

IMPROVING OUTCOMES BY TRAINING PHYSICIANS TO MANAGE THE PROCESS OF RETURN-TO-WORK

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Abstract: In the workers' compensation arena, collaboration among the treating clinician, the injured worker, the employer and the payer is crucial to good outcomes. The information the treating clinician communicates to the patient, the employer and the claim manager sets the stage for the entire workers' compensation process. Yet, this is not something which physicians generally learn during their training. While physicians acquire the knowledge and skills needed to diagnose and treat injuries and illnesses during their medical education, training in process management (i.e. information about best practices for getting patients back to work as smoothly as possible, and the importance of doing just that) is generally missing.

The physicians who founded Concentra realized that avoiding disability and decreasing the time to case closure after work-related injuries and illnesses was an area where medical providers could have a significant impact. Thus, they formulated an approach to injury care with those goals in mind. As it grew, the company also developed an information system to gather practice management data, and used this data to help coach physicians to follow the most effective and efficient management strategies.

Concentra has been able to show excellent outcomes with a low percentage of patients disabled (off work), short case length, and low overall case cost. This has been possible because of the company's commitment to helping newly hired clinicians learn process management skills during orientation. To wit, every clinician learns Concentra's philosophy and approach to work injury care. For many clinicians, this is the first time they become aware of the fact that managing the process of return-to-work can be as important to recovery as doing a thorough medical evaluation and coming up with the correct diagnosis. They learn that honing skills in this arena is crucial in keeping patients working or getting them back to work smoothly. By the end of orientation, they realize that this is indeed an integral part of their role.

When they join Concentra, clinicians learn five basic principles during orientation: Communication is paramount; staying at work or returning to work as soon as possible is in the patient's best interest; the recheck schedule plays a significant role in managing the process of return to work; early use of physical therapy gets the patient to functional recovery sooner; and timing of further testing and referrals is important.

After their orientation, clinicians receive a quarterly Provider Practice Management Report which provides feedback on their practice patterns and outcomes, and enables them to compare their individual outcomes to those of other Concentra clinics in the same city, as well as all other Concentra locations. It is part of the job of physician managers (Area and Regional Medical Directors) to review these reports and coach clinicians whose outcomes could be improved.

A systemic and systematic approach to the process of return-to-work such as that adopted by Concentra is clearly effective in getting good outcomes in WC cases. Active involvement on the part of treating physicians/clinicians is integral in developing teamwork with the worker, the employer, and the payer, thus helping to move the case smoothly through the WC system. Concentra hires well-trained clinicians, and so does not focus on teaching or retraining them how to treat patients medically. Rather, Concentra Area and Regional Medical Directors acquaint clinicians with simple process management guidelines which organize their practice. It's an elegant and cost-effective approach to disability management which has served many patients and clients well for many years.

INTRODUCTION

With work-related injuries in the United States costing the private business sector more than an estimated \$1.25 trillion every year, minimizing disability and better managing the process of return-to-work should clearly be a priority, especially in present world-wide economic circumstances.¹

In an effort to contain medical costs in workers' compensation, many states have adopted fee schedules and/or medical treatment guidelines. However, these attempts have met with varying degrees of success at keeping total case costs in check, at times leading to disappointing results. Yet, there is hope. The approach of teaching clinicians to use principles of process management in return-to-work has been effectively used by at least

one healthcare system, which has found that containing costs and providing high quality care are not mutually exclusive. My optimism about the promise of process management is based on my nineteen years of practice experience at Concentra, a nationwide medical system with more than 300 clinics in 40 states, whose core services are in the realm of occupational medicine.

BACKGROUND AND HISTORY

In 1979, three family practitioners opened a medical practice in Amarillo, Texas. They applied an early intervention model to the care of injured workers and found they were able to achieve decreased costs.

The success of their approach helped them spot something important about the medical care customarily provided in workers' compensation cases: Most physicians are not aware of the critical role they play in *managing the process of return-to-work*. The physician trio realized that process management (monitoring and directing the events that make up the structure and flow in an individual case), while important to their results, was a concept alien to many medical practices.

This lack of awareness about an important aspect of medical care delivery on the part of many otherwise excellent physicians is still apparent when one looks at the handling of workers' compensation cases today. It is the natural result of a yawning gap in general medical education.

The critical piece of tuition missing during medical training has been information about best practices in getting ill and injured workers back to work as smoothly as possible, and the importance of doing just that. For example, I cannot recall a single mention of the physician's crucial role in managing the process of return-to-work after a work-related injury or illness during the four years I spent at the University of Wisconsin Medical School (Class of 1980), or the three years of my emergency medicine residency. And my experience is not unusual. Consequently, during the eight years I spent in the practice of emergency medicine, I took care of many injured workers without ever understanding that getting a patient back to work is a process which starts at the time of the work injury, and that it was one in which I played a part, whether I was a knowing participant in the workers' compensation system or not.

Although well-trained physicians in many fields are equipped with the skill set to medically manage the types of injuries and illnesses that arise from work, they typically do not recognize what a difference they can make in the outcome by how they play their role in the process of getting their patient back to work. Over time, they do come to know that dealing with the workers' compensation system can add burdensome administrative requirements to their practice, and that navigating the system can at times seem a tortuous and torturous process, but often have only a vague understanding of how their state workers' compensation system functions.

In the workers' compensation arena, collaboration among the treating clinician, the injured worker, the employer and the payer is crucial to good outcomes. The information the treating clinician communicates to the patient, the employer and the claim manager sets the stage for the entire workers' compensation process.

The three physicians in Amarillo decided that in order to become even more successful in managing workers' compensation cases, they needed more data on how specific variables affected the outcome of a case. Thus, as their practice grew and became Concentra, they built a proprietary information system to provide the data necessary to evaluate the variables that affect case closure. Using the information system developed for this purpose, Concentra has been able to gather practice management data from 630,000 work injuries per year to study how various management strategies in the return-to-work process affect outcomes. This data is analyzed, distributed quarterly, and used to coach physicians about the most effective and efficient management strategies.

Concentra has been able to achieve excellent outcomes, as reflected in a low percentage of patients disabled (off work), short case length, and low overall case cost because every clinician learns the philosophy and approach to work injury care. This coaching in process management starts at orientation, and is an ongoing endeavor as long as a clinician is with Concentra.

For many clinicians, this is the first time they become aware of the fact that managing the process of return to work can be as important to recovery as doing a thorough medical evaluation and coming up with the correct diagnosis. They learn that honing skills in this arena is crucial in keeping patients working or getting them back to work smoothly, and is an integral part of their role.

METHODS

Clinician Education and Ongoing Coaching

When they join Concentra, clinicians start out with a period of orientation during which they are not counted on to provide patient care. They are given this time to complete courses in Concentra's web-based learning system, and to familiarize themselves with clinic processes and procedures.

Among other materials, they are assigned five required modules containing information considered crucial for any clinician who will be dealing with ill and injured workers. Process management is introduced in one of these modules. There is also one-to-one

individualized training with their Area or Regional Medical Director, as well as time spent in clinic with several experienced Center Medical Directors in their market.

Over and over during orientation, five basic principles of medical process management are emphasized:

The first principle taught is that communication is paramount. This starts with explaining the findings, diagnosis and the treatment plan to the patient at every visit, and giving that injured worker time to ask questions, so that recommended activity parameters and the patient's responsibilities in the return-to-work process are clear. Clinicians are also expected to call the workers' compensation contact at several points in the process: after the initial post-injury evaluation; if the case is not progressing as expected; if the patient needs to be off work; or if ancillary testing or specialist consultation is deemed necessary. To make this easy for clinicians, the contact's name and number are listed on the paperwork that prints out for each visit. To simplify communication with payers as well, the contact number of the WC carrier for that patient's employer is listed in our computerized medical record system repository. After every patient visit, the employer contact gets a copy of the printed Activity Status (which is automatically faxed or e-mailed according to each employer's preference) as soon as the patient is checked out. This helps avoid the lost time that sometimes occurs due to lack of communication, or through miscommunication.

The second principle conveyed is that staying at work or returning to work as soon as possible is in patients' best interests. In *A Physician's Guide to Return to Work*, Dr. Mark Melhorn states "60-80% of the lost work days involve medically unnecessary time off from work."² This unnecessary disability is avoided at Concentra through physician education in the benefits and importance of keeping patients working, and by training clinicians to write appropriate work activity statuses based on risk and capacity.

During orientation, we let clinicians know that physicians and other healthcare providers who treat injured workers are often the most crucial link in the chain because they are the "first responders" in terms of patient contact during the period when occupational health interventions have been shown to be the most effective. We also point out to our new clinicians that physicians are respected opinion leaders in the eyes of patients, and can help assure appropriate expectations and involvement of patients in their own recovery.³ Since treating physicians/clinicians are usually the first to become aware of barriers to recovery and impediments to return to work, they should set the stage for teamwork with the worker, the employer, and the payer, thus moving the case more smoothly through the WC system.

Clinicians learn that prolonged disability affects patients' careers, economic and emotional well-being, quality of life, and the lives of their family members. They are warned that giving in to a particular patient's request for a perceived short-

term benefit (such as staying off work a few extra days or weeks when not medically necessary) may have unintended long-term consequences, such as delaying needed intervention, promoting deconditioning, and increasing the risk of the worker's original job being lost.

We stress that extending time off work for even a short period when not medically required can contribute to a downward spiral with regards to returning to a normal life. We instruct clinicians that it is important to establish with patients early in treatment that both maximal physical recovery from the illness or injury and returning to work are expectations and top priorities. We point to studies which show that workers whose care includes attention to occupational issues have faster recoveries and a more sustainable return to work.⁴ And, while there are plenty of opinions about causes of disability and problems with the structure of workers' compensation systems, we teach clinicians that returning the worker to normal activities as quickly as possible is among the few things that appear to reduce work-related disability.

The third principle presented is that the recheck schedule plays a significant role in helping the patient progress through the process of return-to-work. Our data has shown that it is effective to see the patient back within 2-3 days of the initial visit, and then schedule the next recheck when it is likely the patient's activity could be advanced (generally 4 days or so). This type of recheck schedule initially might seem strange to clinicians new to process management. However, this enables the clinician to have better knowledge of the patient's current status and how modified or transitional work is going. The clinician is thus able to tailor the treatment plan and return-to-work goals to meet the patient's present abilities and loosen restrictions at every visit (whenever appropriate). During each visit, the clinician can reemphasize the return-to-work goals and deal with any workplace issues. Close follow-up appointments allow the physician to play an instrumental role in avoiding medically unnecessary disability by consistently promoting the benefits of staying at work/returning to work. Ultimately, this strategy is cost-effective because it leads to earlier case closure.⁵

The fourth principle is that early use of physical therapy (PT) helps the patient reach functional recovery sooner. If there is loss of movement and functional limitation in a patient with a musculoligamentous injury and PT referral would be appropriate, clinicians are taught not to "wait" and see if that patient will improve without physical therapy. PT is started the same day as the physician's initial evaluation whenever possible, or the next day if the patient is seen late in the day. This avoids deconditioning, and helps patients to progress faster.⁶

The fifth principle impressed on clinicians during orientation is that timing is important. When referring a patient for a diagnostic test not available in our clinics (such as an MRI), or for specialty consultation or surgery, clinicians

are taught to do what they can to keep the process moving forward. In states that require pre-authorization for scans and consults, administrative delay may prolong the length of the case. Clinicians are taught that these are the times when it's particularly helpful to call the payer. It can expedite matters if the clinician touches base and checks on the status of the approval for testing or surgery and explains the benefits of a test or a procedure so that the claims adjuster more easily realizes the importance of doing this sooner rather than later.

Clinicians are also taught to readily seek clinical consultations and second opinions when they are having difficulty in deciding on the best course of definitive treatment. Determining the correct diagnosis and treatment plan affects more than the clinical recovery of an injured worker. The clinical and return-to-work goals are closely linked in workers' compensation and a delay in one can lead to a delay in the other.

After their orientation, clinicians receive a quarterly Provider Practice Management Report which provides feedback on their practice patterns and outcomes, and enables them to compare their individual outcomes to those at other Concentra clinics in their city, as well as all Concentra locations. It is part of the job of physician managers (Area and Regional Medical Directors) to review these reports, disseminate the information, and coach clinicians whose outcomes could be improved.

Tracking of Data

Concentra's ability to track and measure a plethora of statistics is made possible through investment in proprietary data systems. These systems, along with sophisticated analytical and reporting tools, allow for measurement of provider practices and quick assessment of behaviors and trends. This permits early identification and reporting of suboptimal practice, as well as making it possible for correction to be instituted.

To that end, there are various evidence-based quantitative benchmarks measured within our outcomes system. Process management statistics measured for provider services range from rate of referral (to specialists, diagnostics, test facilities, physical therapy, etc.) to utilization of medical services, to case duration. We are able to measure the rate of modified duty or off duty recommendations by our clinicians, the duration of the limited duty and off work periods, the sequence of services provided during this interval, and the intensity and frequency of such services.

These measures are stratified by diagnostic groupings which are built from mapping individual ICD9 codes. Every few years, Concentra reviews all ICD9 codes used and maps each code which has been used at least 10 times or more within a year to 88 body areas. Once ICD9 codes are mapped to body parts, they are additionally aggregated to

two other categories for reporting and analysis. The 88 body parts are mapped to sixteen diagnostic groups to track practice pattern trends and allow for reporting to the internal clinician community. Furthermore, for ease of understanding, the 88 body part categories are mapped to five larger groups to report practice management metrics to the external client community.

RESULTS

Our Practice Management Reports bear out the effectiveness of our instruction in process management, which is continually shaped in turn by the ongoing data collected by our information systems. A summary chart with much of our 2009 practice management data follows the descriptions below.

Concentra employs full-time and part-time clinicians. They come from a variety of backgrounds, including but not limited to family practice, internal medicine, occupational medicine, emergency medicine, and general surgery. We refer to the care they provide as “primary care.” When we look at measures relating to the cases they manage without consulting a specialist, we refer to this as “primary care” measures.

Many of our markets also work with consultants in the specialties which are most germane to our practice. Most commonly, we work with orthopedic and hand surgeons, physical medicine and rehabilitation specialists, and neurologists. These consultants are not employees but see patients either in our clinics, or in free-standing Concentra “specialist” centers. They follow Concentra patients post-operatively to discharge in either a Concentra clinic or specialist center. We refer to the measures in cases in which patients have been referred to one of these consultants as “total utilization” measures.

When looking at data from **all Concentra clinics** during 2009, there were **5.9% off work cases in primary care**. When referred to a specialist, 7.0% of the patients were off work. This compares favorably with the most recent available Bureau of Labor Statistics data listing 29% of recordable injuries as requiring days away from work.⁷

In Milwaukee, the primary market in which I do the coaching, only **4.7% of the primary care patients had any off work days** during 2009. When specialist referral was needed, the percentage of off work cases was 6%.

Looking at all Concentra markets, 31.2% of primary care patients were referred to PT, with an average of 4.5 PT visits total, and 13.5 day duration of PT care. Looking at total utilization of PT in all markets, 33% of patients were referred to PT, with an average of 5.8 visits and 21.7 day duration.

In the Milwaukee market, 38.7% of our primary care patients were referred to physical therapy during 2009. They had an average of 3.8 PT visits, with an average PT duration of 10.8 days. Looking at total utilization in Milwaukee, 42% of patients were referred to PT with 21.9 days duration and 5.4 total visits.

For **all Concentra** clinics, the **average duration of primary care in 2009 was 17.3 days**, with an **average of 2.8 primary care clinician visits/case**. 19% of cases in all markets were referred to a specialist, with 30.4 days average days to release in those cases.

In **Milwaukee**, our **average duration of care** for 2009 was **12.2 days for primary care**, with an average of **2.5 clinician visits per case**. If referred to a specialist (which 12.7% of cases were in Milwaukee), the duration of care was 25.2 days.

Comprehensive data on Concentra's practices are provided in the following table.

SUMMARY TABLE PROVIDER PRACTICES-- 2009

Market	% Ref to Specialist	% Ref to PT	% Ltd Duty	% Off Work	Avg PC Duration	Avg PC MD Vis
Akron	10.7%	37.3%	62.6%	2.5%	30.5	3.0
Albuquerque	21.4%	37.3%	66.4%	5.0%	21.2	2.7
Atlanta	24.5%	34.3%	69.7%	3.8%	16.3	3.1
Austin	16.9%	32.8%	59.8%	3.5%	31.3	2.5
Baltimore	13.3%	41.9%	71.0%	7.7%	16.4	3.1
Baton Rouge	13.7%	8.5%	43.4%	15.6%	9.8	2.1
Bay Area	27.9%	38.4%	57.0%	6.7%	24.8	2.9
Birmingham	17.7%	33.2%	68.4%	3.1%	18.3	2.9
Bridgton	-----	-----	61.9%	-----	39.4	3.7
Carson City	31.1%	21.6%	72.9%	4.7%	18.0	2.4
Cartersville	1.5%	11.9%	70.1%	6.0%	27.1	2.9
Central California	23.2%	35.8%	67.0%	7.9%	30.5	3.4
Charleston	22.2%	29.4%	71.0%	3.9%	18.7	3.3
Charlotte	21.9%	33.0%	73.9%	5.6%	16.7	3.0
Chicago	17.3%	33.0%	65.1%	2.2%	11.0	2.7
Cincinnati	16.8%	39.3%	77.4%	4.4%	16.9	2.9
Cleveland	11.1%	33.7%	54.1%	4.9%	20.2	2.7
Colorado Springs	27.9%	29.3%	57.8%	5.1%	22.8	2.4
Columbus	17.2%	37.2%	67.7%	4.7%	15.6	2.6
Connecticut	22.8%	40.8%	60.8%	10.8%	16.2	2.7
Corpus Christi	13.8%	19.8%	69.2%	4.4%	23.7	2.4
Cranberry	0.1%	-----	61.8%	6.1%	18.5	3.0
Dallas/Ft. Worth	20.2%	28.0%	64.7%	6.8%	17.7	2.7
Davenport	3.2%	14.5%	22.3%	2.2%	13.3	2.0
Dayton	22.0%	24.1%	65.0%	4.7%	19.1	2.8
Denver	30.3%	26.9%	65.3%	4.6%	24.4	2.7
Des Moines	20.0%	40.2%	73.0%	10.9%	14.6	2.8
Detroit	16.0%	26.7%	65.8%	10.4%	11.3	2.7
El Paso	21.0%	37.5%	74.3%	3.2%	23.6	2.9
Flagstaff	13.2%	19.8%	67.4%	12.1%	17.3	3.0
Ft. Collins	51.1%	47.8%	73.7%	10.1%	22.0	2.7
Grand Rapids	12.4%	33.8%	63.1%	2.0%	13.7	3.1
Hammond	15.7%	27.9%	63.0%	3.3%	10.4	2.4
Harrisburg	17.3%	42.4%	71.1%	4.0%	17.6	3.1
Hobbs, NM	23.1%	3.8%	84.6%	7.7%	108.5	7.0
Honolulu	11.4%	37.6%	71.6%	3.3%	25.9	3.3
Houston	23.9%	24.8%	68.0%	4.6%	12.9	2.4
Indianapolis	15.4%	31.3%	64.1%	4.4%	11.9	2.7
Kansas City	18.4%	30.4%	58.4%	5.1%	15.7	2.7
Lancaster	23.7%	37.4%	60.7%	4.5%	20.2	3.3
Lansing	17.6%	33.2%	70.1%	10.5%	12.5	2.4
Las Vegas	21.1%	14.5%	61.8%	7.3%	13.4	2.6
Lenexa	18.3%	41.7%	64.9%	6.3%	14.9	2.8
Lincoln	20.7%	28.9%	54.1%	2.0%	11.7	2.5
Little Rock	11.4%	44.6%	73.8%	3.1%	14.0	2.7
Los Angeles	25.8%	36.5%	63.3%	7.5%	18.7	3.2

Market	% Ref to Specialist	% Ref to PT	% Ltd Duty	% Off Work	Avg PC Duration	Avg PC MD Vis
Louisville	19.5%	37.6%	69.9%	6.0%	12.5	2.6
Madison	2.8%	35.4%	61.1%	4.9%	12.3	2.4
Maine	20.5%	42.6%	62.9%	3.9%	19.1	2.6
Massachusetts	18.9%	44.6%	71.7%	12.0%	17.9	2.8
Memphis	20.8%	32.8%	57.1%	3.2%	12.3	2.6
Milwaukee	12.3%	38.7%	57.7%	4.7%	12.2	2.5
Moline	5.1%	30.5%	62.3%	4.1%	22.8	2.7
Nashville	19.8%	34.0%	60.3%	2.9%	13.2	2.6
New Hampshire	15.4%	46.8%	65.5%	11.6%	13.9	2.6
New Orleans	10.2%	25.5%	59.2%	13.2%	14.1	2.3
New York-Albany	9.9%	29.9%	62.0%	14.0%	14.1	2.5
New York-Western	22.0%	49.1%	76.2%	7.7%	29.6	2.9
Newark	22.3%	49.4%	63.4%	5.9%	12.8	2.6
North Florida	22.0%	39.5%	65.9%	5.6%	20.8	3.2
Northern New Jersey	22.8%	23.9%	46.1%	7.2%	17.1	2.8
Northern Virginia	2.7%	40.6%	68.8%	2.9%	18.6	3.3
Oklahoma City	18.4%	23.3%	68.6%	3.3%	13.6	2.4
Omaha	13.0%	27.0%	58.6%	5.1%	13.0	2.6
Philadelphia	18.5%	43.3%	66.1%	11.5%	21.3	3.1
Phoenix	22.8%	24.3%	65.3%	9.0%	13.9	2.7
Pittsburgh	20.9%	46.1%	60.3%	0.4%	16.0	3.0
Portland	7.0%	39.7%	71.9%	7.0%	32.7	3.5
Raleigh	15.5%	29.1%	63.3%	4.9%	15.7	3.0
Reading	23.7%	57.1%	74.5%	5.5%	23.4	3.8
Reno	24.9%	24.5%	62.1%	3.8%	19.8	2.8
Rhode Island	21.3%	59.6%	71.4%	30.9%	22.0	3.4
Richmond	10.1%	45.9%	66.4%	20.4%	17.4	3.1
Salt Lake City	25.5%	38.5%	69.8%	7.5%	16.2	2.5
San Antonio	21.7%	35.4%	70.4%	6.1%	24.5	2.8
San Diego	28.9%	31.9%	63.9%	8.6%	25.8	3.3
Santa Fe	20.0%	33.5%	64.0%	2.1%	21.2	2.5
Savannah	19.2%	36.4%	75.1%	9.1%	16.9	3.3
Shreveport	5.6%	----	67.3%	12.1%	56.5	3.9
South Florida	25.4%	25.3%	71.0%	2.1%	22.8	3.3
Southern New Jersey	20.7%	27.3%	62.1%	10.8%	16.7	2.9
Springfield	8.0%	22.4%	65.2%	6.8%	18.8	2.7
St. Louis	15.7%	31.2%	48.2%	2.3%	14.3	2.6
Tucson	14.4%	24.3%	63.7%	2.8%	19.5	2.9
Tulsa	22.2%	27.7%	56.5%	3.1%	11.2	2.3
Vermont	5.7%	39.4%	66.8%	8.8%	23.2	2.7
Waco	10.2%	31.1%	61.5%	4.7%	27.0	2.8
West Texas	17.7%	29.0%	78.7%	4.3%	21.5	2.9
Winchester	2.0%	18.8%	70.5%	1.6%	20.2	2.6
Winston-Salem	16.6%	34.7%	57.4%	7.9%	15.1	2.8
York	21.0%	37.7%	57.2%	12.2%	15.7	3.0
ALL MARKETS	19.9%	31.2%	63.9%	6.0%	17.3	2.8

CONCLUSION

Teaching clinicians to follow a systemic and systematic approach to the process of return-to-work is clearly effective in getting good outcomes in workers' compensation cases. Treating physicians/clinicians can set the stage for teamwork with the worker, the employer, and the payer, thus helping to move the case smoothly through the system.

Concentra does not set out to teach physicians how to practice medicine. After all, the clinicians have spent many years perfecting their skills in this area, and were hired because they possessed them; instead, Concentra teaches clinicians simple process management guidelines which can organize their practice. The same process can be followed in all cases and quickly becomes second nature for clinicians when approaching workers' compensation cases.

Process management guidelines have a further advantage. Unlike medical treatment guidelines, they do not require updating on a regular basis to keep up with advances in medical knowledge, as they are based on abiding general principles. For example, communication amongst the stakeholders in workers' compensation is a good process management practice today, and is unlikely to suddenly become passé in the world of medicine of tomorrow.

The ability to track, report and analyze our outcomes information ensures that we can continue to maintain high levels of quality while avoiding overtreatment. The ability to measure and intervene to change clinician practices allows us to maintain control of costs while ensuring appropriate utilization.

For clinicians, having data that shows the benefits of the approach they learn is invaluable on several levels. Philosophers and writers have long told us about the benefits of work. Jose Ortega y Gasset said that "An unemployed existence is a worse negation of life than death itself" and Albert Camus wrote, "Without work all life goes rotten." More recently, researchers in positive psychology have found that people have more optimal "flow" experiences at work than at home ("flow" being defined as a state in which one is immersed in an experience that is rewarding in and of itself, a state in which we feel we are one with the experience).⁸

To know that they are making a positive difference in their patients' lives is the ultimate reward for many clinicians. Finding meaning in one's work goes to the core of human existence for both patient and physician. One of the reasons I left the practice of Emergency Medicine was that I had started to feel like an "enabler" who patched people up so they could return to the same self-destructive activities which had brought them to me in the first place.

It was gratifying to learn and see that by actively managing the return-to-work process using the philosophy promulgated at Concentra, I was able to smoothly guide patients back to a productive life. That this same approach allowed for cost savings for those

patients' employers was an added bonus, rather like the cherry on a sundae, or the icing on a cake.

Helping injured workers get back to work without dallying is desirable at any time, and becomes even more so during hard times. As poet Marge Piercy says, "The pitcher cries for water to carry, and a person for work that is real."⁹ Finding ways to make the process of getting an injured worker back to "real" work as smooth as possible for everyone concerned is a noble goal. For stakeholders in the workers' compensation arena, it could perhaps even be viewed like the search for the Holy Grail. Many have sought to find a way of providing first-class medical care while at the same time keeping the costs reasonable. Some have given up in frustration after various attempts at doing just that and finding themselves tilting at windmills. But there is hope. A methodology that could help us attain this goal is within our reach, if we choose to pursue it. Coaching physicians and other clinicians to effectively handle the process of return-to-work has provided an elegant approach to disability management for at least one healthcare system. This same approach writ even larger offers one possible solution to the troubling problem of ever-rising costs of medical care in workers' compensation.

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¹ Talmage, James B, Melhorn, J. Mark. *A Physician's Guide to Return to Work*. AMA Press, 2005. p. 33-34.

² Talmage, James B, Melhorn, J. Mark. *A Physician's Guide to Return to Work*. AMA Press, 2005. p.25-26.

³ <http://www.lni.wa.gov/formpub/Detail.asp?DocID=1492>

⁴ Loisel P, Abenheim L, Durand P, et al. A population-based randomized clinical trial on back pain management. *Spine*. 1997;22(24):2911-18.

⁵ Derebery, Jane, Anderson, John, eds. *Low Back Pain*. OEM Press, 2nd Edition. 2008. Fogarty, W. Tom, *Chapter 2: Process Management*, p. 20-22.

⁶ Zigenfus G, Yin J, Giang G, et al. Effectiveness of early physical therapy in the treatment of acute low back musculoskeletal disorders. *J Occup Environ Med* 2000;42(1):35-39.

⁷ <http://www.bls.gov/iif/> Bureau of Labor Statistics, Injuries, Illnesses and Fatalities.

⁸ Csikszentmihalyi, M., and Lefevre, J. (1989). Optimal Experience in Work and Leisure. *Journal of Personality and Social Psychology*, 56, 815-822.

⁹ "To be of Use," Marge Piercy, p1 157. *Good Poems*, 2002, edited by Garrison Keillor, Viking.