BACK TO WORK

Disability management and return-to-work strategies in Canada

IN THIS ISSUE

ONTARIO WSIB ISSUES REVISED FUNCTIONAL ABILITIES FORM

As of March 1, Ontario's Workplace Safety and Insurance Board (WSIB) began using a new functional abilities form (FAF) — a form filled out by doctors, chiropractors, physiotherapists and other licensed health care professionals at the request of employers and/or workers in order to help the parties meet their return-to-work obligations under the *Workplace Safety and Insurance Act*.

The new "Functional Abilities Form for Early and Safe Return to Work" differs most markedly from the old in the ways it fosters communication among health care practitioners, injured workers and employers. "It's not about the piece of paper; it's about the dialogue it supports," says Andrea Duncan, director of the Return to Work and Labour Market Re-entry Branch at the WSIB. "The evidence we get from the Institute for Work & Health is that successful return to work happens when the worker, employer and health care professional talk to each other. The form is designed to encourage that."

The revised form adds a number of new elements to foster this communication. They include the following:

- a yes/no question to be answered by the health professional that asks, "Have you discussed return to work with your patient?" According to Duncan, this addition is "the key piece" of the revised form. "This is our push to health care providers. They should be asking all workers arriving for their first visit with respect to a work-related injury or illness if the worker has talked to the employer about going back to work or a return-to-work plan. Return to work should be one of the outcomes of treatment."

Encouraging health care providers to discuss return to work with their patients will also help workers understand their own functional abilities. "A worker's understanding of his or her own body's abilities and restrictions is essential to the recovery process," says Duncan. For example, an unfounded fear of reinjury can be so strong that it actually prevents recovery, she says.

She gives a worker with a low back injury as an example. Although a worker with such an injury may naturally avoid movements that are painful, the worker will be more likely to avoid long-term disability if he or she learns what movements are still safe, even though they elicit some pain, and what movements really are to be avoided. The health care provider plays an important role in communicating this to an injured worker.

- a yes/no question to be answered by the employer or worker that asks, "Have the worker and the employer discussed return to work?" — and, if the answer is no, a place to put the date on which it will be discussed. "We want to make sure that the worker and employer understand that it is their right and obligation to engage in those discussions," says Duncan. "The draft RTW policies really focus on that kind of communication, too."

- a place for the worker to sign authorizing the health professional to provide functional abilities information to the employer and Board via the form. Although, under the *Workplace Safety and Insurance Act*, workers have to consent to releasing their functional ability information or risk losing their benefits, including their consent on the form again provides an opportunity for discussion among the parties. It particularly helps ensure the worker understands why the employer needs the functional abilities — not medical — information for return-to-work purposes.

"We really want to make sure that the worker is engaged in the transfer of information and the communication that is going on," says Duncan, adding that, in the past, it was often just the health care provider and employer involved in that communication.

- a place to put the employer contact responsible for co-ordinating return to work at the workplace, along with his or her phone number. This addition, says Duncan, is meant to encourage the health care provider to "pick up the phone" and discuss functional abilities in further detail if he or she thinks it is necessary.

"We're trying to break down the barrier between the health care provider and employer," she says. "The RTW co-ordinator and the occupational health nurse — all those parties can do a better return to work and make it safer if they have good information from the health care provider."

Pilot finds FAF works

Revision of the form began in 2004 when the WSIB commissioned a consulting firm to evaluate its use. According to the WSIB, the evaluation found that the form had value as a return-to-work tool, but that it needed to be revised to improve its function. The WSIB then put together an FAF project team to gather feedback from WSIB staff and external stakeholders before making revisions.

The revised form was piloted in 22 workplaces in January and February of this year before being finalized. "Most stakeholders found the form beneficial in assisting with early and safe return to work, especially when the injury is musculoskeletal-based, which most of our injuries are," says Duncan.

The only significant change made to the form in the wake of this pilot was the addition of a new check box that allows the health care provider to indicate "Patient is physically unable to return to work at this time" in the area of the FAF that asks the provider to identify the patient's overall abilities and restrictions. When checking this box, the provider must note the date on which the worker's abilities and restrictions will be reviewed. This reflects the need for "time to heal," says the WSIB, while still allowing for the workplace parties to plan for an eventual work-return.

Other changes to the form include:

- an area for the health care provider to sign declaring that the information provided is true. This ensures that the information on functional abilities is based on the provider's formal assessment of the worker, not just on the worker's perceived evaluation of his or her abilities. "We want to know that the health care provider has thought it through and that we hold them accountable," says Duncan.
- changes to the categories related to functional restrictions with respect to walking, standing, lifting, climbing stairs or ladders, using hands and more, as well as a new category on ability to travel to work. These changes, explains Duncan, are based on stakeholder feedback, as well as on a desire to bring the categories in line with industry norms and make them as clear as possible.
- the removal of the request for the worker's Social Insurance Number. For privacy reasons, the WSIB is in the process of removing the SIN from all its documentation.

Duncan emphasizes that the completion of an FAF must be initiated by the employer or worker, and not by a health care provider. "We don't want providers using this as an additional billing piece," she explains. "We want it used by the workplace parties for return-to-work purposes." She also notes that the Board pays doctors ($40) for filling out the Board's form only, not workplace- or industry-specific forms supplied by the employer.

To access the new FAF, as well as the guide to its completion, go to www.wsib.on.ca/wsib/wsibsite.nsf/public/ResourcesFunctionalAbilitiesForm. Any questions about the form or any other return-to-work matter can be directed to Andrea Duncan at the WSIB's RTW/LMR Branch at andrea_duncan@wsib.on.ca. •

ONTARIO WSIB HOLDS CONSULTATION ON ACCREDITATION

Ontario's Workplace Safety and Insurance Board (WSIB) is seeking feedback on a proposed workplace health and safety accreditation program — and return to work is in the mix.

According to the Board, the objective of the accreditation program is to "encourage organizations to incorporate a health and safety management system into day-to-day operations, to uphold superior standards of health and safety practice, and to align with the WSIB's vision of eliminating all workplace injuries and illness." The model being considered by the Board would be a voluntary one.

The model would see workplaces with superior health and safety programs that meet a documented stan-

dard, as confirmed by a third-party audit, receive a "certificate of recognition" that is valid for three years. If the program also resulted in good health and safety performance, the workplace would receive an additional financial reward. To be accredited, workplaces would be required to meet high standards in areas such as leadership, risk assessment and control, safe work practices, training, workplace inspections, accident investigations and return to work.

The WSIB currently does not offer an accreditation program, although it was given the mandate to establish one in January 1998 when the new *Workplace Safety and Insurance Act* came into effect. In August 2006, a group of employer representatives called the Accreditation Working Group presented its recommendations for an accreditation program to WSIB's senior management. These recommendations are the basis of the WSIB's consultation document now being put to stakeholders for feedback.

In listing the elements of a health and safety management system that should be scrutinized by an accreditation program, the Accreditation Working Group included return to work, saying that a company must have policies and practices in place — such as modified work, early medical intervention and regular communications — to assist with the safe return of injured workers. The group noted that including return to work is somewhat novel. "Although disability management is not considered in many health and safety programs or occupational health and safety standards, it is a key focus area for the WSIB," it said by way of explaining its inclusion in the accreditation program.

The WSIB's consultation document points to the success of accreditation programs in five other provinces that have some form of occupational health and safety "certificate of recognition": British Columbia, Alberta, Saskatchewan, Manitoba and Nova Scotia. For example, it says there is evidence that firms participating in Alberta's Certificate of Recognition (COR) program from 2000 to 2004 saw a 14-day decrease, on average, in return-to-work times, as well as seven per cent fewer lost-time injuries than non-participating firms.

The Board is seeking feedback on the design of the program, and is specifically asking what type of recognition would motivate firms to take part in a voluntary accreditation program, what should be included in the accreditation standard and audit, and who should conduct the audits. Feedback is being accepted until April 30, 2007. The consultation document, released on February 22, is available at www.wsib.on.ca/wsib/wsibsite.nsf/public/PreventionAccreditationConsultation. •

YUKON COMP BOARD OFFERS NEW SAFETY, RTW INCENTIVE PROGRAM

The Yukon Workers' Compensation Health and Safety Board has launched a new incentive program to reward workplaces for their occupational health and safety and return-to-work programming. Called CHOICES, the voluntary program allows employers, depending on their size, to choose the programming standard they feel ready to meet — from the "basics" up to "audited excellence" — and to choose whether to participate in both health and safety and return-to-work programming, or in health and safety programming only.

CHOICES also allows employers to choose between an annual cash rebate or twice-yearly "reinvestment" rewards. The latter are to be reinvested in health, safety and disability management programming, with the aim of enabling employers to meet higher programming standards and, as a result, earn greater rebates. Reinvestment rewards can be used to pay for such things as Board consulting time, training (including return-to-work training), personal protective equipment, ergonomic equipment and audit costs.

Cash rebate levels range from 0.5 per cent of an employer's assessment for meeting "basic" programming standards to 5.0 per cent for meeting "audited excellence" standards. The corresponding reinvestment rewards, which are greater, range from 1.0 per cent to 5.0 per cent, respectively. These amounts are earned separately for health and safety and return-to-work programming, meaning an employer can earn an award of up to 10 per cent of assessments. There is no individual claims experience component in this incentive program.

In terms of the return-to-work component of the incentive program, an employer must meet the following to qualify for cash rebates or reinvestment rewards:

- at the "basics" level, an employer must have a return-to-work policy and an injury reporting system;
- at the "foundations" level, an employer must also have a return-to-work planning protocol that outlines the steps to be followed from the time of injury to return to work;
- at the "programs" level, an employer must also have RTW program documentation, an RTW committee, and RTW communications and program evaluation protocols; and
- at the "audited excellence" level, an employer must have a return-to-work program that is audited by an external agency recognized by the Board, which includes the Consensus-Based

Disability Management Audit from the National Institute of Disability Management and Research (and the Board has a NIDMAR-certified auditor on staff).

The incentive program has been put in place to offset the increasing workers' compensation costs that good performers are experiencing in the wake of the Board's decision to remove subsidies. In the 1990s, the Board distributed the surplus in its investment fund in the form of assessment rate subsidies for employers. In the face of increasing costs, the Board gradually rescinded these subsidies, starting in the 2003 assessment years and ending last year. As a result, Yukon's average assessment rate went from the lowest in Canada to one of the highest.

For information on the program, go to www.wcb.yk.ca/fileadmin/user_ upload/PDF_files/ChoicesOnlineInfo.pdf. •

CSME TACKLES ISSUE OF ELECTRONIC RECORDING OF IMES

TheCanadian Society of Medical Evaluators is consulting with stakeholders across the country on the electronic recording of independent medical examinations (IMEs). In the meantime, it is taking the position that such recordings are "generally undesirable and unnecessary."

The primary reason for this interim stance, explains CSME board member Lee Tasker, is that electronic recordings have "a very high risk of invalidating the actual examination itself" because both the person being assessed and the assessor know they are being recorded and, consciously or unconsciously, may do things differently than they otherwise would. So until more is known and until it hears more from stakeholders, CSME is taking the "no" position.

"How does the mechanism of recording factor into the whole practice of assessment?" asks Tasker, who is heading up the informal CSME subcommittee looking into the issue of third-party observations of IMEs. "[Doing recorded assessments] is not a common practice that is taught in medical school nor as a part of ongoing training related to assessments."

CSME, which provides representation and education to physicians and other allied health professionals who conduct independent medical examinations, posted its interim statement after members noticed a significant increase in the number of people requesting that IMEs be recorded. Most of these requests were coming from the Ontario automobile insurance market; specifically, lawyers representing accident victims in disputes with auto insurers.

However, CSME recognizes that the issue is not isolated to that particular market. "It's an issue that cuts across workers' compensation and other disability issues," says Tasker, who also runs Lee Tasker Counselling Inc., an independent case management and rehabilitation counselling firm that offers services to injured parties, insurers and legal counsel.

CSME consulting all stakeholders

The requests for third-party observations of IMEs were coming because discrepancies — although certainly not the norm — were being noted between what the injured party (the claimant) said took place during the assessment and what was eventually written in the IME report, explains Tasker. She gives an example. An injured party might say that an assessor asked him or her to lift a hand and the injured party was unable do so, yet the final report might state that the claimant's range of motion was fine. "People are asking if there is a means available to address this issue," says Tasker.

In response to members' requests for guidance, CSME decided to consult with its members and other stakeholders across the country — including people from the insurance industry and legal profession — about where they stand on the issue of electronic recording of IMEs. "We're just now in the data-gathering phase and getting responses nationally from these groups," says Tasker.

In the meantime, the Society issued the interim statement coming out against electronic recording. The risk of invalidating IME findings as a result of an assessment being recorded is the main reason, says Tasker. However, another issue is the legal complexities involved. Tasker points out that the courts are also grappling with this issue.

"Right now, there is no jurisprudence or matter-of-fact statement in terms … of whether or not [electronic recording] is a reasonable means [of addressing alleged discrepancies in IME reports]," says Tasker. " Judges have yet to weigh in on whether, from a legal perspective, [electronic recording] should be part of the assessment process. At present, there are different camps."

The consultation will also allow CSME to be prepared if it turns out that electronic recording of IMEs is the wave of the future and accepted by the courts, says Tasker. That is, CSME will be better prepared to offer or at least comment on the type of training needed to ensure that examiners carry out a valid assessment in the presence of a recording device.

And there are other questions to be answered as well: How would recorded assessments be standardized? Would the physician be responsible for supplying the camera or hiring a videographer? Who would bear the cost of the recording? Who would get to see the final recorded assessment? "We're no

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B.C. PROMISES TO ELIMINATE MANDATORY RETIREMENT

British Columbia has promised to introduce legislation this parliamentary session to end mandatory retirement as recommended by the Premier's Council on Aging and Seniors' Issues. The promise came in the February 13 throne speech.

The Council, in its December 1 report to the premier, suggested the government immediately change the *Human Rights Code* to extend human rights protections to those over the age of 65, thereby eliminating mandatory retirement in the province and increasing the number of seniors in the workplace. As is the case in other provinces that have eliminated mandatory retirement, the change will likely make the accommodation of an aging workforce an increasingly important human resources issue.

The report is available at www.cserv.gov.bc.ca/seniors/council. •

SASKATCHEWAN UNVEILS NEW EQUITY PROGRAM

Saskatchewan has overhauled its employment equity program. The new program, called "Working Together" and administered by the Saskatchewan Human Rights Commission, allows employers to implement specific measures to ensure its workforce fairly represents people with disabilities, aboriginal people, visible minorities and women.

The new program differs from the old in a number of ways:

- Employers are no longer required to address the needs of all four equity groups within an equity program. They can design a program focusing on one group only (e.g., people with disabilities).
- Employers can seek approval for programs designed for new equity groups beyond the traditional four, if they can provide a rationale for doing so.
- Program approvals by the Commission are now simpler and faster. The signing of a standard-form equity partnership agreement between the Commission and the employer will constitute approval. In the past, the full Commission approved programs, and only after the programs had been fully developed. The new process is expected to take weeks for approval, rather than the year it used to take.
- The annual monitoring process has been changed. Employers will no longer have to submit detailed reports about their programs that are then considered one by one by the Commission before being approved for continuation. Now, ongoing approval will, by and large, be automatic upon employers submitting brief, standard reports.

For a detailed report on the new program, go to www.shrc.gov.sk.ca/pdfs/Working-Together.pdf. •

ONTARIO TO REFORM WORKERS' COMP LAW

The Workplace Safety and Insurance Board (WSIB) in Ontario will be required to determine and calculate benefits for injured workers re-entering the labour market based on what they are likely to earn from employment that is both suitable *and* available. This is the promise made by the provincial government in the 2007 budget delivered on March 22, in which it announced that the *Workplace Safety and Insurance Act* will be amended to make this and other changes.

Currently, an injured worker's benefits can be reduced or terminated if the worker can be returned to suitable work, even if this work is not available. That is, the WSIB "deems" what an injured worker is able to earn based on training and physical rehabilitation, without taking labour market conditions into consideration. The proposed change will require the Board to base loss-of-earnings benefits on employment that is available.

Other proposed amendments announced in the budget include:

- a 2.5 per cent increase in compensation benefits in each of three consecutive years, starting July 1, 2007, for injured workers receiving partial benefits; and
- a review of benefits for some workers who suffer a temporary or permanent deterioration in their condition once their benefit level is fixed 72 months post-injury.

For more information, go to www.labour.gov.on.ca/english/news/2007/07-30.html. •

P.E.I. BEGINS REVIEW OF WORKERS' COMP LEGISLATION

Prince Edward Island's statutory five-year review of its *Workers' Compensation Act* was officially launched on March 1 with the appointment of a Legislative Review Advisory Committee. The Committee, which will complete its work by December 2007, will consult with stakeholders and make recommendations to the Minister of Community and Cultural Affairs about potential changes to the Act.

For more information, e-mail wcactreview@gov.pe.ca or visit www.wcb.pe.ca/index.php3?number=1016689&lang=E. •

STOP COMPLAINING AND FIND SOLUTIONS: PRACTICAL ADVICE FROM A DM EXPERT

Disability management expert Dr. Jennifer Christian has heard one too many case managers complain about the barriers preventing them from helping injured workers return to work. She thinks it's time to solve problems, not just complain about them. **By Cindy Moser, Editor**

I regularly read the postings of the on-line forum Work Fitness & Disability Roundtable. Moderated by Dr. Jennifer Christian, president and chief medical officer of Webility Corporation — a consulting firm that helps organizations in the United States and Canada improve their disability management performance through strategic, organizational and practical initiatives — the forum sparks some very lively and informative conversations among its members, often based on provocative questions posed by Dr. Christian herself. As in the past, I continue to recommend the Roundtable to readers.

In a rare "cranky" moment — "cranky" by her own admission — Dr. Christian posted a message calling on disability case managers to start finding solutions instead of complaining about barriers to return to work. I think her message — and the advice she provided — are worth passing on to *Back To Work* readers (and she has given permission to do so).

Dr. Christian was feeling cranky because she had spent the afternoon with a roomful of case managers and return-to-work co-ordinators, each of whom was, as she describes it, "vying with the others to persuade me that they couldn't accomplish much because of this union rule and that company policy and this geographical distance and that … law." The straw that broke the camel's back was a Roundtable posting that saw an otherwise enlightened disability manager lament the actions of a doctor who was unnecessarily keeping a guy off work for five weeks.

She shot off a message to the Roundtable's readers saying that, if any of the complaining people she had heard that day were working for her, this is what she would have said to them: "Don't tell me this story without telling me what you have already done or plan to do about it. What strategies have you come up with to *get around this problem* and find a mutually satisfactory solution?" (And, in a complex situation in which the parties are at a standoff, she admits the "mutually satisfactory solution" might be finding a way "to get everyone's fur to lie down.")

"Don't tell me this story without telling me what you have already done or plan to do about it. What strategies have you come up with to *get around this problem … ?*"

"Sooooooooo many people spend energy justifying their lack of success by describing how the circumstances they are in are not ideal rather than developing a strategy to be as successful as possible given their actual situation," she said in a later posting. "And I sometimes get impatient."

Of course, Dr. Christian heeded her own words. That is, she didn't simply rant to Roundtable members; she also offered her own practical advice. Based upon the scenario in which the family physician poses a barrier to an employee's return to work, she suggests RTW co-ordinators have a conversation with the doctor, instead of firing written questions at him or her. The purpose of the call, she explains, is to "make the doctor comfortable releasing the patient."

Dr. Christian suggests, first, that RTW co-ordinators offer to pay the doctor well for a 10-minute phone appointment. "What would it be worth to you to come to a good resolution?" she asks. "What is each additional day away from work costing you?"

To reassure the doctor, she suggests sending a written description of what will happen during the call. She also suggests getting the employee on the line during the call, making sure the doctor has the patient's medical chart in hand. Then she offers a script of what the RTW case manager might say during this call (see next page).

After venting her frustration, Dr. Christian ended on a positive note. If any group intends to do what it can to prevent needless work disability, she said, it's the occupational health practitioners, disability managers and RTW co-ordinators who work in this field everyday: "We may be imperfect, but we're the best available."

IS A SUMMIT COMING TO CANADA?

In the meantime, another one of Dr. Christian's solution-oriented activities — this one aimed at systems-level barriers to return to work — is gathering momentum. Webility's "60 Summits Project" is moving across the United States, and may even be coming to Canada if expressed interest pans out.

The aim of the 60 Summits Project

is to use the American College of Occupational and Environmental Medicine (ACOEM)'s new *Guideline on Preventing Needless Disability by Helping People Stay Employed* (see *Back To Work*, August 2006) to catalyze positive changes in workers' compensation and disability benefits programs in each of the 50 U.S. states and 10 Canadian provinces. In each jurisdiction, Webility hopes to spark a summit workshop in which people from all key stakeholder groups — workers, employers, doctors, benefit payers, policymakers, regulators and more — sit side by side and figure out how to implement the ACOEM guide's recommendations in their own organization, community or jurisdiction — and then make plans to take steps towards that end.

STEP-BY-STEP

Talking to the doctor about return to work

Q1: Doctor, your patient Chris is here in the office with me. That's why I'm using the speakerphone. Say hi, Chris! [Pause] The purpose of my call is to see if we can find something safe and productive for Chris to do at work while he is recovering from his injury. His employer may be able to modify Chris's usual job or even provide a different transitional work assignment. But first of all, is there a specific medical reason why it is unsafe or harmful for Chris to get out of the house, travel to work or be in the workplace?

IF NO → **Q4:** What steps do you suggest we take in order to make sure that Chris is safe [or as comfortable as possible] at work? Are there any specific activities, tasks or environments that Chris needs to avoid or special precautions we need to take?

IF YES

Q2: Doctor, is that really a medical contraindication to Chris's working, or are you actually more concerned about Chris's comfort or stamina or safety or the risk of reinjury at work?

IF LATTER → **Q4:** What steps do you suggest we take in order to make sure that Chris is safe [or as comfortable as possible] at work? Are there any specific activities, tasks or environments that Chris needs to avoid or special precautions we need to take?

IF FORMER

Q3: Okay, I can see that. What is the adverse outcome (or bad thing) you are concerned about? [Wait for answer] If we can think of a way to arrange things to avoid that happening, is there any reason why Chris couldn't do some kind of productive work?

IF NO

Okay, that's great. So, let's work together to see if we can find a way to keep Chris active, safe and reasonably comfortable during recovery. I'm sure we both want to avoid worsening Chris's condition or creating a heatlh or safety risk for Chris or others.

→ **Q4:** What steps do you suggest we take in order to make sure that Chris is safe [or as comfortable as possible] at work? Are there any specific activities, tasks or environments that Chris needs to avoid or special precautions we need to take?

IF YES

Okay, I see. Yes, Chris shouldn't work as long as that risk exists. When, if ever, do you think the situation is likely to change?

Q5: Is there any information you are missing that I can get for you; for example, some more objective information about Chris's current strength or stamina, or the exact nature of the job or tasks Chris will be doing during the recovery period?

Q6: Let me give you my phone number and the phone number of the benefits manager at Chris's workplace. If Chris reports any problems at work during recovery, please get in touch with us right away so we can help. Is there anything else you need in order to feel comfortable that Chris will be appropriately monitored and protected while on transitional duty?

"Apparently, the project calls to people who have been frustrated by how systems hurt people and waste money — the ones who are longing to make the stay-at-work/remain-at-work process work better," says Dr. Christian. "We're finding it easy to get people intrigued, inspired and committed enough to actually take on the job of producing the summit meetings — and they are having no problem finding sponsors to help fund the summits." Organizations taking the lead on these summits have, to date, included private-sector corporations, disability management associations, workers' compensation boards and universities.

Summits have already taken place in Oregon and New Mexico and, according to Dr. Christian, sponsors and participants "are thrilled with the results being produced in their states." Summits are also scheduled for Minnesota, California, North Dakota and Arizona and in the planning stages for Ohio and Florida. "Conversations are underway in other jurisdictions, as well, with West Virginia, Massachusetts, Quebec, and Texas next in my sights," says Dr. Christian. Roundtable members in Ontario have also expressed some interest in a summit.

Since Webility is the "connecting hub" in terms of bringing interested parties together, people interested in holding a summit within a Canadian jurisdiction should contact Dr. Christian directly. Webility is also in the process of developing a blog so that people outside the Work Fitness & Disability Roundtable can follow the progress of the 60 Summits Project.

For more information on the summits, e-mail mail@webility.md or visit www.webility.md/sixty_summits_info.htm. For more information on Webility, go to www.webility.md, where you will also find a link that allows you to join up for the free Roundtable. •

SEVEN KEY PRINCIPLES THAT SUPPORT AN EMPLOYEE'S RETURN TO WORK

The Institute for Work & Health has looked to the research and found seven principles that are key to an employee successfully returning to work, thereby reducing the duration of his or her disability and reducing costs. Reprinted with permission from the Institute for Work & Health's Winter 2007 edition of *At Work*.

When workers need time off from their jobs because of a work-related injury, their recovery and return to work can be a complex process. The seven principles of successful return to work (RTW) were developed to provide some guidance on how to approach this process. The principles were developed by the Knowledge Transfer and Exchange (KTE) team of the Institute for Work & Health, in collaboration with the [Ontario] Workplace Safety and Insurance Board's RTW team.

"These principles pull together the messages from research, making them more tangible," says Jane Gibson, director of KTE at the Institute. "We felt that the principles would be useful to a range of players in the field, including disability managers, employers, insurers and, of course, workers."

Each principle has been shown to contribute to successful RTW, which was measured as a drop in the duration of a worker's disability and in costs. The principles are based on findings from a 2004 Institute review of RTW practices, as well as current research in the field. The review, conducted by IWH scientist Dr. Renée-Louise Franche and colleagues, provided particularly helpful insights, as it analyzed both the quantitative and qualitative research (see *Back To Work*, October 2004). "The quantitative research answered the question 'What works?' and the qualitative answered 'How does it work in terms of the context and processes?' " says Franche.

The principles provide a starting point to engage organizations in a dialogue about RTW, as employers and workers can see how the principles apply to their setting, she notes. "These principles are related, and when more than one is in place, there is a synergy that strengthens the impact."

Below is a description of the principles and a brief description of the research behind them. Note that the principles are based on what is known to date and may change as new research evidence becomes available.

PRINCIPLE 1: The workplace has a strong commitment to health and safety, which is demonstrated by the behaviours of the workplace parties.

There is a saying that "actions speak louder than words," and in the case of RTW, this is borne out by research. Certain actions or behaviours of employers, labour unions and others in the workplace are associated with good RTW outcomes. These behaviours include the following:

- Senior management has invested company resources and people's time to promote safety and co-coordinated return to work.
- Labour supports safety policies and return-to-work programming. For example, RTW job placement practices might be included in policies, procedures and/or the collective agreement.
- A commitment to safety issues is the norm that is accepted across the organization.

Studies of disability management interventions where there was strong union support showed reductions in work disability duration and costs. In addition, qualitative studies indicated that a collaborative approach to RTW between labour and management helped ensure there was no conflict between the collective agreement and the RTW process. Andy King, a department leader for health and safety at the United Steel Workers of America, has suggested that creating a RTW strategy could be a point of collaboration for organized labour and management.

PRINCIPLE 2: The employer makes an offer of modified work (also known as work accommodation) to injured/ill workers so they can return as early as is feasible to work activities suitable to their temporary abilities.

Accommodated work is a core element of disability management, which leads to favourable outcomes. "We all know work accommodation is critical," says Franche. "However, it needs to be acceptable to all parties involved, but most importantly to the worker and the employer." Several studies have shown that an awkward fit between the worker and a modified work environment can contribute to the breakdown of the RTW process and should be avoided.

In some cases, it will be helpful to employ the services of someone with ergonomic expertise. The systematic review also suggests that another core disability management component is ergonomic worksite visits. When RTW planners face difficulty in creating an

appropriate modified job, ergonomic expertise should be available.

PRINCIPLE 3: RTW planners ensure that the RTW plan supports the returning worker without disadvantaging co-workers and supervisors.

Return-to-work planning involves more than matching the injured worker's physical restrictions to a modified job. The planning must acknowledge that RTW is a "socially fragile process" in which co-workers and supervisors may be thrust into new relationships and routines. If colleagues are put at a disadvantage by the RTW plan, this can lead to resentment towards the returning worker, rather than co-operation with the RTW process. Two examples illustrate where RTW plans may cause problems:

- when co-workers resent taking on tasks of the injured worker and feel that the injured worker has managed to get an "easier" job;
- when supervisors still need to fulfill production quotas while accommodating a returning worker, and there isn't full acknowledgement of the work that this requires.

Workplaces that create individual RTW plans that anticipate and avoid these pitfalls will have better results.

PRINCIPLE 4: Supervisors are trained and included in RTW planning.

Supervisors are important to the success of RTW because of their proximity to the worker and their ability to manage the immediate work environment, according to the review. When supervisors are left out of RTW planning, they feel ill equipped to accommodate returning workers.

"Because RTW is not a static event, supervisors are in the best position to monitor changes and explain or smooth over issues that arise in the work area," says IWH scientist Ellen MacEachen, who led the qualitative part of the systematic review.

Educating managers and supervisors in areas such as safety training or participative ergonomics also contributes to successful RTW. Dr. Glen Pransky, director of the Liberty Mutual Research Institute for Safety in the U.S., reports positive results from an ergonomics and safety training program for supervisors. In this program, supervisors were taught to be positive and empathetic in early contacts with workers, and to arrange accommodations, follow-up and problem solve on a regular basis.

PRINCIPLE 5: The employer makes early and considerate contact with injured/ill workers.

"Early" contact is a core component of most disability management programs. It is associated with better RTW results. The actual timeframe for making contact may vary, depending on the worker's situation.

Ideally, the immediate supervisor should make initial contact to ensure the worker feels connected to the workplace and colleagues. The contact should signify that the employer cares about the worker's well-being, and should not involve discussions on the cause of the injury or on laying blame. The worker's general perception about the workplace and its concern for workers will influence how he or she responds to employer contact.

"Early contact is most successful when pre-existing conditions in the workplace are positive," says MacEachen.

PRINCIPLE 6: Someone has the responsibility to co-ordinate RTW.

Successful RTW programs involve an RTW co-ordinator, either based at the company or externally, to manage the process. This role involves:

- providing individualized planning and co-ordination adapted to the worker's initial and ongoing needs;
- ensuring that the necessary communication does not break down at any point; and
- ensuring that the worker and other RTW players understand what to expect and what is expected of them.

RTW players include workers, co-workers, supervisors/managers, health care providers, disability managers and insurers. Considering the needs of all these various players will facilitate the RTW process and help ensure its success.

PRINCIPLE 7: Employers and health care providers communicate with each other about workplace demands, as needed, and with the worker's consent.

Contact between workplaces and health care providers reduces the length of work disability, several studies showed. In these studies, contact ranged from a simple report sent back to the workplace to a more extensive visit to the workstation by a health care provider. Depending on the situation, one or more health care providers might be involved, including physicians, chiropractors, ergonomists or kinesiologists, occupational therapists, physiotherapists and nurses.

Health care providers can play a significant role in the RTW process. The injured worker often looks to them for information and advice about their condition and return to work. When employers have contact with health care providers, they are in a better position to understand the worker's abilities and can be more confident about health and recovery decisions, says MacEachen. The more these players understand about the worker's job and the work-

place's ability to provide accommodation, the better able they are to advise workers and participate in informed RTW decision-making.

Contact may only be necessary in complex cases. The degree and nature of the contact between the workplace and health care providers can vary depending on individual circumstances. It may include:

- a paper-based information exchange (e.g., information on job demands and/or work accommodation options sent to the family doctor by the employer);
- a telephone conversation about work and job demands (initiated by either party); and/or
- a workplace visit by a health care provider to view the work activities and converse directly with the supervisor or employer.

In some cases, a health care provider may be involved in delivering a fully integrated clinical and occupational approach to RTW, including medical assessment, follow-up and monitoring, plus jobsite evaluations and ergonomic interventions.

The worker needs to give permission for this contact to proceed. Ideally, the worker should participate in the communications between the health care provider and the workplace.

When family physicians lack time to consult with the workplace or make a workplace visit, other rehabilitation and occupational health professionals — who may have more worksite experience — can act as a "bridge" between the workplace and health care system. That is, they can provide the physician with succinct and essential information about the worker's job and workplace to assist with RTW planning.

For the complete version of the IWH's seven principles, which includes references, visit www.iwh.on.ca/products/images/RTW_7_principles.pdf. •

Journal focuses on mental health at work

The special issue of the *Canadian Journal of Community Mental Health* on mental health and the workplace is now available on-line. The Fall 2006 issue includes a number of articles of particular interest to those looking at mental health from a return-to-work perspective. They include:

- "The Influence of Organizational Factors on Return-to-Work Outcomes";
- "A Systematic Review of Psychological Return-to-Work Interventions for People with Mental Health Problems and/or Physical Injuries"; and
- "Towards an Enhanced Understanding of Factors Involved in the Return-to-Work Process of Employees Absent Due to Mental Health Problems."

To access the issue, go to www.metapress.com/content/h82x40203665/?p=b0f5f8632a574dea8fc2d1585e66d9fe&pi=0. •

Ontario releases guideline on preventing MSDs

The final "Musculoskeletal Disorder (MSD) Prevention Guideline for Ontario" and the "Resource Manual for the MSD Prevention Guideline for Ontario" have been officially released by the Occupational Health and Safety Council of Ontario. The Council is made up of the Ontario Ministry of Labour, the Workplace Safety and Insurance Board, the Institute for Work & Health, and the province's health and safety associations.

The voluntary guideline recommends a workplace framework for preventing musculoskeletal disorders, while the resource manual contains information on implementing the process described in the guideline and on MSD hazard recognition, assessment and control. A third component, the "MSD Prevention Toolbox," is to be released soon, and it will contain recommended worksheets, surveys, hazard identification tools and risk assessment methods.

To access the guideline and manual, go to www.wsib.on.ca/wsib/wsibsite.nsf/public/PreventMSD. •

Quebec's harassment prevention tools available in English

English versions of the psychological harassment prevention tools offered by Quebec's Commission des normes du travail are now available. These tools include:

- a PowerPoint presentation and guide to help managers conduct training sessions on psychological harassment;
- video segments showing what is and what is not workplace psychological harassment;
- a risk factor chart to help managers assess their workforces;
- a guide on developing and implementing a psychological harassment prevention policy; and
- various other pamphlets, guides and newsletters on workplace psychological harassment.

To access the English versions, go to www.cnt.gouv.qc.ca/en/site_hp/outils/default.asp. •

Saskatchewan WCB publishes RTW brochure

A new brochure titled "Recovery and Return to Work" is available this month from the Saskatchewan Workers' Compensation Board. The seven-page brochure offers basic information on the roles of the various parties in return to work, including the roles of the Board, employers, workers and health care providers.

You can download the brochure from https://www.wcbsask.com:443/book_forms_pubs/page_forms_publications_pubs.page. •

Survey asks about RTW/rehab policies

A Ph.D. candidate at the University of Alberta's School of Business is looking for workplace personnel who are willing to complete a survey on rehabilitation and return-to-work policies. Researcher Michael Annett is studying the nature of rehabilitation and RTW policies and procedures in organizations and their relationship to work behaviours.

The two-part survey takes about 30 minutes to complete, and a report of the results will be shared with those who participate. Only overall results — not individual results — will be reported.

You can access the survey at https://www.bus.ualberta.ca/Survey/TakeSurvey.aspx?SurveyID=72KJl92. For more information, call (780) 237-8877 or e-mail mannett@ualberta.ca. •

Participants needed for RTW focus groups

A research team identifying the essential skills and competencies of return-to-work co-ordinators is holding focus groups at a number of upcoming disability management conferences — and you may be able to take part.

The team's lead investigators — Dr. Patrick Loisel of the University of Sherbrooke in Quebec and Dr. Glenn Pransky and Dr. William Shaw of the Liberty Mutual Research Institute for Safety in Boston — are compiling a preliminary set of competencies for RTW co-ordinators based upon a review of the published scientific literature on return to work. In order to verify these competencies, they want to test their validity in the real world and see if they vary by the profession of the return-to-work co-ordinator, the type of illness or injury at the heart of the work-return and the nature of the work situation.

To that end, the researchers are looking for people who meet their definition of an RTW co-ordinator to take part in focus groups being held at a number of disability management conferences. An RTW co-ordinator is defined in the study as someone who is responsible for expediting, co-ordinating and facilitating return to work through integrated communications with employers, workers and others.

The first focus group is being held at the 2007 annual conference of the Disability Management Employers Coalition in Boston on July 15. To take part (and a $50 honorarium is paid for the two-hour session) or to find out more about the other upcoming focus groups, e-mail Quan Nha Hong, a research assistant at the Centre for Action in Work Disability Prevention and Rehabilitation at the University of Sherbrooke, at quan.nha.hong@usherbrooke.ca. •

DM consultant offers RTW series

Gowan Health Consultants is once again staging its workshop series entitled "The Secrets of Being a Return to Work Expert." The series is being offered again in Mississauga, Ont. from April 16-19 and, for the first time, in Edmonton from May 7-10.

For more information, call 1-888-752-9954 or visit www.gowanhealth.com. •

Conference focuses on IMEs and the law

A conference for health care professionals, rehabilitation specialists, insurance adjusters and others with an interest in independent medical examinations (IMEs) is taking place on April 20 in Toronto. Sponsored by the Canadian Society of Medical Evaluators, the conference will look at recent court and arbitration decisions with respect to psychological claims, medical experts, workers' compensation, the definition of "accident" and more.

For more information, e-mail info@csme.org or visit www.csme.org/Pages/Conferences.htm. •

Workshop tackles chronic pain rehab

The University Centre for Research on Pain and Disability is presenting a half-day workshop entitled "Psychosocial Factors in the Rehabilitation of Chronic Pain and Disability." Taking place on April 25 in Montreal, workshop presenters include Dr. Johan Vlaeyen of the University of Leuven in Belgium, Dr. Michael Feuerstein of the Uniformed Services University of Maryland, Alain Gaumond of CBI Santé in Quebec City and Dr. Michael Sullivan of McGill University.

For more information, go to www.pdp-pgap.com/pdf/April%2025%20EnglishBrochure.pdf.

The University Centre has also scheduled more workshops to train clinicians in the assessment and intervention skills required to administer the Pain Disability Prevention (PDP) or Progressive Goal Attainment Program (PGAP), which are designed to tackle the psychosocial barriers to return to work among people disabled by pain. These include:

- June 15-16 in Winnipeg;
- August 17-18 in British Columbia (tentatively, in a city to be named);
- November 2-3 in Quebec City (in French); and
- November 16-17 in Toronto.

For more information, e-mail info@pdp-pgap.com or visit www.pdp-pgap.com. •

Employer forum explores workplace health strategy

Brent Skinner, director of health and pharmaceutical policy research with the Fraser Institute in Toronto, is the keynote speaker at Connex Health's fifth annual employer forum on workplace health strategy. "After Commit-

ment: Developing a Successful Workplace Health and Productivity Strategy" takes place on April 25-27 in Niagara-on-the-Lake, Ont. Co-sponsored by the Institute for Health and Productivity Management in the U.S., the conference includes Skinner's talk on how the changing health care market supports a healthy workplace strategy, as well as other sessions on evaluating workplace health assessment tools, assessing employee health risks, developing a strategy using key measurement criteria and more.

For more information, call (905) 637-2775 or visit www.connexhc.com/eventdetails.asp?id=19. •

IWH talks address RTW and back pain

Two upcoming plenaries at the Institute for Work & Health in Toronto address return to work and low back pain. At the first, on May 8, Jill Hayden of the Centre for Research Expertise in Improved Disability Outcomes (CREIDO) will discuss factors related to disability and return to work in low back pain. At the second, on May 22, Carlo Ammendolia of Rehabilitation Solutions at the University Health Network will talk about the development of a workplace intervention to improve return to work among people with low back pain.

For more information, call (416) 927-2027, ext. 2137, or visit www.iwh.on.ca/about/plen.php. •

Millard Health offers PDA workshops

Millard Health, the rehabilitation arm of Alberta's Workers' Compensation Board, is offering a half-day workshop on physical demands analyses (PDAs). The workshop is designed to help employers develop customized PDAs that outline the physical, environmental and psychological requirements of a job. The next workshop takes place on May 17 in Calgary, followed by another on June 14 in Edmonton.

For more information, phone (780) 498-3363 or visit www.millardhealth.com/news.html. •

Accommodation seminar focuses on union sites

Canadian Information Exchange is offering a one-day seminar in Ottawa called "Duty to Accommodate and Undue Hardship for Unionized Organizations." Taking place on May 17, the seminar will look at the legislative framework of the duty to accommodate, recent court decisions, labour and management obligations for disclosing medical information, accommodating an employee's return to work, and more.

For more information, call (416) 516-7833, ext. 22, or visit www.informationexchange.ca/DUTY07. •

NEWS

CSME and IME electronic recording

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nowhere near having answers to these kinds of questions," says Tasker. "We're very much in the infancy of addressing this issue."

The next step for CSME is to gather the data from this first round of consultations and see whether it offers a balanced perspective. CSME wants to ensure it hears from all stakeholders involved with this issue and from stakeholders in all parts of Canada. "We'll either be able to report on what stakeholders are saying or we will have to knock on their doors again and ask the same questions," says Tasker.

For more information, e-mail ltasker@taskercounselling.com or visit www.csme.org/Pages/Recordings.htm. •

BACK TO WORK

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