Your Words Can Change Outcomes: Communications That Really Count

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Webility Corporation
2022 Workers’ Compensation Symposium
Montana
My goal: a quiet DEEPENING in

• Your respect for the power of
  – language (words)
  – conversations / interactions
  – relationships

• Your view of:
  – the workers you deal with;
  – yourself in your role: your personal purpose;
  – the power you wield, and how you can use it to make a positive – or negative – difference in what happens;
  – the purpose of your interactions with workers

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Jennifer Christian, MD, MPH, FACOEM

• **Training**: Univ of Wash; Board certified in occupational and environmental medicine. ACOEM fellow.

• **Expertise**: Leadership, outcomes improvement (health & function, work disability), innovation & pilot programs.

• **Clients**: Employers, healthcare providers, managed care companies, disability and workers’ compensation insurers, government agencies. Long-term injured workers; US Dept of Labor SAW/RTW Policy Collaborative.

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Many Years, Many Chairs, Many Perspectives

• Emergency room physician, West Virginia
• Primary care, migrant workers’ clinic, West Virginia
• Medical Director, Bath Iron Works shipbuilders, Maine
• Medical officer (public health) for Anchorage, Alaska.
• Private practice of occupational medicine, Anchorage,
• Medical association president (Alaska)
• Medical director, occupational medicine, staff model HMO (CIGNA Los Angeles)
• CMO, VP of a workers’ comp managed are company in MA
• Since 1998, Webility Corporation
• Developer, Maze-Masters – non-medical coaching program for workers “lost in the system” to help them get their lives back on track. ($$$ claims)
• Chair, (20 yrs) ACOEM Work Fitness & Disability Section
• Founder and Moderator, multi-stakeholder Work Fitness & Disability Roundtable list-serv (2001)
• Founder, multi-stakeholder 60 Summits Project (4 awards) 2006-2012 (14 jurisdictions including Montana)
• Member, SAW/RTW Policy Collaborative, US Dept. of Labor, Office of Disability Employment Policy
• Private practice: Multi-Dimensional Medical Care LLC – patients with delayed recovery and chronic symptoms
• Co-founder: Alliance for Bridging Health & Work (2022)
• Lifetime Achievement Award, American College of Occupational & Environmental Medicine
Big Picture:
Why Are We All Here Today?
What does good communication look like?

• **SHARED INFORMATION** so that both parties have the same data & are looking at the same picture.

• An **EASY METHOD** for sending/receiving information, so the parties can share it efficiently.

• **RELATIONSHIP** of trust/respect/connectedness – so that shared information is believed by the receiver.

• **HUMAN CONNECTION**: Empathy – communicating an understanding of the other’s predicament.

• **MUTUAL UNDERSTANDING**: Awareness of what each party wants (and needs)

• **ALLIANCE**: The parties have a shared goal(s) and are actively collaborating to reach it/them.

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Why improve communications?

1) The second worst possible outcome of a working person’s injury or illness is often preventable -- but no-one feels responsible for preventing it.

2) Working age adults deserve a more realistic and inclusive definition of “health and well-being.”

3) Maximizing the number of adults who remain self-sustaining taxpayers and contributors to the economy is vital to our country’s future.
THINK ABOUT IT:

What are the top three worst possible outcomes of an illness or injury in a working person?

#1: DEATH

#2: ????
#2: Job loss, loss of livelihood

Research: Long-term worklessness causes declines in physical and mental health as well as personal, family, social and economic well-being

– Entry onto long-term disability rolls, especially SSDI, is almost always a one-way street

– Loss of livelihood can be caused by needless (potentially preventable) work disability
#3: Permanent impairment

People with disabilities who work have much better quality of life than those who don’t.

- Loss of an anatomical body part or physiological capability (amputation, paraplegia, blindness, kidney or lung damage, chronic pain)
- Includes needless impairments (preventable, iatrogenic, excessive, “system induced,” unacknowledged yet remediable)
What the evidence tells us

• Research has shown that worklessness is harmful to both physical and mental health as well as to marital, family, social and economic well-being. Too often, being “on disability” means a life of poverty and aimlessness.

• Productive engagement, especially paying work, promotes health and many other kinds of well-being, and should be considered an essential part of a good life.

• Disabled people who work enjoy better quality of life – and better health!
2) Working-age adults deserve a more realistic and inclusive definition of “health & well-being”

• Challenges, difficulties and imperfections become part of most human lives -- maybe even the design!
• ALL of us need a positive vision, a pathway to wholeness
  • Including those with medical problems
  • Including those with incurable chronic conditions, fixed disabilities and aging
• Let’s point out the opportunity to grow & develop:
  • Cope successfully with whatever challenges life delivers
  • Participate as fully as possible in human life
  • Engage in purposeful and productive activity, paid or unpaid, for as long as is feasible

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3) Maximizing the number of adults who remain self-sustaining taxpayers and contributors to the economy is vital to our country’s well-being
Affected People Thrust into a Maze

Health status changes

- Emergency Room
- Walk-in Clinic
- Primary Care Practitioner
- Mental Health Practitioner
- Chiropractor
- Internet

Disability Benefits
- Specialist Physician
- MRI
- Union

Wellness Coach
- Attorney
- ADA

RTW Coordinator
- Health Plan
- IME

LTD
- SSDI

FCE
- Disability Evaluation

Disability Benefits
- Workers’ Comp.
- Surgery

PBM
- Voc. Rehab.

Workers’ Comp.
- Rx

UR

Case Manager

Normal rhythm of life resumes
People wonder about impact of new medical conditions on life

• How long am I going to be out of commission?
• How long do I have to take it easy?
• What can I still do? What shouldn’t I do?
• What should I do to speed my recovery?
• When will life be back to normal? ...if ever?
• What does this mean about me? My future?
• Who will really help me? Whom can I trust?
The Four Frontline Players

1. Affected person
   - Whose life has just been disrupted / turned upside down
   - Who decides how much effort to make to get better and get life back on track
   - Who must come up with a strategy for handling this predicament
   - Who usually sees self as “sick” or “injured” (does not identify as “disabled”)

Three professionals in separate worlds

2. Treating doctor/health care practitioner
3. Workplace supervisor and/or HR professional
4. Case manager

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The Gap: Nobody Feels Responsible

Result: Adverse secondary consequences -- iatrogenic invalidism, needless impairment and work disability, job loss, loss of livelihood
3. Typically, none of the three frontline professionals who usually get involved in a worker’s health-related employment disruption feels responsible – nor is assigned the responsibility – for making sure workers actually keep jobs, nor does the organization in which they work, nor do the parties coordinate their efforts.
Variability is the NORM!

- Outcomes of common musculoskeletal and mental health conditions are highly variable, especially low back & joint pain, depression.
- Workers with seemingly identical biology at the start will have wildly different outcomes.
- Physicians/healthcare professionals vary: Competence, philosophy, attitude, outcomes.
- Employers vary: Work environment, hazards, response to injury, sophistication, etc.
- And so do claims handlers / case managers.
Small sub-groups of interest

“Classic” Catastrophes
- Look serious from day 1
- Obvious immediate or imminent anatomical or functional destruction or multi-system insult -- often irreversible loss.
- Can be congenital issue, devastating illness, major trauma, etc.
- More likely to receive outpouring of support and encouragement for fullest possible recovery.

“Creeping Catastrophes”
- Start out looking like common health problems
- Recovery stalls; nothing works; Illness > disease
- Desperation drives search for expensive / destructive measures
- Go downhill over time
- Life has been ruined
- “Lost causes” leave the workforce, stay on disability
- PREVENTABLE over-impairment and worklessness

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This is where the big money is!
... and the saddest stories
10-20% of Cases Account for 80-90% of Costs

Hypothetical
Total Resource Utilization by Percentile

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A hidden cause of variability: Adverse Childhood Experiences

• The ACE score is the strongest known predictor of adult health status per the US CDC

• Montana has a HIGHER prevalence of ACEs than many other states.

• For more information about ACES in Montana:
  https://www.americashealthrankings.org/explore/annual/measure/ACEs_8/state/MT
10 point ACE Score

1 Raised by single parent
2 Witnessed physical abuse of mother
   • Someone in household
      3 In jail
      4 Drug addict / alcoholic
      5 Mentally ill / suicide
   • Neglect, whether 6 Emotional or 7 physical
   • Repeated abuse, whether 8 emotional, 9 physical or 10 sexual.

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Obvious connection between ACE Score, self-soothing behavior & disease

- Smoking
- Alcohol Abuse
- Overeating
- Risky sexual behavior
- COPD, lung cancer, heart disease
- Alcoholism, liver disease
- Obesity, high lipids, hypertension, heart disease, joint problems
- STDs, HIV, AIDs,
ACE: Dose-response relationship

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Population Attributable Risk of ACE:

Conditions that impede ability of adults to function, work, enjoy life and survive.
4 key facts & concepts relevant to Creeping Catastrophes

1. Illness ≠ Disease in most of these cases.

2. ALL human experience is mediated by the brain; the body is the carrying case for the brain.

3. More medical care is not the answer; strengthening the person’s ability to cope is.

4. ACEs are a major unaddressed root cause of BOTH subjective illness & organic disease.

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“It’s amazing how much of something you need – if it almost works”

ACE survivor
Three professionals in separate worlds

A. Treating doctor/health care practitioner
   • Who works in a health care delivery organization
   • Who makes decisions about treatment and SAW/RTW
   • Who decides whether / how hard to look for a solution

B. Workplace supervisor and/or HR professional
   • Who acts on behalf of the employer
   • Who decides whether/how hard to look for a solution

C. Claim handler / case manager
   • Who acts on behalf of the health plan or disability benefits program—whether private or public
   • Who decides how to respond and what to pay for, given the rules
   • Who decides whether / how hard to look for a solution
How it looks to those three professionals

A. The treating doctor/health care practitioner
   – Focus is diagnosis and treatment
   – Not trained in why/how to provide helpful SAW/RTW advice
   – Pressed into service as “designated guesser”
   – Time spent on SAW/RTW issues is unrewarded
   – Unaware of workplace realities

B. The workplace supervisor and/or HR professional
   – Focus is administering employer’s policies/procedures
   – Not typically evaluated on outcomes (e.g., total $$, job loss)
   – Unsure how to interpret medical advice
   – Usually inexpert at SAW/RTW dialogue, finding solutions

(continued)
How it looks to those three professionals

C. The claim handler / case manager
   – Main focus is administering claim correctly
   – Accountable for compliance with laws, regulations, business rules, company policies, and processes.
   – Typically not accountable for aggregate outcomes of their whole case load (total cost, lost workdays, lost jobs)
   – Often unfamiliar with workplace realities and the employer’s other obligations
The Worker and His/Her Future
If not you, who?

Firefighters are trained to run towards danger. Will you run away from creeping catastrophes – or towards them?
A New Way to Look at Words:
A powerful tool / technique that changes brains which improves outcomes
Where do these known risk factors for poor outcomes live?

• Health illiteracy / ignorance
• Expectations
• Catastrophic thinking (fatalism)
• Fear avoidance behavior
• Perceived injustice (anger)
• Passivity
• Low self-confidence / self-efficacy
• Lack of coping skills / resiliency
• Lack of life skills
• Distrust
Dr. J’s Super Simplified Summary: Effect of Words on the Brain
The brain is carried by / part of the body.
Brain: Areas have different functions; some more primitive than others.
Limbic System ("Reptile brain"): A group of interconnected structures that mediate emotions, learning and memory.
When we don’t feel safe, we get stupid

AM I SAFE? WHEW!
THIS IS SCARY BAD!!
FIGHT, FLIGHT, OR FREEZE

INCOMING INFO
No biggie. I can handle this. I’ve got a good plan.

Here’s the facts

Huh?

Huh?

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Rider = Frontal Lobe
Elephant = Limbic System
Words

• Reassure – or frighten
• Signal interest / empathy – or not
• Build trust / confidence – or distrust/insecurity
• Create expectations – positive or negative
• Grow relationships – or alienation
• Transfer factual information
• Empower – or undermine
Your words will be most powerful when:

A. You are seen as a “credible authority”:
   1. benevolent
   2. trustworthy
   3. expert in the matter at hand

B. When you are familiar with and respect the worker’s specific situation: what they are wondering and worrying about, and what they want to accomplish.
↑ Trust = ↑ Speed ↓ Cost
↓ Trust = ↓ Speed ↑ Cost

Source: Jason Parker, Centrix Disability Management Services
Your Words Are Powerful

• For workers with commonplace conditions, your interactions with them will be the most important thing you do -- the words and tone you use, what you focus on, what you educate them about and how, your predictions.

• For many problem issues, advice from a trusted expert has been shown to affect outcome (alcohol, drugs, seatbelts, exercise, nutrition). Here, too.

• For workers with serious conditions, these things may be even more important.
Make sure workers get these questions answered

- How long am I going to be out of commission?
- How long do I have to take it easy?
- What can I still do? What shouldn’t I do?
- What should I do to speed my recovery?
- When will life be back to normal? ...if ever?
- What does this mean about me? My future?
- Who will really help me?
- Whom can I trust?
Typical communications mistakes

• Failure to be curious and listen
• Assume authority without agreement
• Abdicate your role; fail to offer your expertise
• Failure to align worker’s goals with yours
• Imply goal of medical care is symptom relief.
• Imply that working is harmful or “too much”
  – Over-protect – create fear
  – Over-limit – underestimate capability
• Negative predictions – destroy hope
Avoid NOCEBO effect -- Don’t make things worse

**SAY THIS**

- Your recovery process
- Getting life back to normal
- What progress have you made? What can you do now that you couldn’t do last time we talked?
- Back ache / shoulder trouble
- Many people your age -- who don’t have any symptoms at all -- have abnormal MRI’s.
- Stay active; movement has been proven to be good. Walking will reduce your pain and improve your mood.
- Try not to let this get in the way of your life; you can probably find a way to do the things you care about.

**NOT THIS**

- Your injury, illness, medical condition
- Getting you back to work
- How’s your pain-- from 1 to 10?
- Back injury / shoulder pain
- The findings on your MRI: bulging disc, disc protrusion; loss of cartilage; bone on bone.
- Avoid activity; get plenty of rest.
- You must follow your doctor’s restrictions.
Ignorance = Information Deficit

- Illiteracy / reading difficulties
- Language barrier / cultural disparities
- Health illiteracy
- Inexperience with this particular predicament / new to “the system”
- Their role / rights / responsibilities
- What they are headed for – the best / worst outcomes
- Route out of the maze – What else is possible, such as alternative jobs / careers
Good outcomes in tough cases require:

• Earning the worker’s trust
• Creating an alliance – shared agreement on the goals / intended outcomes
• Building the worker’s sense of ownership & control of the situation / solution
• Providing access to information, education, instruction
• Structure, continuity, & personal (human) support
• Enough time for the worker to build skills and confidence that they can manage this situation: learn, practice, relapse, etc.
Create “Engineered Interactions”: align, develop, guide, move forward

Align:
• Increase cooperation / adherence
• Engage and activate the worker

Develop:
• Identify / correct knowledge or skill deficits

Guide:
• Deliver key messages that improve outcomes
• Shift their thinking

Push for progress:
• Identify and commit to next specific step forward
A few examples of good messages

• As another injured worker said: “You have two choices: get bitter or get better.”

• “Your two biggest treasures are your health and your livelihood. I’m here to help you protect both of them.”

• “The insurance company is just here to pay your benefits – not to figure out what you will do with the rest of your life. Your future is still your responsibility.”

• “See if you can find a way to keep your job. If not, then find some other way to stay employed, even though it may be difficult.”

• “Being on disability long-term is toxic. It’s worse for your long-term physical and mental health -- and your overall well-being -- than almost any job, including one you don’t like. A future on disability means a life of poverty.”
Take the long view

• Workers are faced with a life predicament as well as a medical condition / disability benefits claim.

• They are naïve, vulnerable, listening for advice – and you are the gateway. First do no harm.

• Ask yourself: How can I help this person have the best possible future? How can I keep this person a productive member of society?
Restoring health & hope for workers with more illness than disease

Swing Groups

- Good Outcome Certain
- Good, unless . . .
- Bad, unless . . .
- Bad Outcome Certain

Noticed?
- Cared about?
- Respected?
- “Heard”?
- Coached?
- Offered practical help?
- Developed & strengthened?
- Informed?
- “Deprogrammed”?
- Educated?
- Taught new skills?
- Encouraged & supported?

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Their words reveal activation level

Level 1: Disengaged and overwhelmed
Individuals are passive and lack confidence. Knowledge is low, goal-orientation is weak, and adherence is poor. Their perspective: “My doctor is in charge of my health.”

Level 2: Becoming aware, but still struggling
Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals. Their perspective: “I could be doing more.”

Level 3: Taking action
Individuals have the key facts and are building self-management skills. They strive for best practice behaviors, and are goal-oriented. Their perspective: “I’m part of my health care team.”

Level 4: Maintaining behaviors and pushing further
Individuals have adopted new behaviors, but may struggle in times of stress or change. Maintaining a healthy lifestyle is a key focus. Their perspective: “I’m my own advocate.”

Increasing Level of Activation

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What activation looks like: Arthur Boorman’s Story

https://www.youtube.com/watch?v=qX9FSZJu448
What does good communication look like?

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- **ALLIANCE:** The parties have a shared goal(s) and are actively collaborating to reach it/Them.

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Learn more! Stay in touch!

• See handout: “7 Tips for Managing BPSE Issues”
• Research Summary: Robert Cialdini *Influence*
• Email: Jennifer.Christian@webility.md
• Blog: www.jenniferchristian.com
• List-Serv: Work Fitness & Disability Roundtable
  – Discussion via email or on-line
  – Free since 2001
  – >1,200 members
  – Multi-disciplinary / multi-stakeholder
  – For information or to apply go to www.webility.md
Thank you for listening!

Comments?

Questions?