guideline's 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.

Following the keynote, attendees moved to their mixed stakeholder group assignments. Each group was comprised of 10-12 people from a variety of stakeholder types. Each group had been assigned different recommendations from the ACOEM paper, varying from one to three recommendations per group.

In addition, the Ohio Summit Planning Team decided to modify the usual Summit format by adding same-stakeholder work groups sandwiched between two multi-stakeholder work group meetings during the day's agenda. Participants began the day in a mixed stakeholder group where they developed tentative action plans, than moved to a same stakeholder group where they looked at similar issues from a different angle, and then returned to their original mixed stakeholder group to refine their thinking and create a final report. While this led to a logistically challenging day, the change created new enthusiasm, insight and valuable contributions to the day's discussion. (See the text box at right for the tasks assigned to same-stakeholder groups.)

TASKS ASSIGNED TO EACH STAKEHOLDER WORK GROUP:

1. Identify the factors in today's current system that might make our stakeholder group reluctant to fully support the ACOEM recommendations.
2. Identify new or existing things that need to be created or supported in order for our stakeholder group to thrive and prosper in preventing needless work disability.
3. In light of the guideline, what parts are our stakeholder group doing effectively and what needs to be improved?
4. How can we as a stakeholder group remove obstacles that are getting in the way of improving the outcomes of the SAW/RTW process in Ohio?
5. What are our personal commitments and action steps that will make a difference in implementing the ACOEM guideline in Ohio?

Small group break-out sessions followed by brief summary reports from each group to the entire assembly were held both in the morning and the afternoon. The eleven mixed small groups, each composed of multiple stakeholders, were challenged to decide whether they agreed with the ACOEM recommendations 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 the action to take "tomorrow.**"**

All of the work groups indicated that they agreed with the ACOEM recommendations that they had been assigned and that they **should** be implemented in Ohio. The mixed small groups presented their initial reports before lunch and received feedback from Dr. Christian on how to be more concrete and specific in their action steps. Following lunch, the groups convened into same-stakeholder groups to address the importance of the ACOEM guideline for their group and the action steps they would like to take. Due to the size of employer, payer and industrial therapist representation at the Summit, two groups were formed from each of these stakeholder types creating a total of 11 groups. A spokesperson was then selected from each group to form a panel to report on their group tasks. The stakeholder panel consisted of representatives of the employer, labor, clinical provider, industrial therapist, payer, policy/judiciary, case manager/vocational and specialty provider groups. Audience questions and answers followed this panel presentation.

Following the stakeholder panel reports, the mixed groups reconvened to refine their final reports for the Summit. Their refinement was to include any feedback from Dr. Christian on concreteness and any new information that they gleaned from listening to the stakeholder reports. One of the major outcomes from a Summit is to give attendees the opportunity to listen in a way that they have never listened before to what other attendees are reporting is "true" for them. Dr. Christian emphasizes "*listening for the new"* and *not* listening from the position of what you already know. The action plans developed by the work groups demonstrate the commitment this Summit group has to improving the SAW-RTW process in Ohio. Their practical "to do list" appears in Appendix D, a comprehensive list of all of the action plans developed by the mixed work groups. The stakeholder group reports are consolidated in Appendix E.

In addition to the output of the small groups, 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 Ohio 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 gist of this form appear sin the text box to the right. 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 F 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 adjourned. 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. 42% of the attendees signed up to be part of the Ohio Summit Action Group.

The Ohio planning group chose to include a small exhibit area for related vendors. During registration and the breaks attendees were free to visit these exhibits. The aggressive agenda of the Summit provided only limited time for interaction with exhibitors. However, some of the exhibit representatives also became valuable participants in the Summit meeting.

Action Plans

All of the work groups thought the individual ACOEM recommendations that they had been assigned were worthwhile. Therefore, all of the small groups developed action plans to begin implementing them. Commonalities among the plans became apparent as the small groups gave their reports. The major domains in which most of the action plans were focused were the following:

1. **Education – to make sure that everyone is aware of the ACOEM guideline so they can begin implementing it's recommendations**

   All of the work groups felt that it was critically important to share the work disability prevention model with as many audiences as possible 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. One group came up with creating a manual "SAW-RTW for Dummies" Other examples included development of materials: informational brochures, tool-kits 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, association meetings and incorporating it into existing company training materials and courses, creating short videos for websites etc.). Among the audiences at which these messages are to be aimed are employers, workers/ unions, physicians, claims/case managers, payers etc.

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. 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. For example, one group spoke about engaging the OBWC Oversight Commission leadership in implementing the ACOEM guideline recommendations, another the leadership within OBWC. Another spoke of engaging the insurer payers of group health and disability benefits to recognize the importance of recovery on the job. Many identified the need to bring their representing associations into the discussion. For example the Ohio Physical Therapy Association (OPTA) is bringing the ACOEM guideline to the attention of its members through upcoming conferences. Others spoke of leveraging

the expertise of self-insured employers' effective programs to support the SAW-RTW process in medium to small employers.

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

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

4. **Operationalizing the ACOEM guideline recommendations** …

   to put 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 and "just in time" 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.

The list above 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:

- "humanizing" the process by paying more attention to what people need during the process,
- advocating for legislative/regulatory action (though not as many as some might have expected) , and
- continued personal development (the deepening of one's own knowledge or expertise).

Next Steps

The Ohio Summit planning team intended this workshop to be a landmark event for Ohio with the goal of spreading the word of work disability prevention throughout the state. Summit planners recognized that the one-day Summit is an important beginning, but in order for the paradigm shift to occur throughout the state, an ongoing structure is needed to support the shift. This is not the first time that multidisciplinary stakeholder groups have come together to make a difference in Ohio, so what will be different this time? It's more than the fact that this Summit addressed not only the workers' compensation system but the group health and disability benefits systems as well.

The shift begins with getting as many of the right people as possible in the room to do more than *talk about* ACOEM's recommendations, but to *speak for* actually implementing them and to make specific plans for how to do that, by when, and with whom. The Summit starts with asking attendees to identify what is possible through communication and collaboration across, and in this case within, stakeholder groups. The 60 Summits Project supports a structure for fulfillment that starts with the workshops offered during the Summit and continues with the Follow-Up Action Groups. Having a structure to support attendees who have made personal commitments for action is key.

42% of the attendees at the Ohio Summit expressed an intention to participate in the follow-up action group. The co-chairs of the Ohio Summit planning committee and members of the steering committee offered to launch that group for Ohio on May 1st 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. Ohio currently has a webpage on the 60 Summits website that can be used to continue to share information.

Beyond Ohio, the 60 Summits website (www.60Summits.org) provides a central clearinghouse for all the other state groups participating in The 60 Summits Project. The 60 Summits 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 action 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.

Appendices

Appendix A
List of Planning Committee Members

CO-CHAIRS:

Terry Driscoll, MSN, RN, CCM, QRP, TWD is the founder and President of Working Options, Inc., a vocational rehabilitation company that offers transitional work case management as well as nurse case management and development of transitional work programs. She is a graduate of Ohio University and Wheeling Jesuit University and is a certified case manager and an Ohio Certified Transitional Work Developer. Her specialty is promoting a multidisciplinary approach to return to work through transitional work, vocational case management and formal transitional work programs. She has established more than 300 transitional work programs for employers in the past six years.

Christine Moranda, LSW, CDMS, CCM is currently Manager of Disability Programs, Associate Health and Wellness for OhioHealth. During this time she was instrumental in creating a Leave of Absence packet to assist OhioHealth associates in need of a disability leave and co-chaired a Supported Employment Team which resulted in a new position for a Workplace Accommodation Specialist (WPAS). Chris has worked in the field of rehabilitation for twenty plus years. Her experience includes director of case management operations; regional supervisor for a home services facilitation company administering the Medicaid Waiver program; and program manager for two group homes for developmentally disabled adults. A graduate from Western College, Oxford, Ohio, she later received a Masters of Arts from Goucher College, Towson, Maryland in Dance/Movement Therapy.

MEMBERS:

G. Steven Baer, DC, DABFP, DACBOH Dr. Baer graduated from Palmer College of Chiropractic in 1978 as class valedictorian. He has been in private practice for nearly thirty years. He is board certified in forensic science, impairment rating and occupational health. Dr. Baer served as past president of the College on Forensic Sciences affiliated through the Council on Chiropractic Orthopedics (CCO) of the American Chiropractic Association. In addition to memberships in the College on Forensic Sciences, American College of Chiropractic Consultants and the American Chiropractic Association, he belongs to the Ohio State Chiropractic Association and is the only chiropractic member of the National Society of Insurance investigators. Dr. Baer has provided retrospective claims reviews and independent medical evaluations over the past twenty years. He is part of the Disability Evaluator Panel and Alternative Dispute Resolution panel through the Ohio Bureau of Workers' Compensation. He also has been actively involved in fraud investigations. He is a member of the post-graduate faculty of Northwestern University of Health Sciences in Bloomington, Minnesota. He also works as a monitor for Affiliated Monitors of Boston, Massachusetts, auditing doctors working through disciplinary measures with the State Board of Chiropractic Examiners. He currently practices in Middletown and in West Chester, Ohio.

Brenda Barker, RN, BSN, CRRN, CCM began her medical career in the field of rehabilitation as an occupational therapy assistant (OTA) which she complimented with a degree in nursing. Over the years she has been very fortunate to have practiced in a variety of settings including: rehabilitation, home health, field nurse case management, hospital case management program

and occupational health. Since 2003, Brenda has been employed as a disability manager with The Scotts Miracle-Gro Company in Marysville. She also serves on the Central Ohio Self Insured Association Board of Directors.

Nancy Garland, JD CAE, Chief Executive Officer, Ohio Physical Therapy Association Nancy has served the Ohio Physical Therapy Association as its chief executive officer for the past five years. She has helped to make health care directly available to patients. She is also clinical assistant professor at The Ohio State University School of Allied Medical Professions where she teaches health policy in the physical therapy doctoral program. When Nancy worked in Washington D.C. she was a legislative assistant on Capitol Hill, then as an advocate for the American Optometric Association and finally as the director of government affairs for the American Physical Therapy Association. She worked on one of the original Patient's Bill of Rights and continues to work on similar legislation in Ohio which would simplify insurance for patients and providers. Nancy is running for state representative of Ohio's 20th House District in the 2008 election.

Stephanie Ramsey, MPH, Director, Managed Care Services Department, Ohio Bureau of Workers' Compensation Stephanie joined the Ohio Bureau of Workers' Compensation in July, 2004 as Assistant Director of the Self-Insured Department responsible for operations of the bankrupt self-insured claim unit. In March 2006 she joined the Medical Services Division as Director of Managed Care Services with responsibility for the Medical Policy Unit, Injury Management Unit, Employee Health Services, Vocational Rehabilitation Policy Unit, Provider Relations Department, and the Hospital Reimbursement Review Unit. She has an extensive background in the insurance industry and has held a variety of positions within group health product lines; claims and underwriting; as well as strategic planning for medical claims management. Stephanie earned a Bachelor of Science degree in nursing at Carlow College in Pittsburgh, Pennsylvania. She completed graduate studies at the University of Pittsburgh earning a Masters degree in dual concentrations of health services administration as well as health policy.

Judy Vincent, Director of Operations, Workers Choice Health Services Judy has been with Workers Choice in an operational role growing and developing physical and occupational therapy at the worksite for the past nine years. She has worked in the field of occupational/workers compensation rehabilitation for nineteen years. Her experience includes Director of Operations for three CARF accredited outpatient clinics for ten years, the last three of which she successfully implemented an occupational medicine component. Judy also holds a license in nursing home administration and worked in this field for five years prior to entering the industrial rehabilitation and workers' compensation field. Judy received her BA degree from West Virginia University.

Rick Wickstrom, PT, CPE, CDMS is a licensed physical therapist, certified professional ergonomist, and a certified disability management specialist. He earned his bachelors degree in physical therapy from The Ohio State University and completed his Ph.D. coursework in occupational ergonomics at the University of Cincinnati, Department of Environmental Health. As President and owner of Workability Systems, Rick has been a consultant in occupational health and ergonomics for over twenty-five years. He has provided expert testimony and published many articles and technical papers related to functional capacities evaluation, work injury management, and ergonomics. He serves in multiple leadership roles at a national and state level for the American Physical Therapy Association, including the update of professional guidelines for administration of functional capacity evaluations.

Appendix B
List of Sponsors

North American Sponsors

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Whole Health

Workability Network

Workers Choice Health Services Inc.

WorkHealth/OhioHealth

Working Options

Silver

Coventry

GAB Robins

Huntington

IHG-Interplan Health Group

Mount Carmel Corporate Health & Wellness

VocWorks

Bronze

Lyon Video

Ohio State Chiropractic Association (OSCA)

UNUM

Appendix C
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Appendix C
Summit Attendees

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Summit Attendees

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Appendix D

Action Plans Developed by Multi-stakeholder Small Groups

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.*

Group Members: (* indicates the group facilitator)

- Adkins, Doris - Sedgwic CMS
- Alltop, Fritzi - Midwest Express
- Barnett, Irene* - BWC
- Enderle, Linda - Nationwide Insurance
- Fay, Michael - Honda of America
- Jones, Julie - Matrix Vocational Solutions
- Kruszewski, Theresa - GAB Robins
- Nolan, Maria - Workability Network
- Poe, Kelli - The Health Plan
- Schreiber, Matthew - PMSI
- Smith, Kirk - Jim Beam

Report:

Group A focused on education and communication.

The strategy we believe is best for making this actually become the standard of practice in our organizations or communities is: through proactive communication and education with employers, supervisors, employees, physicians and providers.

A concrete first step we can take to get started on making this a reality is:

1. Create concrete checklist of action steps for each party
2. Review internal RTW policies and procedures
3. Hold provider and employer meetings

Specifically, action steps that are specific to each party on this checklist should be attached to FROI incident reports.

Who needs to do it? The employer should initiate through HR.

And the next step after that? Irene (BWC) will email a template of transitional work model to group so that the group can build upon it then share this best practice with the employer group.

Here's what we intend to do starting tomorrow:

1. Maria intends to be more aggressive in calling case manager and employer by Monday to accomplish calling and communication.
2. Irene will educate providers and try and implement CEU education – BWC certification with CEUs for the education (free). Provider stakeholders need to be involved. To accomplish by 2009 after NPI; create curriculum to use on web stream.
3. Irene will create a checklist for all stakeholders and will email it to the group
4. By Monday initiate the review of internal policies for supporting injured worker upon injury so that they know what to do.

Group B – Recommendations 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.*

Group Members:

- Cannelongo, Joseph - VoCare Services Inc
- Connor, Tom - Industrial Commission
- Cowans, Timothy - Scott, Scriven & Wahoff LLC
- Elliott, Tina* - BWC
- Frigy, Pamela* - Americhem
- Hadley, Thomas - Concentra
- James Scott - Doctors Urgent Care
- Long, Melissa - Honda of America
- Michael, Marissa - Workers Choice
- Moranda, Chris - Ohio Health/ WorkRehab
- Oriti, Helen - Kaiser Permanente
- Pemberton, Kim - VocWorks
- Simons, Sandra - Genex

Report:

Group B focused on: employer strategies, PTO policy that integrates disability management and disability and RTW programs.

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is: to accept the recommendation. We also are the group that wants to make RTW programs more equitable so they are not punitive. This group would like to partner with the employer group.

A concrete first step we can take to get started on making this a reality is:

1. Research for model PTO/integrated models
2. Research best practices – attend association meetings to educate employers-who out there has the best integrated benefits delivery model
3. This group should contact HR associations
4. Combine team of labor, group, work comp payers and employers to come up with best practice template for integrated disability program

Specifically:

1. Develop a credible educational group (identify the best model)
2. Train at the HR level, then executive sessions with top management to obtain buy in. Must demonstrate success for employees to buy-in.
3. Develop template for employers, educate employees
4. Use publications to support use of the template

Here's what we intend to do starting tomorrow:

1. Research model PTO, involve HR Association by May 1st to accomplish fact finding on who's using best practices.
2. Establish committee to come up with template by June 1st to accomplish buy-in.
3. Develop template policy by August 1st to educate, promote and demonstrate success.
4. Meet with stakeholder groups to discuss internal RTW program that addresses both occupational and non-occupational components by August or September

Group C – Recommendations 3 and 5

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.*
>
> ***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.*

Group Members:

- Birdsall, Richard - Risk Management Financial Solutions of Ohio
- Cox, Melinda - Coventry Health Care
- Fiorella, Kristie - Ohio Health/ WorkRehab
- Fiorini, William - Whole Health
- Harpen, Geraldine - TriHealth
- Heidenhoffer, Linda - Kaiser Permanente
- Hibner, Robert - Rehabilitative Services
- Lawhorn, William - Miami Valley Hospital
- Salisbury, Beth* - VocWorks
- Siebert, Laurie - Cigna Group Insurance

Report:

Group C focused on: Recommendation 3, prevention not mental health diagnosis along with providing pathways for education.

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is:

1. Education for mental health practitioners on not diagnosing or labeling too soon
2. Education for employers on all available resources such as EAP

3. Education for providers, physician of record etc.
4. Prior authorization – allow service for up to 6 visits?; preventive service not mental health counseling
5. Link state and national level organizations

A concrete first step we can take to get started on making this a reality is:

1. Train physician of record on mental health screening process and on current treatment pathways, such as when to refer to another level.
2. Insurance carriers, MCO and BWC should allow initial visits with emphasis on prevention not diagnosis, up to 6 visits.
3. Employee, employer and labor should be educated on the options that are available to employees at work and when off work, EAP and other resources. Employees need to understand benefits.
4. Employers need to be demystified by mental health issues with strategies for return to work and stay at work.
5. BWC can educate at WCU. EAPs need to be involved along with other mental health professionals in the community.

Specifically, need to get a mental health panel together to set guidelines, treatment policy, certification and documentation. William Lawhorn, psychologist from Miami Valley Hospital volunteered to start this panel. If you are interested in working with him on this panel, contact him at wtlawhorn@mvh.org. The panel should consist of a psychologist, physician, nurse case manager, employer and employee/injured worker. The next step is to set mental health standards for service outcomes, standards of care, role definition and responsibility, mental health disability evaluations and global assessments.

Here's what we intend to do starting tomorrow:

1. Develop 5 screening questions on anxiety and stress to share with the POR, when and how to use the screening test and documentation guidelines by December 2008. The POR, MCO, BWC and nurse case managers need to be involved to encourage the physician to address treatment sooner so that the employee doesn't develop a full blown diagnosis.
2. Develop education process with CEUs for providers on mental health issues within 1 year. Involve mental health providers and employees. Educate providers to identify issues up front and address the issues early.
3. Add the 5 screening questions to the 45 day exam in hopes of warding off something bigger. Involve IME docs and BWC medical review at 45 days.
4. Add a behavioral health form to the Medco 14 with 1 year to obtain better information for RTW. Involve mental health professional, employer, field case manager and BWC.
5. Study of EAP programs within 6 months. Involve BWC and EAP providers. Share success stories from Cleveland Clinic to educate employer on the benefits of early intervention.
6. Study prior auth outcomes of mental health services within 6 months as to whether pre-existing conditions have been created. MCOs and BWC need to be involved to determine the benefits of mental health utilization.

7. Dig out the prior authorization study that BWC did with a couple of MCOs on up front behavioral health treatment – did this treatment lead to psych claim? Can Karen or someone else help us?
8. Work with the group that is building the SAW/RTW Manual for Dummies, include adjustment reaction to injury/illness, behavioral health and psych management in the book

Group D – Recommendations 14 and 15

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.

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.

Group Members:

- Arnold, Karen - Doctors Urgent Care
- Blaser, Lori - KKSG & Associates
- Bowsher, Marsha - Midwest Express
- Haas, Chuck - City of Cincinnati
- Hansen, Tammie - Mt. Carmel Health Services
- Jones, Sarah - Doctors Urgent Care
- Mitchell, Michael - Interplan Health Group
- Pappas, Hilda - Lumi-Lite Candle Company
- Rossi, Lori - The Health Plan
- Vincent, Judy* - Workers Choice
- Wanat, Robert - Kettering Workers Care
- Wickstrom, Rick* - Workability Network

Report:

Group D focused on: simplifying and standardizing the information exchange between employers.

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is:

1. Better designed injured worker packets for occupational and non-occupational injuries.
2. Single, simple form for relating worker abilities to job/task demands – one page
3. Get job analysis authorized early during lost-time process with worker participation.

A concrete first step we can take to get started on making this a reality is:

1. Share our existing methods for injured worker packet and workability report.
2. Clarify procedures with BWC and non-occupational disability carriers for getting job analysis with worker participation earlier.
3. Convene a multi-stakeholder group to develop one simple form for workability and guidelines for developing injured worker packets for work-related and non-occupational.

Here's what we intend to do starting tomorrow:

1. Lori Rossi will clarify by 4/20/2008 with BWC how an MCO or employer can authorize functional job analysis with worker participation w/out going through the traditional C9 approval process which presents barriers in the time the decision needs to be made.
2. Then we could disseminate to Summit participants and MCOs specifying components and estimated cost.
3. Marsha Bowsher will contact disability carriers to establish a process for getting job analysis early on during a disability and also putting some time frames around components with estimated cost.
4. Members will send RTW forms to Rick by 4/20.2008 and injured worker packets to Karen Arnold for discussion at follow-up group meeting on May 1.
5. Our group decided we want to continue to meet regarding IW packets and job analysis.

Group E - Recommendation 8

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.*

Group Members:

- Barker, Brenda* - The Scotts Company
- Cacioppo, Rose - Ohio Health/ WorkRehab
- Eakin, Kay
- Esch, Clyde - Heights Chiropractic Physicians
- Gaudiose, Martin - Vision & Vocational Services
- Jacobs, Marcella - The Health Plan
- Leeper, Nancy* - BWC
- Risteff, Stephanie - Ohio Health/ WorkRehab
- Sawyer, Will - Sharonville Family Medicine
- Szymanski, Duane - Corvel
- Wendell, Heather - VocWorks

Report:

Group E focused on: taking the physician out of the role of deciding employment issues and focusing on physical and mental abilities.

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is:

Standardized form initiated by the employer with job description, transmitted by the employee with portion completed by the physician outlining medically related physical and mental abilities, f/u appt, not employment decisions.

A concrete first step we can take to get started on making this a reality is:

1. Develop universal standardized form to be completed by employer, employee and physician – Rose is going to help initiate and send around to the group for input by May 1st – place in the SAW/RTW for Dummies toolkit – place on the 60 Summits website so employers can access from anywhere
2. Goal of form is to provide effective communication between stakeholders.
3. Utilize the form for communication- a presentee form
4. Committee to be formed of all stakeholders (BWC, physician, employers, therapists, safety managers, voc rehab personnel.
5. Set effective date for committee to meet.

Parking lot issue: Pay employee reward not physician to ensure form is completed and turned into employer.

Here's what we intend to do starting tomorrow:

1. Will Sawyer will help develop form – be on committee, give input. Rose will help draft electronic form. Heather Wendell, Martin Gaudiose, Stephanie Risteff and others need to be involved along with employee and employer rep. Create draft of electronic form by May 1, 2008 to accomplish communication among all stakeholders.
2. Create a SAW/RTW employee toolkit that they can carry with them so the employee and physician have a clear understanding of the process

Group F – Recommendations 1 and 13a

Text of Assigned Recommendation(s) 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.*

c. *Reduce discretionary disability by increasing the likelihood that employers will provide on-the-job recovery.*

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

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

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

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;

Group Members:

- Carollo, Judi - Ohio Health/ WorkRehab
- Coleman, Judith - Spectrum Rehab
- Cross, Bonnie - State of Ohio, Dept. of Admin Services
- Dumas, John - Sheakley Unicomp
- Fitzsimmons, Karen* - BWC
- Gorner, Daniel - CompManagement Health Systems
- Grome, Geneva - Restaurant Management Inc
- Jackson, Jean - Honda of America
- Pearce, Debbie - Doctors Urgent Care
- Platoni, Kathy - Clinical Psychology
- VanHorn, Toi Lin - Vision & Vocational Services

Report:

Recommendation 1

For Recommendation 1, Group F focused on: early intervention/notification to reduce injury reporting time and directing/selecting appropriate care providers.

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is:

1. Promote disability management/prevention programs for all employers/medical providers
2. Minimize the event through the reporting timeline (promote early intervention/care direction)

A concrete first step we can take to get started on making this a reality is:

1. Promote disability management/prevention programs with employers and providers.
2. Specifically, visit medical schools to review curriculum and promote minimizing disability.
3. MCOs, disability companies, OBWC all need to work to make it reality.
4. Promote a sense of urgency for reporting and intervention of care (if necessary) through the same stakeholders as above.

Here's what we intend to do starting tomorrow:

1. Visit medical schools to discuss curriculum by June 2008 to help direct focus on identifying abilities and positive aspects. John Dumas and Dan Gorner need to be involved. Within 2 weeks Dan will contact a contact that he has at Ohio State University.
2. Go to physicians (PMR, occupational medicine, family practice, general practitioners and chiropractors) who teach residents. Judi Carollo will contact Dr. Montanez at Riverside on Monday to set up an appt. by May 1st.
3. Work with case management companies to discuss RTW practices by September 1, 2008 to have PORs who are resistant to RTW to understand the benefits of minimizing disability prevention. Judi from VocWorks needs to be involved.
4. Judy Coleman will commit to present these guidelines at the October PT Association Conference. Judy will be working with other stakeholders and therapists for continuing education course development.
5. For spreading the word we need to tell them that the resources are there but we need to get others to go to these.
6. Karen Fitzsimmons will research whether there is a replacement for Focus Magazine. Suggest email with a link to the BWC website and other resources and have a Summit column within it.
7. Script for frontline managers on how to keep in touch with absent workers in Toolkit for Dummies already in Group 5.

Recommendation 13

For Recommendation 13, Group F focused on: physicians driven by outcomes – financial.

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is:

1. Disseminating best practice guidelines to providers.

A concrete first step we can take to get started on making this a reality is:

1. Conference training for OTs and PTs in the October Conference. This information needs to be on the agenda. Judy Coleman will make that happen.

Here's what we intend to do starting tomorrow:

1. Judy Coleman to call state rep by ____ to educate legislators on updating work comp regulations to support/increase RTW.
2. Contact BWC on fee schedule (payments vs. outcomes) like non occupational insurance companies (non work comp carriers?). Data is needed to incentivize providers by outcomes by December 31, 2008.

Group G – 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.*

Group Members:

- Baer, Steve - Chiropractic Utilization Review and Evaluation
- Bowen, Juliene - Work Health/ Ohio Health
- Bro, Becky - VoCare
- Burnip, Doug - Unum
- Davidson, Kathy - TriHealth
- Hall, Suzanne - Complete General Construction
- Jackson, Marsha - Ohio Health/ WorkRehab
- Kemo, Valerie - The Health Plan
- Linz, Douglas* - TriHealth
- Mihaly, Tammie* - BWC
- Seggebruch, Steve - Nationwide Better Health
- Zrinyi, Beverly - Cigna Group Insurance

Report:

Group G focused on: the entire recommendation and 2 sub-recommendations

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is:

1. Establish list of behaviors distinguishing physician/providers who support SAW/RTW (See below)
2. Establish measurable outcomes that reflect success in physician/provider SAW/RTW management.
3. Establish incentives to selectively reward physicians/providers who exceed minimum standards for objective outcomes.

A concrete first step we can take to get started on making this a reality is:

1. Physician/provider group needs to develop (flesh out these lists)
2. See draft lists
3. Next steps will be part of "to do" list for May 1 reconnect

Definition of Work Disability Prevention Provider Behaviors

1. Performs in depth evaluation of medical/social/occupational/family factors
2. Focus on abilities vs. disabilities/restrictions
3. Communicates with all stakeholders.
4. Eliminates delays in obtaining diagnostic testing and therapeutic interventions (i.e. same day specialist appointments).
5. Utilizes "tools" from MCO, employers, TPAs to facilitate SAW/RTW outcomes, eg job analysis, FCE.
6. Works as a partner with disability case managers.
7. Utilizes best practice treatment guidelines
8. Timely and effective utilization of SAW/RTW oriented PT/OT services.
9. Buy-in to expectations for exceeding objectives metrics of outcomes
10. Pursue training and certification to support these learning objectives.

Outcomes

1. Care Management Measures
    - Time to complete/submit PIO, treatment plans, C9
    - Time to communicate with employer/employer representative same day (within 24 hours) for lost time.
2. Evidence of training certification in behaviors
3. Medical documentation that includes objective measures of health and function, i.e. if back injury – physical examination to document findings.
4. Medical release to RTW vs. benchmarks – elucidating residual abilities for modified duty and full duty
5. Timely utilization of PT/transitional work/FCEs/job analysis
6. Global functional score for workability incentives and options

Reimbursement

1. Varies with outcomes

2. First, pay for service, second, measure outcomes, third, provide additional payment reflecting outcome.
3. Up code visit charges in exchange for documented behaviors See first list on behaviors.
4. Fee for service reimbursement for incentives
    a. telephonic case management
    b. medical case management
    c. RTW case management
5. Percent of disconnected savings to employer (i.e. cost and % of savings to employer)
6. Pay providers at full fee schedule.

Group H – Recommendations 3 and 4

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*
>
> ***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.*

Group Members:

- Beck, Deborah - Hamilton County
- Campbell, Terrance - Kaiser Permanente
- Caston, Howard - Caston & Associates
- Davies, Ann - Workable Solutions, Inc
- Habash, Steve - Habash, Reasoner & Frazier
- Hilliard, Johnnie* - BWC
- Murphy, Pat* - Workers Choice
- Nauman, Mary Lou - Honda of America
- Pavlic, Elaine - Whg Pitt Steel
- Rodriques, Pam - The Health Plan
- Schechtman, Jean - TriHealth
- Vermeulen, Mark - PureSafety

Report:

Group H focused on: each of the recommendations.

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is:

1. Overall to promote education and communication about resources that are available and then to ease access to these resources.

2. Specifically to promote ease of access through the system by promoting an “I care” contact internally in HR/employer case management in addition to MCO case management.
3. Education pre and post injury and available supports such as EAP programs or employer triaged community resource.

A concrete first step we can take to get started on making this a reality is:

1. All individuals at table will see value and take “I care” concept back.
2. Several nurse case managers already screen for mental health issues and will continue with screening for mental health issues.
3. County medical association education about work disability.
4. Involvement from BWC – use Safety Congress process to promote education of EAP.

Here’s what we intend to do starting tomorrow:

1. All group members will take back “I care” attitude to employees. Deborah will include “I can” outline information in the SAW/RTW for Dummies. Lou will outline he experience contacts re: “I care” to Johnnie to share with Safety Congress Chairs. We will encourage all employers we have contact with to adopt caring attitude toward employee, identifying issues. HR/coworker to followup with work disabled individuals. Encourage internal case management to identify early need for support services.
2. Create pilot project for mini mental health assessment – screening for high risk and how it can be used to channel/access support. Jean Schechtman to contact professor of occupational health nursing at Ursula.
3. Education, education, education. Lou, our doctor rep will educate county medical association and medical schools regarding ACOEM guidelines. Our occ. Health nurse rep will work with their association on communicating/educating about this issue as part of assessment/case management process. Our employer rep will incorporate education about EAP program use pre and post injury. Ohio Chapter of IARP (International Association of Rehabilitation Providers) will commit to education and provide speaking assistance.

Group I – Recommendations 6 and 13b

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*
>
> ***13. Disseminate Medical Evidence Regarding Recovery Benefits of Staying at Work and Being Active***
>
> *Sub-recommendations:*
>
> *b .Or preferably, adopt an evidence-based guideline as the standard of care.*

Group Members:

- Babka, Tersa - The Health Plan
- Dhillon, Robin - Greater Cleveland Automobile Dealers Association
- Harrington, Pat - Greater Cleveland Automobile Dealers Association
- Hubach, Lynn - Cleveland Clinic
- Krieger, Jeffrey - Cigna Group Insurance
- Mullins, Ann - Mt. Carmel Health Services
- Page, Nick - PMSI
- Reeder, Jeffrey - TriHealth
- Schaaf, Jim - Doctors Urgent Care
- Venn, Debra - Venn Consulting
- Weaver, Jean - Ohio PT Assoc
- Wilks, Janet* - BWC

Report:

Group I focused on: education and use of some sort of guidelines to alleviate hidden agendas.

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is:

1. Create a stakeholder discussion group (self insured and state fund) to talk about the development of Ohio guidelines – having Ohio guidelines would/should be affordable to use, tailored to Ohio.
2. Involve all stakeholders in updating www.ohiobwc.com (including self insured employers)
3. Use BWC website for more in-depth education.

A concrete first step we can take to get started on making this a reality is:

1. Group will send email to Janet Wilks to forward concerns about developing Ohio guidelines and other recommendations.
2. Specifically, get email addresses from group – send out request for feedback. Send group information regarding this public forum in April.
3. Once guidelines are developed, set time for follow-up and possible revisions.

Here's what we intend to do starting tomorrow:

1. Utilize better communication practices.
2. Involve case managers and all stakeholders immediately to reduce stress, enhance communication, build rapport
3. Janet to forward an email to members of group to solicit their concerns and thoughts on developing Ohio guidelines and other recommendations, then will forward those recommendations from the group to internal BWC staff for review
4. Janet announced provider open forum on April 24th from 9:30-11:30 am Wm Green Building to discuss provider barriers and enhancing service deliver to injured employees – register at www.obwc.com
5. Create multi-stakeholder group to benchmark ourselves using SI and state fund best practices
6. Janet to speak with Carrie Sullivan in BWC Communications Dept. about updating BWC website to exhange and gather info from SI employers as well regarding guidelines and benchmarks

Group J – Recommendations 12 and 16

Text of Assigned Recommendation(s) from ACOEM Guideline:

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.

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;

Group Members:

- Collins, Deana - Corvel Corporation
- Driscoll, Terry* - Working Options
- Guyer, Richard - Risk Management Financial Solutions of Ohio
- McGee, Debi - The Health Plan
- Patterson, Victoria - Honda of America
- Radecke, David - Peak Performance
- Ringley, Lori - TriHealth
- Rudwall, David - Rudwall Law Office
- Vail, Matthew - Ohio Health/ WorkRehab
- Williams, Michael - Corvel

Report:

Group J focused on: developing RTW/field for physician offices. Focused on the concept of using field RTW reps like the drug rep concept, an impartial, knowledgeable, credible individual that can promote and maintain relationships with physicians and staff

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is:

1. Mike with Medical Director to present idea/concept of RTW reps to BWC Board which will result in BWC support and funding
2. RTW reps should be seen as an impartial rep that is knowledgeable and credible to promote and maintain relationships with physicians and staff on the occupational side. Hopefully will result in a model to share with the non-occupational side.

A concrete first step we can take to get started on making this a reality is:

1. Mike Williams to contact leading professionals in community to help share concept
2. Mike Williams to contact Medical Director to work with Dr. Christian so he has a clear understanding
3. Contact providers and follow up with Medical Director
4. Doug Linz to talk to BWC Board in April
5. Share concept with Phil Fulton for labor

Here's what we intend to do starting tomorrow:

1. Review current practice for provider education by the end of week 3/17 to determine current successful strategies and develop new ones. Involve customer service reps and case managers.
2. Coordinate statewide training. Specifically educate account managers and case managers on how to discuss and educate their providers by mid May.

Group K – 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.*

Group Members:

- Basich, Mark - Innovative Work Solutions
- Boyer, Joann - Crown Equipment Corporation
- Commons, Darlene - GAB Robins
- Dunbar, Shanna - Ohio Assoc of Occ Health Nurses
- Ecenbarger, Glenda - TriHealth
- Hanniger, Judith - The Health Plan
- Lindquist, Charles - Chiropracter
- Melton, Rebecca - Vision & Vocational Services
- Mitchell, Ken - Unum
- PureSafety Sponsor Person - PureSafety
- Ward, Alan* - Award Consulting

Report:

Group K focused on: formal transitional programs, accountability, ombudsman services and expert resources.

The strategy we believe is best for making this actually become the standard practice in our organizations or communities is:

1. Communication: Health and productivity mission statement and functional job descriptions up front.
2. Educate: Employees – at time of hire and time of injury/illness; Upper management – on roles; Healthcare providers with positive rewards

3. Representation: Internal resource at company. Have an external independent ombudsman, expert resources and employer/physician incentives

A concrete first step we can take to get started on making this a reality is:

1. Create a tool kit supporting outcome of realtime RTW/SAW – a Toolkit Campaign.
2. Include vision statement, easy to read and covers all stakeholders
3. Specifically, look at current best practices (maybe from self-insured employers).
4. The group with all participants of the Summit need to campaign to get the word out to stakeholders.
5. Disassociate MCO reimbursement from premium.

Here's what we intend to do starting tomorrow:

1. Post health and productivity philosophy and treatment information by first aid kits. Take this idea back to all of our companies.
2. K group is committed to living on. Meet with the rest of the employer groups quarterly. Share ACOEM recommendations at the OHOHN meeting this weekend.
3. Committee members willing to be on speaker's bureau. Shanna Dunbar is speaking on transitional work programs at BWC Safety Congress April 1-3, 2008.

Appendix E
Stakeholder Group Reports

Participants were divided into groups of people in the same stakeholder group. Stakeholder groups were instructed to use the following format to deliberate and develop their group's report. They were advised to think like the MAJORITY of stakeholders for each of their groups and not to dwell on the "bad apples". The employer, payer and rehabilitation provider / industrial therapist stakeholder groups were split into two groups each due to their size and to support effective discussion and communication.

Stakeholders	**Group #**
Employers (2 groups)	1a and 1b
Labor/Workers	2
Payers (2 groups)	3a and 3b
Clinicians: Physician/Chiropractor/Psychologist	4
Rehabilitation Providers/Industrial Therapists (2 groups)	5a and 5b
Policy/Regulator-OBWC	6
Legal/Judiciary	7
Intermediaries: Case Manager/Voc/Specialty Provider	8

The stakeholder groups were each asked to address 5 issues:

A. What factors present in today's system in Ohio might make many of the people in your stakeholder group reluctant to fully support implementing the work disability prevention model here?

B. In order for the members of your stakeholder group who are committed to creating better outcomes of the SAW/RTW process to THRIVE and PROSPER under the work disability prevention model in Ohio, what new things need to happen or existing things need to be preserved, strengthened or protected? (Be as specific as possible. Please comment on monetary as well as non-monetary things.)

C. In order for others to be willing to support your stakeholder group in getting what you need they (a) will want to know whether you are actually doing your part effectively, and (b) will want to be able to deal differently with those who are versus those who are not. How can that be accomplished? Exclude "bad apples" and be as specific as possible. Please make practical -- do-able -- suggestions of objective ($, service measurements) and subjective (promises, satisfaction, behavior) outcomes for your stakeholder group that fit or could fit within existing data and reporting capabilities, and comment on both. Imperfect is OK.

D. What obstacle to improving outcomes of the SAW/RTW process in Ohio might your stakeholder group be able to help eliminate or reduce -- even if legal or regulatory change does not occur? And, how can you do it? **(**Describe how your group can assist in this Summit group's efforts to move the WHOLE system forward and to improve what USUALLY happens in the SAW/RTW process even if you can't change the law or regulations. NOTE: We are NOT looking for descriptions of what you will do everyday in your own practice or organization.)

E. Give at least two examples from your group's Personal Commitment Sheets that describe what some of you intend to do starting tomorrow.

Stakeholder Group Assignments

Employer Group 1a

- Alltop, Fritzi - Midwest Express
- Barker, Brenda* - The Scotts Company
- Beck, Deborah - Hamilton County
- Cacioppo, Rose - Ohio Health/ WorkRehab
- Cross, Bonnie - State of Ohio, Dept. of Admin Services
- Ecenbarger, Glenda - TriHealth
- Enderle, Linda - Nationwide Insurance
- Grome, Geneva - Restaurant Management Inc
- Hubach, Lynn - Cleveland Clinic
- Jackson, Marsha - Ohio Health/ WorkRehab
- Melton, Rebecca - Vision & Vocational Services
- Moranda, Chris - Ohio Health/ WorkRehab
- Mullins, Ann - Mt. Carmel Health Services
- Pappas, Hilda - Lumi-Lite Candle Company

Employer Group 1b

- Bowsher, Marsha - Midwest Express
- Boyer, Joann - Crown Equipment Corporation
- Davidson, Kathy - TriHealth
- Dunbar, Shanna - Ohio Assoc of Occ Health Nurses
- Fiorella, Kristie - Ohio Health/ WorkRehab
- Frigy, Pamela* - Americhem
- Gaudiose, Martin - Vision & Vocational Services
- Hall, Suzanne - Complete General Construction
- Heidenhoffer, Linda - Kaiser Permanente
- Jackson, Jean - Honda of America
- Patterson, Victoria - Honda of America
- Pavlic, Elaine - Whg Pitt Steel
- Smith, Kirk - Jim Beam

Labor/Workers Group 2

- Campbell, Terrance - Kaiser Permanente
- Oriti, Helen - Kaiser Permanente

Payer Groups 3a & 3b

- Adkins, Doris - Sedgwic CMS
- Babka, Tersa - The Health Plan

- Birdsall, Richard - Risk Management Financial Solutions of Ohio
- Blaser, Lori - KKSG & Associates
- Burnip, Doug - Unum
- Collins, Deana - Corvel Corporation
- Dumas, John - Sheakley Unicomp
- Gorner, Daniel - CompManagement Health Systems
- Guyer, Richard - Risk Management Financial Solutions of Ohio
- Hanniger, Judith - The Health Plan
- Jacobs, Marcella - The Health Plan
- Kemo, Valerie - The Health Plan
- Krieger, Jeffrey - Cigna Group Insurance
- Kruszewski, Theresa - GAB Robins
- McGee, Debi - The Health Plan
- Mitchell, Ken - Unum
- Pemberton, Kim - VocWorks
- Poe, Kelli - The Health Plan
- Rodriques, Pam - The Health Plan
- Rossi, Lori - The Health Plan
- Seggebruch, Steve - Nationwide Better Health
- Stevenson, Jill - BWC
- Szymanski, Duane - Corvel
- Williams, Michael - Corvel
- Zrinyi, Beverly - Cigna Group Insurance

Clinicians – Physician/Chiropractor/Psychologist Group 4

- Arnold, Karen - Doctors Urgent Care
- Esch, Clyde - Heights Chiropractic Physicians
- Fiorini, William - Whole Health
- Hadley, Thomas - Concentra
- James Scott - Doctors Urgent Care
- Jones, Sarah - Doctors Urgent Care
- Lawhorn, William - Miami Valley Hospital
- Lindquist, Charles - Chiropracter
- Linz, Douglas* - TriHealth
- Nauman, Mary Lou - Honda of America
- Pearce, Debbie - Doctors Urgent Care
- Sawyer, Will - Sharonville Family Medicine
- Schaaf, Jim - Doctors Urgent Care
- Wanat, Robert - Kettering Workers Care

Rehabilitation Providers/Industrial Therapists Groups 5a & 5b

- Basich, Mark - Innovative Work Solutions
- Bowen, Juliene - Work Health/ Ohio Health
- Carollo, Judi - Ohio Health/ WorkRehab
- Coleman, Judith - Spectrum Rehab
- Davies, Ann - Workable Solutions, Inc
- EXTRA PERSON PAID - Mt. Carmel Health Services
- Harpen, Geraldine - TriHealth
- Hibner, Robert - Rehabilitative Services
- Long, Melissa - Honda of America
- Michael, Marissa - Workers Choice
- Nolan, Maria - Workability Network
- Reeder, Jeffrey - TriHealth
- Risteff, Stephanie - Ohio Health/ WorkRehab
- Salisbury, Beth* - VocWorks
- Schechtman, Jean - TriHealth
- Vincent, Judy* - Workers Choice
- Ward, Alan* - Award Consulting
- Weaver, Jean - Ohio PT Assoc
- Wendell, Heather - VocWorks
- Wickstrom, Rick* - Workability Network

Policy/Regulator-OBWC Group 6

- Barnett, Irene* - BWC
- Fitzsimmons, Karen* - BWC
- Hilliard, Johnnie* - BWC
- Leeper, Nancy* - BWC
- Mihaly, Tammie* - BWC
- Wilks, Janet* - BWC

Legal/Judiciary Group 7

- Cowans, Timothy - Scott, Scriven & Wahoff LLC
- Elliott, Tina* - BWC
- Habash, Steve - Habash, Reasoner & Frazier
- Harrington, Pat - Greater Cleveland Automobile Dealers Association
- Rudwall, David - Rudwall Law Office

Intermediaries-Case Manager/Voc/Specialty Provider Group 8

- Bro, Becky - VoCare Services Inc
- Cannelongo, Joseph - VoCare Services Inc
- Caston, Howard - Caston & Associates
- Commons, Darlene - GAB Robins

- Cox, Melinda - Coventry Health Care
- Driscoll, Terry* - Working Options
- Eakin, Kay -
- Jones, Julie - Matrix Vocational Solutions
- Mitchell, Michael - Interplan Health Group
- Murphy, Pat* - Workers Choice
- Radecke, David - Peak Performance
- Simons, Sandra - Genex
- VanHorn, Toi Lin - Vision & Vocational Services
- Venn, Debra - Venn Consulting

STAKEHOLDER GROUP REPORTS & ACTION PLANS

Issue A: The main factors present in today's system in Ohio that might make many of the people in our stakeholder group -- <u>including the ones not here today</u> -- RELUCTANT TO FULLY SUPPORT implementing the Work Disability Prevention Model here are:

Employer Group 1a

- Lack of knowledge
- Preconceived notions of other stakeholders
- Administrative barriers
- Waiting for the bureaucracy to catch up with the actions required
- Confidentiality – non-occupational
- Work loads already maxed out

Employer Group 1b

- Cost to employer
- Time to make change
- Who will be responsible?

Labor/Workers Group 2

- Communication with labor and worker that this is a benefit
- Education to be productive, to report injury
- _____injury protection from BWC

Payer Group 3a

- Financial disincentive
- Fear of accountability
- Fear of abuse of system
- Employer lack of support
- Providers have loss of direction
- Legal ramifications

Payer Group 3b

- Reluctant due to lack of money, time and resources
- Unrealistic for payers to educate medical community
- Opening Pandora's box to mention psych at onset of claim

Clinicians – Physician/Chiropractor/Psychologist Group 4

- Employer non-compliance with restrictions = abuse = off duty easier
- Loyalty bind for patient advocate physician = stay out
- Paperwork burden of WC cases
- No or delayed reimbursement
- IC deficient in medical knowledge
- Unsupportable by enablers of disability

Rehabilitation Providers/Industrial Therapists Group 5a

- Authorization and paperwork – difficult to manage
- Not skilled or educated in injury management
- Psych involved – outside PT scope of practice
- Do not want to be the managers of the situation

Rehabilitation Providers/Industrial Therapists Group 5b

- Semantics barrier prevents authorization and reimbursement
- Referral for profit keeps persons off work and separated from employment

Policy/Regulator-OBWC Group 6

- Perceived monetary and personal commitment cost
- Organizational commitment
- Organizational stability – changes in administration
- Stakeholder pressures
- Interest groups financial disincentives

Legal/Judiciary Group 7

- Claimant side – lose control over process and system
- Both sides – greater _____ to employers
- Trust – this is what's driving the issues

Intermediaries-Case Manager/Voc/Specialty Provider Group 8

- Lack of measurable outcomes and results that are tied back to objectives

Issue B: In order for the members of our stakeholder group who are committed to creating better outcomes of the SAW/RTW process to THRIVE and PROSPER under the work disability prevention model in Ohio, we think the following new things need to happen or existing things need to be preserved, strengthened or protected: (Be as specific as possible. Please comment on monetary as well as non-monetary things.)

Employer Group 1a

- Education for everyone
- Orientation for new employees
- Senior leaders w/in companies need to get more involved for buy-in
- Need to develop tool kits
- We are very fired up about our ideas!

Employer Group 1b

- Existing things to preserve = RTW decision is ultimately the employer's decision
- Decrease premiums for decreased work comp experience and better outcomes (true for occupational and non-occupational)
- New: Best practice templates and early intervention strategies = set up provider network
- Health & productivity initiative thru a mission statement company wide and strategy for the whole company to follow

Labor/Workers Group 2

- Employees need to know if there is transitional work available
- Tools are needed to assist employees and employers
- Engage labor in learning more about the benefits of RTW

Payer Group 3a

- Incentives for providers
- Developing provider profiling
- Better qualifying guidelines for disability/restrictions
- Recognize the limitations w/in our own organizations
- Educating employers and providers on RTW (for both occupational and non-occupational)
- Financial incentives to employees to participated in wellness programs
- Team approach in communications (improved and quicker)

Payer Group 3b

- Recognize that ¾ of claims come on the non-occ side, the disability and health care cost side
- More light duty, transitional work grants need to be reinstituted
- Incentives for employers to support RTW
- Compression of ADR – it's a long and drawn out process that needs to be consolidated
- Collaboration between MCOs, employers, BWC and providers – all are siloed at this point – if it's a problem in one silo it's a problem in all

- Grants/incentives for wellness programs, disease management programs, both for physical and behavioral
- Expand handicap diagnosis

Clinicians – Physician/Chiropractor/Psychologist Group 4

- Tool-kit to guide treating provider that provides access to accessible benchmarks, info on particular system's requirements (WC, FMLA, ADA)
- Evaluation of importance of patient's ability to RTW/ADL in treating provider's mind
- Testament to knowledge
- Productivity = 5th V.S.
- Insurers require commitment to standards of care as outlined in the ACOEM Disability Prevention Guidelines
- Employers best practices and adherence to benchmark standards

Rehabilitation Providers/Industrial Therapists Group 5a

- Certify PTs and OTs in occupational health or industrial medicine
- Add ACOEM recommendation information to the OT and PT curriculums
- Need psych/social support added to PT and OT curriculums
- Add psych to the PT and OT teams in health care management

Rehabilitation Providers/Industrial Therapists Group 5b

- Remove semantics barrier for onsite therapy and transitional work
- Provide finance incentives for the therapist to visit the work-site
- Protect the existing W0637 code for transitional work therapy – maybe even allow that code to be used in the course of clinic based care so we are allowing clinic based therapists to go to the worksite to further refine their RTW plan of care
- Monitor physician and other self-referrals for outcomes – if they are expending a lot of visits and the employee isn't back to work – that should trigger some other service by an independent provider to look at the potential for accommodation at the worksite
- Modify MEDCO 14 language to eliminate factors that don't relate directly to the job demands and to serve as a tool that industrial therapists and physicians can use to report in functional terms
- Functional job analysis is authorized by employer or MCO – involve worker w/lost time claim

Policy/Regulator-OBWC Group 6

- Customer care plan to increase consistency
- Setting expectations up front, w/first contact with all parties
- Increase IW involvement and participation
- Re-align agency application of BWC policies and procedures
- Re-align agency team collaboration within BWC staff and eliminate silos

Legal/Judiciary Group 7

- Ability to challenge the guidelines – preserve ADR
- Buy in by providers
- Panel needs more credible guidelines

Intermediaries-Case Manager/Voc/Specialty Provider Group 8

- We need to take an active role in educating on the delivery model from end to end including the employer/TPA/carrier and providers of care.
- Specifically we need to educate on the appropriate and timely transfer of data to establish and meet benchmarks

Issue C: In order for others to be willing to support our stakeholder group in getting what we need they (a) will want to know whether we are actually doing our part effectively, and (b) will want to be able to deal differently with those of us who are versus those who are not. Here are some thoughts on how that can be accomplished: Exclude "bad apples" and be as specific as possible. Please make practical -- do-able -- suggestions of objective ($, service measurements) and subjective (promises, satisfaction, behavior) outcomes for your stakeholder group that fit or could fit within existing data and reporting capabilities, and comment on both. Imperfect is OK.

Employer Group 1a

- Work on the manual SAW-RTW for Dummies

Employer Group 1b

For those of us who "get it" to thrive.

- Database of specific physician outcomes to include RTW and functional data both from the health insurer, as well as, workers' comp
- Educate employers to ask for this data (Health Plan & BWC "A" or "B" providers) a lot don't know that it is available
- Rate employers based on RTW outcomes, "A" or "B" and provide incentives
- Recognition to employers who have good RTW outcomes
- Encourage employers to implement wellness health promotion program thru tax incentives

Labor/Workers Group 2

- Obtain metrics and track transitional days to see if successful

Payer Group 3a

- Report card for measuring results/developing benchmarks
- Encourage different organizations to provide wellness programs
- Pay providers for their outcomes
- Grants and funding for wellness programs

Payer Group 3b

- Track results, sort data and show stats to providers
- Employers should guide IW to select providers
- Rewards/incentives for employees for early and safe RTW
- Incentives for completion of health assessments & regular check ups

- Bring to attention of labor the benefit of RTW in regards to payment of union dues, productivity
- Recognize that 50-60% of claims are impacted by chronic diseases (disease or mental/nervous issue)

Clinicians – Physician/Chiropractor/Psychologist Group 4

- Identify benchmarks. Metrics=duration of case until RTW w/medical release
- Adherence to best process measures
- Identify components of productivity – return to modified duty, full duty vs w/restrictions, sustained duty w/follow up and seek patient feedback; feedback on what has been helpful to the IW in keeping them engaged in active work and production

Rehabilitation Providers/Industrial Therapists Group 5a

- Need consistency of forms required by insurance companies – requirements are tedious and different for all insurers/payers
- Cover this and the ACOEM guideline at the OPTA Insurers Summit
- Certify therapists in transitional RTW program
- Add test questions regarding transitional work, RTW strategies and health care management strategies to licensure exams

Rehabilitation Providers/Industrial Therapists Group 5b

- # visits to achieve a release to RTW with restrictions
- # visits to achieve a release to full duty or measure the time period
- Customer rating system of industrial therapists reports by quality and timeliness – the best report not delivered before the physician visit isn't going to have the impact that it needs or achieve the intended purpose

Policy/Regulator-OBWC Group 6

- Public forums
- Focus groups
- BWC become more transparent – transparency in all operations and become more user friendly for example, website
- Stakeholder relations outreach – department change with meeting w/external stakeholder groups

Legal/Judiciary Group 7

- Include chiropractors and trial lawyers
- Representative group has buy-in – it's good for the system as a whole

Intermediaries-Case Manager/Voc/Specialty Provider Group 8

- Establish standard quality benchmarks
- Publish rankings of providers based on standards
- Develop a best practice based on evidence based medicine with constituents across the delivery model to achieve better outcomes, quicker RTW

<u>Issue D: Here's an obstacle</u> to improving outcomes of the SAW/RTW process in Ohio <u>that</u> <u>our stakeholder group might be able to help eliminate or reduce</u> -- even if legal or regulatory change does not occur. And, here's how we can do it. (Describe how your group can assist in this Summit group's efforts to move the WHOLE system forward and to improve what USUALLY happens in the SAW/RTW process even if you can't change the law or regulations. NOTE: We are NOT looking for descriptions of what you will do everyday in your own practice or organization.)

Employer Group 1a

- SAW/RTW for Dummies
- Email list to share questions

Employer Group 1b

- Employers lack education on what data/resources are available – like WCU and SHRM
- Have employers speak at WCU and represented at HR conferences
- Set up award for employers based on these good RTW outcomes
- Set up a system with an easy to use template that is based on good RTW outcome; use this system to help employers know they are on track; should be easily understood, applicable to small and large employers, tailored to them and maybe even by industry

Labor/Workers Group 2

- Since I'm a labor leader, I want to speak to the labor leaders about why integrated disability management is important and preventing needless work disability
- There aren't many people from the trial attorneys or those who represent the treatment of IW in the room, so we need to get more involvement from the other side of the table

Payer Group 3a

- Communication to break down barriers
- Developing uniform standards and RTW criteria

Payer Group 3b

- Prompt attention in non litigious manner – reduce the number of employers who appeal every single claim – how is this forwarding SAW-RTW?
- Clear communication in regards to programs
- Relieve some administrative burden (the daunting paperwork) on providers
- Track results, sort data and share data with providers – showing how their engagement with the employee is driving results- providers need to know they are helping the employee
- Employers should be able to guide the IW to select providers who have shown much better RTW results
- Provide rewards and incentives for employees safe return to work – we already incent employees to do healthy things for themselves – incentives for completing risk assessment forms, getting annual physicals, care plans to manage chronic conditions, lose weight etc.

- Bring to the attention of labor that bringing an employee back to work results in payment of union dues and productivity

Clinicians – Physician/Chiropractor/Psychologist Group 4

- Lack of addressing total patient condition – mental, emotional and physical
- Physical and mental – holistic/.total care incentives
- Improve knowledge of productivity-clarify definition and components of productivity
- Create productivity as a 5th vital sign and pain scale as the 6th vital sign to stress the importance of a physician's responsibility to help their patients be productive is of primary importance to vital health
- Explore "out of box" community service partnering – a win-win, putting people in non-standard care, keeping them active in programs, on schedules, feeling important if they can't get back to their old jobs right away
- Bridge employer non-compliance w/restrictions which creates lack of trust w/the SAW-RTW Manual being developed by the employer group
- Help the employer to keep the role of making the employment decision thereby reducing the loyalty bind for physicians – communication is so important
- Work to reduce the overwhelming amount of paperwork required by work comp and health insurance companies
- Expedite a toolkit to simplify forms – clarify, simplify – use electronic means to decrease work disability
- Can we require insurers commitment to these (ACOEM) guidelines?
- Help physicians to take time to know what the benchmarks are
- Commit as physicians and providers and choose beginning today and going forward to continue to work w/in these guidelines to prevent the work disability gap
- Educate those who continue to enable disability which is inappropriate medical care; educate on the importance of addressing total patient care – mental, emotional and physical

Rehabilitation Providers/Industrial Therapists Group 5a

- Clinicians tend to keep patients until totally medically stable – not focused on functional work
- Not a topic of interest to present at association meetings
- Lack of communication/collaboration among professions

Rehabilitation Providers/Industrial Therapists Group 5b

- If we can move from a clinic based model to a community based model-we can better help define job demands, more objectively define worker capacities and define earlier on in the claim's process accommodation options
- Get the IW involved in a functional job analysis earlier on in the claim's process without having to get permission from the physician – if that were a service that employers or MCOs would authorize when lost time is triggered, this would be a big step forward

Policy/Regulator-OBWC Group 6

- Obstacle – lack of information, communication

- Eliminate silos w/in BWC
- BWC can create consistency in all departments with RAW/RTW expectation
- Create contagious RAW/RTW environment like tentacles that reach out to all internal and external meetings and conversations so that if I am enthusiastic about this RAW/RTW process, others will pick up that enthusiasm

Legal/Judiciary Group 7

- Implementation

Intermediaries-Case Manager/Voc/Specialty Provider Group 8

- Data accumulation not shared with all constituents with the goal of achieving better outcomes and quicker RTW

Issue E: Here are a few examples of what some of us intend to do starting tomorrow: (Give at least two examples from your group's Personal Commitment Sheets).

Stakeholder Group	What are you going to do, specifically?	Who else needs to be involved?	By when?	To accomplish what?
1a. Employer	1. Best practice email list- come up with a new topic every 2 weeks – the first one is RTW policies-what best practices we have in place	Employers	April 1	Share best practices
	2. Feed the info from best practices into the Toolkit-SAW-RTW for Dummies	All stakeholders	Draft outline by 6/1/2008 – Meet in Columbus 9/08	Education
1b. Employer	1. Apply for an innovation award that emphasizes healthy Ohioans			
	2. Participate in a speakers bureau	(TWP)		
2. Labor/ Workers	1. Go to different employers and speak to union leaders			
	2. Share benefits of staying productive with workers			
3a. Payer	1. Doug w/Unum – develop CEUs for physicians on the nonocc side	BWC and non-occ service providers	Non-occ by July 1;	
	2. Work w/BWC on standards w/in occ. side		It's a longer process to work with BWC	
3b. Payer	1. Valerie Kemo & Jill Stevenson to meet w/BWC administrators	BWC administrators	7/1/08	Employer based claim assignment

	2. Jeff Krieger, Dick Guyer and Laurie Siebert to set up Summit to discuss with employers	Employers	Late Spring 2008	RTW for non-occ, educate about the advantages of disease management, wellness and behavioral health programs; pre-emptive strategies
4. Clinicians – Physician/Chiropractor/Psychologist	No response			
5a.Rehabilitation Providers/Industrial Therapists	1. Jean Weaver is presenting course on work injury management at PT conference – include this new info in conference	Physical therapists	Oct 18-19, 20008	Educate PTs
	2. Those at the table agreed to organize a CEU conference across disciplines to address work injury management in the new paradigm	RNs, case managers, PTs, OTs and insurers	3/2009	Educate all to hear the same thing/same goals – consistency in injury management model
5b. Rehabilitation Providers/Industrial Therapists	1. Form a joint stakeholders group to recommend guidelines for a functional job report	Need to identify who needs to be participating in this group	By June 1	
	2. Develop C-9 language that facilitates transitional work progression	BWC		
	3a. Contact BWC – Voc Rehab Policy to revise/update Chapter 4 – include definitions to eliminate semantic confusion- as to when W067 would be appropriate to reimburse 3b. Drive criteria for authorization to encourage work site evaluation to better define job demands and accommodation options			
6. Policy/Regulator-OBWC	1. Nancy Leeper to focus on early intervention; identify claims that need early intervention-contacting IW, provider, employer, TPA and educating them on reducing stress, setting expectations, reducing financial impact and the possibility of a psych condition coming into claim	IW/provider employer/TPA	Monday, 3/17	Educate, decrease stress, set expectation, decrease financial impact to IW and employer, decrease potential for psych conditions

	2. Janet Wilks to work on 2-5 minute web streaming segments for BWC topics – "training in your jammies"	AFL-CIO partner, Peggy Griffin	Monday, 3/17	Decrease barriers, simplify BWC interactions and processes, create partnerships, empower stakeholders – web based training. Get all this information out to smaller employers and their employees.
7. Legal/Judiciary	1. Tom Connor and Steve Habash to meet w/Phil Fulton (BWC Oversight Commission member) to see if there is anything that can be done from the BWC and Industrial Commission side to get more active involvement in labor, trial lawyers and the medical community-chiropractors – we will be happy to work with any other group in trying to work with Phil Fulton in bringing these ideas presented here today to BWC's attention from the top down			
8. Intermediaries-Case Manager / Voc / Specialty Provider	1. Educate on a one-to-one basis – every case manager and vocational counselor 2. All specialty service providers will make it their mission to educate what is important 3. Through all associations – demand that the stakeholders help drive compliance through education	BWC/Physicians Employers and TPAs	Immediately – grass roots effect	Tie back objectives to results

Appendix F
Personal Commitment Forms

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
2	• Communicate with case manager & employer sooner • Review ACOEM best practices	• Work to educate physicians & employers & other therapists in benefits of tools available to facilitate early RTW / transitional work including functional. job analysis, fitness for duty exams	
3	• Assume personal responsibility for educating workers, employers, physicians and providers about disability prevention • I will suggest / introduce the option to Ohio IARP to form a support group presence within 60 Summits organization. • Testify at Ohio WC Board in April.	• I / my company will hold educational meetings with local entities (worker organizations, employers, physicians, and providers) on disability management / disability prevention.	• Network with other professional on disability prevention. • I will personally visit 100 employers over the next year (2008-2009) and demonstrate an interactive DVD on Ohio Workers' Comp that also includes integral components of disability management.
4	• Educate PT / OT's in process • Enhance continuum for case velocity	• Follow-up meeting with DPT & CARF; may work on committee • Work with my professional assoc to create cont education	• Copy / share information with WR Advisory Group • Go to OPTA meeting in fall. Share stuff • Encourage employers to refer to EAP. • United Disability Front
5	• Communicate with a few local employers to reinforce FP's working with therapists to expand access to combined medical & psychological		• Disappointed that there was not much incorporation of the increasing mental health impact on work disability which would lead to trying to create a more "open architecture" system
6	• Work with employees in organization to educate them on the ideas in this group to improve communication about SAW / RTW for improved outcomes.	• Work with PPO representative to investigate ways to foster or improve SAW / RTW outcomes with patients and employers through improved communication techniques.	• Contact our medical director to discuss items learned in this conference and investigate with him any possible areas he can assist in SAW /RTW concepts

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
7	• Compile resources and information I learned today so that I can educate my employees so they can spread the information.	• Education of the employers of what is going on in this Summit in order to get more people involved who can contribute to the organization.	• Contact other case managers / disability consultants & management re: this initiative
8	• Discuss with HR group how we can improve new associate orientation / Injury & Illness Packet of Info presently given to associates • Go back to main providers - offer lunch / open house to foster relationships, provide our RTW policies (We have in place to a degree, need to revisit) • New thoughts - mental health screen if out > 90 days; pursue logistics with provider (check ADA liability) • Contact several disability companies to outline logistics for a functional Job Analysis - when 4-8 weeks (to get BTW)	• Attend central Ohio AAOHN meeting & ask if the group wants to get involved. • Send my RTW form to Rick Wickstrom by 5/1/08	• Write an article for AAOHN magazine under title: "Healthy Workers: Healthy Business" (current contest for Nurse's Week) & incorporate OHN role to improve SAW / RTW practices.
9	• Research PTO for non-occupational absences • Re-instate bi-monthly or quarterly Provider meetings - close the gap • Reviewing "outside" accommodations to place injured associates • Communicate & educate • BWC to listen to employers - express gaps on treatment & pay	• Network - TPA / MCO & BWC meetings • Doctor meetings - educate on what we want to see • Talk to BWC reps on RTW issues / barriers	• Sit down with management to discuss ideas learned here today - benefits & how to "take control".
10	• Improve communication with providers and employers in a timely manner. • Educate providers	• Meet with providers, employers. • Under job description of IW's	• Discuss with co-workers (cm) how to better educate providers and employers on communicating injury and directing treatment.

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
11	• Communicate with doctor / MCO immediately after an employee is treated for a workplace injury. Follow-up on a continual basis until the worker returns to work.	• Communicate more with the employees who are injured and explain the process they entered in.	• Reach out to my company's medical provider and review company's expectations.
12	• Bring back to my company SAW / RTW Summit information for my AVP, Health and Productivity and our Associate Health Services dept to continue idea generation.	• Share information about what my employer is doing to prevent disability at the workplace through our health and wellness programs.	• Participate in "Employer" networking group formed from SAW / RTW Summit to embrace and move forward this noble initiative.
13	• Work with stakeholders to change WC system to prevent the system from driving bad behavior.	• Participate in education of positive results of these concepts	• Meet with interest groups with other speakers to ensure that necessary changes be considered be made to the system to, at minimum, not provide obstacles to these concepts.
14	• Communications with HR - develop legitimate proactive SAW / RTW. • Develop materials, newsletters for education • Research successful models - best practices - for education • Commitment, support, example, rewards, demonstrate success	• Stay educated, promote cooperation among all stakeholders - working together for resolutions.	• Work with HR - develop legitimate proactive SAW / RTW incentives. • Find ways to reward employee, employers, providers to buy into getting back to workforce.
15	• Education of associate, manager. • Research, identify, buy in, implement with employer • Demonstrate success	• Connect people within company - top down • Articles into newsletters	• Educate on ACOEM Guidelines • Self-improvement • Increase knowledge, share with colleagues
16	• Strive to be representative of the culture change needed with regard to management / employee use of an integrated disability program	• Participate in OH 60 Summits	

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
17	• I am going to print and provide an informational package to the injured worker in our accident packets to help clarify the system and avoid worker suspicion. We have a PTO program - I will discuss integrated disability with my HR reps.	• I can talk at my local nurse association regarding RTW. • I can effect change at my organization by meeting with my corporate HR to start integrated disability mgt.	• I am requesting A/B provider info from my company's insurance info; also integrating tracking with day RTW to find out if we are an A/B level provider.
18	• Education of my TPA by in-service on psychological conditions associated with claim. Refer to EAP initially and re-evaluate education of main providers (sport / ortho or impact of RTW in decreasing anxiety and return to pre-injury status.	• Encouraging managers to contact injured workers to show they care. • Call state rep • Refer to EAP • BWC free CEU's • What % use EAP • Time of hire - educate employee • Fear of repeat injury • Return to work reps visit MD offices	• As above - discuss with my director

19	• Learn EOR's EAP program / ancillary services available to IW to address their basic needs.
	• Open lines of communication.
	  • Bring IW to EOR for meeting to discuss barriers to RTW.
	  • Secure from MD work capacities and barriers to RTW.
	  • Have EOR coordinate alternative work options based on this
	• Provide support to ensure successful RTW.
		• Participate in developing / supporting the ACOEM meeting outcome.	• Ask more questions of EOR on EAP program, alternative work options / philosophy.
			• Educate and educate EOR's on this leadership summit.
			• Development of Case Management Guidelines to ensure all the information that is bestowed upon the Case Manager to be responsible for would be implemented in a consistent manner.

20	• Provide in service / education CEU on how to recommend better service to person; when can mental health service be offered	• Work with Licensure board in my profession to bring attention to this issue. • Training of staff on better ways to return to work • Work with National Association • Help participate in seminar	• Send email to staff about impacts of mental health issues.

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
21	• Getting all on same page about docs, employer, employee in each claim. • Educate employer re: providing injured / ill employee with information about EAP. • Realizing there can be a psych issue - not only physical condition	• Talk about creating W/C handbook	• Better communication between employee and employer about steps of W/C or leave re: benefits.
22	• Be more aware and reactive to psychological aspects of injury.	• Educate employers on psychological aspects of injury management	• Present at a local safety Council meeting regarding these concepts. • Help plan a multi-disciplinary May Conference.
23	• Focus on preventing psych conditions • -employer based claim assignment (NBM)	• Revise MEDCO 14 • Approach BWC Administrator with BWC "To Do's"	• Share info with my peers (SOMS)
24	• More education - participate in programs specific to these issues • Create communication pattern (including form) to discuss with Disability Manager inclusion of psychological support resources in each case. • Bring education to my own company - create a "champion" for SAW / RTW to be the resource for all Occ Med docs in our company. • Review company data RTW - find appropriate benchmarks	• Request CME on SAW / RTW for physician stakeholders at local and state groups	• I will contact our company Occ Med Chief - and talk about designing and marketing SAW / RTW program to our customers.
25	• Put together a seminar on adjustment issues or construct a roundtable discussion.	• Speak with DAPA, OPA, BWC, Medworks	• Speak with other psychologists and case managers.

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
26	• Letter to physician of record when that physician is not our occ health doc indicating our commitment to return to work and requesting work activity instructions with employee abilities for what can or cannot perform.	• I am on the Employers Advisory Board at WorkPro (Southeastern Regional Medical Center) & have good relationship with Genesis Occ Health from many years	• Communicate with other occ health nurses and human resources in local businesses.
27	• Functional analyses of high risk jobs	• Pilot programs with the occupational health clinics and physicians I supervise) • Work on "best practice" templates.	• Send transitional work form to Rick Wickstrom by 4/15 • Send EE instructions for non-occ and occ to Karen
28	na	na	• Working with my group to use new forms • Gather information for next meeting
29	• Review existing programs - processes and persons involved • Integrate with other stakeholders and commit to …	• Engage - show up and contribute	
30	• Increase communication with physicians and provide job descriptions to physicians to enable them to make better decision on if claimant can do his job and/or if could RTW / SAW	• Could meet with my SI providers to explain our mission to provide appropriate treatment to expedite RTW safely with transitional duties.	• Find out how to obtain job descriptions from employer I work with and share that information with treating physicians.
31	• Revise policies and procedures that are in line with the development of the proposed universal standardized form	• Become involved in the stakeholder group that develops the Universal Form for the employer and claimant	• Talk to people who are taking the lead with this issue
32	• Continue to educate new hires, therapist with little experience in Workers' Comp or RTW. • Continue to educate employees at various job sites re: early RTW • Continue to educate employers with "modified duties", transitional work tasks, early RTW	• At employer level • Educate employees • Participate in training PTs, OTs	• Educate employers on their commitment to abiding by restrictions, RTW • Be involved with committee to establish [?] - part of development of PT symposium for industrial rehab

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
33	• Focus on physician education regarding IW's RTW status and release	• Get involved on an appropriate committee to develop a functional abilities form	• Share this information with Ohio IARP
34	• Pass this information / ideas along to my staff. • Continue to keep the focus on disability prevention, open communication with providers, employers, injured workers.	• Research PM&R, OM, FP, GP, Chiro? curriculum. Is the current curriculum focused on disability prevention?	• F/U with John to discuss meetings • F/U with Dr. N & Dr. G & Steve H
35	• Share the guidelines with the injury management program at my hospital. • Convince OPTA to provide website info and links re: this summit and guidelines. • Write article for OPTA Newsletter about this summit	• Influence legislation via OPTA per recommendation from the Summit & Steering committee • Facilitate multi-disciplinary CE conf at state level for sharing of guidelines	• Share the guidelines and have a conversation with my company HR dept/ work injury management team
36	• Since I am in Voc Rehab, one thing we can do is promote the 'ability' and not the disability for the employer. • Promote workplace accommodations to keep employees working to 100% capacity determined by the employee / employer needs.	• Look for ways to expand knowledge of folks working with temp or long term disability. • Stay on top of legislation and factors that effect the displaced worker.	• Contact National Rehabilitation Assoc and see if they will put a link on their website with the ACOEM Guide. • I am also V.P. of the Job Placement Division of NRA and am working on building their website - will see if board will approve link on their website as well.
37	na	• To educate through our state agency WC Coalition group.	• Work on getting this info on the next agenda
38	• Educate managers in what to do when an accident happens. • Make sure employees know that we can accommodate restrictions for non-work injuries.	• Network with other employers on best practices for our employees.	• Communicate to co-workers and upper management the commitment to keep employees at work.
39	• Review LOA policy to determine whether it promotes time off • Strive to have communication with injured workers more timely.	• Educate others in case management process. • Perform mentorship for new case managers.	• Get more focused on broad range instead of day by day activities • Change culture of disability at our company

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
40	• Improve education and communication with physicians of record regarding a collaborative approach to helping the IW RTW in a more timely manner.	• Becoming involved in organizational development and planning steering committees.	• Gather additional information to crystalize the idea of incentivizing and measuring outcomes - How do you do it objectively?
41	• Increase communication with outside physician groups (after obtaining release) from C.M. level for non-work injury cases to follow progression toward improved health.	• Support educational efforts in promoting the SAW / RTW process • Education areas should include "whole health" from a physical, social, mental and spiritual aspect of an employee.	• Obtain an improved nursing / CM assessment of each employee and see to it that the assessment is adequately communicated to provider for f/u and continued care.
42	na	• Work adjustment - training /counseling • Provide CIGNA calculators for medical, absenteeism and presenteeism • Send Powerpoint on Case Management	• Provide format for telephonic case mgmt. • Provide format for physician case management • Provide combined DODM / ODG RTW benchmarks data base • Provide standard new pt / return pt evaluation • Provide format for "OM" E&M coding • Provide summary of employer needs • Provide "core maps" process • Productivity scale - not condition specific
43	• Educate my peers regarding the information received at this seminar with particular attention to incentives to present to physicians and employers	• Participate with other groups and sharing info	• Become more knowledgeable myself with Guidelines (BWC, etc)
44	• Clearly communicate RTW expectations with provider • Share assessment and CM plan - Request input into the plan • Share all work info with provider i.e. job description • Push TWP with employer of record.	• Work at implementing best practices in communications between parties - professional, caring manner	• Evaluate existing forms of communications with parties and develop means by which to accomplish

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
45	• Additional education on WC/RTW - lead discussions in local /state /regional /national settings	• Continue to champion RTW with ERs -> educate -> move to action. • Hold additional ER Forums to disseminate information in tandem with email distribution of supporting materials	• Develop CEU for physician groups and forward to 60 Summits / Ohio by May 1
46	• Better communication with physicians on initial lost time claims. Give them job analysis, rehab resources, contact names for payors, ask for release to onsite TWP.	na	• Refine our transitional (on site) RTW programs • Sign up to receive emails for employers group
47	• Know and carry forward that physicians must be incentivized to improve participation, and enhance learning /education along these lines once we get these incentive enhancements made. (I have involvement in BWC Group to address division initiative for possible "Blue Ribbon Panel" concept	• Update all info or improvements on our website and other standard mass communications and new areas along those lines (list serves)	• Really consider and try to present incentives and this whole approach vs. punitive (or - BWC decertification)
48	• Educate physical therapists on managing injured workers (work related and non-work related) back to work	• Provide a CEU event /symposium for education of therapists	• I am a speaker at the OPTA Fall Conference re: Injured Workers. Put together an interdisciplinary symposium for generalist health care providers educating on Return-to-Work - all group members (stakeholder group) are participating. I am helping to organize.
49	• Develop training for employees broken down by division to address what they need /can do to communicate with employees that they have an advocate within the County willing to assist	• Continue to raise issues that are barriers in RTW and look for opportunities to join. ERs with on site medical report better results	• Present Ohio SAW /RTW to Commissioners to get buy-in to plan. • Then ask for support to incorporate into P+P manual for all of our employees as official guidelines.

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
50	• Consider with technical staff how we can integrate capabilities in our software to: • Promote education of employees and supervisors of programs and processes • Facilitate employer 'I care' contacts • Tools to foster and grade relationship of case mgrs / adjusters with IW	• Capabilities in software will promote better mgt of their processing within our customers' organizations	• Will communicate this information to our software design and development personnel • Will participate in action committee with the idea of contributing from technology perspective, e.g., facilitate: 1. Capturing information 2. Managing processes and programs 3. Measuring performance
51	• On-going education (1:1) with employers and providers connected to VR referrals of SAW /RTW	• Interact / participate in Action Groups / Focus Groups	• Use my affiliation with Ohio Rehab Assoc and Nat'l Rehab Assoc to publicize SAW / RTW Guidelines. • Keep Ohio group abreast of on-going developments resulting from Summit
52	• To assist BWC in providing education to the employers, medical community and employees regarding the EAP programs and procedures for what happens before and after injuries and implement the I-Care supervisory program.	• At The Safety Congress and during training sessions throughout the state.	• Utilize the I-Care system with my own staff.
53	• Implement I-Care to my national groups to implement in all regions. • Incorporate expectations when they go on leave	• Very soon	• Meet with Team
54	na	na	• Contact Chris M for discussion / implementation at Ohio Health and also Judi C

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
55	• Continue to push for improved communication within current Case Management; promote Employer active role • Recommend physician providers be given ACOEM Disability Guidelines • Copy / educate partners and insurers on 60 Summits' vision	• Continue to support progressive multi-disciplinary case management	• Work with Ohio Action Group • Investigate and support Ohio Medical School (+ Law schools, nursing schools, PT/OT schools) curricula incorporation of Disability Management education, AMA endorsement ? • Productive life = 5th vital sign (move "pain" to the 6th vital sign)
56	• Support, acknowledge resources within a company (EAP, HR, case mgmt) • Encourage access to community mental health resources; become more aware of same • Connect with my state and nat'l assoc to ID consistent semantics use for work disability	• Work with state Ohio OT Assoc / partner to work on consistent communication / semantic within our discipline and to work cooperatively with P.T. assoc	• Online search of state / national assoc resources. • Online search for local community resources for companies with EAP
57	• Talk to employer clients regarding IW contact after an injury. Improve case management assessment process.	• Educating employers and providers regarding RTW programs. • Assess their RTW policy during employer meetings • Educate assigned case managers on their employers of record's policies (HR & RTW)	• Include discussion / update to my case management staff regarding this Summit. • Nurse case managers can ask to speak directly to IW's direct supervisor when facilitating RTW
58	• Initiate "I care" contacts; • Watch more closely for signs EAP is needed by injured employees and initiate earlier	• Talk with professors at OHN masters program re pilot for assessing employees immediately following an injury - • "I care" contacts; • Educate other employers	• Contact professors immediately (meeting tonight and tomorrow)

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
59	• Open lines of communication and support collaboration with IW's, providers, employers, BWC • Encourage providers to consider RTW / SAW rather than promote disability for their IWs	• Give doctors recognition they've been trained in RTW • Have provider rep visits / contacts / account managers	• RTW rep needs to be seen as "impartial" and credible and knowledgeable and able to promote /maintain relationships with physicians / staff. • Could come from payers, vendors, voc rehab certified • * BWC develop RTW specialist. Mike Williams rehab counselors will take to the Medical Director. Add discussion topic to BWC board agenda by end of April
60	• Increase education of CM (telephonic & field case managers) staff to educate physicians and employers on advantages of early intervention for RTW. • Develop presentation / CEUs focusing on RTW / SAW policies	• Make myself available for work groups focusing on policy change or procedure development	• Schedule state-wide CM meeting for second week in May
61	• Work with all stakeholders to promote and support an environment / process for RTW (occ & non-occ) • "RTW" reps promote / educate providers on RTW benefits - use our PPO developers / AM's and CM's to do education • Recognize those providers that support SAW / RTW philosophies	• Collect data and information to support SAW/RTW standards and benefits from providers' point of view • Develop "RTW" rep structure / focus within our current structure • Develop provider recognition of education being completed	• Discuss plan with our Medical Director to speak in front of BWC Board and with key employers in April -> present this concept
62	• Join the Summit groups to continue to improve my practice	• Speakers bureau to educate	• Keep in contact with my team
63	• Formulate plan • Relay expectations to employer and employee	• Convey SAW/RTW program to physicians • Getting commitment / educate	• Change my approach to EE on disability giving expectations • Expand more in community with physicians

Person	*Internal Opportunity*	*External Opportunity*	*Immediate Action*
64	• Take back to my organization the thoughts and ideas to ….	• Communication. Be a source for early RTW/SAW options. • Communicate ideas learned at this Summit	• Utilize in my daily management of my caseload what was discussed here today.
65	• To encourage the BWC to UTILIZE the programs (i.e. Transitional Work Program) that they already have.	• To continue to educate groups (workers, unions, employers) about transitional work models	na
66	• Get info on BWC safety programs (free) • Help formulate tool kit / RTW for dummies outline • Post philosophy and BWC # and where to go by First Aid kits	• Discuss with our administration how we can help employers (through career testing, etc) by being a bridge with their employee. (vocational services, objective)	• Quick outline to my boss
67	• Train supervisors in importance of TWP	• Share information learned with other occ. health nurses by email.	• Present information on importance of training supervisors on TWP for work and non-occ disabilities next week to upper management.
68	• Use IWCI model as a way to solicit input / promulgate tools and improvement.	• Being on the board of IWCI, determine how best to share ACOEM initiatives. • Have Dr. Christian speak ? at annual seminar 8/08	• Stay in touch with K group via email to enhance action plan and complete goals discussed.
69	• Don't ask for ERTW end date from doc. Instead work with employee for next appt. date etc. and get medical restrictions and abilities from doc. • Educate mgrs, employees on RTW/ and Workers' Comp process	• Join the SAW/RTW book for dummies employer roundtable	• Work on form for use by physicians, employees, employers
70	• Educate employers and providers. • Employers -> disability RTW programs • Providers -> outcomes and early RTW benefits (through IHP)	• Discuss issues with local legislators. (Michelle Schneider -> majority whip Ohio)	• Call Michelle Schneider • Meet with CRM's
71	• Check on orientation to WC process for new and existing employees	• Volunteer for speaker's bureau to reach: medical societies and small employers on SAW/RTW	• Speak with my regional and medical directors to recommend participation in up-coming Summits.

Appendix G
Tabulation of Summit Evaluation & Sign-Up Sheet Results

SUMMARY

Overall, the attendees were extremely satisfied with their experience at the Ohio Summit. More than half of them asked to stay on the Ohio group's mailing list, and more than 40% intend to participate in the follow-up Ohio action group.

More than 90% of the attendees reported that:

- the workshop was a good use of their time and effort,
- the information presented was very interesting,
- having met the other attendees will help them in the future,
- the event made them think differently about some important things.

More than 87% of attendees reported that:

- They left with a list of practical next steps they can take to improve their participation in the SAW/RTW process
- They think this workshop will really bear fruit in the future.

DETAILED DATA

Sign-up Sheet Results

71 respondents out of the135 attendees submitted sign-up sheets indicating the level of engagement they want to have with the Ohio initiative going forward.

Of all 135 Summit attendees:

- 42% (n = 57) said they want to be part of the follow-up Ohio Action Group
- 46% (n = 62) said they want to be on the 60 Summits Project mailing list
- 53% (n = 71) said they want to be on the Ohio group's mailing list

Evaluation Results

Items # 1-3 addressed Meeting Preparation

1. The email invitation and conference brochure

47%	Great
36%	Good
11%	Acceptable
1%	Not acceptable
5%	Not applicable

2. The phone call or personal invitation you received

32%	Great
25%	Good
5%	Acceptable
3%	Not acceptable
36%	Not applicable

3. The reading materials sent prior to the meeting

48%	Great
33%	Good
10%	Acceptable
1%	Not acceptable
8%	Not applicable

Item # 4 addressed Logistics and Venue

4. Location and facility (meeting room, food)

52%	Great
34%	Good
11%	Acceptable
1%	Not acceptable
1%	Not applicable

Items #5-7 addressed Design & Flow of Meeting

5. Overall plan for the meeting; what was on the agenda

55%	Great
32%	Good
12%	Acceptable
0%	Not acceptable
1%	Not applicable

6. Flow of the meeting; facilitation of general sessions

49%	Great
32%	Good
16%	Acceptable
0%	Not acceptable
3%	Not applicable

7. Value of small group facilitators

40%	Great
41%	Good
14%	Acceptable
1%	Not acceptable
4%	Not applicable

Items # 8-14 addressed Meeting Events

8. Welcoming remarks

49%	Great
37%	Good
5%	Acceptable
0%	Not acceptable
8%	Not applicable

9. Keynote presentation by Dr. Jennifer Christian

82%	Great
14%	Good
3%	Acceptable
0%	Not acceptable
1%	Not applicable

10. Multi-stakeholder small group work session

55%	Great
36%	Good
7%	Acceptable
1%	Not acceptable
1%	Not applicable

11. Reports from multi-stakeholder groups

41%	Great
42%	Good
15%	Acceptable
0%	Not acceptable
1%	Not applicable

12. Same stakeholder work session

48%	Great
36%	Good
10%	Acceptable
3%	Not acceptable
4%	Not applicable

13. Stakeholder panel presentations and Q&A

40%	Great
42%	Good
11%	Acceptable
1%	Not acceptable
5%	Not applicable

14. Wrap-up session

41%	Great
26%	Good
4%	Acceptable
0%	Not acceptable
29%	Not applicable

Items # 15-20 addressed Value to You of the Meeting

15. The information presented was very interesting to me

68%	Great
26%	Good
3%	Acceptable
0%	Not acceptable
3%	Not applicable

16. Having met the people here will help me in the future

58%	Great
34%	Good
7%	Acceptable
0%	Not acceptable
1%	Not applicable

17. This new angle or approach has made me think differently about some important things.

51%	Great
41%	Good
7%	Acceptable
0%	Not acceptable
1%	Not applicable

18. I have a list of some practical next steps I can take to improve my participation in the SAW / RTW process.

40%	Great
47%	Good
10%	Acceptable
0%	Not acceptable
4%	Not applicable

19. This workshop was a good use of my time and effort today.

52%	Great
40%	Good
8%	Acceptable
0%	Not acceptable
0%	Not applicable

20. I think this workshop will really bear fruit in the future.

58%	Great
33%	Good
10%	Acceptable
0%	Not acceptable
0%	Not applicable

Comments from Evaluation Sheets

A space was provided at the bottom of the evaluation form for attendees to comment on the best and worst features of the Summit, and make suggestions for improvement. Below is a list of all of the comments made.

1	Having 2 groups meet in the same relatively small room presented a distracting environment. Fantastic information presented implementing a much needed initiative.
2	Multi-stakeholders coming together & the expectation that we will do something concrete when we leave.
3	Heard some facilitators were not as effective. Develop the facilitators' skills. Maybe the 1st meeting is 1 1/2 days in order to obtain more productive action steps. Great to meet new contacts who have similar philosophies and who want to contribute to improve our system. NO worst part. Great/ comfortable chairs!
7	have access to prior summit info to build upon or use as a starting point.
8	re: invite. I was a last minute sub for Dr. Ronald Klein. For Providers - identify barriers to providing effective & timely care. More clearly identifying individuals &/or orgs who have the authority to change systems & processes. A lot of great ideas, but implementation side weak.
11	Like multidisciplinary approach.
12	3 groups in 1 room - too noisy. Small grp facil - not enough time Flow of meeting prob - up and down stairs
13	Best: Keynote, small group session – multi-group much more substantial than same stakeholder. Report of groups suffered - this may have been due to the expanse of the room. I met some awesome people. I experienced many varied viewpoints. How are we funding our future efforts?
16	Need more time in groups. Better facilitating. How to engage "outlyers" plaintiff attorneys.
17	Best part - people & thinking outside the box. Worst - lots of info & ideas compacted into one day! * Need a time set aside for casual networking - lots of great attendees & no relaxed interaction time.
19	I think the Columbus committee did an excellent job in bringing this to fruition in such a short amount of time. THANK YOU. I think we should have a summit next year.
20	For break-out session should be separate Group H . Shared room with Group I was distracting.
23	Facilitator group K could have kept us on track. We had 1 member that had own agenda & kept getting us off track.
25	Remember, our employees are our greatest asset
26	Reading materials - rec'd by assoc. Definitely a great concept & this is only the start - key is with the action plans and our follow-up groups to make it all happen.
30	* Please ensure that all participants receive copies of all of the recommendations. Thanks.

31	Limit one work group to a room Attendees should know assigned recommendations in advance of meeting
32	More time on guideline in AM. Keynote could be shorter to get to small groups sooner. Need to get facilitators organized to room assignments sooner and get name tags prepared by day before.
33	Best: Feedback from all parties involved in this process. Worst: Very, very long day for Friday; not enough time to complete all tasks.
34	Better organization at onset. Do not put more than one break out session in a room - hard to hear.
37	Meeting room was very, very cooollldddd
39	Improve facilitation of small groups to stay on task. Loved the networking & group think. Would like more info budget (so is there one? availability of these plans / next steps. Report out should be removed - It could have been better time spent on creating GREAT plans
40	Materials sent too late. Vendor locations were poor -> lack of recognition for sponsorship - not sure I will be able to return as vendor. Very exciting to be included in this first meeting.
42	Meeting room - a little chilly
43	Mixed group was a 2. Stakeholder group was a 4 Sm. Grp facilitators seemed OK, but needed to be more open-minded past BWC. Voc Rehab is instrumental in assisting consumers to getting gainful employment. I would like to see more community partners such as V+VS be involved in the Rehabilitation process.
45	Focus more on take aways / action plans - eliminate background on Dr. Christian and QA.
46	Best part was the multi-stakeholders session. Worst was same stakeholders as I was placed in ?? a group of therapists.
50	Very good info. Frustrating because of time constraints & the appearance of duplication of efforts of groups.
51	Facility - parking problem
52	I was in Payer Stakeholder group, but am not a Payer. This was a very beneficial START.
53	Day is too long
55	If the small group facilitators are not strong facilitators, the small group wastes time with non-directional conversations.
56	Meeting room too cold. Would have been nice to have drinks throughout!
57	Better facilitation in small groups. Let attendees know what topic their group was going to discuss. Timeframes were so tight it may have been beneficial to have the materials in advance of the summit.
59	Meeting room too cold!
63	Value of small group facilitators varied by group. First, Thank You! Exciting to see us on the cutting edge of new information philosophy.
65	Feel too much information for 1 day was rushed all day. Need 2 days !!!

67	re: value of small group facilitators - had difficult job - groups too big. Re: Reports - common themes repeated.
69	More labor / union & attorney presence.
70	Allowing only 2 min for reports from stakeholder groups was too short. 3 min would have been more effective for those that needed the time.