NATIONAL ACADEMY OF SOCIAL INSURANCE

Health and Income Security for Injured Workers: Key Policy Issues

Luncheon Address

Thursday, October 12, 2006

This session convened at 1:00 PM in the Ballroom of the National Press Club, 529 14th Street, NW, Washington, DC.

Introductions

Bob Aurbach, CEO, Uncommon Approach

ROBERT AURBACH: Good afternoon. My name is Robert Aurbach. I'm the president of a company called Uncommon Approach, a company that I started after being the chief legal counsel for the New Mexico system for quite a few years. Nowadays I spend my time doing research on legal aspects of workers' compensation and helping jurisdictions, businesses and workers in the evaluation and redesign of workers' compensation systems.

I've been asked today to introduce our luncheon speaker. It's kind of a rare privilege for me, because it gave me an opportunity to meet in person somebody whose work I have admired for some time, but had never met.

The thing about Jennifer is that it's a really rare opportunity to talk to somebody who is at the same time both extremely credible but down to earth, and authoritative, but commonsensical, and who manages to present her message in a way that makes people want to listen to what she has to say. Jennifer has devoted most of her professional life to the reduction and prevention of workplace injury. Those of us who spend a lot of time worrying about return-to-work and its implications for workers' comp system design, such as the ripple effects on litigation resolution, benefit adequacy, stakeholder buy-in and reduction and system costs, know that the design and implementation of return-to-work programs is no easy task, but an extraordinarily important one, as you've heard this morning.

Dr. Christian's work provides both systematic and very specific assistance in this regard. Dr. Christian has over 20 years experience in occupational medicine, and she's the president of Webility, a company devoted to the dissemination and implementation of progressive return-to-work strategies. The website includes a link to the important ACOEM report that bears the same title as this speech, "Preventing Needless Work Disability to Helping People Stay Employed." There's a good reason for that. She chaired the ACOEM committee that developed that report, a process which if you take a look at the names that are on there, was probably somewhat more challenging that herding a large number of cats. By the way, if you haven't had a chance to pick up a copy of the report, there are extra copies over at the end of the table.

Her website also includes a monthly column formatted as a question and answer session with some of her clients. The columns contain wonderful commonsense insights presented in a delightfully conversational tone. Let me just give you an example of one. When she was asked by one of her clients, what kind of health care provider ought to be used for a particular kind of injury, she said very gently, "You're asking the wrong question. What you really ought to be asking is: what do you want to see happen with regard to this worker. And then, when you have the answer that question, you have a chance of picking somebody who could actually address those issues."

So it is my pleasure to introduce Dr. Christian, and I'd like to introduce you to her in the words that she uses to end each and every one of her monthly columns. So here is Smiling, Dr. J.

Preventing Needless Work Disability by Helping People Stay Employed

Jennifer Christian, M.D., President and Chief Medical Officer, Webility Corporation

JENNIFER CHRISTIAN: Well, hi. It's fun to be here. Some of you I've never met before. Some of you are my phone friends or my e-mail friends. I've only seen your name and never seen your face. And some of you are actually people that I didn't know came to these meetings, so this is kind of good to be here.

We only have a few minutes, and I'm basically loquacious and like to do two- to eight-hour things, so I'm going to roll you through these slides really fast. One of the hallmarks of a Jennifer Christian presentation is that I try and put all the words that are important on the slides so after the presentation, you will remember what I said. But there may appear to be too many words on the page, so pay attention to me, and you can have the slides later, how about that?

What I'm going to be doing today is introducing ACOEM's newest guideline. This is not the ACOEM Practice Guidelines that you may be familiar with. This one has another title: Preventing Needless Work Disability by Helping People Stay Employed. And I'm going to introduce Webility's 60 Summits Project, which is to convene stakeholder workshops and use the new ACOEM guideline as a framework to catalyze positive change in workers' compensation and disability benefit systems. That's Webility's purpose, to catalyze positive change, and we see this guideline as a great vehicle for doing so.

Now, actually Bob already told you most everything about me that's important here. I guess you might also want to know that I have been in private practice of occupational medicine; I've been a corporate medical director in heavy industry. I've been a chief medical officer of a workers' comp managed care company for which I actually helped build provider networks in about seven states. Worked for an HMO, worked in local governments. So I've sat in every chair, actually, except academia. And by the way, my career plan is I would like to end my career in an academic chair.

I'm an advocate of disability prevention, which is a new term. And the idea is not that we're preventing the injury. Other people are doing that. What we're doing is we are mitigating the impact, the disruptive and destructive impact of injury and illness on people's lives. As Bob said, I am active in ACOEM. I chair the Work Fitness and Disability section, which is the largest section in ACOEM. And I not only chaired the group that wrote this guideline, but I chaired an earlier group that wrote a previous guideline called, The Treating Physician's Role in Facilitating Return to Work.

Now, needless work disability is destructive and harmful. It's harmful for employees. It disrupts their daily life. It threatens their career and their self-esteem and leads to iatrogenic invalidism. I use the word iatrogenic here in a very broad sense. Technically, iatrogenic means, "caused by the physician or caused by the health care system." So for example, iatrogenic illness would be a hospital-acquired infection. But

there's another way of defining iatrogenic. It is how you and I and all of us respond to an injured or ill person. The way we respond or don't respond potentially creates their view of themselves as an invalid.

Needless work disability is also disruptive and costly for employers because it fundamentally reduces their productivity, and creates unnecessary hassle and expense. And at the employer level, at the level of the person who's really running the business, it's not the benefit cost that's the problem; it is the disruption in the production line.

And lastly, at the economy level, obviously, needless work disability is wasteful because it's diverting dollars from productive use, inviting petty fraud and corruption, and reducing economic efficiency.

The purpose of ACOEM's new guideline is to describe for the first time in detail the stay-at-work and return-to-work process, and to point out opportunities for improvement and provide some examples of current best practices. And, the way we managed to get all those 21 cats to work together is that all of us wanted to begin an ongoing dialogue among all the stakeholders. We saw that in our role as physicians we were trained to tell what was medical from what was not. And we're the most reliable tellers to you about that, so you know what's non-medical and you can work on it.

The authors are all ACOEM members and represent several specialties in occupational medicine, orthopedic surgery, internal medicine, family practice, physical medicine and rehab, psychiatry and emergency medicine. And we came from 15 U.S. states and Canada, and we're working in private practice, government, academia, heavy industry, and workers' comp and disability insurers. We looked for a doctor working for a union. We couldn't find one. But our goal was to represent the rainbow of all the places where physicians see these systems working. We used a collaborative and consensus-seeking method, and we widely circulated our paper before it was published for feedback from the stakeholders, and we also peer-reviewed it inside the college.

The structure of the Guideline starts with some introductory material, and then orients you to the stay-at-work and return-to-work process, how it works and the variability of medical conditions and their impact on work, and the relationship of the stay-at-work and return-to-work process with other processes. And then, in the last half of the paper, there are 16 findings and recommendations, each one of which is laid out with observations, discussions and examples.

So, what is the stay-at-work and return-to-work process? It is a sequence of questions, actions and decisions made separately by several parties that together determine whether a worker stays at work despite a medical condition, or whether, when and how that worker returns to work during or after recovery. And, this process often stalls or becomes sidetracked because the focus tends to be on corroborating, justifying or evaluating the disability rather than preventing it. The long and the short of this is that the stay-at-work and return-to-work process is a team sport, but we have not been playing it that way.

There are five parallel processes. There's the stay-at-work and return-to-work process, which is working in parallel with the medical care process of diagnosis and treatment; in parallel with the personal adjustment process, by which the worker is deciding how to respond to the situation and figure out what the implications are of this injury and illness for their future life, in particular, their vocational life. There's the benefits administration process and sometimes there's an ADA reasonable accommodation process. The sick and sad part is that the stay-at-work and return-to-work process, which is the one which is going to actually determine the outcome – along with the medical care process and the personal adjustment process – is being overwhelmed by the benefit administration process. The benefit administration process is frequently viewed as the real one, and yet the other ones are the one that are going to determine the outcome.

So I want to run you through at high speed the four general and 16 specific recommendations made in the report. The general ones are:

Number one, adopt a disability prevention model.

Number two, address behavioral and circumstantial realities that are creating or prolonging disability.

Three, acknowledge the powerful contribution that motivation makes to outcomes, and make changes to improve incentive alignment.

Four, invest in system and infrastructure improvements, and you're a good audience to be talking about that with this.

"Adopt a disability prevention model" means that we need to increase awareness of how rarely work disability is actually medically required. And we need to instill a sense of urgency, because prolonged time away from work is harmful. Some years ago, when I was the chief medical officer of a managed care workers' comp company, my boss asked me, how often after work-related injury does somebody really need to be away from work for strictly medical reasons? And when I told him my answer, he thought I was nuts. So I did a survey in order to prove my point. My favorite four words used to be: "I told you so"

So the key question in the survey that we did (we surveyed 99 occupational medicine docs who did work in 40 states) was: "Based on your clinical experience, what fraction of workers with work-related injuries and illnesses who seek medical care – which means it's bad enough they went to see the doctor – really need to be off work for more than a couple of days for strictly medical reasons?" And more than 90 percent of the doctors said it was less than 10 percent of the cases, and more than 50 percent of them said it was less than five percent of the cases. And the more experience that the doctor had with running transitional work programs or with helping people under ADA to stay at work, the lower the number got. I had told my boss two percent, because I had run an alternate work program for a shipyard. Now, the actual number nationwide has dropped

down to about 23 percent nationwide. I don't know what it is in your state or in your company, but if the real number is 25 percent – this makes the math easier – if the real number is 25 percent, and the most that is needed is 10 percent, that means we've got 60 percent of cases with non-medically required days away from work.

Today, my company, Webility, has a web-based course for doctors on disability prevention, and we're continuing that survey, continuing to get those same results. But we've added now a second question about non-occupational conditions. And the closest we could come to a similarly-constructed question was to ask: "What fraction of your patients with a condition that's not work related, but who have asked you to sign a form excusing them from work, really needed to be away from work for more than a couple of days for strictly medical reasons?" And the results are turning out to be pretty similar-looking on the left-hand side of this chart. Eighty percent of the doctors say it's less than 10 percent of the time of the people who asked them to sign a note. And 54 percent say it's less than five percent of the cases. But oddly enough, up to100 percent of these people are actually away from work because they are asking the doctor for a note.

So, when is work disability really required? Remember: by work disability, I mean, absence from work. When is absence from work attributed to a medical condition really required? The new ACOEM occupational medicine practice guidelines, chapter five – if you have not paid attention to it, it's a landmark chapter – is called Disability Prevention and Management. The definitions that you're going to see here are very similar to what's in there. In fact, Webility donated our language to the ACOEM practice guideline. These definitions have also been in front of hundreds of doctors, and they don't push back. So those of you who are not medical doctors, you can feel comfortable with these definitions. You need to be away from work if you have to be at a place of care – if you have to be in a hospital, you have to be in a day treatment program, if the p.t. office closes at 5:00 – because your healing should take priority over being at work. You also need to be away from work if you have to be confined to at-home or in-bed. And usually the reason for that is as follows: Immediately following injury, the body has a biochemical cascade where basically you're prostrate; you need to be still in order to heal. Or, you may need to be at home because there's a risk of infection, contagion or quarantine. Either you're dangerous to me, or I'm dangerous to you. You need to be in the house. Or, you may need to be in a protected environment. Somebody who's delusional or psychotic has to be protected from the real world, or the real world needs to be protected from him or her.

And lastly, if there's some reason why working or commuting is medically contra-indicated. And by that I mean, there's something about all kinds of work, or any kind of commuting that would worsen the medical condition or delay the recovery. But many circumstances that look like they are medical contra-indications turn out to be environmental. So here's an example. I used to work on the north slope of Alaska for British Petroleum, and guy wanted to come to work for BP. He had hemophilia. I said, whoa, I don't think it's a good idea for you to work on the north slope of Alaska, because if something bad happens and you need blood, we're an hour and a half away by jet from the nearest blood, and we're frequently weathered in. You can't come to work here. But,

the guy could work just about anywhere else, right? He could work anywhere where there was blood near by. So, many times when something looks like it's a medical contra-indication, you have to look at the circumstances and say, if we shifted the circumstances, could this person work? If so, then they do not need to be away from work for medical reasons only.

Work disability prevention is not about eliminating medically required disability; it is about eliminating unnecessary disability or preventable disability, which shows up as the result of discretionary decisions. And most often, those discretionary decisions are being made by somebody who may say it's for medical reasons, but they are actually making a business decision. It's usually a cost-benefit decision. Is it worth making use of whatever productive capacity this person has while they're recovering? And usually that shows up as, oh, we can't find anything for him to do. Or, there's no way to get him to work. Or, the bother of dealing with it seems to be more than the benefit. Et cetera. Many times, when you hear someone describe why somebody's not back at work, it needs to be unmasked and revealed for the business decision it really is. Because sometimes, the leaders in the business have made a decision – they want to reduce their workers' comp costs, or they want to increase workforce availability, but at the first-line of supervision, they're getting undercut by supervisors who are making decisions for their own convenience or out of ignorance. Sometimes it's an appropriate decision to keep somebody away from work. For example, if they only need a week of recovery time, and it would cost you 20 grand to get them the wheelchair that would climb the stairs that would let them work for that week, then that might be stupid. But if somebody's going to be away from work for a year, it might make good business sense to invest in getting that person back to work right away.

And there are a lot of medically unnecessary disability days caused by system friction, by ignorance, by resistance, and by administrative and bureaucratic delays. Again, these are masquerading as medical reasons for time away from work, but are in fact not. And the awkward part is those delays are decreasing the likelihood of people ever going back to work. You guys already know that length of time away predicts bad outcomes, and yet you persist in systems that have unreasonable delays.

So the second group of recommendation is intended to address behavioral and circumstantial realities. People's normal human reactions need to be acknowledged and dealt with. When somebody has been injured or become ill, even if it appears to be minor to you, their life might have been turned upside down. Today, when so many people have two-career families and childcare and work here and there, even a modest thing can turn a family upside down. Somebody who is uncertain whether they're ever going to be able to work again, or uncertain what the meaning of this injury is for their future has a big deal going on. And when I first came in to workers' compensation 25 years ago, I was so struck that people with injuries and illnesses have the question arise whether or not they can work again have a major life situation they are facing, and who is going to help them with it?

The doctor's just going to do the diagnosis and treatment. The claims adjuster is just going to decide whether to pay it. The employer is just going to frequently tell stories about him behind their back and decide to fight the claim. Who is helping the person sort out the situation? Who is helping them identify the optimal resolution of this for today, for tomorrow, and for the rest of their life?

Also, one of the peculiar things about workers' compensation is how inauthentic and superficial it is. There are social and workplace realities that we know from all the evidence have a profound impact on outcomes, and yet the system says, don't tell me about any of that stuff. I only want to talk about the stuff that's in the law. And lastly, people with injuries and illnesses – about 20 percent – this number may not be exactly right, but about 20 percent of us already have psychiatric conditions at the moment we're injured or ill. And the co-existence of a psychiatric condition with an illness or an injury prolongs recovery. Many of us, when we develop a chronic illness, will then also develop a psychiatric condition with it. Fifty percent of people with chronic illnesses have diagnosable psychiatric conditions. The fact that you guys don't want to deal with it doesn't mean it doesn't exist. The fact that you guys don't want to deal with it, doesn't mean that it isn't screwing up outcomes, right? So this is an issue, which absolutely has to be addressed if you want to achieve optimal outcomes in this system.

And there are modifiable factors that predict long-term disability. Dr. Gordon Waddel in the UK did a big study of all the things that predict long-term disability. Some of them we can't do anything about, like age, like educational attainment, like what kind of work you do. But here is the list of things, which are modifiable. And what is fascinating is that with the exception of number one, interval away from work, which we can do something about by helping people recover on the job, getting them right back on the horse. All the rest of them have to do with how the person sees their situation. Remember what I said about expectations? Who is helping set the expectations for people? Who is helping them envision the best possible outcome, and who is on their side trying to achieve that best possible outcome. Pain intensity and pain behavior, by the way, are intensely driven by expectations and the person's perception of their situation. And time is of the essence.

This is my slide from a population from General Electric; on the left is the likelihood of ever going back to work and on the right-hand side is time away from work. And for that population, by three months, the likelihood of ever returning to any job had dropped by 50 percent. So the reality is, every day the odds are dropping, and unless you're managing your system by elapsed time, you don't know where you are. Instead, everybody is managing by from when they got the case or the claim, as opposed to from the day the person left work. So when you talk about iatrogenic disability, if you have any part of your system, which is operating slowly, you are creating disability.

Three, acknowledge motivation and align incentives. You have to pay doctors for disability prevention work if you want to increase their commitment to it. Right now, any doctor who provides assistance with return-to-work is a sucker in most systems because they're not paid for those minutes. They're in a revenue maximization program

like everybody else. In today's world, doctors are basically high-priced assembly line workers. The only CPT codes that they get paid for are ones where the patient is in the room. They don't get paid for time speaking to employers. They actually don't even get paid for time spent talking to employees about return to work. If you want them to do the work, you've got to signal that it's valuable and important, and you've got to pay them to do it.

You also want to help doctors by supporting appropriate patient advocacy, by getting treating doctors out of a loyalty bind. I do a lot of workshops with employers and payers, and basically employers and payers love to blame doctors rather than do anything about it. One way to help doctors get out of that loyalty bind is make it easier for them to give you an answer that you will find useful. And there actually is a self-assessment you can use on our website that helps you figure out whether you are teeing the doctor up to help you, or are you just looking at the world from a you-centric point of view – and simply feeling comfortable blaming the doctor for your problem.

And lastly, obviously we need to increase the availability of on-the-job and recovery and transitional work opportunities, because this is the thing that helps people stay well: getting them right back on the horse. I want to comment, though, that I don't use the phrase "get everybody back to work", because that may not be the solution for some people. Everyone will agree that what people want is to get their life back to as normal as possible. And for most people, that will include a return to work. We can all get behind looking for optimal resolutions of situations, which usually will include return to work. But just be careful; because most workers might feel jammed if all they hear is "get you back to work."

And also, we need to reduce distortion of the medical treatment process by hidden financial agendas. Employers, payers, and workers love to basically trick doctors into saying things they want them to say, and the doctors feel uncomfortable and manipulated. That's part of why they don't want to participate in this system. We really want this system to be transparent to all players. Also, because we allow so much minor abuse and cynicism in workers' compensation, we make the system unattractive to people. We need to be more rigorous, more fair and more kind all at the same time, in order to reduce the cynicism which permeates the system and makes it so unattractive to people.

This November at the National Workers' Comp and Disability conference in Las Vegas, Richard Pimentel and I are going to be doing a session called "Are you being hostile or firm? Are you being kind or a sucker?" And that essentially is the balance point we need to find in this system. We want and need to be kind and firm, and neither hostile nor a sucker.

And lastly, we need to devise better strategies to deal with bad-faith behavior. And that's not just doctors. And that's not just employers who hide their premium. And that's not just employees who falsify injuries. There is another problem, which is the employer who will not work with you to bring somebody back to work. That is a huge problem for many workers. In fact, the employee has the most power to determine the

eventual outcome of a disability situation. Because he or she decides how much discretionary effort to make to get better and get life back to normal. And many of these systems really do not acknowledge that the employee has responsibility in these situations. I've never been able to understand why the worker doesn't have responsibility to mitigate the impact of his or her own situation. And the employer plays the second most powerful role in determining the outcome by deciding whether to manage the employee's situation actively, passively, supportively, hostilely, and whether to provide for on-the-job recovery. When I was at the shipyard, the senior VP of Operations one day said to me, "Jennifer, you know, in the medical department, the only ones you see are ones where there's a problem between the employee and the employer. Because whenever the first-line supervisor and the worker are in alignment, those cases never even become visible because they work it out."

So by definition, we see problematic cases where we have a problem between the employee and the employer at the first-line level. And why are we not paying attention to that?

Lastly, the fourth big group of recommendations is intended to invest in system and infrastructure improvements. First of all, I don't know if you know this, but doctors have never been educated on what their role is in preventing disability or in managing disability. And they have never been trained in how to assess functional limitations or put on medical restrictions or do work capacity. You guys want them to know how to do it. You guys insist and write a role for them in the law, but they do not know how to do it. I do a lot of lecturing to doctors, and when I say, I know you're making it up, there's this great sigh of relief. They're making it up, right? So stop writing mandates for doctors without providing and insisting that they have the wherewithal to do the thing you're asking them to do.

It's a peculiar feature of this whole system that you not requiring that doctors actually know how to do the stuff you think it's so important they know how to do. And you need to disseminate information about the strong scientific evidence that staying active and at work fosters recovery -- and not just to doctors, but also to employers and payers the.

We also need to improve in standardized methods of information exchange between employers, payers and medical offices. It's so bizarre. In this country, 100 to 200 million return-to-work slips are flowing back and forth between doctors' offices, employers and payers every year -- and it is a non-standardized paper process. Every big employer has to deal with thousands of different forms from different doctors' offices. And every doctor's office has got to deal with hundreds of forms from so many different employers and insurance companies. This is a place where we really have a lot of system friction. We also need to improve and standardize the methods and tools that provide data for stay-at-work and return-to-work decision making. The AMA Guides to the Evaluation of Permanent Impairment is one example. The ACOEM Occupational Medicine Practice Guidelines are another great example. Evidence-based disability duration guidelines are another one. My favorite is Presley Reed's Medical Disability

Advisor because the data is the most solid. What is really missing right now is an encyclopedia where a doctor goes to look up what should be the medical restrictions or considerations for specific conditions. Actually, right now, in order for a doctor to figure out what you should or shouldn't do because of your diabetes or your lung disease or your insomnia or whatever, they just have to pull it out of their head. And we need to increase the study of and knowledge about stay-at-work and return-to-work.

It is bizarre that we've spent so much money in this country studying the way health services are delivered to children, to Medicaid recipients, and to Medicare populations, and how little investment we have made on how well the workers' compensation system is delivering care, and how well the stay-at-work and return-to-work process is working.

So that's a fast overview of the ACOEM Disability Prevention Guideline. I was thrilled when I got a totally unsolicited call from the risk manager of Wal-Mart telling me he thought this was the best written description of the stay-at-work and return-to-work process he'd ever seen, and that it is a blueprint for improvement. So I really do recommend you to it. I think you'll enjoy it.

Webility, as a company, has invented a project to take this new Disability Prevention Guideline to 50 states and 10 Canadian provinces, and use it to move the system forward in those states – to waste less money and needlessly disable fewer people. The idea is to assemble the stakeholders, have them learn about the guideline, learn about the stay-at-work and return-to-work process, and then to break into small groups. Each one then considers one of the recommendations and asks, how can we implement that recommendation here? What is the concrete next step that would make that possible?

We've already held summits in Oregon and New Mexico. The one in Minnesota is being planned. And part of why I'm talking to you is, hey, you want to do a summit in your state? So in your packet are several papers: (a) a vision for what a summit might look like, (b) some questions to ask yourself on what would help a summit in your state achieve maximum impact, (c) a draft editorial written by the guideline authors on what we hoped and the reason why we wrote our paper, and (d) the new ACOEM guideline itself.

That's it. Any questions? Reactions?

(Applause.)

Discussion

Q: I'm from the House Ways and Means Committee. Should I use the mike?

DR. CHRISTIAN: Yes.

Q: Your chart from GE looks pretty depressing when I think about Social Security Disability Insurance and return to work under that, because clearly it's showing that if somebody's been out of the workforce for a year, chances are they're really never going to go back to work. Can you talk about that for a minute?

DR. CHRISTIAN: Actually, this year we've had a contract with Social Security to think about how they can make better use of functional and vocational expertise in SSDI and SSI. . So for the first time I've really been doing – this is my new term – deep thinking about Social Security. You know, it's really two processes. One is the disability prevention end and the other is the rehabilitation end. And I don't know if anybody's really looked hard at what the batting average is when you put a good full-faith rehab effort to work on somebody who wants to go back to work. Because the system has been so uncurious about its fruits, we don't know. What I do know is that where I learned this stuff was at Bath Iron Works Naval Shipyard, and we put in place two groups. We put in place a group that managed hard the first six weeks to get cases on the right track. We had fabulous results. Here's the metaphor I used – I walked in there and they have 425 people out of work, and they wanted me to work on the ones that had been out of work a long time. And I said, listen, you just invited me into your kitchen. You've got the faucet going full blast, you've got the sink overflowing, you've got water all over the floor, and you want me to work on the floor? No, to heck with that. I'm going to go turn off the faucet. Right?

So disability prevention is where we need to start. Stop creating these fiascoes, right? But in order to appease the shipyard's management, I also set up what I called the Rehab Roundtable. We took people who had been out of work one or two years – and we knew that the odds, because I'd actually seen the slide myself, I knew the odds were one to two percent. We got 40 percent of them back to work. And of those 40 percent we got back to work, we got them back in the shipyard and more than 75 percent of them were performing above average by the time we got them back. Now, what we did is we decided to take a complete look at those people from every dimension. We had their claim behavior, their previous personnel record, their discipline record, and their labor relations record. We had the department they'd been working tell us whether this guy was ever any damn good at the start. We looked at the whole person. And my role was to interview the person and figure out if there was a hook in their heart somewhere that we could haul on that we could pull them back. And that turns out to be a big piece of it. What is there in you that I can call out that makes you want to try again when you've gotten into a hardened or a hopeless position.

So we made three decisions. We had a group that included the top management of the shipyard – medical, labor relations, personnel, everybody that had done the

evaluations. And the three decisions were, (1) we'll put the full faith of the shipyard behind your recovery. (2) We will give you conditional support, because we're not sure you can make it – or, we want to give you enough rope to hang yourself. (3) Or we will go for a claims-oriented defense period. But what happened is we took claims that had been dragging, and we said, what this person needs and what this situation needs is a resolution. They need to figure out what life is about for them, going forward. I think there is better luck at the back end, but it took a lot of work (and resources) to accomplish what we did.

Thanks very much. Let's talk later.

(Applause.)

MR. AURBACH: Wonderful panel. We're going to have a 15-minute break. Please come back and be in your seats at 1:45 for our next panel.

(Break.)