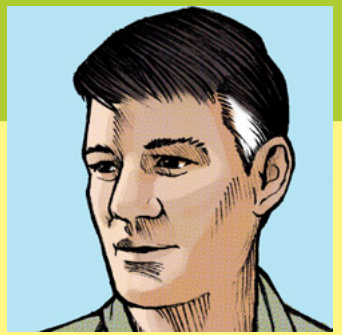

# Back On The Job:

## A Guide To Promoting Early, Safe Return To Work

Following Occupational Injury In Healthcare Workers


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The purpose of this manual is to address some of the challenges encountered when returning employees to work after occupational injury. This manual was inspired by a study conducted by members of the University of Washington Department of Environmental and Occupational Health Sciences aimed at evaluating the effectiveness of a multimedia return to work training module geared toward supervisors and managers of injured employees. Healthcare administrators are the primary audience for this manual, although many of the steps and lessons learned can be extrapolated to other industries.

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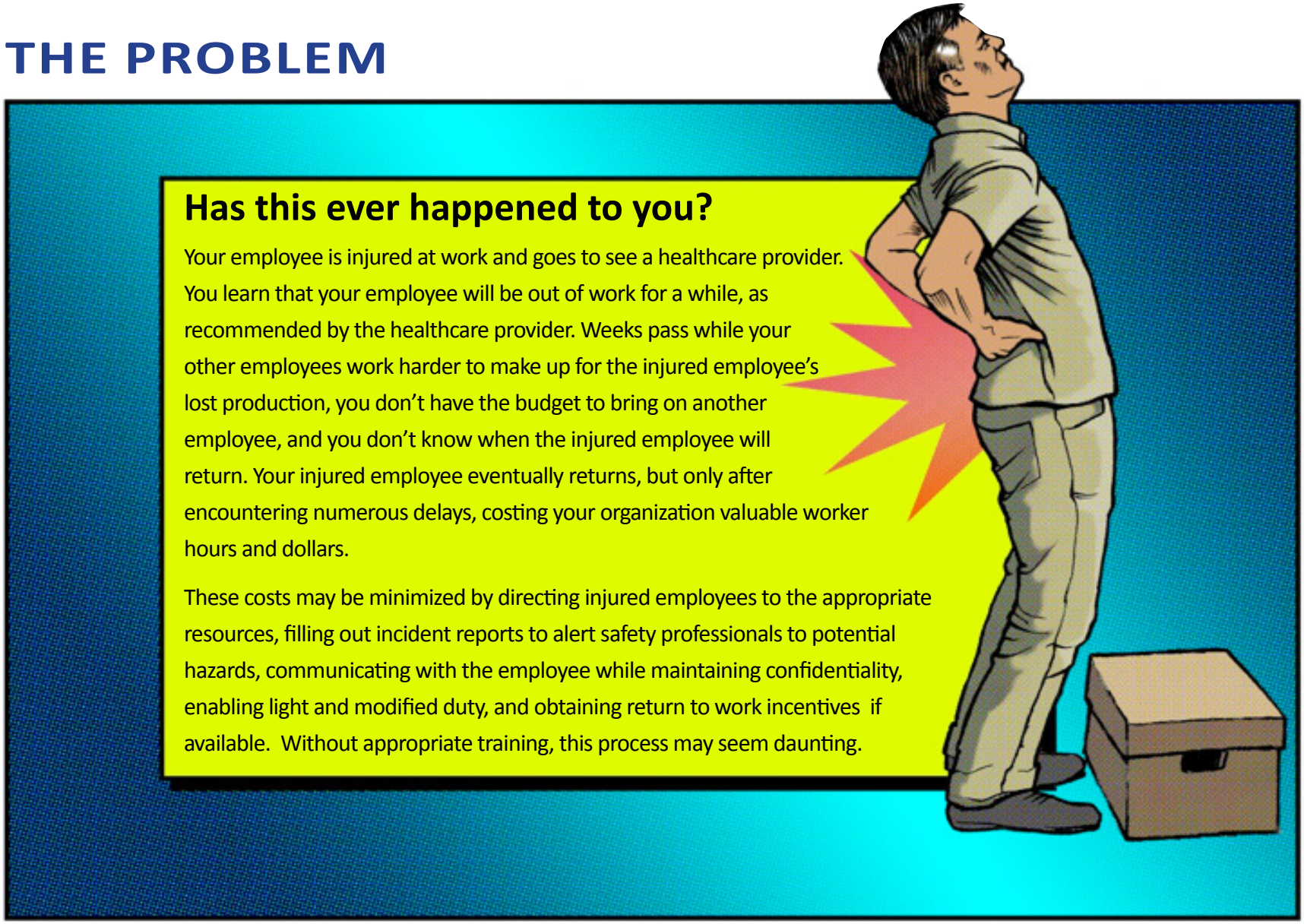
# THE PROBLEM




When surveyed by the Office of Risk Management at our institution (the University of Washington), managers at Harborview Medical Center (HMC) validated this scenario. Supervisors and managers reported lacking the appropriate training to navigate the complex return to work process (UW Risk Management Internal Data). This has had financial consequences and affected the work atmosphere at HMC. Aware that changes were needed, the Office of Risk Management at the University of Washington and administrators at HMC partnered with us (researchers in the Department of Environmental and Occupational Health Sciences) to develop an intervention to improve the return to work process.

# Complexity of the Process

At a large organization, the return to work process may involve many stakeholders and steps. This increases complexity and can lead to confusion.

The more complex the process, the more likely it is that communication can break down and paperwork can get lost in the shuffle. If every actor in the process isn't communicating efficiently, the process can dramatically slow down. A slow process increases missed work (time-loss) days and costs, decreases productivity, and can be a cause for considerable frustration for the employer, injured employee, and the insurer. Yet, an early, safe return to work from injury is beneficial to all parties. Studies show that the longer an injured employee is away from the work, the less likely he or she is to return.

Fig. 1 shows a map of the return to work process created by the Office of Risk Management at our institution, the University of Washington. Each row/color corresponds to a different individual involved in the process. The columns describe activity at different points in the return to work and claims process for a single injury. As you can see, there are many people involved at many steps in the process at our institution. While the University has made great strides in streamlining the process, the size of the University and number of individuals involved increases the complexity.

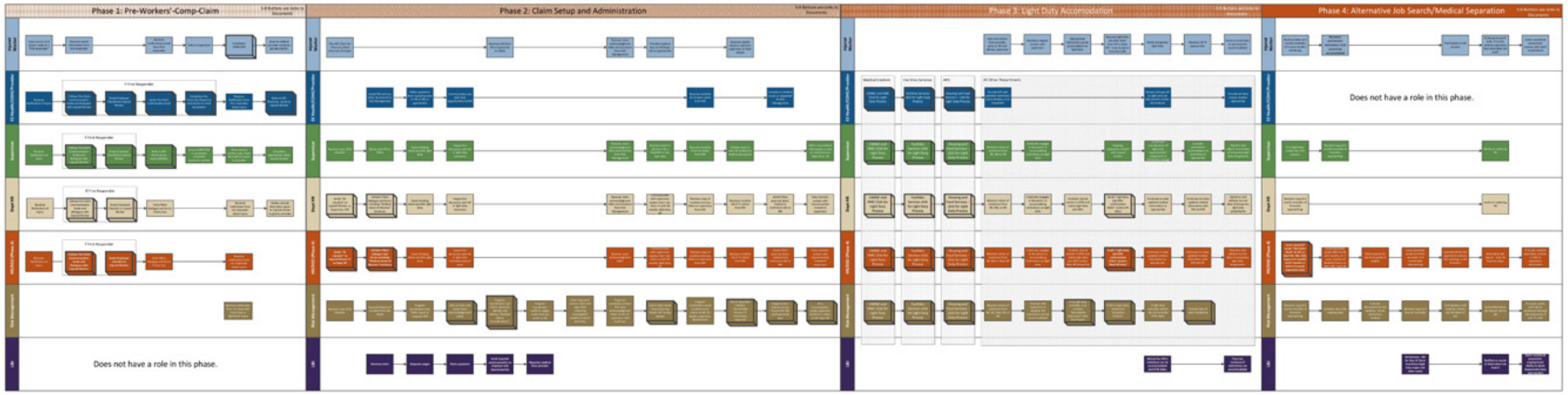



*Fig. 1 Process Map for Return to Work at University of Washington (http://f2.washington.edu/treasury/riskmgmt/sites/default/files/WCProcessMap.pdf)*

## Healthcare Institutions May Struggle

Returning injured employees to work quickly and safely is a major public health challenge with which many organizations struggle. This is especially true in the healthcare industry.

There is a high rate of work injury in healthcare settings. Patient handling causes a higher number of work injuries than in many other industries, and the physical nature of the work coupled with the high skill level needed may result in challenges in bringing injured employees back to work quickly and safely.

From 2007 to 2011, the highest contributor to time-loss at the University of Washington was HMC, which accounted for 36% of time-loss days and 42% of time-loss costs. The University's two medical centers, HMC and the University of Washington Medical Center, were the units at the University with the highest number of time-loss costs.

## THE SOLUTION

In this manual, we illustrate the methods we used to help improve early, safe return to work of injured employees in a healthcare setting at our institution and the rationale for our efforts.

We chose HMC as a test site for our project because of its high rates of time-loss, which reflect the high rates of time-loss in healthcare in Washington State. The Office of Risk Management at the University and senior administrators at HMC chose to partner with us as one of the many steps they are taking to improve the return to work process. Their support and leadership were invaluable as we undertook this project.

We created and tested a return to work multimedia training module for managers and supervisors at HMC. By promoting safe and quick return to work, we aimed to reduce the time-loss days and costs that follow from employee work injuries.

# Importance of Managers

Managers and supervisors often serve as a point of first contact and gatekeeper for injured employees.

A supervisor can facilitate finding modified work, interpret institutional policies, facilitate access to medical resources, monitor the employee's health and function, and communicate a positive message of concern and support. Studies have also shown that low support from supervisors leads to more missed days by injured employees.

A survey conducted by the Office of Risk Management at our healthcare institution showed that many managers felt they lacked the resources and knowledge to effectively guide their injured employees through the return to work process. Given the key role they play in return to work, we chose to focus on managers and supervisors as the target audience for our intervention.

# Power of Education

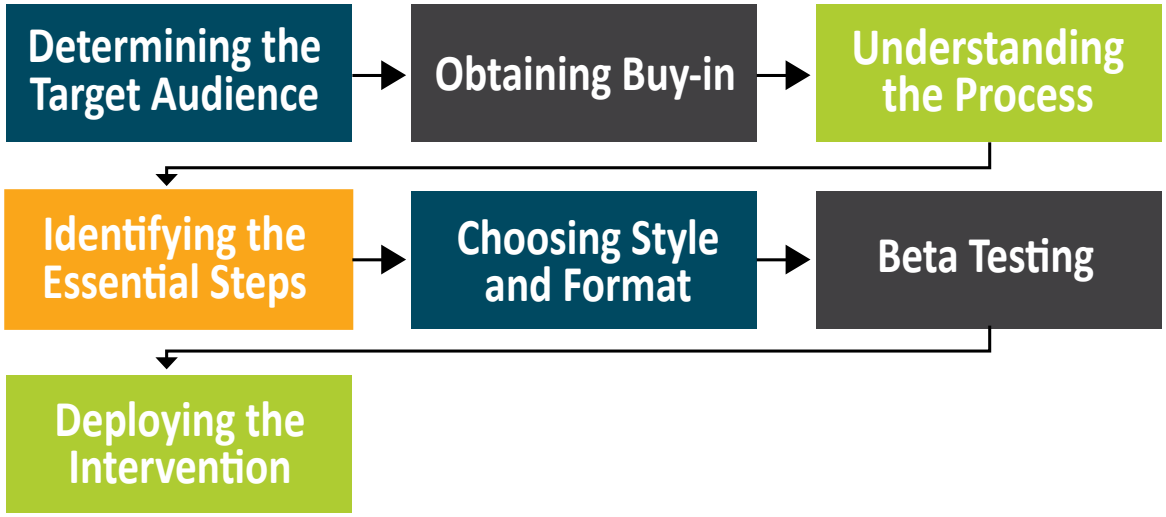
Training in healthcare settings is performed in a variety of ways, including online modules/quizzes, in-service training, and classes. Due to the busy and urgent nature of healthcare work, it can be difficult to achieve complete participation. However, it is vital that key information is effectively distributed throughout the institution.

Many managers and supervisors that we talked with at our institution described having inadequate knowledge and access to information about the return to work process. Our goal was to educate managers and supervisors about promoting safe return to work, focusing both on general principles and how those ideas fit into HMC's specific processes. In order to most effectively engage supervisors and managers, we chose to create a multimedia return to work training module. Managers and supervisors at HMC agreed that a multimedia return to work training module delivered electronically would be the best method to relay valuable information about the return to work process. This method allows the target audience to access the training at their leisure and is interactive enough to sustain their attention. We chose to use Social Cognitive Theory (SCT), which has been successfully applied in organizational management settings, for the module. SCT includes the idea that learning new behaviors is done best by observing others. In our module, we present hypothetical examples using characters involved in key steps in the return to work process as the primary method to convey information.

# THE INTERVENTION

Interventions that are engaging, convey all necessary information, and are accessible are most likely to be effective.

For our intervention, we chose to develop a multimedia (audiovisual) training module on return to work best practices. We identified the following key steps needed to develop our intervention:




## Determining the Target Audience

For an intervention to be most effective, choose a target audience for which the intervention is most likely to have a substantial impact.

Within our target industry of healthcare, we had to decide if we should include all managers or only focus on managers in clinical departments such as patient care services, emergency services, radiology, etc. While the majority of the injuries at healthcare institutions are in clinical departments, there are also injuries in non-clinical departments such as facilities, housekeeping, and food services. Creating an intervention that applies to all managers (clinical and non-clinical) might require less specific content, but focusing only on clinical departments limits the size of the target audience. We decided to include clinical and non-clinical managers in our target audience because we believed that the key messages were general enough that they could be conveyed effectively to both groups.

Identifying the specific supervisors and managers for enrollment in our study presented several challenges. To identify potentially eligible supervisors, we used job titles (e.g. any job that included the word manager, supervisor, director, or administrator) in combination with a status of supervising one or more employees.

# Understanding the Process

After identifying the target audience, it is important to map out the existing return to work process for that audience.

At our specific institution, the return to work process was complicated and in flux. To understand the process, we first looked at the University of Washington Return to Work Process map (Fig 1). Then we talked with various stakeholders. Not all stakeholder viewpoints on the return to work process were the same. We compared viewpoints on how the process was operating with existing policies and guidelines.

Invite your target audience to participate in developing the solution. It is important to ask hospital managers/supervisors to point out barriers in the current process and suggest potential solutions. It is far more likely participants will find value in the intervention if they actively contribute to it.

# Obtaining Buy-in

Buy-in matters. Projects often cannot be successfully completed without buy-in from important stakeholders.

You must first determine who the important stakeholders are. Start by building a map of the return to work process at your institution.

We identified human resources, the Office of Risk Management (our institution's designated return to work coordinator), employee health, our occupational health services quality improvement program [(Centers of Occupational Health and Education (COHE)] , and upper level administrators in the hospital as key stakeholders in the return to work process. We noted that each of these stakeholders played an important role in the process at our institution. The Office of Risk Management's leadership and support gave our study institutional legitimacy and access to needed resources. They also helped identify other stakeholders. Upper level hospital administrators helped facilitate interaction with our target audience (managers and supervisors). The Office of Risk Management's return to work coordinators provided us with time-loss data.

Make sure to obtain appropriate approval before collecting any information from your participants in order to protect participants' rights. We obtained Institutional Review Board (IRB) approval prior to conducting the evaluation of our intervention module.

# Identifying the Essential Steps

Given the complexity of the return to work process, your intervention can't contain every detail; it would be too long and overwhelming. Simplify your intervention by identifying the steps that are essential to the process.

With adequate investigation into the process and insight from managers/supervisors, we distilled the return to work process into these essential steps:

- Directing injured employees to seek appropriate medical care
- Filling out incident reports (to prevent future similar injuries in other employees)
- Communicating with employees
- Assigning modified and light duty
- Claiming return to work financial incentives

While we don't provide our target audience with all of the specifics of each step, we make sure they learn enough to keep the process moving. We also provide resources so they can acquire more information when needed.

# Choosing Style and Format

In addition to preparing content, you will need to choose the style and format of your intervention, as well as determine what expertise is needed during development.

Strike a balance between aesthetics and content. You want your intervention to be visually appealing in order to hold your audience's attention but still be informative. Our module included colorful illustrations with the essential steps mentioned earlier (Fig 2). Each step included simulated conversations between a manager/supervisor character and other players in the return to work process.

To create our module, we first developed a storyboard and provided it to a graphic design group at the University of Washington. We also added audio narration to the module to enhance its effectiveness. We designed the module to be editable, as we expected the return to work process might change over time.

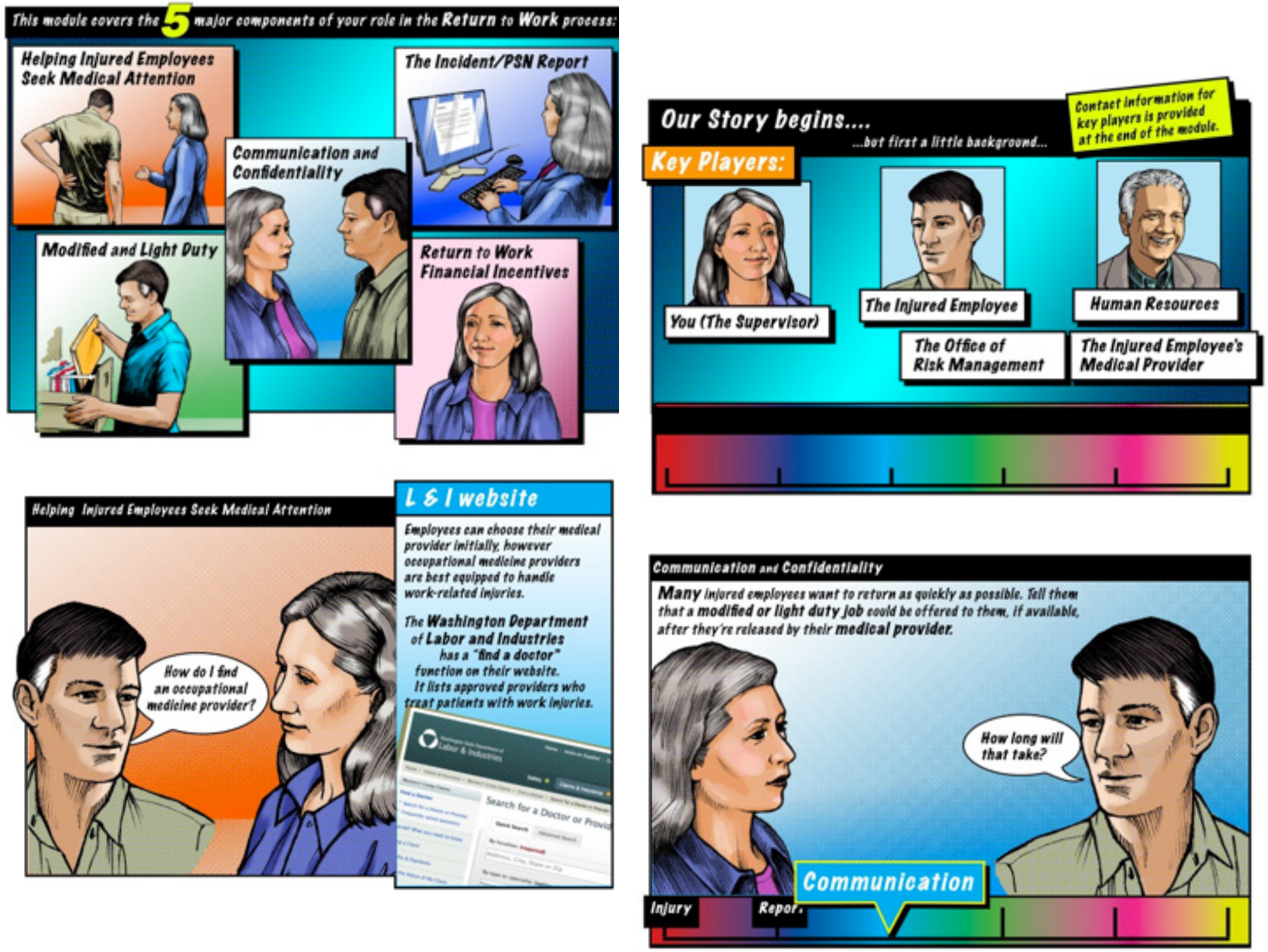



*Fig. 2 Panels from our return to work multimedia training module*

## Beta Testing

Once you have created your intervention, it should be beta tested. Beta testers can identify unclear or confusing areas, as well as aspects of the intervention that might require more development. You must decide who will beta test your module and how to recruit beta testers, as well as how many people should beta test.

We decided to identify beta testers from our target audience (managers/supervisors). Our target audience group was small, just over 100 people, so we only recruited four managers/supervisors for beta testing. Senior Administrators directed us to four managers/supervisors who were amenable to beta testing the module. We made sure these managers/supervisors came from both clinical and non-clinical departments at the institution to assure adequate representation of our target groups. We performed the beta testing in person, using a tablet computer, so that we could obtain feedback immediately and to minimize any inconvenience to the beta testers.

# THE EVALUATION

Intervention effectiveness can be evaluated using qualitative data from surveys and/or quantitative data from administrative databases, such as time-loss databases.

Using surveys and administrative data can help to determine if the intervention had an impact on metrics such as return to work knowledge, attitudes, practices, and time-loss days and costs. Qualitative and quantitative data can address different aspects of effectiveness. For example, qualitative data from surveys can help determine if the module was effective in delivering its message, from the perspective of survey respondents. Quantitative data can help determine if the intervention resulted in reduced time-loss days and costs.

## Evaluation Procedure

To rigorously evaluate the impact of your intervention, you may benefit from creating an intervention group and a comparison group. The intervention group receives the intervention, while the comparison group may receive usual practice. Comparing results between these two groups should illustrate the effect of the intervention rather than the effect of other factors that may have nothing to do with the intervention.

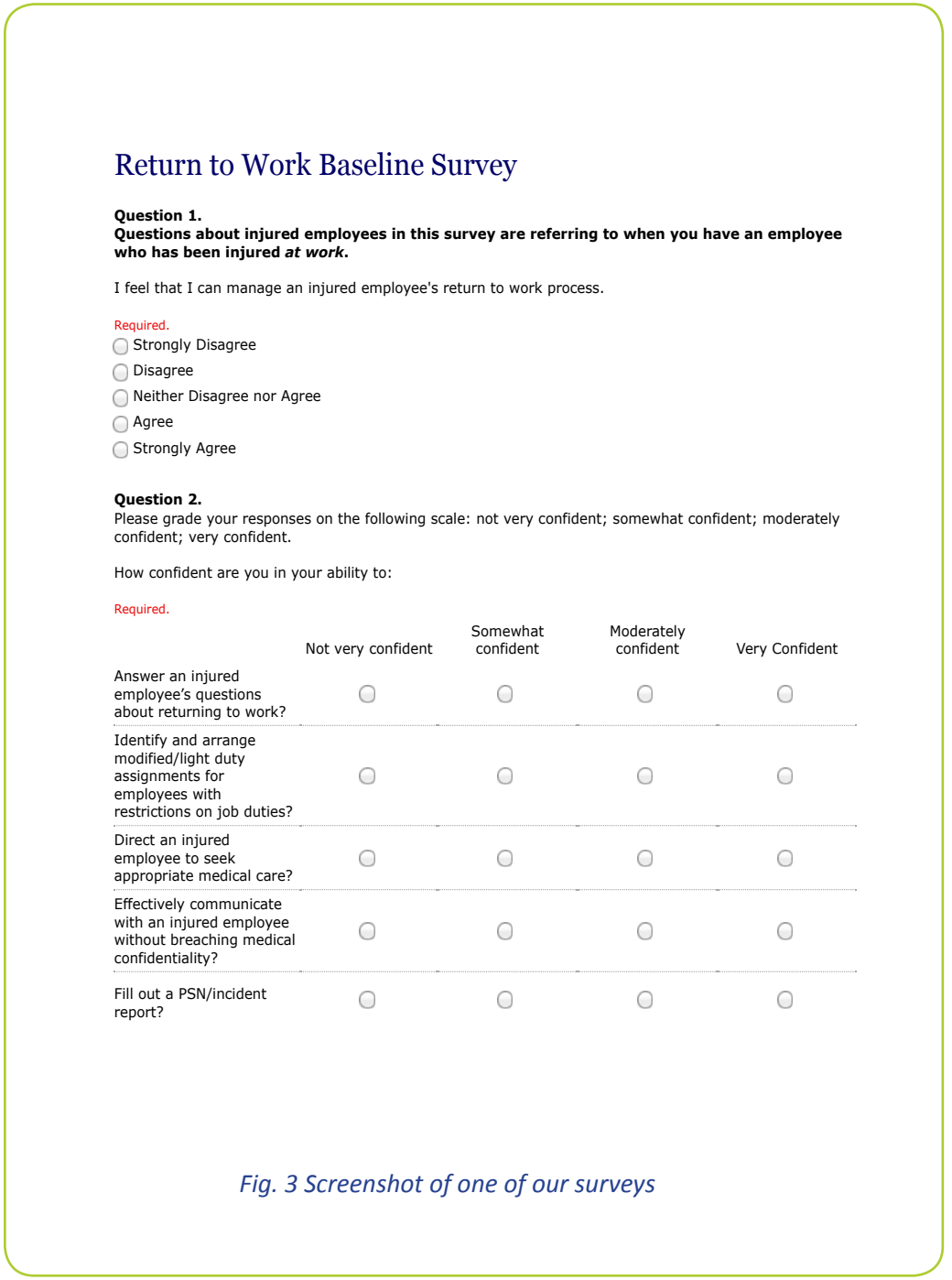
We randomized participants to a usual practice group and an intervention group. If we purposefully placed participants in each group (did not randomize), we might have introduced our own bias into the evaluation.

# Developing Evaluation Tools

Develop evaluation tools with the intervention's purpose in mind.

Our module's purpose was to improve the knowledge, attitudes, and practices of managers/supervisors in the return to work process. We developed a survey to specifically assess these outcomes (Fig 3). We asked questions to determine participants' confidence in the return to work process, their knowledge of what to do in certain situations, and how they conducted themselves when an employee was injured. We also gathered demographic information and information about the total number of injured employees over a pre-specified time period.

We distributed surveys three times during our study period. The first survey was distributed to every manager/supervisor at baseline. This survey allowed us to collect baseline information on supervisors' knowledge, practices, and attitudes regarding the return to work process and demographic information. After providing the module to our intervention group, we sent a second survey to the intervention group. This survey contained the same knowledge and attitude questions as in the first survey, along with additional questions asking for feedback on the module itself. We distributed a third survey three months after the first survey was completed to both the intervention and comparison groups. This survey contained the same knowledge, attitude, and practice questions as the first survey. It allowed us to assess whether the intervention group retained information from the module over time as well as compare the intervention group with the usual practice group.



Return to Work Baseline Survey

**Question 1.**
**Questions about injured employees in this survey are referring to when you have an employee who has been injured *at work*.**

I feel that I can manage an injured employee's return to work process.

Required.

- Strongly Disagree
- Disagree
- Neither Disagree nor Agree
- Agree
- Strongly Agree

**Question 2.**
Please grade your responses on the following scale: not very confident; somewhat confident; moderately confident; very confident.

How confident are you in your ability to:

Required.

| | Not very confident | Somewhat confident | Moderately confident | Very Confident |
|---|---|---|---|---|
| Answer an injured employee's questions about returning to work? | | | | |
| Identify and arrange modified/light duty assignments for employees with restrictions on job duties? | | | | |
| Direct an injured employee to seek appropriate medical care? | | | | |
| Effectively communicate with an injured employee without breaching medical confidentiality? | | | | |
| Fill out a PSN/incident report? | | | | |

*Fig. 3 Screenshot of one of our surveys*

# Our Results

After collecting data, you will need to analyze the data and generate results.

For our study, there were 120 managers/supervisors eligible to participate. Eighty-one of them enrolled in our study (68% participation). Of those 81, 70 completed the study. Individuals chose not to participate or did not complete the study for various reasons, but the most common were a lack of time or that they felt the study didn't apply to them. The people who felt the study didn't apply to them typically worked in administrative settings with very few injuries.

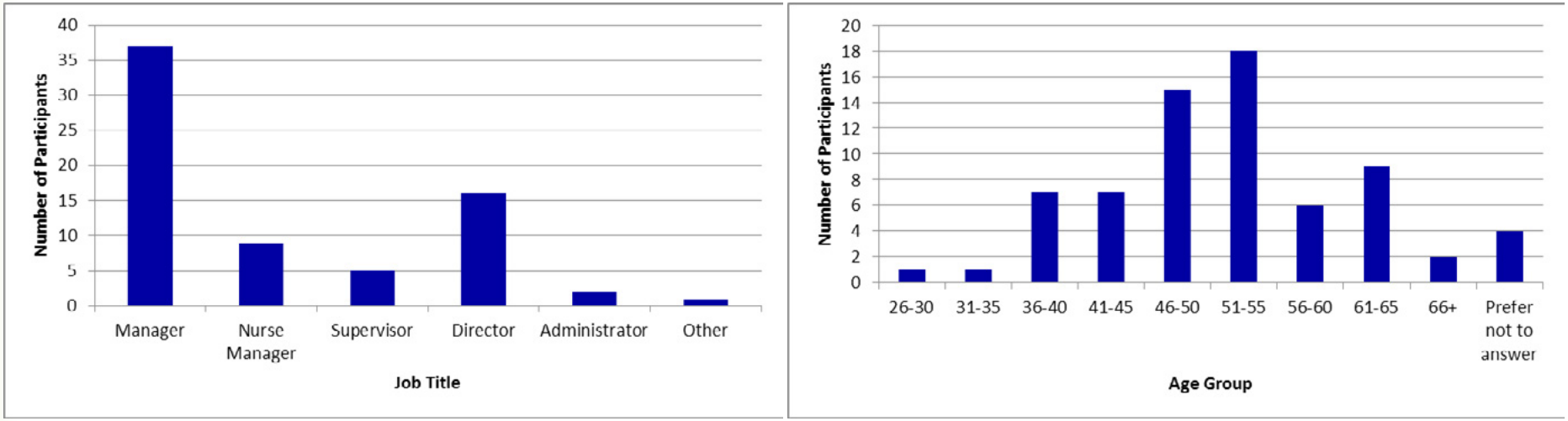



*Fig. 4 Demographic data from participants who enrolled in our study (n=70)*

Our surveys included demographic questions in addition to questions specifically addressing return to work. We collected demographic information because it helps us understand our results. As shown in Fig 4, the majority of participants were in their 40s or 50s. Manager was the most common job title. Additional demographic data included department, years as healthcare manager/supervisor, and number of employees who report to them. Of the managers who participated, 65% were from clinical departments and 35% were from non-clinical departments. Participants worked on average for 10 years as managers/supervisors. Managers had on average 46 employees working for them (range 1-165).

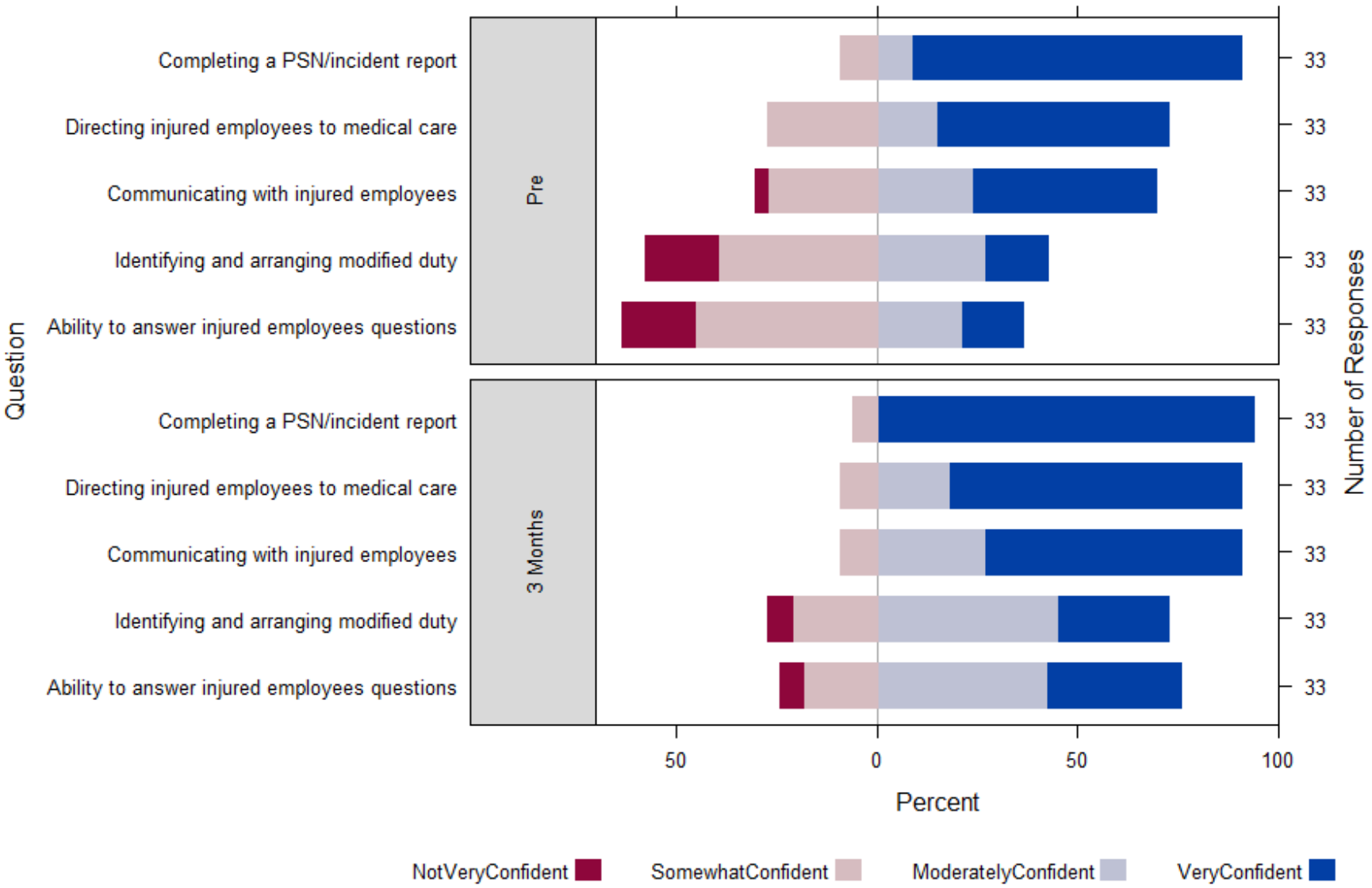



*Fig 5.1 Survey responses to questions regarding confidence in return to work steps for the intervention group. Survey responses 3 months after completing the module (3 Months) are compared with responses before being given the module (Pre). PSN (Patient Safety Net) is the institutional tool used to report incidents.*

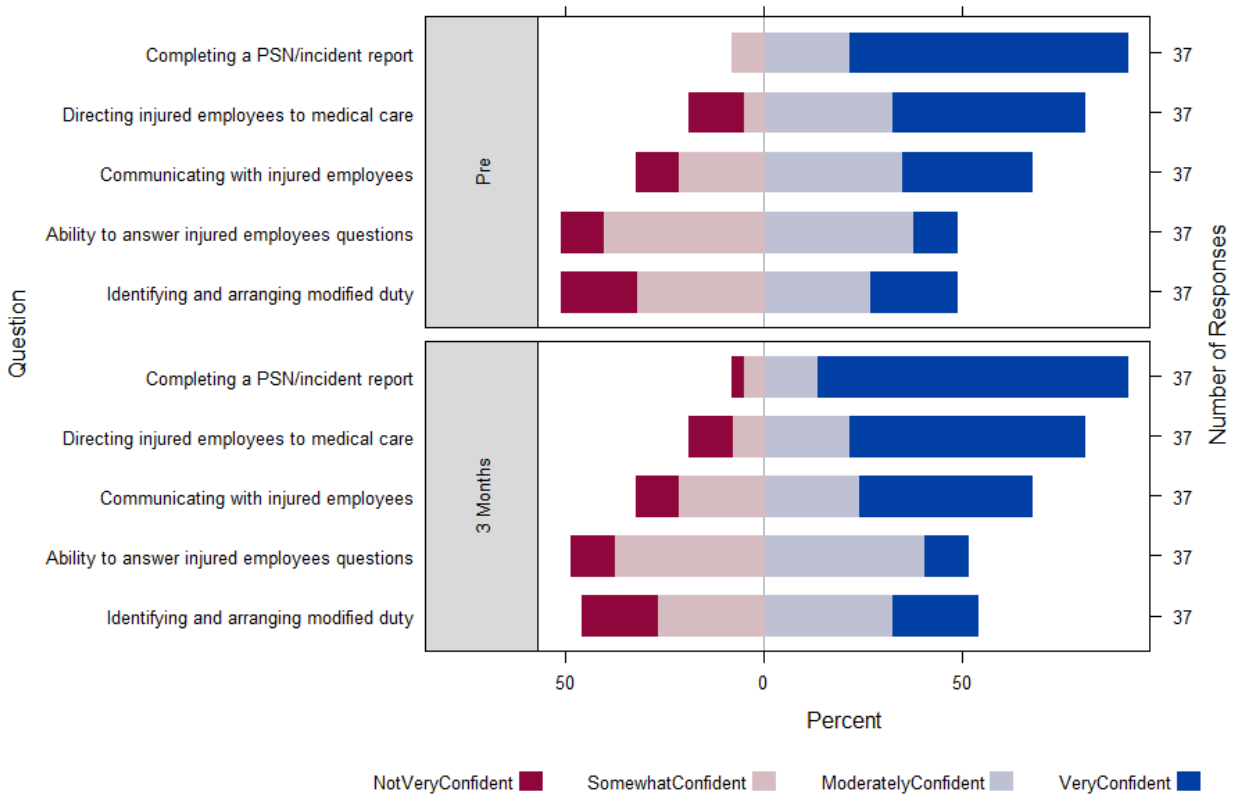



Figure 5.1 compares survey responses in the intervention group before receiving the module and 3 months after receiving the module. Darker blue indicates greater confidence in carrying out key return to work steps. When comparing figure 5.1 (the intervention group) with figure 5.2 (the usual practice group), it is apparent that the module had a positive impact, particularly on identifying and arranging modified duty and the ability to answer employees' questions.

*Fig 5.2 Survey responses to questions regarding confidence in return to work steps for the usual practice group. It compares survey responses during the same time period as the intervention group. PSN (Patient Safety Net) is the institutional tool used to report incidents.*

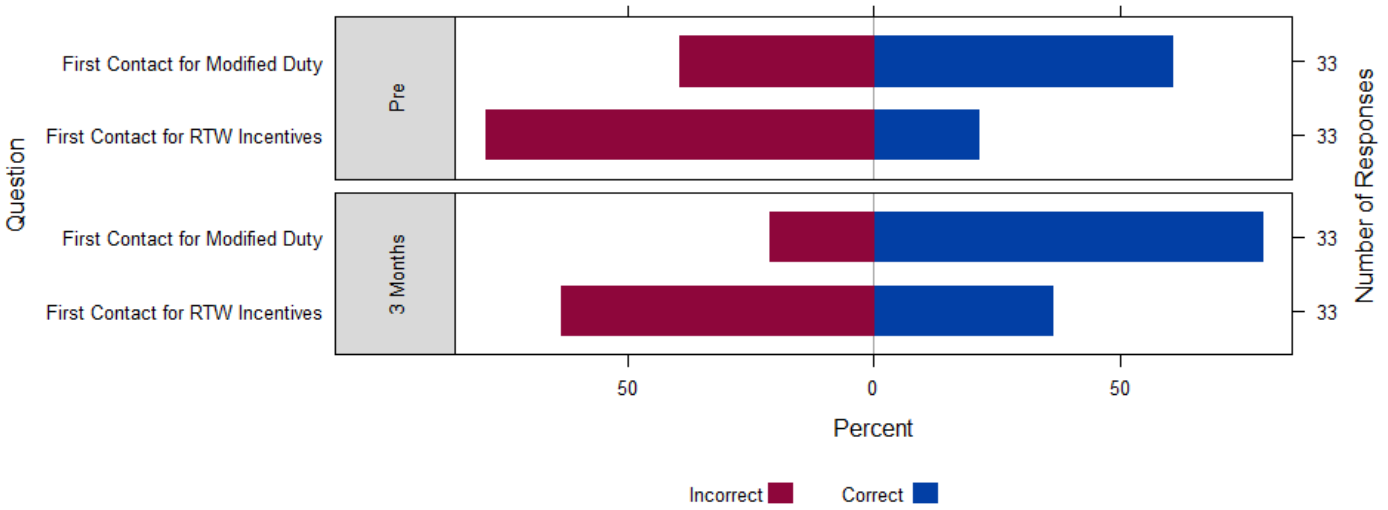



*Fig 6.1 Survey responses to knowledge questions comparing answers 3 months (3 Months) after receiving the intervention with answers before receiving the intervention (Pre).*

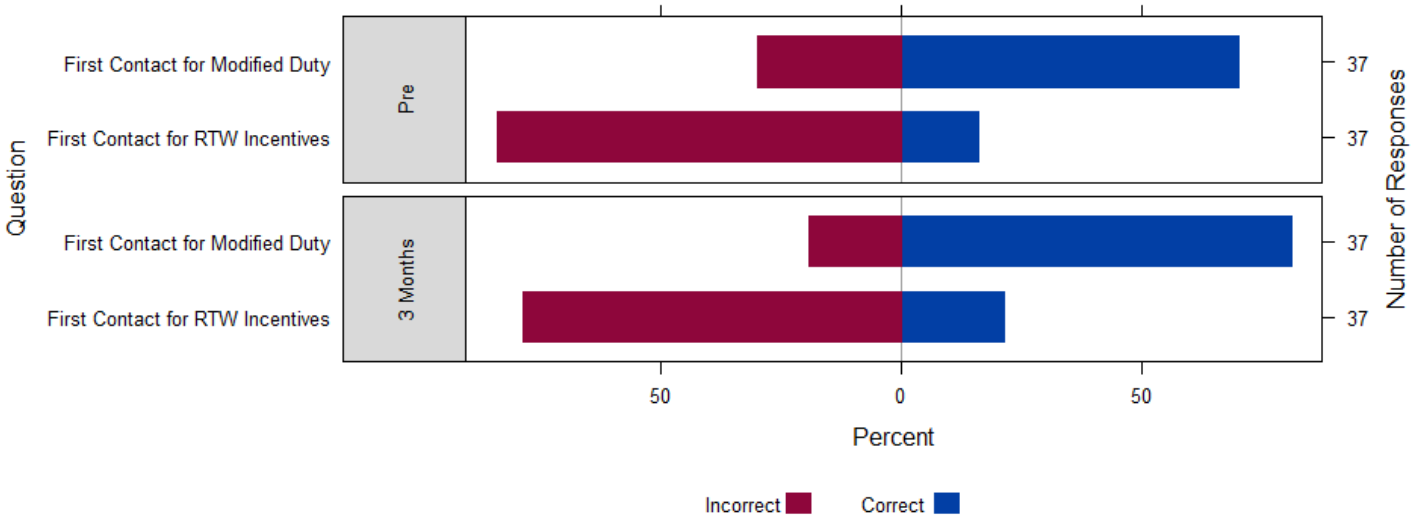



*Fig 6.2 Survey responses to knowledge based questions comparing answers given by the usual practice group during the same time period as the intervention group.*

Figures 6.1 and 6.2 compare knowledge based questions we asked in our survey. These questions asked who to contact to arrange modified duty and who to contact for return to work incentives. Figure 6.1 suggests that knowledge improved in the intervention group before and after receiving the module. However, this improvement was not statistically significant. Figure 6.2 shows results from the usual practice group, where there has been less change during the same time period.

We are currently in the process of retrieving and analyzing time-loss information from Risk Management. If the module was effective, time-loss days and costs should have decreased more over time in the intervention group than in the usual practice group.

## Interpretation of results

Data are not always clean. We discovered this while collecting survey data. Some questions were answered inconsistently within a single survey, suggesting that an individual didn't understand the question or selected the opposite answer of what they had intended. In certain cases, reported time-loss days and costs were incorrect because injured employees incorrectly accounted for days missed or didn't fill out the required paperwork. You must decide how to handle such anomalies in data. We are in the process of making such decisions and comparing results of the intervention group to the usual practice group.

Comparing results from our immediate post intervention surveys and our three month post intervention surveys also showed an interesting trend. While both surveys showed an improvement in confidence and knowledge from the pre intervention surveys, the immediate post intervention surveys showed more positive responses. This indicates that, over time, participants became less confident and knowledgeable about the details of the return to work process. However, confidence in the overall ability to manage the return to work process was significantly improved at three months. Even if, over time, supervisors and managers do not fully retain the details of the return to work process, the module may help them remember where to look for needed resources.

## SUSTAINABILITY

Make an effort to ensure all members of your target audience have access to your intervention, if it is effective. Work to make it standard in your healthcare facility. Select a platform, for electronic interventions, that is used by the institution. Over time, the intervention may require updates. If the intervention is out of date, it will lose effectiveness and will no longer be used. If the intervention is discarded after one use, it will not have a long-term impact.

## Ownership of the Intervention

Make sure that a specific individual or entity has ownership of the intervention you develop.

Fortunately, the University of Washington and HMC are making concerted efforts to improve the return to work process. The Office of Risk Management and HMC's continuing education department will take ownership of the module and resources to ensure the module is used and relevant.

## Integration of the Intervention into the Process

The intervention will be most effective if it is hard-wired into the return to work process.

We are working to integrate our module into our hospital learning management systems, where it may be required for each manager/supervisor to complete. HMC and the University plan to integrate our intervention into standard protocol, creating a lasting change.

# Accessing the Intervention

Make sure the intervention is accessible to everyone who needs it. Also, ensure that people know where to access the intervention.

We are working to integrate our module into our hospital learning management systems, where it will be accessible to our target audience. It will also be available on institutional websites, so that managers/supervisors can reference the module and supporting information at any time. Fig 7 shows a template we created of a resource page and link to our training module.

We will also make our module available publicly, outside of the University, on the Washington State Department of Labor and Industries Safety and Health Investment Projects (SHIP) program website.


*Fig. 7 Resources webpage template*

# CONCLUSION

Improving the return to work process benefits all parties involved. This manual provides a framework for developing and evaluating interventions aimed at promoting employees' early, safe return to work and ultimately reducing associated time-loss days and costs. We use our experience in developing a multimedia training module at the University of Washington as an example of this iterative process, which involves determining the target audience, understanding the return to work process, obtaining stakeholder buy-in, identifying essential steps in the process, choosing the style and format, beta testing the intervention, and deploying the intervention. The results of the evaluation of such an intervention may require careful analysis and thoughtful consideration to arrive at a meaningful interpretation.

Our experience indicates that developing an effective intervention is possible. In addition, we found that the process of creating and evaluating the effectiveness of a return to work intervention may secondarily provide direction and contribute to efforts to streamline the return to work process itself. We hope that this work is helpful not only to other healthcare institutions but also to other industries to which the general principles outlined in this manual may apply.

## Acknowledgements

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