STAFF AND EMPLOYEE PERSPECTIVES ON RECOVERY MANAGEMENT: A STUDY OF A TERTIARY HEALTH CARE FACILITY

KIMBERLY J. LAROUCHE

Your file Votre référence
ISBN: 978-0-494-33426-3
Our file Notre référence
ISBN: 978-0-494-33426-3

Staff and Employee Perspectives on Recovery Management: A study of a tertiary health care facility

by

Kimberly J. Larouche

A thesis submitted to the School of Graduate Studies in partial fulfillment of the requirement for the degree of Master of Science

Faculty of Medicine
Memorial University of Newfoundland

September, 2007

ABSTRACT

Lost time from work as a result of sickness or workplace injuries has considerable financial repercussions for both employers and employees. Employers suffer financially when trying to recruit new and/or replacement staff, training new people and ultimately in losing valuable productive employees either temporarily or on a more permanent basis. Employees also suffer financially but more importantly in ways that are much more difficult to measure such as their loss of a productive role, their routine and opportunities to socialize and sense of contributing to the community through their work. Within the multidimensional construct of return to work, it is recognized by employers and health care providers that whether or not a person successfully returns to work after a period of illness/injury depends on a variety of factors. These include worker factors such as the functional capacity of an individual, their health and psychosocial status and overall attitudes towards work. Workload factors include such things as the type of work that is performed, the physical and psychosocial demands of the work and the pace of work, for example. Recovery management is a process whereby the recovery from an illness or injury of a worker is managed by the employer. The goal is to address all of those factors which impact on return to work so the worker can return to work as early as possible and in an environment that is safe. In recognizing this, injury and illness related recovery management strategies require an appreciation of the potentially wide-ranging issues associated with return to work. However, less is known about the strategies that are utilized in enabling an effective and durable return to work.

The purpose of this thesis was to explore the perspectives of the various stakeholders in the recovery management process including recovery managers, employees and those who supervise those employees when they return to work. Specifically, this thesis was designed to describe the process of recovery management which was implemented in a large tertiary health care institution and which was designed to address absenteeism and return to work after a period of injury and illness.

Nineteen employees including nine recovery managers and five supervisors and the same number of workers, participated in this study. They all were employed in the health care facility. Each of them participated in a semi-structured interview. The interviews were transcribed and subjected to a thematic analysis.

The results showed that it was believed by the participants that all stakeholders in the recovery management process should be knowledgeable of the process, in order to avoid delays in the process and miscommunication, particularly when returning to work. Additionally, it was perceived by the participants that it was important for the recovering worker to feel appreciated and to be involved in meaningful return to work activities in order for return to work to be successful. Specific thematic analysis for each group revealed that recovery managers felt that increased workload was an issue for them since the implementation of a recovery management program. The supervisors for their part felt conflicted in trying to meet their production quotas, in addition to accommodating recovering workers in their area. Workers often found the follow-up upon return to the worksite not adequate leading to fears of re-injury or medical setback. Many of the worker participants felt that they had little support from either their supervisor or their assigned recovery manager when they participated in the return to work process.

In concluding, although the recovery management and return to work process seemed to be supported by the participants in the study, common themes to all stakeholders such as education around the process, effective communication and ensuring the recovering workers felt appreciated when returning to work, were areas that were identified as needing further development.

ACKNOWLEDGEMENTS

I would first like to acknowledge that this project would not have been possible without the support of the Health Care Foundation and the Director of Research and Planning, Mr. Wayne Miller, who collaborated with myself and Ms. Maureen Meaney, in identifying a research question which was not only worthy of investigation but would be feasible within the context of a masters program.

Secondly, I feel extremely privileged and honored to have worked under the tutelage of Dr. Michael Murray, an expert in my view, in qualitative research. He provided me with just the right amount of direction, but knew where I needed more guidance and feedback to keep the process of research going. I would also like to thank him for his understanding of my busy schedule as a private consultant, part-time student, mother of three small children and my need for flexibility in that regard. He also demonstrated knowledge of my profession as an occupational therapist which I sincerely appreciated. I also have to thank Dr. Rick Audas and Dr. Anne Kearney for their excellent and prompt feedback throughout the many drafts of this thesis.

The participation of the workers, supervisors and recovery managers who took time in their busy schedule and lives, to talk to me, I also truly appreciated!

My husband who has been so patient and supportive throughout this academic endeavor, I could honestly never thank enough. I also want to thank my mother, for her words of encouragement and letting me know how proud she is of all my accomplishments big or small. My in-laws, Bernice and Claude were always there to

provide child care when I needed it the most. All these people made my life easier, showed me support, and made it possible for me to spend the time and effort this project deserved.

TABLE OF CONTENTS

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

Lost time from work as a result of sickness or workplace injuries and illness has considerable financial repercussions for both the employers and employees alike. Employee health and productivity losses as a result of sickness or workplace injuries and illnesses are estimated by the Canadian Centre for Occupational Health and Safety (CCOHS) to be in the billions annually to Canadian companies or approximately 15% of the gross domestic product. Other estimates by CCOHS have suggested that annual disability costs can range from 8 to 15% of a company's payroll. Costs associated with absenteeism range from those required to hire and train new staff, to those associated with productivity losses and delays. As such, many employers recognize the importance of disability management approaches in controlling costs associated with absenteeism.

Employees also can suffer the financial consequences of absenteeism as a result of illness and/or injury, in addition to other losses which are often difficult to measure in a quantitative manner. These can include physical, emotional and financial losses such as chronic pain, diminished self-esteem and reduced abilities to be as productive as per their pre-morbid state.

Large employers, particularly those who employ health care workers from both professional and non-professional disciplines, are acutely aware of the financial repercussions of employee absenteeism as a result of injury and/or illness. Considering that the most prevalent and expensive conditions affecting workplaces are soft tissue injuries, primarily those of the low back and the upper extremities (Armstrong, Haig, Franzblau, Keyserling, Levine, et al., 2000), and the nature of the physical and psychological demands of providing health care services (providing nursing care,

preparing large amounts of food, cleaning and sanitizing large areas for example), is one of the reasons why health care facilities are at further risk of increased costs for both themselves and their employees. Workers in health care facilities are exposed to many risks of injury and illness because of the nature of their work as noted above. Addressing return to work issues with these employees is further complicated by a variety of other issues within these organizations including the fact that there are a number of union groups and bargaining units within these organizations, with individual collective agreements. Each unit typically would have their own agreement with the employer which might include different provisions for accommodation to transfers to new positions. For example, suitable work for a recovering worker may not be available because of their lack of seniority in their bargaining unit. Other issues which also may impact on return to work include the inherent risks for injury and/or illness in health care occupations, the need for highly skilled and trained employees in many areas, (particularly clinical areas), the public service provided by these organizations and potentially wide ranging public relation and risk management issues associated with this.

On the other hand, as health care facilities, these organizations have the potential benefit of having resources in occupational health which may not necessarily be readily available to other employers. These resources could include facilities such as on-site rehabilitation facilities that injured workers can access easily without leaving the premises and specialized clinical staff with the expertise to supervise and monitor return to work programs.

Health care organizations are of increasing size and complexity. In Newfoundland and Labrador, one of the largest employers is a regional health authority, formerly

comprised of several health care corporations. Given its size, varied occupations, number of unions, complexity and more importantly the need to investigate whether or not the return to work strategies that it has undertaken in the last few years are effective, this health care employer was seen as an ideal setting for this study.

In trying to understand recovery management and return to work strategies that are effective, it is important to consider the view of all stakeholders in the process. Critical stakeholders in the whole process of recovery and return to work include but may not be limited to the worker, the treating physician and other health care providers in the community who may be involved in treating the worker (such as physiotherapists and psychologists for example), the worker's supervisor who has integral knowledge of job duties and tasks available, and the human resources department and labour representatives.

Statement of purpose

Given the inherent risk for injury and illness to workers in the health care sector, as well as the cost associated with managing injury and illness-related absenteeism, many of these organizations have implemented various strategies to manage absenteeism. In order to effectively manage the costs associated with sickness or injury related absenteeism, a set of *Disability Management Guidelines* (Hewitt & Associates, 2004) was developed through external consultation in February 2004 by the health care corporation. This was done through the prevention or minimization of absence, facilitation of employee recovery, and encouragement of prompt return to work by providing employees with a supportive approach involving the proactive management of the work and non-work related injury and illness process. These guidelines were partly designed to assist the human resources department in the recovery management of employees through workplace coordination and disability management. In these guidelines, the recovery management process was defined as a method of coordinating and integrating a variety of medical, treatment, rehabilitation and/or other support services to optimize recovery, and working in partnership with workplace coordinators to orchestrate early and safe return to work. This involves an understanding and integration of numerous complex issues related to work injury, disability, early intervention, rehabilitation and management participation, as well as good labor relations (Williams and Westmorland, 2002). With this approach, it is essential that all stakeholders work together to achieve this goal of early, safe and durable return to work. Recovery managers provide expertise in the clinical and/or functional assessment of the worker in addition to ergonomic and modified work suggestions in relation to the worker's assessed needs. Supervisors have

the knowledge about the work duties that are essential to the employer and what is important in terms of the overall goals of the employer's "business". Workers are central to the whole process of recovery management and need to be continually consulted in the development, implementation and evaluation of any recovery management plan (Williams and Westmorland, 2002).

As such, the purpose of this study was to describe the process of recovery management and return to work in the context of a health care facility and to gain insight from the various stakeholders who are involved in the recovery management and return to work process. Considering that these three stakeholders need to be involved in this complex process, it is essential to know what their attitudes, approaches, and perceived barriers and facilitators to the process. To understand the workings of recovery management and return to work, we need to explore the perspectives of the stakeholders who engage in the process.

Significance of the study

Talking directly to workers, recovery managers and supervisors in an attempt to gain their perspectives is a particularly appropriate way of obtaining insight on those areas which are more difficult to assess using quantitative methods. In order to understand the barriers and facilitators perceived by these stakeholders, it is important for them to have the opportunity to speak about these in an open ended and non-intimidating forum. In an editorial written by Feuerstein for the September 2003 issue of the *Journal of Occupational Rehabilitation,* which was dedicated to publication of qualitative studies in occupational health, he acknowledged the importance of having an appreciation of the varying perspectives of the various stakeholders in the return to work process. He noted that without the consideration of all perspectives, it can be difficult to develop innovative and effective workplace and clinical management strategies that will help address absenteeism due to illness or injury, particularly those related to persistent musculoskeletal pain or chronic medical disorders.

On-site evaluation of return to work programs that are conducted by the employer may be perceived by the worker population of this employer as being biased and in the best interest of the employer only and may not be perceived favorably by workers. This may make it difficult to implement any changes and/or recommendations that arise from these smaller scale evaluations conducted by the employer.

An independent study in this area can provide important findings for understanding why stakeholders behave in particular ways when participating in the recovery management and return to work process. This information can then be shared with all stakeholders who may then be more sympathetic to each others points of view.

The information can also be used to implement changes which will facilitate positive outcomes for all stakeholders.

Results from the study will reveal not only differences in perceptions of the various stakeholders specific to their particular needs, but also show that common issues amongst all stakeholders exist. These common issues can form the basis for working together towards shared problem solving.

CHAPTER 2: LITERATURE REVIEW

As costs associated with sickness and illness related absenteeism have risen, so has the need for holistic, individualized and interdisciplinary disability management. Shrey (2000) describes disability management within the context of interventions that occur on a continuum, from the point of injury or disability onset, through "job retention" interventions that ensure that the worker has been properly accommodated and that future lost time and work disability are minimized. Shrey (2000) also noted that early intervention plus timely return to work are critical to achieving successful outcomes for the worker and the employer. Offering workers with modified work options such as work tasks that are safe given their injury is a significant factor in return to work outcomes.

Considering that disability management is an interdisciplinary process, it requires careful planning, effective coordination and communication, and the resources of skilled and knowledgeable disability managers. The steps associated with enabling a worker to get back to work must be orchestrated and coordinated to occur in parallel with the workers progression and rehabilitation. This must be done within the context of the employer's management policies and procedures which are jointly supported by labor groups within the organization and management.

Although it is important to understand that most workplaces have fairly standard administrative responses to sickness related and workplace injury related absenteeism, the following describes a generic series of steps which would be considered by most large employers as an effective method of managing disability costs. The first step would be to ensure that there is a quick initial report of an injury or illness. Failure to do so may be

the reason for increased lost time from work for a number of reasons including lost opportunity for the employer to provide suitable and safe options for work. Given that the supervisor is often the first person to become aware of the injury or illness they are also usually responsible for completing the report. In cases where a workplace injury has occurred reporting is required by workers' compensation legislation or federal laws dealing with occupational health and safety. The accident or illness is then typically communicated to other parties within the workplace as appropriate and within the confines of confidentiality. Likewise, such incidents would be communicated to external parties including third party claim managers or workers' compensation boards. The next step is to ensure that the work injury or illness is attended to through immediate medical attention to administer treatment and to evaluate the worker's impairment. If there is any expectation of lost time from work, an early response to this is critical and a worksite representative such as a disability manager or recovery manager should contact the worker's treating physician and/or health care provider. This is when information about the worker's physical and functional restrictions and abilities are identified and the worksite representative will use this information to form the basis of a return to work plan (Shrey, 2000).

Coordination and communication with, and between the workplace parties begins. Supervisors are critical players in identifying the workplace activities that are available and required in order to meet the needs of the organization. The workers are responsible for liaising with their supervisors regarding their progress and disability or recovery managers are responsible for ensure that the process of return to work is monitored,

evaluated and changed accordingly based on the needs of the worker and the organization.

2.1 Return to work and Recovery management

2.1.1 Return to work

There is a multitude of factors that have been explored by researchers in health and rehabilitation research that are believed to be important contributors and predictors of return to work. The health and rehabilitation studies have often used retrospective data sets or predetermined questionnaires to examine objective and descriptive factors which influence return to work. For example, age can be easily understood as a factor that can predict work disability considering that as a person ages, the overall health of an individual begins to decline (Shaw, Segal, Polatajko & Karburn, 2002). Severity of injury is another example of a factor which can predict return to work as are the characteristics of the pre-injury work. Heavy physical work is the most common workplace characteristic which is predictive of return to work in that the more strenuous the work, the less likely the worker will return to work (Carmona, Faucett, Blanc & Yelin, 1998; Lancourt & Kettelhut, 1992).

In a recent study conducted by Hansen, Edlund and Hennignsson (2006), the authors analyzed information from a questionnaire containing socio-demographic items and information on symptoms, consequences for daily life, expectations and psychosocial factors using the multivariate Partial Least Squares (PLS) of Latent Structures method. Additionally, data about the incidence of sickness over a four year period were included. This method can handle a large number of variables even when the number of

participants in a study was low. The PLS method was noted by the authors to optimize the relation between a set of x descriptors (the data collected from the subjects) and y variables (the data representing the outcome). They concluded that the strongest predictive factors for return to work for both genders included the individuals' expectations about the likelihood that they would return to work, having had few or no days of sick leave in the past, no somatic disorders (disorders where bodily symptoms are created from the conversion of mental experiences), a high satisfaction and high sense of coherence in life, higher education and being employed in a white-collar job in the private sector. Predictive factors for not returning to work were the belief of not returning to work, having had many days of sick leave, a multifaceted set of symptoms, low satisfaction and sense of coherence in life, lower education and being employed in a blue-collar job in the public sector and the illness having many consequences on the daily life of the person. The authors recommended that it would be worthwhile for employers to consider the worker's attitudes and their resources (physical and psychosocial) for adaptation to illness during the recovery and return to work processes.

The construct of "return to work" is widely regarded by researchers in the area and health care providers, as multidimensional. Whether a person successfully returns to work or not depends on a variety of factors including but not limited to the functional capacity of an individual, job related demands and the type of injury/illness incurred. Work characteristics which impact on return to work after a period of injury and/or illness include the labor management relations of the workplace, public versus private sector environments, the physical demands associated with the work, the social environment of the workplace, offers of modified work by the employer, and the

characteristics of the work tasks. Worker characteristics which have been noted to impact return to work include the individual characteristics of the worker (such as their age, gender, anthropometrics, for example), the health and functional status of the worker, and the psychosocial status of the worker (Carmona, Faucett, Blanc et al., 1998). The complex interaction of all these characteristics is what makes it difficult to predict what kinds of strategies will work best in different situations. For example, it might take a pre-morbidly well conditioned worker much less time to return to work performing their full duties, than would be the case with a worker with the same injury, performing the same job, who has concurrent health issues. Another less obvious example would be in a job which involves a lot of direct verbal prompting by a supervisor throughout the day and expected quotas and outcomes at the end of each shift. This type of structure might suit one individual but be difficult for another to tolerate. One recovering worker may need to continue to have this level of supervision upon return to the worksite while others might need to have the opportunities to self-pace. Other complications which may arise in this situation includes the physical and functional restrictions as prescribed by the health care provider which may dictate what and how the worker can perform in terms of work tasks.

While one study has explored the cost benefit of implementing return to work programs (Yassi, Tate, Cooper, Snow, Vallentyne & Khokhar, 2002) and others have identified factors which influence duration of temporary wage benefits (Hogg-Johnson and Cole, 2003; Krause, Ragland, Fisher, & Syme, 1998), few studies focus on the perspectives of the disability managers, employees and supervisor/managers' associated

with these return to work programs and their interaction and influence on positive return to work outcomes.

It is clear from some studies in occupational health that the perspectives of employers, employees and health care providers need to be incorporated in any evaluations of occupational health programs (Gatchel et al., 2003; Krause et al., 2001; McGrail et al., 2002; McLellan, 2001). Krause et al. (2001) not only recognize the need to develope a conceptual framework for inter-disciplinary research but the authors also feel that it is necessary to combine qualitative and quantitative research methods to bridge existing knowledge gaps in return to work and disability management.

The findings of Gatchel et al. (2003), Krause et al. (2001) and McGrail et al. (2002) have led to changes in how and by who return to work programs are delivered. Others have led to more global interventions such as those discussed by Burton and Conti (2000) which looked at addressing short term disability in the workforce of a very large banking organization. The goal of their program was to minimize the personal and economic impact of short term disability through early intervention, to validate the extent and duration of short term disability and to coordinate medical services in addition to providing guidance to supervisors/managers that would facilitate return to work. As a result of these efforts, short-term disability event duration declined after the management program was implemented.

McLellan, Pransky and Shaw (2001) explored employers' changing attitudes and practices that impede return to work and rehabilitation for injured workers. They piloted a training program developed by occupational rehabilitation specialists, geared at improving the response of supervisors to employees reporting work-related injuries. Post

intervention results demonstrated a significant decrease in supervisors blaming employees for the injury, not taking the condition seriously and discouraging workers from filing a claim. Although they were not able to demonstrate a decrease in work-related lost time, this pilot study shows promise in addressing attitudes and practices that affect return to work, with supervisors.

One group of researchers compared international guidelines dealing with the management of low back pain in an occupational health care setting. Despite the fact that they looked more specifically at the management of low back pain, Staal, Hlobil, van Tudler, Waddell, Burton, et al.(2005) found that common flaws included lack of proper external review of the development process, lack of attention to organizational barriers and cost implications. They also identified a lack of information on the extent to which the developers of the guidelines were independent of the various organizations using the guidelines. They found that assessment recommendations consistently included diagnostic triage, screening for "red flags" and neurological problems. More significantly in the context of this study, the authors identified psychosocial and workplace barriers to recovery as being an important consideration. Additionally, the guidelines were consistent in highlighting the need for remaining at work or early (gradually or not) return to work, with or without modified duties, and that consideration should also be given to the fact that among some workers, low back pain is a self-limiting condition. This last point means that some individuals with back pain will limit their activity level thereby limiting ability to function in everyday activities over time and achieving maximum recovery and capacity.

Hogg-Johnson and Cole (2003) concluded in a prospective cohort study of 907 injured workers with soft tissue injuries, that triaging of injured workers within the first month, based on a small set of prognostic factors, can improve return to work outcomes. These factors include injured part of body, specific functional status, change in pain, workplace offers for arrangements for return to work and recovery expectations.

In a recently published systematic review of quantitative studies investigating the effectiveness of return to work interventions in the workplace (Franche, Cullen, Clarke, et al., 2005), the authors found that among the 10 studies which were included in the review, there was strong evidence that work disability duration was significantly reduced by work accommodation offers and contact between healthcare provider and workplace. The authors also found that there was moderate evidence that work disability duration was reduced by such interventions as early contact with the worker by the workplace, ergonomic work site visits and the presence of a return to work coordinator. Moderate evidence was found that these five return to work interventions reduce costs associated with work disability duration. There was however, insufficient evidence that the effects of any of these return to work interventions were sustained over time and that there was a positive impact on quality of life.

Another group of researchers synthesized the findings from the qualitative literature on the effectiveness of return to work interventions (Franche, Cullen, Clarke et al., 2004). The review findings revealed that conditions of goodwill and mutual confidence between the workplace parties are influential factors contributing to the success of return to work arrangements. Other findings included developing good relationships between the unions, management and health-care workers and that return to

work is laden with potential for miscommunication and misunderstanding. The authors also found that modified work has important social aspects and can involve difficult social dislocation which produces new sets of relationships and routines. They also found that return to work requires careful coordination and consideration of the needs of all the players in the process, and that supervisors play an important role in the process. Finally, findings of the review revealed that rehabilitation and occupation health professionals can be key to the success of return to work given that they are a bridge between the workplace and the health care system.

In summarizing, return to work involves a complex set of variables which includes addressing and integrating work environment issues as well as addressing and including worker variables which impact on return to work. Employers have knowledge, through their supervisors and disability managers, of the work characteristics and more importantly, have the potential to change these characteristics to a certain degree. Such changes might include changing the pace of a production line or purchasing equipment which is safer for workers when performing a certain task, for example. Workers can provide insight into issues that would be difficult to measure through surveys and questionnaires, in terms of their perspectives on what is important to them and what makes them feel supported in the process of return to work.

2.1.2 Recovery Management

Recovery management is a method of coordinating and integrating a variety of medical, treatment, rehabilitation and/or other support services to optimize recovery, and work, in partnership with workplace coordinators to orchestrate timely return to work

(Disability Management Guidelines, Health Care Corporation of St. John's, 2004). It is facilitated through the use of guidelines which are utilized as tools by such recovery managers, as occupational health nurses and occupational therapists. It is typically part of an overall disability management program, which also attempts to prevent and minimize absence, in addition to encouraging prompt return to work.

The primary goal of recovery management is to facilitate return to work as quickly as possible. This is done in a step by step process by making initial contact with an absent employee to provide support in managing the illness or injury. Abilities and restrictions related to work demands are identified to see if the worker is well enough to look at return to work at the time. If the worker is not well enough, the recovery manager provides a time frame for continued contact until return to work issues can be addressed.

There is limited research on recovery management. However, disability management strategies have been recognized by employers as an effective way of managing and preventing sickness and/or injury related absenteeism. This is reflected in part to the growth in worksite-based disability management programs which address both worksite (environmental) variables and worker (individual) factors as opposed to more traditional rehabilitation interventions which focus on the individual (Shrey, 2000). Most disability management programs recognize the need for an interdisciplinary approach that requires careful planning, good communication and the establishment of trusting relationships amongst all stakeholders. Shrey (2000) described a model which involves many steps that parallel the injured or ill worker's progression from the point of injury or illness, through successful return to work. He provides a step by step model which is designed to focus on the worker's abilities and the job demands. He also discusses factors

which impact on successful return to work and breaks these down into factors which are specific to the worker, the work environment, to the availability and quality of community resources and services (such as medical specialties, occupational rehabilitation, for example) and to laws and regulations.

More recent studies have suggested that effective disability management begins with maintaining a work connection between the employee and the employer (Cole, Mondloch & Hogg-Johnson, 2002; Gatchel, Polatin, Noe, Gardea, Pulliam, & Thompson, 2003; Krause, Frank, Dasinger, Sullivan, & Sinclair, 2001). Curtis (2004) has suggested that it is difficult for employees to advocate for themselves in a compromised health state and that a health professional, such as an occupational health nurse can provide direction for employees on how to get appropriate care, particularly early in the illness or injury related absenteeism phase. This information confirms the need for continued and effective communication between the worker, the employer and the health care providers and the need for a trusting environment in the process of disability management as Shrey (2000) has suggested.

Bull, Riise and Moen (2002) focused more on the prevention of absenteeism and argue that frequent inspection of safety devices in combination with feedback from the workers were probably the most effective means of attaining the desired result of reducing injuries in small mechanical enterprises in Norway.

In an empirical study, Loisel, Lemaire, Poitras, Durand, Champagne, et al., (2002) found that a fully integrated disability prevention model for occupational back pain appeared to be cost effective for the workers compensation board, saving more on days on benefits than usual care or partial interventions. This was based on a randomized trial

design with four arms of care, standard care, occupational arm, clinical arm and combined (fully integrated) occupational and clinical arm.

A retrospective cohort study conducted by Krause, Dasinger, Deegan, Rudolph and Brand (2001) found that high physical and psychological job demands and low supervisory support were each associated with about 20% lower than average return to work rates during any disability phase, whereas high job control (such as control over work and rest periods) was associated with over 30% higher return to work rates (during sub-acute/chronic disability phase starting 30 days after the injury). Interestingly however, they also found that job satisfaction and co-worker support were unrelated to time to return to work.

McGrail, Calasanz, Christianson, et al. (2002) proposed an integrated benefits and medical care model that would effectively implement disability prevention principles within a primary care clinical setting. This would increase health care provider awareness regarding the disability relating to a specific impairment. They demonstrated that this approach can be positively affected by specific clinical strategies. The authors suggested that the care systems should not only be committed to providing the best quality medical care but also include interventions which promote return to optimal functioning for the worker in all settings, both at home and in the work place. This was based on the premise that disability is in part a social rather than purely medical phenomenon. There is support in the literature for the observation that a patient's own perceptions about disability can be more important than the nature and severity of the condition in determining prognosis for return to work (Feeney, North, Head, Canner, & Marmot, 1998; MacKenzie, Morris, Jurkovich, Yasui, Cushing et al., 1998; Murdick et al., 1998; Väänänen 2005).

At every level of the disability management process, whether it is for prevention, recovery management or return to work, all stakeholders need to be able to communicate effectively with each other, build and maintain relationships and plan carefully to include all stakeholders throughout the process. Financial, human and administrative resources are also critical. They include guidelines for management that are jointly supported by labor and management. In order to obtain that support, it is critical to explore in more detail the perspectives of the workforce, the supervisors and the disability managers who will be either administering and/or participating actively in the process of either return to work, recovery, or prevention.

2.2 Stakeholders

The stakeholders involved in the process of recovery management and return to work can vary depending on the nature, size and goals of the organization. Recovery or disability managers often have a health care background with human resources experience while some organizations use individuals with less clinical training and more training in human resources and occupational health. Their role is to coordinate the whole process and to ensure that the needs of the organization and of the recovering workers' are met.

The supervisors may or may not be unionized personnel who are assigned to ensure that the goals of the organization are met within their specific areas. Their experience in dealing with recovery management and return to work issues may vary depending on the amount of exposure they have had to this, their specific level of

professional expertise and the amount of related training they have and continue to receive from their employer.

Likewise, the workers' experiences in dealing with recovery management and return to work would depend on their personal experience with this, their specific level of professional expertise and the amount of training they have and continue to receive from their employer. Their involvement in labor related activities may also influence their knowledge and experience with recovery management and return to work.

Given the varied situations and perspectives that could arise in the processes of recovery management and return to work, it is important to understand the perspectives of all these stakeholders.

2.2.1. Recovery Managers

The perspective of recovery managers is difficult to find in the literature. This role has been referred to as return-to-work coordinator, case manager and disability manager. Employers not only employ individuals to carry out their day to day business, they also often employ their own disability managers or own health care providers. Ultimately, employers, through their disability managers, have the power of initiative, competence, economic resources and motivation, which are needed in order to create effective solutions in the occupational and work rehabilitation process (Gard and Larsson, 2003). In an indirect way, the disability managers are the "voice" of an employer in the process of recovery management and/or return to work and/or overall disability management. Despite the use of guidelines in the process of recovery management, the interpretation of the guidelines is often left to the discretion of the individual using them. Whether the guidelines are developed solely by the employer or through consultation with labour, how

they are translated on the front lines of recovery management may not be the same as expected or as hoped by the employer.

McGrail et al., (2002) elaborate on problems with the current workers compensation and disability benefits system, noting that a concern amongst employers and physicians (in the community) that patients do not often take an active role in facilitating their own recovery. They conclude that the communication between stakeholders is perceived by employers and health care providers as often fragmented and delayed. This communication gap is further compounded by the fact that there are economic incentives in the compensation and benefits system which create adverse incentives for return to an optimal level of functioning, according to employers and physicians.

Shaw, Feuerstein, Miller & Wood (2003) conducted a more specific study on work related upper extremity disorders, concluding that problem-solving skills training for case managers (comparative to recovery managers in this study) may help focus case management services on the most salient recovery factors affecting return to work. The study demonstrates the need to look at creative solutions when educating case managers and others who manage recovery and return to work.

The authors concluded that the development of a broad base of skills (such as problem-solving skills) for recovery managers (or disability managers), which can be utilized in day to day practice in conjunction with the use of guidelines, may offer more consistency in the interpretation of guidelines. Training gaps may best be identified by the recovery managers themselves as they will be more specific to the organization and its particular needs.

In concluding, recovery managers (or disability managers) who represent the employer and are responsible for facilitating the process of recovery and return to work, need to have the skills, knowledge and resources to do this. These not only include direct clinical skills but other generic skills such as the ability to communicate effectively and the ability to problem solve, may be just as important in facilitating the process. Overall, based on a review of the literature on recovery management, there is somewhat limited research on recovery management specifically particularly within the health care setting. There is a need for further research in this area within this particular setting.

2.2.2 Supervisors

Supervisors also have a critical role in disability prevention, recovery management and successful return to work as McLellan et al., (2001) recognized in their study. Within the context of this study, supervisors are those who are responsible for the management of areas in the workplace through the direction and supervision of other workers. They are the individuals who ensure that the "business" of the areas for which they are responsible is completed on time, on budget and according to the goals of the organization. They are typically responsible for human resource management of individuals working in their area including hiring, laying off, and providing ongoing performance management to these individuals. Additionally, they are responsible for identifying meaningful job accommodations for recovering ill or injured workers returning to the worksite at any given time. They are often caught in the middle between meeting their own departmental production responsibilities and the need to accommodate workers who may be perceived as less productive, either on a temporary or permanent basis.

In a large qualitative research project conducted in three Canadian provinces (Baril, Clark, Friesen, Stock, Cole, & the Work-Ready group, 2003), supervisors were observed to experience role conflict when responsible for both production quotas and return to work programs. The supervisors noted that these difficulties could be alleviated by providing innovative suggestions to the researchers such as the consideration of return to work program responsibilities in the determination of production quotas and in performance evaluations. Overall, return to work program success seemed to be related to labor-management relations and top management commitment to Health and Safety.

Freisen, Yassi and Cooper (2001) studied stakeholder perspectives on barriers and facilitators for return to work. Included in their sample were supervisors/managers as well as union/worker representatives, workers, occupational health professionals and other groups (such as government department representatives) for a total of 55 participants. Although the supervisors/managers' specific views were not distinguished in this study, perceived barriers to return to work identified by all participants in this tudy included processing or delivery of information and treatment, and ineffective communication and team work amongst stakeholders. Facilitators of return to work identified included the establishment of return to work programs in the workplace, effective communication and team work, as well as trust and credibility amongst stakeholders.

The importance of the role of supervisors in the process was supported by a study conducted by Shaw, Robertson, Pransky and McLellan (2003). They looked at employees' perspectives on the role of supervisors in preventing workplace disability after injuries. As part of a needs assessment for a supervisor training program, 30

employees from four companies were interviewed about the role of supervisors in preventing workplace disability after injuries. Affinity mapping with an expert panel produced themes of accommodation, communicating with workers, responsiveness, concern for welfare, empathy/support, validation, fairness/respect, follow-up, shared decision-making, coordinating with medical providers and obtaining co-worker support of accommodation. They concluded by noting that the interpersonal aspects of the supervision may be just as important as the physical work accommodation in facilitating return to work. This is consistent with supervisors' integral role in providing ongoing feedback, supervision, management and direction, with regard to the day to day job tasks of workers in their area.

In one study by Baril et al. (2003), differences in what supervisors, workers, health care providers and employers perceive as barriers or facilitators to return to work were explored. They concluded that some supervisors experienced role conflict between their responsibilities with production quotas and the coordination of return to work activities. In other words, these supervisors were more concerned with their production quotas and budgets, as opposed to the safety and well being of the worker.

Another, more recent study by Shaw, Robertson, McLellan, Verma and Pranksy (2006), used a case control study design to assess the effectiveness of a four hour supervisor training workshop aimed at improving the response of supervisors to workers' health and safety concerns and reducing workforce disability in the food processing industry. The workshop emphasized communication skills and ergonomic accommodation for workers reporting injuries or health concerns. By using workers' compensation data, the researchers were able to demonstrate a greater reduction in new

claims and active lost-time claims in the experimental group than the control group. They concluded that improving the response of frontline supervisors to employees' work-related health and safety concerns may produce sustainable reductions in injury claims and disability costs.

To summarize, according to the research reviewed, supervisors can play a critical role in the recovery management and return to work process. They are often the first point of contact for the recovering worker the day they return to the worksite; they assign daily tasks to the work and essentially control their workload; and they provide ongoing feedback to the worker about their work performance and their ability to contribute to the workplace. The studies reviewed showed that clear, effective and, most importantly, supportive communication is an important aspect of the supervisors' role in the process of returning to work. Additionally, early involvement of supervisors in recovery management efforts can be reinforced by informing them of the recovery plan and progress of the worker, encouraging supervisors to maintain their supportive communication throughout the process, and including supervisors in the development and implementation of workplace accommodation.

2.2.3 Workers

Workers who have been affected by injury or illness clearly play a pivotal role in their return to work process. Their views and attitudes towards work and relationships at work are bound to have some impact on whether recovery and return to work will be effective. It is difficult to imagine how these variables would not play a significant role in how quickly a person recovers given the percentage of time a person spends at work. For example, if they did not get along very well with their supervisor pre-morbidly, or if there

had been disciplinary issues, it would be reasonable to assume that these issues would impact return to work efforts. It is also difficult to imagine how a person's experiences with illness and injury would not impact on recovery and return to work. How a person copes with pain, for example, may limit their ability to work through their pain as they participate in occupational rehabilitation. Clearly, it is important to explore their perceptions and experiences with recovery and return to work.

In terms of the experiences of workers on return to work after a period of absenteeism due to injury and/or illness, one study explored the perceptions and experiences of injured workers (Beardwood, Kirsch and Clark, 2005). The authors conducted a participatory research project where injured workers were trained as peer researchers who conducted interviews with other injured workers and participated in the inductive coding and analysis of interview transcripts. The results revealed that many of the interviewees believed that the process of return to work had victimized them and rendered them powerless and dependent on others. They also felt that health professionals and bureaucrats impeded their rehabilitation by coercing them to return to work before they considered themselves ready, or to pursue vocational training in areas that they felt were unsuitable. They felt that these experiences increased their financial, psychological, marital, social and physical problems. They felt victimized by the compensation, medical and rehabilitation systems, which they felt failed to grant them legitimacy and respect and yet affected every aspect of their lives.

Fisher (2003) explored the different perceptions of employees about factors which influence return to work after a work-related musculoskeletal injury. Employee groups included safety professionals, supervisors and workers who completed surveys which

examined the perceptions of the participants relative to factors linked to return to work, company policies and procedures, job satisfaction, worker relationships and work environment. The results indicated that the perceptions of safety professionals and supervisors differed from those of workers, in terms of job satisfaction, worker relationships and work environment. However, there was no difference between the three groups on the factors relating to company policies and procedures.

Differences in what workers perceive as barriers or facilitators to return to work, and what supervisors, health care providers and employers perceive as barriers or facilitators, have been observed in other studies. Baril et al. (2003) noted in their qualitative study that injured workers were perceived by many participants in the study as the key figure in the return to work process. Attitudes and beliefs as well the motivation of the workers were seen as the main facilitators to return to work by the human resource managers and health care professionals. In contrast, injured workers, worker representatives and health and safety managers described workplace culture and the degree to which workers' well-being was considered as having a strong influence on workers' motivation. The authors concluded that some injured workers simply did not want to work while in pain. However, for others, being active and at work was perceived as therapeutic. Some workers expressed fear of injury or were embarrassed by their condition. In settings where strength was important to the completion of work, workers might be reluctant to ask for assistance or decline potentially unsafe (in relation to their condition) work tasks.

In an earlier study, Friesen et al.(2001) found similar results to those in Baril et al.(2003) in terms of worker attitudes and behaviors. Workers in this study also felt that

having a positive attitude towards work was important, but also have a positive attitude towards life in general. The workers in this study spoke about the disempowerment or imbalance of power they felt between themselves and the health care or the workplace systems, similar to the Bearwood et al. (2005) study noted earlier.

Two other studies, one conducted in Australia (Sager & James, 2005) and the other in Canada (Kirsh & McKee, 2003), both explored the perspectives of injured workers specifically. In the Australian study, which focused on the perceptions of six injured workers' regarding their rehabilitation, the participants noted that they felt they had limited knowledge and understanding of the process, felt unsupported throughout the process, had unsatisfying return to work duties and often experienced negative attitudes from key stakeholders. In Kirsh and McKee's (2003) participatory research study, 290 injured workers in Ontario responded to a survey that was developed and administered by a group of university researchers in partnership with injured worker peer researchers. The findings indicated that many injured workers experienced undue financial, emotional and physical hardship during the compensation, treatment and rehabilitation process. The participants also noted that these hardships were experienced due to perceived lack of respect, insufficient information concerning rights and the return to work process, and limited opportunities for input into the medical and/or rehabilitation process.

Svensson, Karlsson, Alexanderson and Nordqvist (2003) looked more specifically at sickness related absenteeism (as opposed to work-related injury absenteeism). They conducted focus groups with workers who had experienced sickness related absenteeism to discuss factors which facilitated or impeded return to work. They found that reports of demeaning experiences were common and divided these into two major categories: 1)

rehabilitation professionals were indifferent and nonchalant; 2) the participants felt discredited or belittled.

Maunsell, Brisson, Dubois, Lauzier and Fraser (1999) explored work problems following breast cancer. They interviewed 13 breast cancer survivors who had paid employment at diagnosis, returned to work afterwards and mentioned work-related problems to a clinic nurse or physician. Experiences of job loss, demotion, unwanted changes in tasks, problems with the employer and co-workers, personal changes in attitudes to work and diminished physical capacity, were reported by women in various types of jobs. Another area of concern which emerged included the lack of discussion with health professionals about work and return to work issues.

In conclusion, there is some evidence in the literature that workers' attitudes about return to work and their experiences are important to consider in the process. Attitudes about their health, perceived abilities and restrictions, supervisors' and co-workers' support and job security and benefits, can influence the outcome of successful return to work. It is apparent that workers who have been absent from work either because of an illness or an injury generally perceive lack of support and respect from other stakeholders when they return to the worksite through rehabilitation. They also expressed the need to be informed about the process and for a better balance of power in the decision making around the process.

2.3 Summary

The views of all stakeholders are important to consider when looking at the factors which impact recovery and return to work after a period of absenteeism due to an

injury or illness. All stakeholders have an important role to play in the process whether it be the recovery manger (i.e. the disability manager or health care provider), the supervisor or the worker. The recovery manager can provide the expertise about the process and guidelines within the organization that the employer is promoting and has clinical knowledge about the condition of the worker and standard recovery guidelines. They can also be the liaison between the organization and health care providers in the community including the worker's treating health care provider(s).

Supervisors are critical in that they can identify suitable, appropriate and hopefully rewarding work duties for the worker, until they recover to complete full duties relative to pre-injury. The supervisors' support of the process is critical if the worker is going to feel recognized for his or her efforts in the return to work process. The supervisors are also often placed in situations where they may feel conflicted between the production quotas they need to meet and the needs of accommodated workers in their area. This conflict needs to be recognized by the employer who can provide support to the supervisors around accommodation in the workplace.

Workers are often seen by other stakeholders as being the key participant in the process. Returning and staying at work after a period of injury or illness are often seen as being in the hands of the worker. Issues such as the worker's attitudes towards their work, their ability to cope with their illness/injury and perhaps the pain and disability associated with this, and their perception of support from co-workers and supervisors, are critical areas to investigate in relation to successful recovery and return to work strategies. It is also important to describe the experiences of workers in the process of

return to work and recovery because it can provide insight to all stakeholders about the impact they may have on the person they often see as the key participant in the process.

The purpose of this study is to explore and describe the views of stakeholders who have experienced recovery management and returned to work in a large tertiary health care organization. Specifically, this study is designed to meet the following three major objectives:

1. To explore the perspectives of recovery managers who were involved in facilitating the process and to get their views on what they felt was effective and what could be improved with the process of recovery management and return to work.
2. To explore how supervisors/managers who have been involved in the process of recovery management and return to work (by accommodating workers back in the workplace) perceive the process and what they identify as factors that could be improved.
3. To explore the perspectives of workers who have participated in recovery management and returned to work, to identify what were the barriers and facilitators for them.

Chapter three will provide a detailed account of the methods used including the design and setting of this study. Participant selection and recruitment of the participants will be described as will the interview process and method of analysis of these interviews. This chapter will also discuss ethical issues for consideration including the role of investigator in this study and specific considerations given to the study sample.

Chapter four will outline the results of this study and describe the findings through the use of quotes from the participants.

Chapter five will provide a summary of the findings and relate these to the existing literature but also provide a discussion on the findings from this study which are new to this body of knowledge. This chapter will also address the strengths and limitations of this study and conclude with recommendations for further research and those specific to this setting.

CHAPTER 3: METHODOLOGY

3.1 Design

A qualitative study design was used, in which a sample of the key participants in the recovery management process at a particular institution share their views on the program. The key participants, namely the recovery managers, the recovering workers, and supervisors affected by the guidelines, were interviewed using a semi-structured interview guide. This method was chosen as the most appropriate for assessing stakeholder perspectives on the recovery management process as it provided the opportunity to ask broad questions and follow up with probing, in order to elicit detailed and personal descriptions of the process. Zwerling, Daltroy, Fine, Johnston, Melius and Silverstein (1997) recommended a hierarchical approach to evaluating occupational injury interventions, beginning with qualitative studies, followed by simple quasi-experimental designs using historical controls, continuing with more elaborate quasi-experimental designs comparing different employers' experience and when necessary, implementing randomized controlled trials. This was based on a review of the literature on the design, conduct and evaluation of different models of occupational injury interventions including engineering, administrative, personal and multiple factor interventions.

Absenteeism from work as a result of sickness or injury is a complex phenomenon in that it is influenced by a variety of factors which are both worker and workplace related. Qualitative methods are particularly appropriate in studies that aim to

uncover factors that have an impact on phenomena such as return to work and recovery management, particularly when those factors are qualitatively different (Murray & Chamberlain, 1999). As such, they need to be explored and described so the experiences can be constructed along with the ways in which the experience matters in the lives of those concerned. In other words, qualitative methods were appropriate for this study because I was interested in the experiences and consequences of the interactions as perceived by the various players in the return to work process. Additionally, qualitative research methods are particularly pertinent to occupational health when little is known about certain aspects of the job that may influence the health and well being of workers (Ballared, Corradi, Lauria et al., 2006).

3.2 Setting

The setting for this particular study was the largest health care organization in Newfoundland and Labrador and one of the province's largest employers. In March 2005, it had an annual budget of $400 million 6500 staff members, 500 doctors and over 1000 volunteers. As a corporation, it provided health care services to the capital region, with a local population of about 200,000 but was also the tertiary, or high-level center for the entire province.

The health care corporation consisted of 13 clinical programs and 19 support services departments including Human Resources and Development. Employee Wellness was one of four departments in Human Resources and Development, which introduced the Recovery Management program as part of their Attendance and Disability Management service.

In the fiscal year 2005/2006, over 1600 work-related incidents of injury or harm were reported for the health care corporation alone. Over 330 of these claims involved lost time for the worker and another 260 required the need for medical aid above and beyond a visit to their family physician including everything from physiotherapy to specialist visits. Provincial workers compensation board claims cost the corporation over $5.1 million with an additional $1.8 million for staff replacement costs and $640,000 for support of return to work activities. These costs do not include compensation assessment costs which all employers are required to pay on a yearly basis.

The percentage of total payroll costs for sick leave was at 4.6% for 2005/2006 or over $11 million. These costs included the sick leave benefits paid to workers while they were off. Another $6.7 million was spent on additional staff who were hired and trained to replace those workers who were unable to work due to illness or injury (Eastern Health Regional Authority, Department of Human Resources). These costs are those associated with the health care corporation (which was the setting at the time of this study) and would not include other facilities which now make up the enlarged regional health authority.

As a health care organization, the Department of Human Resources documented that of the 1630 incidents of workplace injury or harm to workers in 2005-06, 453 were directly related to either patient handling activities such as assisting a patient to change position in bed, or to incidents related to patient aggression. Clearly, health care workers are at inherent risk for injury or illness because of the nature of their work activities. And as the sick leave data demonstrates, sick leave is also a significant cost to the

organization. As such, there is an incentive for this organization to study and evaluate the strategies that are utilized to manage these costs.

Prior to implementing a formal recovery management process within the health care corporation in February 2005, much of the sick leave and workplace injury management process within the corporation was evaluated from an outcomes perspective. This might have included looking at average sick days taken by particular individuals, patterns of sick leave, absence management and counseling when needed. Very little was done to look at the process of returning to work and why it might or might not be effective. With existing information it was easy to see which departments were more at risk for the development of soft tissue injuries to the shoulder but not so easy to understand why some individuals returned to work after two weeks off and others remained off for months and months. With the introduction of legislation promoting early and safe return to work, by the provincial workers' compensation board in 2002, employers are now required to work with health care providers to agree on early and safe return to the worksite as quickly as possible. Seeing the reduction in claims durations in many jurisdictions across Canada with similar legislations, many employers have applied these same principles with individuals who are off work due to non-work related injuries or illnesses. Thinking along those same lines, the health care corporation introduced new communication documentation for treating physicians in the community that employees have been required to provide after every visit to their physician. These functional assessment forms provide critical information to the employer (confidential medical information is blacked out) on the functional abilities of the worker, who can then be "matched" to suitable and safe duties as quickly as possible.

3.3 Participant selection

The sample of recovery managers interviewed in this study, consisted of 9 individuals from nursing and occupational therapy backgrounds who worked at various sites of the Health Care Corporation of St. John's. Each performed recovery management tasks as part of their job description, but also such other tasks within the Human Resources and Development Department as immunizations for employees, functional assessments or ergonomic assessments. They were not allocated to particular departments, clinical areas/programs or facilities within the Corporation however approximately one half of the group had their offices in one facility, the others in another facility and one recovery manager at a third facility. This sample included all but one the of recovery managers at the Health Care Corporation of St. John's. All agreed to be interviewed with one being excluded from the study due to the nature of their clinical role and the potential for identification as a result of this role.

The sample of supervisors consisted of 5 individuals from a variety of clinical and support programs at the Health Care Corporation. They were also responsible for the management of approximately 20 to 100 workers at any given time in addition to completing other duties specific to their area of practice or job tasks. All had qualifying experience in their field and in supervising and managing other workers from a variety of union groups such as nursing, other health care professional groups or support services groups. Supervisors were responsible for finding appropriate and safe work tasks for the recovering worker based on a specific set of functional abilities and limitations identified by the worker's health care provider and/or recovery manager. They would not have access to specific medical information (such as diagnosis, medications and other

treatments being provided for example) about the worker. Although several more supervisors agreed to participate, data saturation was reached early with this group in the interviews, therefore 5 participants were deemed appropriate. Saturation is considered to have occurred in the qualitative research data collection process when no new categories are found relating to the central issue being researched (Murray & Chamberland, 1999). Similar themes and comments were noted early on in the interviewing process including comments about conflicts regarding workload and productivity as detailed in the discussions, and comments regarding communication problems.

The sample of workers consisted of 5 individuals, also from a variety of clinical and support programs, who were represented by either the Newfoundland and Labrador Association of Public and Private Employees (NAPE) or the Newfoundland and Labrador Nurses Union (NLNU). The workers had completed the process of recovery management and were back to work either to their pre-injury or illness capacity, or in another permanently modified and/or accommodated capacity. Some had experienced a work-related injury and others had non-work related illnesses or injuries which resulted in sick leave related absenteeism, while others had experienced a combination of both work-related and non-work related absenteeism due to injury or illness. The self-selection process of this group as per the study design dictated the number of participant workers in this group. The potential impacts on the study results of this self-selection process are discussed in Chapter 5.

3.4 Recruitment Procedures

3.4.1 Recovery Managers

Recruitment of participants consisted of obtaining a list of the recovery managers from the Employee Health Division through the approval of the Wellness Advisory Committee (Appendix D) at the Health Care Corporation of St. John's. As per approval from Memorial University's Human Investigations Committee (HIC) (Appendices E and F) and the Research Proposal Approval Committee (RPAC) of the Health Care Corporation of St. John's (Appendix G), the recovery managers were then contacted by the researcher to set up an interview time at their convenience, in their office, (if verbal consent was provided). On the day of the interview, a signed consent (Appendix H) was obtained from the recovery manager following a verbal and written explanation of the study and procedures. The participants were assured that any information they provided would not be traceable to them and they would not be identifiable in the study.

3.4.2 Supervisors

Recruitment of the supervisors consisted of asking for their participation in a study pertaining to recovery management, by the Human Resources and Development Department via e-mail as per the amendment approval from HIC to include supervisors in this study (Appendix O). Any interested individuals who responded to the e-mail were contacted by the researcher where verbal consent was obtained, at which time an appointment was scheduled at their convenience in their office. On the day of the interview, a signed consent (Appendix J) was obtained from the supervisor following a verbal and written explanation of the study and procedures. The participants were once again assured of their anonymity.

3.4.3 Workers

In addition to HIC and RPAC approval, specific permission to approach workers was obtained from the various unions (Appendices K, L and M) prior to starting this study. As per HIC requirements, recruitment of workers was limited to those who had completed the recovery management process and were back at work. For confidentiality reasons, these workers were identified and contacted by the Human Resources and Development Department, via letter, providing for the opportunity to participate in this study (Appendix N). Potential workers for this study were provided with a contact reply form (Appendix P) with a self-addressed stamped envelope, in addition to a copy of the supporting letter from their respective union. All returned contact reply forms were reviewed and workers were contacted by phone, by the principal investigator. Verbal consent to participate was confirmed by the worker over the phone, at which time an appointment was made at their convenience, for the interview to be conducted at either the worker's home, in a quiet and private office in the Division of Community Health at Memorial University, or at a location of their choice at the worksite. On the day of the interview, a signed consent (Appendix I) was obtained from the worker following a verbal and written explanation of the study and procedures. The participants were assured that any information they provided was neither traceable to them nor would they be identifiable in the study. Additionally, they were reassured that participating in this study would not affect their work status, any benefits they may be receiving now and in the future from their employer and/or any other insurance benefits (Rose & Pietri, 2002).

Thirty five packages were sent out to workers by the Human Resources and Development asking for their participation in this study as per HIC and RPAC

requirements. Five workers contacted the principal investigator and agreed to be interviewed for this study.

3.5 Interviews

All of the interviews were audio taped and transcribed verbatim, soon after their completion. Field notes were also kept with each interview and reviewed with the relevant transcribed interviews to help clarify certain points. The participants were given the choice of where to meet, whether at the worksite or in their own homes, and could choose whether the interview would take place during their work time or when they were off. All of the interviews ended up being conducted at the one of the facilities of the health care organization, some of which occurred at the Faculty of Medicine onsite, in a private office.

For the users of the guidelines (recovery managers), open-ended questions relating to the usability of the guidelines, their experiences with the guidelines, how they felt the guidelines could be improved and why, were explored through the use of an interview guide as shown in Appendix A. The format of a semi-structured interview process was chosen to allow for more liberal expression of issues, and provide participants an opportunity to express their own opinion but also to obtain more concrete evidence of the usage of the guidelines in practice. The recovery managers were encouraged to recount their experiences by thinking of how they proceed with approaching a worker, beginning with their first phone call to the worker, how they introduce themselves all the way to how they proceed with discharging the client from their caseload. They were encouraged to discuss in further detail any clinical practice

related activities if they brought these up during the interview. For example, if the recovery manager provided information about how they proceeded to describe to the worker what their role was as a recovery manager, they were encouraged to verbalize exactly what they would say to the worker. They were also questioned about why they would use a particular clinical practice: for example, is it more efficient for them, does it help create a better rapport with the worker, is it a clinical practice guideline of their profession? The purpose of this approach with the recovery managers was to get them to describe their practice as clinicians in the process of recovery and return to work.

The supervisors were asked to describe their experiences when workers came back to work after a period of injury or illness. Attitudes and beliefs about the process of return to work and recovery management were easily elicited this way and more probing questions regarding these attitudes and beliefs would be related back to their experiences. For example, if they discussed a particular situation with a worker which appeared to have been a frustrating experience, they were encouraged to describe more details about this particular case and why they felt frustrated with it.

For the workers, open-ended questions were used to obtain information relating to their experiences with the process, satisfaction and/or dissatisfaction, and suggestions on how to improve the process. Again, a semi-structured interview, with the use of an interview guide (Appendix B) was utilized to allow opportunity for expression of views in their own words, but also to allow the researcher to have some framework for discussion around recovery management. A chronological recount of their injury and/or illness was felt by the principal investigator to be an effective method to help them remember their experiences. They were encouraged to talk about how they sustained

their injury or how they got sick and how their condition affected their ability to function in every day activities including work, leisure and self-care, how they coped with their condition and deteriorated function and what kinds of support they had in their environment. Although some workers had difficulties remembering specific events and dates, they all appeared able to recall how they felt about these events and experiences.

3.6 Analysis and theme extraction

The analysis of the transcripts was completed in several steps. The first step was to re-read the transcripts and record emerging and/or recurring concepts within each group (recovery managers, supervisors and workers) as well as unusual and unexpected responses, discussions of particular intensity and/or comments. These concepts were then coded and re-grouped in broader themes within each group. The themes were generally developed using key words which were documented directly on the transcripts. Key words were generated when re-reviewing the transcripts closely which were deemed interesting by the principal investigator or significant based on the literature reviewed at the time.

The next step was to analyze inductively, the data from the transcribed interviews by using the constant comparative method (Silverman, 2005). This method involves comparing and contrasting new information with previously obtained data. Each transcript was reviewed and examined numerous times by the researcher to identify and code the emerging themes. The codes were then arranged under common themes with the analysis continuing until no new themes appeared.

The process of analysis and theme extraction was generally completed within a few days of completing the interviewing when they were fresh in the principal investigators mind, at the level of identifying key words. Groupings in the broader themes were completed after each group of participants had completed their interviews.

3.7 Role of principal investigator

In describing the perspectives of individuals in research, qualitative researchers have recognized the central role of the researcher in the process. The use of self reflection and ones own consideration of the research topic, plays a central role in helping the reader to recognize the extent to which these views and experiences may have impacted on findings and conclusions. As a result, in increasing data credibility one strategy used was reflexivity during the course of this study. This is a process of self examination whereby reflection on bias, theoretical predispositions and perspectives and how these have influenced data collection and analysis, was undertaken by the principal investigator by recording any particular thoughts, ideas or feelings after each interview. This process of reflexivity provided the principal investigator the ability to recognize the extent to which personal and clinical experience in the area of occupational rehabilitation may have impacted on the findings and the conclusions drawn from them (Murray & Chamberlain, 1999).

During the interviews, there were also opportunities to provide workers with information about their condition which might have further prompted their memory, given the principal investigator's clinical experience. For example, if a worker talked about different tasks that were offered at the worksite while they were recovering from a

disc bulge, their memory could be prompted due to the writer's understanding of what activities would and would not be appropriate for individuals with this type of condition.

3.8 Ethical considerations

The protection of the rights, confidentiality and welfare of human research subjects is required under the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (2005). With more and more studies being conducted with workers, it is important to consider the vulnerabilities specific to this group, whether or not they are injured and/or ill workers (Rose and Pietri, 2002). In the absence of risk to their health and/or safety, the risks involved for workers includes those which Rose and Pietri termed "paycheck vulnerability". That is, workers may feel required to participate in research projects, or risk losing benefits, career advancement or even their employment, by either the employer or their union, particularly if their participation is perceived by either to be advantageous to the organization. This paycheck vulnerability is further complicated by the employer's ownership of the employees' records, perhaps the employee's relationship with the employer's occupational physician and by unstated or organizational agendas promoting studies to determine or to suppress certain health and/or safety risks. Additionally, while the researcher had no access to confidential employee records, the inappropriate release of individual identifiable health or other personal data could adversely affect a worker's retention of their job, promotion opportunities, and insurance benefits. This information or any other information which could identify the worker was destroyed or changed in the transcripts to conceal the identity of the worker.

A balanced approach was used to address the unique risk to the workers in this study and the need for conducting such research. Although the principal investigator was independent of the employer, the participants and their recovery management and return to work process, given the type of clinical practice associated with my consulting work which consisted of providing opinions on injured worker claims for the workers compensation board, at the time of this study, there was a possibility that I might be in a situation where I would be asked to review a worker's claim who may have also been involved in this study. Prior to conducting this research consideration was given as to how this would be addressed through other private providers in the community to ensure that workers would not have difficulties having access to occupational rehabilitation services should they need these for recovery and return to work.

In this study, careful consideration was also given to approach the union groups which represented all of the various worker groups, in addition to other groups represented by the Wellness Advisory Committee which represents the non-unionized workers within the organization. Potential participants had the opportunity to contact their union representative or other representative on the Wellness Advisory Committee should they have any questions regarding this study, in addition to the Human Investigations Committee. Union group consent was obtained prior to any individual consent so as to avoid potential conflicts for individuals in the event that these union groups did not support this study.

Given that the participants had various work roles within the large health care organization other ethical considerations were taken into account. Firstly, all the interview transcripts were transcribed so that the individuals could not be identified by

the principal investigator in the results. Field notes of any observations made by the principle investigator during the interviews were kept with the interview and labeled with the coinciding tape (which were numbered for each group of participants) in order to note any non-verbal reactions and other forms of non-verbal communications. Due to the possibility of recovery managers and/or supervisors identifying workers and vice versa, any quotes which could potentially identify particular individuals were modified to assure anonymity, without compromising the meaning of the quote. For example, if a worker was particularly descriptive about their work activities and/or their illness which could easily identify them, this was removed from any quote which was used in this study.

Debriefing and access to the report will be made available to all the participants, in addition to the health care organization. This will vary depending on the needs of each group. For union groups, a complete report will be made available and any requests for summarizing and interpretation will be provided at their request. A formal presentation of the paper will be offered to the health care organization with the setting, format, and target group based upon the organizations needs and requests.

In summarizing, careful consideration was given to the fact that individual workers, recovery managers and supervisors would have the opportunity to review this paper through debriefing. Any comments which could lead to the identification of specific individuals were noted and every effort was made to modify these without compromising the point and allowing the research to proceed.

CHAPTER 4: RESULTS

The findings in this chapter have been organized according to the sample groups with associated themes which emerged from data. A short summary is provided at the end of the chapter for each sample group.

4.1 Recovery Managers

Thematic analysis of the recovery manager interviews identified ten themes related to increased workload, lack of specific clinical direction from guidelines and communication issues with stakeholders, including workers, health care providers in the community and other staff in the facility.

4.1.1 Increased Workload

The majority of the participants in this group felt that performing recovery management activities added further work to an already busy workload as clinicians in the human resources department. Many felt overworked with doing recovery management work and other responsibilities in their day to day work. As one recovery manager pointed out:

> It [recovery management] has added a big workload to what we did. You know, what I have done over the years as an occupational health nurse is now... you know, this added on is really the extra load, and the other things are still, basically there. You know, you have your pre-employment people, you have people coming for all their immunizations and testings. You have to do all that.

Another recovery manager noted:

> We got to look at the structure of the recovery management. Now it's been added to an already existing, very busy service and I think it could be done better if we had fewer people with full concentration in recovery management.

Another said:

> We're responsible, not just for recovery management, but also we're also responsible for injury prevention so we also do a lot of workstation reviews. Tracking down the chairs and finding the right equipment, which is something which ideally, an OT assistant could be doing.

As recovery managers, some felt the frustration of not being able to follow up on the workers who were on their caseload because of workload issues. They felt they were not as available as they would like to be to deal with the complicated issues associated with return to work in particular. One recovery manager said:

> You know, like I say, it's such a people focused process right now that it doesn't work this way. So I think we really need to try to figure out, if we are going to continue to do that [recovery management], that if we want it to work, it needs to be driven by us [recovery managers]. We need to have the time to talk to the workers, help them sort out their issues when they get back to work and they are having problems.

4.1.2 Lack of specific clinical direction from the guidelines

Many of the recovery managers felt that the guidelines, although helpful were not specific enough to provide direction for them as individual practitioners. Additionally, they felt that the guidelines were too generic to deal with the many complicated and varied diagnoses they deal with on a day to day basis. The variety of issues that may arise with individual workers in addition to the variety of jobs within the organization were also seen as issues which were not specifically addressed through guidelines. Some also felt that the background of the recovery manager could make a difference in dealing with the nature of the absenteeism as opposed the actual guidelines which were utilized. For example:

> Like, I'm a nurse and a nurse is calling me [as an injured worker] and I know a nurse's education and background but if an OT [occupational therapist] calls, I think, I would be more inclined to accept the help of the OT as opposed to the

> nurse's help because I would see them as being more educated in musculoskeletal areas.

The participant in the above quote noted that she felt their clients might feel an occupational therapist likely would have more knowledge and skills to deal with workers with injuries and/or illnesses of a musculoskeletal nature. The guidelines were not seen as providing the recovery managers with direction with going through the process with workers but rather the individual characteristic of the recovery manager was more important.

Another noted:

> Yeah, it's [recovery management] more sort of, probably more discipline specific. Like if I've got mental health people... than I need to look at what the mental health demands are with respect to their job. If it's pregnancy, I don't know. I mean, you could accommodate... some managers accommodated... accommodating people in less strenuous jobs than the regular nursing work. They [pregnancies] need to be looked at... but we don't have specific things per se, a program specific.

4.1.3 Frustration with the lack of knowledge of other stakeholders

Some recovery managers noted that the workers and the supervisors they dealt with were not always familiar with the recovery management program. In addition to this, they felt that the workers they were contacting were surprised to have been contacted by a recovery manager when their treating physician had indicated that they would need a certain amount of time off for recovery.

One recovery manager remarked:

> So you just have to explain who you are and why you're calling without harassing them [workers]. So it's a real difficult line actually, because it's a cold call. They haven't contacted you; you're contacting them and they're wondering who on earth you are and they may never have heard of you before.

With regard to health care providers in the community, particularly treating physicians, one recovery manager noted:

> I think, the most common issue is... well, the GP involvement because GP's don't have a good understanding of the process [recovery management]. The GP is still trying to keep that control, and they don't have a good understanding of either what we can offer in terms of alternative work, or we can offer the person's actual job duties... and... I find that it has been a real challenge to get the GP's to buy in bringing them back early. So that's really been a challenge.

4.1.4 The need to educate physicians and other stakeholders (supervisors and workers)

One recovery manager described a strategy to deal with communication issues with physicians which was not specific to the guidelines and was seen by this recovery manager as one way of addressing communication issues with physicians:

> Every week I'm in touch with them to, you know see what's coming out of this. I write to their doctor, I know not everybody does that. I always write to their family doctor up front... I have a generic letter, introducing to them that... who I am and what recovery manager is and how I'm able to assist their patient and what kinds of programs we have, so that opens my door to be able to, you know communicate with them, right.

Most of the recovery managers felt that either the workers and/or the supervisors would really benefit from education around the process of recovery management. They felt that the supervisors might be more supportive of the process if they had more information on it. One recovery manager said:

> I think from... the other thing is that there's... a lot of managers and a lot of employees don't exactly...even though you explain it to them, they still don't know what it is. So that is kind of a hindrance because you're not getting as much communication as you should, or support from the managers as you would hope to get.

Another recovery manager also conferred:

> I think education of the staff is probably one thing that we have missed. Like you know, I think the employee wellness should be having staff education sessions as opposed to me telling your manager and the manager passing it on or me meeting with the union reps and the union reps passing it on. So I think there needs to be an education program for the staff in some manner, and then the education with the managers.

4.1.5 Communication is important

Communication in general, amongst all the stakeholders was felt to be one of the critical components of any recovery management and return to work process by the recovery managers. Some felt that communication was not effective at times while others noted that they felt communication was not a major problem for them when dealing with workers.

One recovery manager noted:

> And it seems that the communication piece between parties sometimes is a little weak and sometimes that's because people are so busy or they can't connect. So you know, if someone is waiting to come back to work and they've been off for an extensive period of time and it's a complex issue, I think it would be to our advantage and, together, develop a plan of action to bring that person back.

On the other hand, it was noted by another recovery manager that the communication with the workers was positive:

> Most are quite happy to hear from somebody from the workplace, I've had a lot of... people say you're the first person who's called me, you know they also get kind of... felt they they've been forgotten about so they're really happy to be called by somebody from the workplace, to know there's somebody for support.

4.1.6 Strategies to encourage early return to the workplace

Other recovery managers found strategies to encourage workers to come back to the worksite despite not being cleared for full duties by their treating physician. These

included strategies which encouraged workers to "save" their sick leave for more serious situations as noted in this quote:

> I had one lady, who fractured, you know, the left wrist.
> She's a nurse, right. So she can't get... she has a cast on. She can't come back to nursing, but I'm bringing her in... transitional work... her right hand is good, her dominant hand, to prepare some patient education material. So we brought her in and people like that because they get to save their sick leave, you know, for sometime when they're really, really sick, right?

Another strategy was not to focus on the sick leave issues but rather on the worker getting well. This is reflected in this quote:

> My concern is that you're [the worker] not well now and you need to get well to come back to work; you know, and if you have a sick leave issue, getting back to work would benefit you in that regard, right, but we need to get you well to come back to work because if you're not well and you come back to work, then you get further injured or you get another ... or something else on top of whatever is on the go, then you know, you're not going to be productive.

4.1.7. Setting expectations and educating workers is important

The recovery managers found that it was useful to set expectations with the worker in relating to return to work. As well, recovery managers felt that it was important to provide workers with education about their condition and recovery if they were to return to work early and safely.

> If they don't have a lot of knowledge, then I really stress the importance of recovery management and how beneficial it is that we keep in contact, and I update them and provide education as needed.

Another noted:

> So by us helping them out, we are providing them with the service. We help them in kind of managing any kind of condition that they might have. Whether it's at work or at home, you're helping them manage the condition in a general sense. The idea behind it is that they'll be able to come back to work much more, you know, illness free... or not illness free, but be able to come back and work safely, without getting hurt again.

Another noted:

> So then I will say to them, with your type of injury, your best bet is you return to work within 4 to 6 weeks. You know, I'm going to expect the maximum recovery during that time.

And another noted:

> So I think in... like everything is so dependent on the person, the injury or the illness and the severity of the impairment and also the attitude, because some people want to get back A.S.A.P. and others are, depending on the doctor... and, you know, I think being a recovery manager, it throws out options to the person that they may have never have thought about and the possibility of, you know, taking control of their own illness and the direction in which it may go.

Having said that, others noted that workers would return to work when they were ready to return to work or more commonly, when their sick leave benefits ran out. Setting expectations about returning to work would not make a significance difference in the outcome of return to work. In this regard, one recovery manager remarked:

> It's not uncommon to have somebody saying, look, I've got to get back on Monday. I have to get back because my sick leave is running out. And I say, well, you, know, if your aren't ready... if you weren't ready two weeks ago, why are you suddenly now, return to work. But I've got no money coming in. I've got to come back. I've got to come back. Now many people do come back just because of that reason.

In the above noted quote, it was evident that despite setting expectations about when return to work should occur and how long it would take for the worker to recover, other external factors such as running out of sick leave would prevail in getting the worker back to work, even if the return was seen as unsafe by the recovery manager.

4.1.8. Assuring confidentiality for workers

Confidentiality was seen by all recovery managers as being a critical component of recovery and returning to work. Workers involved in recovery management needed to be re-assured that confidential information about their illness and/or injury would not

only be kept from their supervisors but also from their peers and co-workers. In trying to accommodate workers in the workplace, with the implementation of specific restrictions on what the worker can and cannot do, this proved to be a challenge for all. The recovery managers noted that confidentiality was usually discussed at the beginning of the process, when they first met the worker, however, when addressing return to work issues, it was evident to the recovery managers that confidentiality became more and more difficult to maintain. Confidentiality issues were noted to conflict with having an open communication process with the physicians, supervisors and other stakeholders in the process.

One recovery manager noted:

> I like the idea of having teamwork. I think though, unfortunately, the mental health ones, and some of them have become quite anxious about that because they think, that if you're coming in with a meeting with an HR [human resources] wellness officer, your manager and it could even be somebody like, return to work coordinators, then they think, well,... am I going to get disciplined, do they think I'm really ill... do they think I'm faking it, they're going to know my whole life story.

Ensuring confidentiality for workers was noted in these quotes:

> Everything is done with informed consent. It's a confidential process. Like everything should... the employee should know exactly everything that's happening and if we give informed consent for everything that we do, it's not an issue.

And as noted in this quote:

> I tell them that I got the form and I tell them who I am and that... when I call them, their information is completely confidential. I don't discuss their diagnosis with their manager or HR personnel who's taking care of them.

4.1.9 Supervisors seen as critical players

Recovery managers also identified issues related to supervisors. Recovery managers felt that the process of recovery management was a burden to the supervisors:

that the productivity and performance quotas of the supervisors would be affected when trying to accommodate recovery workers, which resulted in added stress to the supervisors. More specifically, in this setting some recovery managers noted that patient care was potentially affected when supervisors were required to accommodate a worker who was not able to perform all the tasks required of their job and there was no additional money in the budget to supplement for the extra tasks and/or hours needed to provide adequate patient care. This next quote reflects how recovery managers saw how supervisors as impacted by recovery management and the return to work of workers:

> Some have only a small number of people working under them, anywhere from 9 to 10, probably even less, while others have a couple of hundred. So managers are definitely stressed trying to keep up to date with all the changes and seeing who's off, who has functional assessments form in and then... yes, they do have the human resources officer to help them out, but still, it comes down to their total responsibility. So I see a lot of stress there for managers [supervisors]. So something to help... something more to lighten their load would be good.

4.1.10 Injury, diagnosis, and work-impact on return to work

It was evident to the recovery managers that the type of injury or illness, and the severity of the condition impacted on when and even whether a person will return to work. In this light, recovery managers often had expectations about how successful return to work would be depending on the workers' conditions and the severity of those conditions. This is reflected in this quote:

> You get a lot of mental illness, a lot of depression, a lot of anxiety, a lot of stress-related problems. You got people with cancer, and then they're going through surgery and their treatments and stuff. We have a lot of flues and sinusitis and influenzas, that type of thing. Musculoskeletal, bad backs are probably fairly common and a lot of broken bones and stuff but not work related, like a lot of outside of work. It depends what they come with, it makes a difference about how long they'll be off and what we can do for them at their workplace.

Another said:

> If their doctor has written in their remarks that they will be off for that period of time, then we don't need to contact them because we know that's a normal time. If I feel however, especially with psychological... so if psychological is ticked off [on the doctor's note], I do call all of those people because I want to make sure that they are being looked after adequately by their doctor, and I let them know that I have a mental health background and that seems to be an introduction, that they kind of talk to me a little bit more.

Another noted:

> If it's pregnancy... a lot of the pregnancies will not [be accommodated] at this point in time with the program [recovery management]. Especially high risk pregnancies. If you've got, in the last 6 weeks... and you just had some back pain and you're uncomfortable, I don't know, I mean you could accommodate in a less strenuous job than the regular nursing work, for 6 weeks. Some are just so uncomfortable that there's really nowhere in the workplace that they should be. They say they should be home resting because my [worker's] delivery is going to take this amount of me and I'm going to have a new baby and I need to be healthy when I go into that delivery room.

This recovery manager felt that for workers who are pregnant, recovery management was not a good use of a recovery manager's time considering that, for the most part, the worker would not be accommodated in the workplace. In other words, the use of sick leave in these cases was felt to be justified by this recovery manager and should not warrant the intervention of a recovery manager.

In addition, recovery managers noted that the type of work a worker was involved with impacted on their ability to return to work. This is noted in this quote:

> Say, if you have a nurse on the medicine floor where you know that this is going to affect you [worker] over a period of time, so you will need more support. Say if you've been in a motor vehicle accident, you got whiplash and all of that, it makes recovery more difficult.

4.2 Supervisors

Thematic analysis of the supervisor interviews identified that this group was supportive of recovery management. They all felt that it was beneficial for the worker

and the organization to have the individual return to work as soon as possible. Having said that, they also found there were issues around recovery management that needed to be addressed, more specifically in the return to work phase.

One of the more obvious themes which was expressed by the majority of the respondents was how the supervisors thought that time spent in accommodating recovering workers back to the worksite was affecting the productivity of their department or area. This was seen in either the perceived or real slowed pace of the worker or in having to train new workers into unfamiliar areas. Other broad themes which emerged with this group was their reported lack of knowledge of the process of return to work and recovery management and difficulties they were having with accommodating workers in their area in a way that would be a useful contribution to the productivity of the area.

4.2.1 Impact on productivity and patient care

Many supervisors agreed that in trying to integrate an injured and/or ill worker into a worksite, productivity and/or patient care would ultimately be affected. Some felt that this was related to the type of work that the recovering worker was participating in as part of their return to work plan. That is, workers were assigned to areas in "modified" and/or "alternate" work that was inappropriate for their skills, experience and abilities.

One supervisor noted:

> It was difficult for one person I had. That one is still there and is not able to keep up and you know, because it's a work performance issue and not the injury. This individual was not able to maintain the required standard and she's been here for a year.

Others noted that the recovering worker was not always well accepted by the other workers who had to work harder and/or longer hours to meet the needs of the

department and/or production quotas. These supervisors felt this created a negative social working environment, and thereby impacted patient care.

Comments about this are included in the next couple of quotes.

> They're current discharges and so we had the backlog in this particular area. The medical staff were delayed because they were delayed in getting their charts.

> And I had two people who were doing the training, one you know, seemed a bit resentful and gave one of the new trainees a bit of a hard time. They (recovering worker) come in and that's it. You have to disrupt and it's disturbing and a fair bit of frustration in a position that had to be done.

The supervisors in the preceding two quotes were expressing concern on how the particular areas they supervised were getting backlogged in terms of the work which was expected to be completed by their particular department. This was seen as affecting other areas (in one particular case discharges were delayed because physicians in the facility were not getting their charts). In the other case, other workers were frustrated because they had to train a recovering worker in their area which the supervisor felt created tension in their work area.

Other impacts on productivity were noted by supervisors in areas where a significant amount of "bumping" had occurred. This resulted in areas where the work was considered more sedentary or light in nature, not requiring a significant amount of specific qualifications and open to a wide variety of individuals in unionized group. The frequent bumping of different individuals into certain positions resulted in increased training for these individuals by the supervisors and to some degree other co-workers, taking time away from the day to day work. This was also felt to impact on the overall productivity of the department or the patient care area.

In this light, one supervisor noted:

> When the bumping occurred… this seemed to be a position that was targeted because it's a Clerk I position I guess, and the qualifications are not that specific and there's not a lot of heavy lifting. But I mean, from an operational perspective I have, I am constantly using extra staff and new staff, which is costing me.

4.2.2 Return to work and recovery process too slow

The supervisors were frustrated with the speed with which the process of recovery management was progressing. They felt that this also affected the productivity of their area. They noted that they had experienced situations where the worker wanted to be back to work and even though they were cleared for some duties by their treating physician, the proper documentation was not completed and the worker could not get back to the workplace as a result.

One supervisor noted:

> The other challenge that one of my employees faced was just having meeting with HR people and Employee Wellness and then trying to get them and, you know, waiting for correspondence and waiting for follow-up and you know, it doesn't happen as quickly as you would like it to, and this is the person who wants to work… you know, doesn't really want to sit home and wait for things to happen.

Another noted:

> So then, they've been home using up their sick leave and you know, it's a bit slow getting things moving but then there's a push to get the person back and you know, they are running out of benefits.

4.2.3 Lack of knowledge about the process

Many supervisors mirrored the views of the recovery managers on the need for more education and communication around the process.

One supervisor described:

> I'm not really satisfied with the way it was introduced because the first thing I saw on the computer one day was this recovery management form sent to me and I had to call HR and say, what is this? It was the first time I'd ever seen it… "recovery management" or had to avail of this "recovery management" program.

In that same light, another supervisor noted:

> You know, what is this? It was the first time I'd ever seen it [recovery management]. So then, you know, it was kind of... I think it should've been introduced a little bit more formally or you know, where it was recovery management or have this recovery management program and this is what you can expect to see come up.

Another supervisor said:

> Some staff members sense it's way out of the way of doing a good day's work, you know, this accommodation, but I think we've... if there would be some proper presentations around what a recovery management system is, then I think it would be good for staff.

Some supervisors noted that they did not know about the process of recovery and return to work until they were contacted by a recovering worker in their area who was due to be back at work soon.

In this regard, one supervisor said:

> I know the impetus for them coming back would be soon losing salary because they are running out of sick leave. And I have to be honest with you, in saying that...the ones who are pushing to come back are those who will soon be without pay. Actually, that's how I first heard about it [recovery management].

4.2.4 Difficulties with accommodating workers; finding suitable work

These supervisors noted that they felt a lot of pressure to "find" work for these workers based solely on a physician's recommendation or assessment of functional abilities, which for reasons of confidentiality, would not have included specific information about the recovering worker's diagnosis.

One supervisor talked about this pressure:

> And sometimes you know, I certainly would like to see them come back because I know all the statistics show that the sooner a person gets back to work, you know the better it is for them psychologically and so on. Physically too, it's good, their doctor tells you what they can and can't do. But there's only so many of these projects, you know, that I can have here through my office to accommodate. We

> have projects like audits or fire drills or you know, a chart but, you know, you can't keep those up forever, right. So that's my only concern is where do you find appropriate non-physical work for someone.

Along the same lines another supervisor noted:

> Well, there's a challenge trying to incorporate them [recovering workers] into the nursing units in terms of their restrictions. It affects other staff... you get comments from staff, at staff meetings or generally, off the cuff comments that you know, "how many people are we going to have to accommodate here and what's that going to do to the rest of us" [co-workers]. They're [co-workers] are saying, "pretty soon, we're all going to be off with our backs because Mary or Johnny or whoever can't lift thing over a certain number of pounds or can't do any patient handling".

Another also noted:

> A big problem with accommodating people and certainly say, from a budgetary point of view, but also from a functioning... I've a service to provide and I need people who are able to function and produce. When these people come back off of work, they always got to go back to another orientation to work through it slowly and so it's a costly issue as well as it's a big challenge to try to provide that service with a workforce that may or may not be able to meet those needs.

Another noted:

> You know, without telling the rest of the staff exactly what the restrictions... you let them know the restriction but sometimes the questions will be, well why... what's wrong with him or what's wrong with her. You can't answer that, and that makes it a bit tricky sometimes to just ask the staff to trust you that you're trying to get their... probably a co-worker back to work and giving it a trial and give everybody the opportunity the benefit of the doubt, because it is their livelihood. You know, a lot of the nurses who work in intensive care want to work there.

The last quote reflects two points under this theme. The first point is that they found it difficult to accommodate a worker without disclosing specific information about the worker to their peers. The second point is that they saw the importance placed by some recovering workers on their pre-injury or pre-morbid occupation. The supervisor in this quote noted that for nurses working in intensive care, this is where they chose and

want to be and trying to accommodate that need was felt to be an important concept in accommodating this worker.

Another supervisor noted similar experiences in relation to the co-workers of the recovering worker:

> I think the thought sometimes prevailing amongst other staff... and it has the potential for people... well, you know, I can't work on a weekend, and it's a very difficult thing to set up with co-workers.

This supervisor felt that it was difficult to accommodate a worker who could not work on weekends not only because it was likely difficult to do from a scheduling perspective but also that other co-workers would not be very happy with this, that perhaps this would be seen as preferential treatment for that recovering worker.

4.2.5 Finding creative solutions

In support of the program, the supervisors also demonstrated positive experiences with recovery management and return to work. Some noted creative ways of accommodating workers who had been unsuccessful in previous return to work attempts in the past, by taking risks and demonstrating confidence in the recovering workers' commitment to the process.

One example of this was proudly noted by the supervisor:

> You know, this individual was extremely sick, for a long time, so we opted to fast-track this (pilot accommodation) and work it as an accommodation. You know, the union was in full agreement and employee wellness and the employee herself, and I have to say that this type of accommodation worked out extremely well; and the first year that this individual was working from home... and this is an individual who rarely made a full week... rarely was in for a full week. Her productivity almost doubled.

Others felt quite strongly that in order for recovery management and ultimately return to work, to be successful, recovering workers needed to be presented with work

activities that were meaningful and useful to the organization. They felt that it was not enough for a worker to come to work but they also need to contribute to the work area in a productive and meaningful way. One supervisor said:

> You can't just get them to shred paper or something like that. It's pretty bad if you have a good education and you love what you do and then your asked to do something like that. It has to be useful to me, to the Corporation in my mind.

On that same note, others noted that verbalizing the efforts and accomplishments of the recovering worker was also critical, as well as acknowledging their continued contribution to the area. These supervisors also felt all workers in their area should be made to feel appreciated and respected for their efforts and accomplishments on an ongoing basis so that when they did get into a situation where they have illness or injury related absenteeism, they were more likely to want to come back.

The need to communicate respect and appreciation was noted in this comment:

> You know, you show respect in the way you approach somebody... like you say to them "I want you back (at work). I need you here". So that makes a big difference in... you know, at least people are feeling valued as an employee so, you know, they'll want to be back. You know, they'll get a sense of, you know, I'm actually contributing here.

On a similar note, this supervisor said:

> This person, who was off for 6 months, I said, I'm going to be calling you on a regular basis. You might want to come back to work (laughs) because I... no question, I am! And again, there's only so much of it that you'd know as a manager of multi-disciplines and I mean, you depend on them to know their job.

It was felt by these supervisors that creative solutions were actually in how they dealt with recovery workers. Perhaps the solution lay within themselves to be more positive or change the way they may have traditionally dealt with these workers.

4.2.6 Suggestions for change

The supervisors who participated in this study provided suggestions on how the process of return to work and recovery for injured or ill workers could be improved:

> They go through an HR person and they go through us. It seems to me that's an awful lot of money spent on managing... you know, I think it's much better if somebody is dealing with one person, rather than 3 different people because then they'll say I'll call them and they'll say I was talking to so and so.

Another suggestion was:

> You know, and the thing is that I really feel there should be some limit on how often, you know, you can bump [displace a less senior person] into a position. I mean, it was really, I think, unfair that we would be forced to accept four bumps within the... in the same position.

Another suggestion that was made:

> I think that there should be monies come out of the wellness budget, or what have you, that I can now take and put in overtime to clear up this mess instead of trying to, you know, here and there. I think I should be allowed to, you know, and I don't think it should come from my budget. It's not my inefficiency that caused the strain.

This quote also reflects the frustration felt by this particular supervisor in dealing with accommodating recovery workers and its impact on the productivity of the particular area being supervised by this person.

4.3 Workers

Overall, the workers who participated in this study verbalized both negative and positive attitudes towards recovery management. Even though the health care organization promoted recovery management and the facilitation return to work after a period of injury or illness for workers as a service to workers, it was not always seen in that light by workers. Thematic analysis of the interview of workers identified that workers found it difficult to return to work after a period of absence due to illness or

injury for many different reasons, even though they felt motivated to return to work. Some felt worried that they would get re-injured, particularly if injured on the job or if their work was physically demanding, while others felt guilty for not being as productive as they were pre-morbidity. Communication issues were also identified by workers either as being a limiting factor to returning to work early and safely (lack of communication). Some of the workers, by their own admission, thought that their lack of knowledge about recovery management and return to work process was part of the reason for delay in their returning more quickly.

4.3.1 Feeling appreciated and respected

Some workers felt that the process of returning to work after long periods of absence was very difficult. They noted that they did not feel appreciated by their supervisor until they were able to fully participate in all their pre-morbidity job duties. This was particularly evident with individuals who worked in areas where productivity and reliance on each other was important such as nursing units or areas where quotas needed to be met. One worker said:

> That (return to an ease back program) was just pure torture, not only with the staff that I work worked with but also with my manager. One thing that really… and I mean, it hurt me, was I was talking to my manager on the phone one day and she told me I wasn't cost-effective. And I mean, I'm at work and I was trying to do what I could and do so many hours a day.

Some felt that they were not respected by either their employer or their supervisor, either when they were sick or when they attempted to return to work. Another worker felt this was a thoughtful gesture that someone from work was calling them to find out how they were feeling. This dichotomy is shown in these two comments:

> So when I was off with surgery, I pretty well felt that I was being harassed by the employer. I mean, at the time when she called me and said that I was supposed to

> report back to work that day, I couldn't even... I ... at that point, I was still buckled over. I wasn't even standing straight because I had complications and I got ... my incision was infected.
>
> Versus:
>
> I thought it was really nice to get a call from the occupational health nurse because I really didn't know what I could do from here. I didn't know I could come back early and do something else, you know, without using up all my sick leave.

In the return to work phase, many felt that they were not being respected by their supervisor because they were being asked to perform activities that they felt were unsafe for them or that their supervisor did not really care about their problems. They felt that they were being left on their own, to figure out what they should and should not do and did not have much direction at the worksite by either their recovery manager or their supervisor, in regards to their return to work plan. This was reflected in these comments:

> When I went back to work after my surgery, the day I did a 12-hour shift... boom, right into it!
>
> Another said:
>
> Well, you know, my doctor said, you can do 6 hours but you can't do what the 6 hours is telling you here on paper [full duties].
>
> Another comment was:
>
> It was supposed to be a sort of ease back sort of thing but I didn't. Actually, my physician requested where we do shift work, was that for the first 3 to 5 weeks do all day shifts. I was more or less felt that you're back; you're back to work and you must do all the shifts, part of your job involves shift work. That came from the supervisor.
>
> Another worker noted:
>
> It [the ease back] was like a week or so... and she [supervisor] said, yeah, well okay, you know, you can have... you can have a week, but that's it. I'm making up the schedule and you're on it.

These quotes demonstrate that workers felt their return to work plan was not individualized to meet their specific needs and the demands of their job.

4.3.2 Feeling guilty

Many workers also felt guilty when returning to the worksite when they were not able to perform to their full capacity, often putting themselves at risk for further re-injury or set back. They noted that they felt guilty about not being able to participate fully, not being able to contribute as much as their peers and watch their peers work harder and/or more shifts. This was reflected in these comments:

> One of the things that I did find though was that when you're back in the workplace, it... it's... it may not suppose to be like, you know, well, you got to take everything on your shoulder; but when you're only two people who work in an area, that's usually the way.

Another worker noted:

> The patient was being discharged from hospital. The discharge was actually delayed because the patient coming to me, which delayed... and it took longer to teach them what it would normally take. I also think that when your body is there, you're kind of expected to a certain degree to perform. People say, okay, she's back at work.

And another said:

> When there are certain things that need to be done... when you're talking about a patient, I mean, you just can't... when the clock strikes 3 or 4 or whatever, you just can't get up and walk away.

Some carried this guilt to the home, noting they felt guilty about not being able to contribute fully to their household activities as a result of their injury and/or illness. This was reflected in this comment:

> And it's definitely impacted on my family because, I mean, they've had to change their whole concept of what mom can do and what mom can't do. And you know when you... and when you're at home you can't do anything. It doesn't make you feel very worthwhile, so to speak, as well, right?

One worker noted that there were no negative feelings verbalized with regards to their peers and their perceptions of them as a recovering worker. This worker noted that she perceived good support from her peers, as noted in this quote:

> They [peers] treated me real good. Like I say, from the day one I went in there and not knowing basically what I was going to be doing or ... you know, again... you know a day... they brought me... they made me feel at ease, you know. There was no pressure, no nothing. For a few days had orientation sort of thing, right. So, you know, but no, I must say they treated me really, really good since I've been here.

This seemed to alleviate the quilt associated with not being able to perform the work activities as per their pre-injury work.

4.3.3 Lack of knowledge about the process

As with the recovery managers and supervisors, the workers who participated in this study either felt that lacked of knowledge about the process and/or felt that their supervisor did not know much about recovery management and return to work. This relates to the comments made by the recovery managers who at times noted that workers were surprised by being contacted by them.

One worker remarked:

> Well, I really don't know what you're talking about because in 2004, when this was started, I don't know, there wasn't much information about it. Is it like ease back or something; like when you return to work?

Another worker admitted:

> So, anyway, the physician had filled out a functional assessment form, and I wasn't quite sure where I had to... it was a good thing that she knew about it because I wasn't really aware of it.

With regards to the perceived knowledge of supervisors by workers, this remark was made by the worker:

> And... because these forms were fairly new, I'm trying to think now if I phone

him (supervisor) first how to… I phone the manager and he didn't know. He said like this is out of my hands, with this new system, I don't know. He didn't really know.

On that same note, this other comment was made:

Well, I think there's something missing between the supervisor… you know, like information I was getting from that… because if they had said… even if the supervisor had said to me, you know, there are programs in place; why don't you go back and speak to so and so in HR or in staff health or something like… like I feel they should've had that information to give me when I was kind of like at odds as to who to turn to, and they certainly didn't say, well, go to speak to staff health or go speak to HR with your issue. You know, like… it seemed all they could say is we don't deal with sick leave anymore so…

4.3.4 Poor communication amongst stakeholders

Some workers noted that they were the ones who had to initiate or ensure the process progressed before they exhausted all their sick leave. Some had concerns about how the whole process was handled and the miscommunication that occurred along the way. This comment was made by one of workers:

I found that the left one didn't know what the right one was doing. There were too many people involved like and it wasn't going up the channels. You know, Human Resources… can't remember… again, I think the Wellness program or something like it that, didn't know what department of Human Resources was doing because they weren't relaying with the unit [nursing unit]. Like Human Resources said I was supposed to start on a certain date. I went down and when I phoned my supervisor up on the unit, they didn't have no… the first time… first time they never heard of me. So I mean, the chain of command wasn't… wasn't going on at all.

Another comment was made on that same issue as noted:

I was seeing… yeah, I was seeing a lot of people. Again, that was my own initiative. I was making appointments, making my own contacts. I was keeping tabs, but no…like nobody was keeping tabs with me. I'd leave messages but nobody would get back to me.

One worker noted:

> ...certainly when you were off sick, you felt like the big issues that you had concerns about weren't being addressed until it was... you know, 2 months into your sick leave.

With regards to communication, many felt that the process of return to work was too slow for them and as a result they lost valuable sick time when they could have been at work in some capacity. They also found that there was too much paperwork associated with getting back to work such as filling out forms and that their recovery manager was too busy to address issues when they were back at the worksite. All of these communication issues seem to lead to the conclusion that communication was ineffective.

One worker remarked:

> ... I think an occupational therapist... and they're really, you know, overbooked and I think they could get things done faster that way, you know, got to an external person.

Another worker said:

> It was mostly me contacting... I was making most of the contact. Most of it [communication] was done by me like through the Wellness Centre.

Others felt that they would have liked to have their restrictions clearly communicated to not only their supervisors but also to their peers as they were concerned that their restrictions would not be respected. This made them fearful of re-injury or becoming ill once again.

One worker remarked:

> I felt that my doctor was going to be... I felt she was going to be very specific in what I could and could not do and I thought that this would be relayed to the OT, to the manager, I expected and you know, I resigned myself to the fact that I just could not afford to do anything that was going to put me back to where... where I had been. I didn't want to go on that road again.

This worker was concerned that their doctor was not communicating their specific restrictions to other stakeholders including the occupational therapist or the manager.

Whether or not this was accurate is unknown but the perception by this worker was that their restrictions were not specifically communicated and this made them fearful that as a result they may be required to participate in tasks that would put them at risk of re-injury.

Another noted:

> It was just a matter of... you're back to work, then you're back to... normal. Although my doctor had specified on it that he would prefer... you know, he actually wrote the note, you know, he was the one that said to me, what is your work, and what will it involve; and when I said it would be night shifts and he... one of his concerns was being alone because I still had like fainting spells and dizzy spells from (the illness) even though I was recovering. And I still hadn't been completely tested because you know how long it takes to get through the system. Anyways, that was a bit scary for me, not knowing if I was, you know going to be able to do that.

This worker noted that their restriction for work on night shifts was "invisible" to others around them and because their condition was still under medical investigation, they felt at risk if this restriction was not accommodated (not working the night shift) in the workplace. They felt that their specific issues (not able to work night shifts) were not being communicated and this made them fearful of re-injury.

Along the same lines of communication, others felt that they were dealing with too many people, such as a recovery manager, their supervisor, the occupational health physician, their family physician, perhaps a medical specialist or other health care provider in the community, a human resource officer and perhaps, a case manager with the Workplace Health, Safety and Compensation Commission.

One worker noted:

> I believe in dealing with my own doctor... and there's somebody in human resources. Yeah, I don't want to be dealing with 7 or 8 people.

4.3.5 Motivated to return to work

Most workers interviewed wanted to come back to work for intrinsic reasons. This was in contradiction to what was perceived by supervisors and recovery managers who, as noted earlier, perceived that workers were coming back to work because their sick leave ran out.

One worker said:

> And, actually, half the time you're off you wish you were back to work because... what are you doing? Nothing. And you know... you want to be there. You want to be at work. You want to get up in the morning and have your routine and you know, because that's healthy, right?

Another said:

> I mean, gee, I got 2 days off now, today and tomorrow and I'm kind of looking forward to Thursday. You know, it's nice to have that break and if you haven't got a lot to do... oh yeah, sometimes, I thinks I'd sooner be working and that's what I lost for a period of time.

This worker expressed his desire to be at work even on his days off and noted that when he was off sick for a period of time felt that he had lost the feeling of being a productive member of the community and a sense of contributing.

In summarizing, workers felt that it was important for them to feel appreciated for their efforts to return to work. Even though they wanted to return to work, they were fearful about re-injury or becoming sick again due to either poor communication problems and/or lack of understanding on the part of their supervisors. They also felt guilty at times as well about their perceived inability to fully complete all their job duties.

Recovery managers, supervisors and workers who have participated in recovery management and return to work can provide valuable insight in these processes. In this chapter, recovery managers who participated in this study found the introduction

recovery management to their already busy workload to be difficult to manage effectively. Due to the increased workload they found it difficult to complete essential tasks such a frequent and timely communication with workers, supervisors and health care providers on the progress of the worker in recovery and attempting return to work. They also noted the general lack of knowledge of other stakeholders about the processes of recovery management and return to work.

The supervisors in this study felt conflicted about their role in facilitating recovery and return to work. While they supported the processes, they felt that these impacted on the productivity of the functioning of their department or area. They also felt uninformed about the processes.

The workers in this study generally found the process of recovery and return to work to be difficult for them in terms of being worried about re-injury and/or fearful of relapse. They generally wanted to be back to work and felt that it was important that they be recognized for their efforts in returning to work given their fears and apprehension about this. Communication issues were also felt by workers as being at the heart of some of those fears such as not being able to talk to their recovery manager in a timely fashion and/or not knowing about the process of recovery management and return to work and the importance of their role in these.

CHAPTER 5: DISCUSSION

The purpose of this study was to explore and describe the views of different groups of stakeholders who have experienced recovery management and return to work in a large tertiary health care organization. The specific objectives were to explore the perspectives and viewpoints of recovery managers, supervisors and workers who were involved in the process of recovery management and return to work. The participants were provided with an opportunity to describe their perspectives in a confidential setting through the use of open-ended questions and discussion. This was done by conducting interviews with participants from each group with a thematic analysis of the transcribed interviews. The results of this study showed that the recovery and return to work process is indeed a complex process involving stakeholders with distinct objectives, priorities and roles. Their differing viewpoints are a reflection of the dynamic nature of their interactions with each other and the meanings they attribute to the behavior of others related to the work environment.

As themes related to recovery management and return to work emerged, a visual representation consisting of themes for each group of respondents and how these overlap, was developed based on the data analysis (Fig. 1).

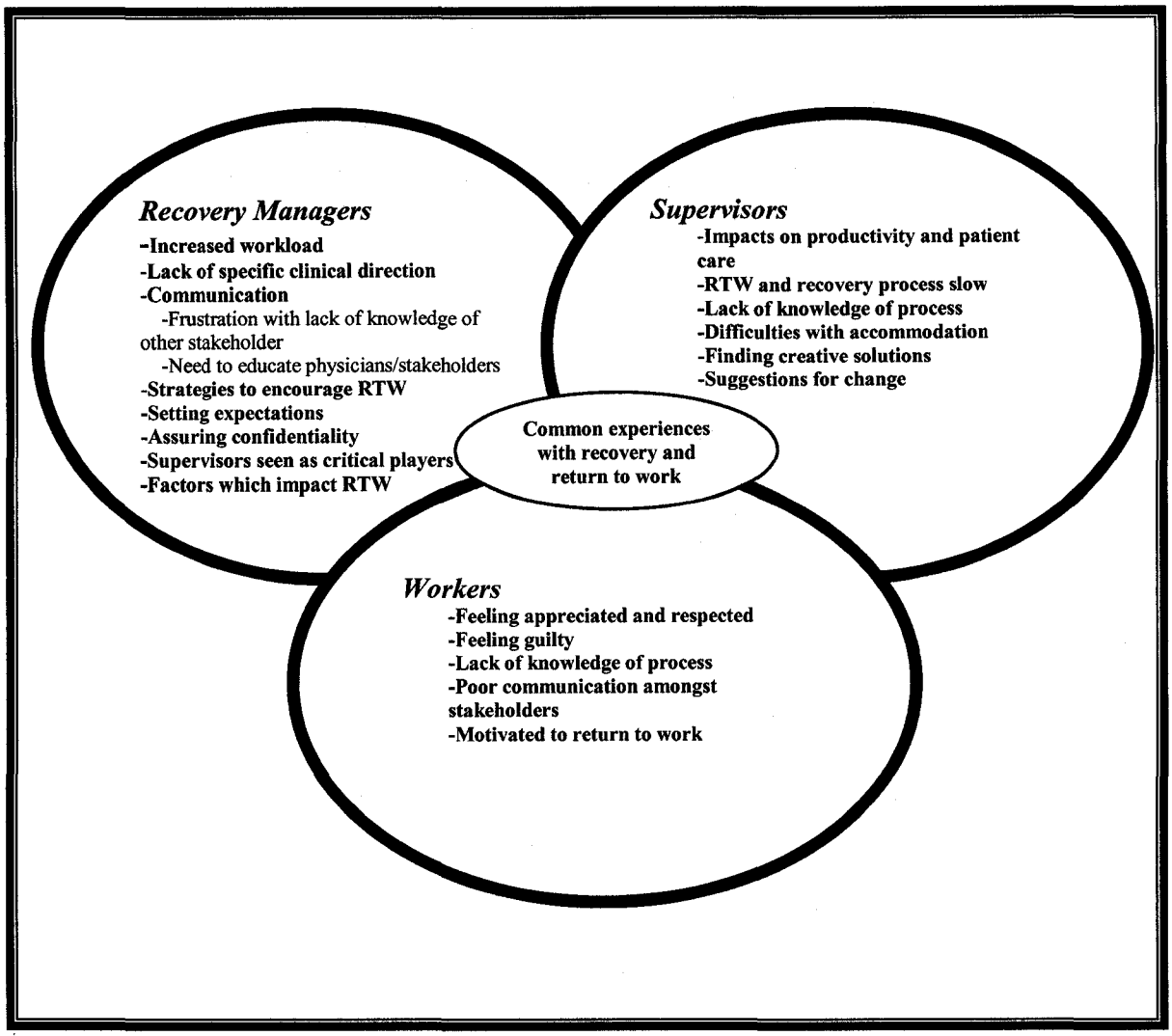

Fig. 1. Reported experiences of stakeholders regarding recovery and return to work.

5.1 Common Themes

5.1.1 Lack of knowledge

One of the findings of this study is that all three groups of participants in this study felt that they lacked knowledge of the process of recovery management and return to work. The supervisors were perceived as being the least knowledgeable about the process by the recovery managers and the workers. By their own admission, they also felt

misinformed about the process and noted that they did not educate themselves until they were required to do so in the process of accommodating a recovering worker. It would be reasonable to conclude that if any one of the major stakeholders (the worker, recovery manager, or supervisor) was not fully aware of the process, this could potentially lead to delays in the process of recovery and return to work of workers within an organization. This is supported by McLellan et al., (2001) who found that it may be worthwhile addressing attitudes and practices that affect return to work with supervisors, including their basic knowledge of the process as this may improve disability outcomes of work-related musculoskeletal disorders.

All workers within an organization who could potentially become participants in a recovery management and return to work process, should also be fully aware of the process if they are to be full participants. Much of the rehabilitation that is associated with return to work requires active participation on the part of the worker and without proper knowledge of the process, the worker is likely to be more passive as opposed to proactive in keeping the process moving. Friesen et al., (2001) also identified the delivery or processing of information (or lack thereof) as a potential barrier to returning to work, in addition to ineffective communication by all stakeholders. Shrey (2000) also recognized the need for good dissemination about information of the process of return to work to all stakeholders as an essential component to effective return to work planning.

5.1.2 Communication

This study has suggested that effective communication amongst all stakeholders was important to successful return to work. This is also well supported by the existing research (Baril et al., 2003). Some of the comments on communication in this study

focused on the lack of expedient written and verbal communication and/or the need for a lot of paperwork for the process to occur.

Other comments on communication were conflicting in that although there was a recognized need to communicate accurate and important information amongst all stakeholders, this was sometimes hindered by the need to maintain confidentiality for workers, particularly with certain diagnoses. The participants in the study who commented on communication seemed to recognize the need for effective communication, however they also acknowledged the need to ensure that confidential medical information about the worker was not communicated in meetings and/or with certain individuals who did not have the right to it. With potentially wide ranging stakeholders, confidentiality could easily be violated inadvertently leading to mistrust on the part of the worker. This is especially true in situations where co-workers may complain to supervisors about a recovering worker who has no visible functional deficit. Supervisors may feel compelled to explain and inadvertently provide more information about the worker, particularly when others are expected to work harder to fill the gaps.

Friesen, Yassi and Cooper (2000) also note that facilitators of return to work include effective communication and teamwork as well as trust and credibility among stakeholders. The workers in this study were more concerned with communication that was occurring between their health care provider or physician and their employer. This was particularly noted in regards to their restrictions related to their condition and whether or not they would be appropriately accommodated in the workplace.

Some workers experienced fear when returning to the worksite because they felt that their restrictions had not been clearly communicated. Whether they were placed on a

return to work schedule that was contraindicated by their treating physician (as in working a night shift when this was not advised) or working on a nursing unit with the staffing level requiring them to take on more responsibility that was not within their functional abilities, they felt that this was a result of their particular restrictions not being communicated to their supervisor. This was compounded by their perception that their recovery manager was not always available or readily accessible to ensure that these restrictions were communicated to the supervisor.

5.1.3 Workers feeling appreciated

Another common theme that emerged was that of respect and the need to ensure that workers feel appreciated when returning to the worksite after a period of absenteeism. Some supervisors in this study discussed this, in addition to several workers in this study. It seemed that if the worker felt welcomed back to the worksite, they were more positive about the process in general, whether or not they were medically ready or not. This finding is similar to that in Shaw et al.'s (2003) study where the authors found that the interpersonal aspects of the supervision such as communicating with workers, responsiveness, concern for welfare, empathy/support, validation and fairness/respect, may be as important as the physical work accommodation, in facilitating return to work after injury.

Interestingly, although the supervisors perceived the other workers (peers) as sometimes resentful of the recovering worker as getting "special treatment" through accommodation, the workers who participated in this study did not perceive this problem with their peers or did not verbalize this in this study. The workers in this study seemed to feel more pressure from their supervisors as opposed to their own peers in that they

were placed on a certain schedule despite being on an "easeback" or feeling like they need to complete tasks which might be harmful. This finding seems to mirror some of the results which were noted in the Fisher (2003) study which found that perceptions differed between the workers and the supervisor on variables of job satisfaction, worker relationships and work environment. As with the Fisher study, the supervisors and workers in this study perceived different issues regarding relationships at work and the work environment when returning to work

This issue of feeling appreciated was closely related to the need for meaningful and useful tasks for the worker to perform when back at the worksite. The difficulties and challenges in trying to accommodate recovering workers in meaningful tasks seemed to become the responsibility of the supervisors, based on this study. It is reasonable to conclude that the supervisors would find this frustrating considering that it may not be very easy for them to find tasks in their area that are meaningful to the worker, (this may vary greatly from one worker to the next), which will meet the needs of the department or the area they supervise, and which will be within the worker's functional abilities and limitations.

5.1.4 Workload issues

Several recovery managers felt that their workload had increased after more formal recovery management and return to work processes were introduced in this organization. Some noted that it was difficult for them to take on the extra activities associated with what was termed by the organization as "recovery management guidelines". These activities, such as completing specific documentation, using specific verbal scripts when contacting recovering workers and communicating with specific

individuals, conflicted with their usual activities as part of the human resources employee wellness department (such as providing immunizations for staff or performing ergonomic work station review). The principal investigator found that many recovery managers were difficult to reach at times and some had to reschedule their interview time. In comparison, the interviews with the workers and the supervisors were easily scheduled and all were completed fairly quickly as compared to those with the recovery managers.

Additionally, workers also talked about how busy their recovery managers were and how they felt they were difficult to reach at times. It is easy to see that if a worker is at the worksite on a return to work program with specific restrictions and faced with the introduction of new tasks which may be contraindicated in relation to their illness or injury, that they might be fearful of re-injury or set-back. This fear could be compounded if they can not reach anyone to discuss these issues, particularly their assigned recovery manager who would be the link between the supervisor and the worker in terms of the medical information on this worker.

Supervisors also felt that their workload was increased whenever they were accommodating a worker back to the worksite. Some of the activities associated with increased workload included having to re-work schedules and find replacement staff, for example, to ensure that the productivity of their unit remained the same. Additionally, activities such as training in new staff or having to do more work themselves were noted to contribute to their increased workload.

5.2 Recovery manager specific themes

Themes which were specific to recovery managers about recovery management and return to work, would be those related to their workload and conflict with other duties. They often expressed frustration in not having the time to spend with individual workers to deal more in depth with psychosocial issues such as fears of re-injury, depression and anxiety, and other issues associated with return to work. Additionally, they also had concerns about not having the resources to spend on workers who were struggling with mental health issues. The recovery managers seemed to feel strongly that it was just as important to address these psychosocial issues with recovering workers, as well as the physical limitations associated with their injury and illness, if successful return to work was going to be the outcome of their intervention.

Another comment made by some of the recovery managers was the issue related to workers participating in recovery management more fully once they had exhausted their sick leave. They described frustration at times in trying to address return to work issues with workers who were determined to get back to work due to the financial implications associated with a delay in this process, when in fact they may not have been fully ready given their health status. The recovery managers felt that it would have likely been more beneficial for the worker to fully participate in recovery management earlier in the recovery and subsequently return to work.

On the other hand, it was evident that individual recovery managers had developed practice strategies which enabled them to deal with time constraints in their schedule or which would facilitate effective communication between them and the health care providers in the community. Examples of these strategies included automatically

sending a letter to the treating physician as soon as worker was referred to them and performing all the recovery management work on a given day or half day. Although Shaw et al. (2003) specifically focused on work related upper extremity disorders, they noted that problem solving skills training may help focus case management services (or recovery management) on the most salient recovery factors affecting return to work. The results of this study, as well as those of Shaw et al. (2003) suggest that it may be worthwhile looking at site specific and/or diagnostic specific strategies for recovery managers to provide them with better skills and resources to address recovery and return to work.

5.3 Supervisor specific themes

In relation to recovery management, supervisors in this study felt that it was often frustrating for them to try to meet the productivity needs of their clinical or support service area while trying to accommodate recovering workers back at the worksite who were perceived as not being fully productive. It was also noted that recovering workers who were new to the area often needed a period of training and adjustment which also affected the productivity of their department or unit. This role conflict experienced by the supervisors in this study (being responsible for production quotas and return to work activities) was also observed by Baril et al. (2003). They concluded that these difficulties could be alleviated by innovations such as consideration of return to work program responsibilities in the determination of production quotas and in performance evaluations.

Supervisors were also candid in admitting their lack of knowledge of the recovery management and return to work process. Although they understood that they were

obligated to accommodate recovering workers and usually had a basic understanding of the process, they also felt that they had insufficient knowledge, particularly when dealing with complicated issues. Some of the issues they found difficult to deal with were the psychosocial issues that workers often face when returning to work such as fears of re-injury or pain, poor pain coping strategies and abilities at the worksite or issues at home in addition to their injury or illness. Workers who were suspected by their supervisors of having mental health problems and/or addiction issues were also noted by the supervisors as being more challenging to accommodate, particularly when the supervisors themselves did not have a clinical background. The supervisors who participated in this study also perceived that it was difficult to deal with the frustrations of other co-workers when trying to accommodate the needs of a recovering worker. They noted that it was difficult for them to compromise the needs of one worker for the needs of another without having the ability to discuss the confidential issues of the recovering worker.

McLellan et al. (2001) were able to demonstrate in their pre- and post training results that supervisors were more confident when investigating and modifying job factors contributing to injury, getting medical advice and answering workers' questions related to their injury and treatment. The training sessions consisted of the reinforcement of proactive and supportive responses to symptoms and injuries from employees. The authors in this study also noted that more supervisors reported decreases than increases in lost work time within their departments. The results of this study suggest that it may be worthwhile spending time on educating the supervisors on the gaps that they verbalize, which are specific to the needs and the needs of the organization.

5.4 Worker specific themes

It is difficult to know if the group of workers who participated in this study was biased either negatively or positively towards the process of recovery management and return to work. The worker participants seemed happy to be back at work and the recovery management process had enabled them to do so, therefore the outcome was good from their perspective. Process issues included feelings of lack of support and appreciation from their supervisors when attempts to return to work were initiated. Shaw et al. (2003) observed similar findings in their study on employee perspectives and on the specific role of the supervisors in return to work after an injury. Workers in the Shaw study found it just as important for their supervisors to provide empathy, support, validation of their injury and pain, and respect, as for them to provide suitable tasks (from a physical standpoint).

Additionally, the pressures felt by the supervisors regarding their role conflict, appeared to be wearing on the worker participants in this study. For example, if the supervisor needed a staff person on a given day to ensure that all the jobs on a particular unit and/or shift would be completed, the workers noted that they felt pressured by their supervisor to fill those gaps, despite not being fully recovered. On the other hand, the workers in this study did not seem to feel any direct pressure from their peers when they returned to work. In fact some of the workers in this study felt supported by their co-workers when they returned. As discussed in the previous section, it appears that the supervisors however, were the ones who felt the pressures from the co-workers, which added further to their already existing perceived pressures. It appears that some of the

supervisors' may have, in turn, been placing that additional burden back onto the recovering workers.

Some workers also felt at risk of re-injury, perhaps because of the perceived lack of support by the recovery managers or because of their perceived lack of support and understanding from their supervisor. The recovery managers confirmed this perception of the workers noting that they also felt that they did not have the time to address certain issues with recovering workers. The supervisors also admitted to having difficulties in addressing more complicated health problems (including mental health) and having difficulties with the psychosocial limitations of the worker.

5.5 Strengths and limitations of the study

Having the opportunity to obtain the view points of three groups of stakeholders with diverse perspectives, would be considered the strengths of this study. This provided not only substantial variability amongst the three groups but strengthened the common themes which emerged amongst the three groups. The fact that all three major stakeholders in return to work were included in this study would be strength of this study.

Another strength of this study would be the principal investigator's clinical experience in this area of study. My experience in this study could strengthen the analysis because I would be sensitive to the themes which may have been overlooked by another less experienced principal investigator. Working as a consultant in occupational rehabilitation, I have been involved in coordinating recovery programs and return to work plans for employers and workers. As a result I have seen what the barriers and facilitators can be in returning to work after a period of injury or illness and have been involved in

trying to remediate the barriers. I think this may have contributed to the identification of issues and themes that may or may not otherwise have been identified by another researcher in the analysis of the interview transcripts.

Although the semi-structured interview format was appropriate for simply identifying central themes in each of the stakeholder groups, there may have been researcher bias in leading the interview. Careful attention was given however, to avoid leading the participants by referring to the interview guide whenever there was a lull in the interview or the participant was finished making a specific point. Given that my experience in consulting in occupational health has been primarily with employers as opposed to workers, there could have been some orientation towards management issues as opposed to worker issues in the analysis of the transcripts. The transcripts were read and analyzed solely by the principal investigator therefore any other analytic perspective would be missing from this study.

Another limitation of this study was the fact that the worker participants self-selected and this may have led to the participation of only those workers in particular, who were either more satisfied with recovery management or those who were not. As well, where the interviews were limited to those workers who had completed recovery management (upon the recommendation of HIC) it is difficult to say if those who were still actively involved in the process would have had differing views.

Approximately 40 packages were prepared for the human resources department, which was the estimated number of recovered workers who met the criteria for this study (as per HIC) with a response rate of approximately 12%. No additional recruitment

efforts could be attempted as the whole population had already been canvassed so there was no way of recruiting any more workers for this study.

Another limitation of this study would be in relation to the recovery managers and the supervisors. Although these two groups were not seen to be nearly as vulnerable from a research perspective, it may be that these individuals may have been reluctant to speak negatively or voice their true opinions about a service that is funded by their employer.

5.6 Conclusions

This study was designed to explore the potentially wide ranging views of stakeholders in recovery management and subsequent return to work. The findings showed that it was believed by the participants that all stakeholders in the recovery management process should be knowledgeable of the process in order to avoid delays in the process and miscommunication, particularly when returning to work. Additionally, it was perceived by the participants that it was important for the recovering worker to feel appreciated and to be involved in meaningful return to work activities in order for return to work to be successful. Increased workload was felt to be an issue for both the recovery managers and supervisors with more specific themes for each group of participants.

This study could provide the basis for further outcome research into the recovery management process by identifying the variables which impact on return to work, in the views of the stakeholders, and perhaps lead to development of more specific recommendations for implementing educational, financial and human resources support, into the recovery management program, or perhaps any other program which could address sickness and/or work related injury. For example, it might be useful to focus on a

specific nursing unit where workers are prone to shoulder injuries and develop a recovery management program with these specific parameters in mind.

The results of this study have shown that it was believed by the participants that all stakeholders in the recovery management process should be knowledgeable of the process in order to avoid delays and miscommunication, particularly when returning to work. Additionally, it was perceived by the participants that it was important for the recovering worker to feel appreciated and to be involved in meaningful return to work activities in order for return to work to be successful. Specific thematic analysis for each group revealed that recovery managers felt that increased workload was an issue for them since the implementation of a formal recovery and return to work process within their organization. The supervisors felt conflicted in trying to meet their production quotas in addition to accommodating recovering workers in their area. Workers often felt the process did not allow for good follow-up upon return to the worksite and that they did not receive adequate support from their supervisors and recovery manager leading to fears of re-injury or medical setback.

It is concluded from this study that a formal recovery management and return to work process was generally supported by the participants in the study. However, common concerns among all stakeholders such as education around the process, effective communication and ensuring the recovering workers felt appreciated and supported when returning to work were identified as needing further development by the participants. The results of this study show that there are wide ranging implications for stakeholders when addressing recovery and return to work issues in the workplace.

5.7 Recommendations

In terms of recommendations for further research in this area, there is a need to continue to explore the views of the various stakeholders in the recovery management and return to work process. Investigating issues in other types of work environments such as private versus public sectors, unionized versus non-unionized environments and looking at industry specific areas, such as the fishing in industry in Newfoundland and Labrador, for example, may be of value to stakeholders.

More targeted studies could also address specific categories of absenteeism such as work-related injuries and illnesses, versus non-work related problems like needing to take time off to care for children or an ailing parent, or investigate specific categories of injuries or illness such as chronic low back pain or specific categories of workers. The benefits of more targeted research are that it may provide more targeted recommendations or solutions for employers and workers alike in dealing with problems. For example, investigating the perceptions of administrative assistants with upper extremity disorders such as carpal tunnel syndrome may lead to different recommendations from those associated with an investigation of the same condition with sheet metal workers.

Outcome related research would also be useful to pursue in terms of what kinds of strategies are effective, both from a financial and human resources perspective. In light of this study, it might be useful to investigate which recovery management and return to work strategies work best and what level of effort is required on the part of all stakeholders to accomplish this.

Finally, the connection between meaningful work activities, job satisfaction and successful recovery and return to work, needs further exploration. Workers who are seemingly satisfied with their work pre-morbidity verbalize the need to feel useful and needed when returning to the worksite.

Because of all the different stakeholders associated with the recovery management and return to work process, the writer recommends the use of participatory action research principles when investigating occupational rehabilitation problems. This type of research is well suited to this environment because the participants are part of the research investigating team and part of finding solutions to problems which directly impact them in the long term. This includes involving unions, managers, human resources and all other levels of governance within organizations to work together to find evidence-informed solutions to complex problems. Participatory action research also allows for some flexibility for change as the research process progresses, in coordination with the changes which may be occurring within an organization.

On a more practice-related level, it seems that issues around workload for recovery managers need to be addressed if the process of recovery management is to be perceived as a worthwhile program by both the employer and the workers. Recovery managers expressed a struggle in managing their workload, and recovery management was perceived as an added responsibility for them, without the addition of new resources. In that light, it might be worthwhile exploring the possibility of allocating recovery managers solely this activity or reducing their responsibilities in other areas. Considering the specialized practice associated with recovery management, it is easy to see how nurses and occupational therapists who do this type of work may become frustrated at not

being able to spend the amount of time they feel is required to meet best practice guidelines. The fact that workers felt that they did not have the support and guidance by their recovery manager when returning to the worksite is alarming when considering the time, energy and resources that are spent by all stakeholders, including the worker, in getting back to the worksite after illness or injury related absenteeism.

It may also be beneficial for recovery managers to have practice-related meetings to share ideas and strategies, particularly in dealing with more complicated cases, through case conferencing and/or rounds. This may also lead to more specific guidelines around recovery management with certain diagnoses and/or certain areas of the organization. For example, it may be worthwhile to have a different set of guidelines specifically for use with pregnant nurses versus guidelines for use with individuals with chronic mental health issues.

Supervisors and all other workers within the organization would certainly benefit from ongoing education around the process of recovery management and return to work. Issues around accommodation, easing back, transitional work, modified work and all the paperwork associated with this, should be clearly communicated on an ongoing basis to all employees, to avoid any confusion about how to proceed and perhaps prevent further delays in the process.

Supervisors in particular may also benefit from added resources (such as more staff) and support from human resources, particularly in areas where there is traditionally a lot of bumping and/or accommodating of workers occurring. As Baril et al. (2003) have suggested, it may also be useful to acknowledge these types of activities by the

supervisors (participating in the coordination of return to work activities), in their performance appraisals.

For workers, it is recommended that frequent, timely and encouraging feedback be provided when they return to the worksite after a period of absenteeism, whether they return to full duties or not. This type of feedback could include ensuring that workers get a phone call from their recovery manager on any problem tasks, symptoms and/or pain they might be experiencing, especially in the early phases of return to work. It could also include encouraging them to discuss relationships with peers and supervisors now that they are back in the workplace. This could be followed by mutual problem solving to address issues before they become unmanageable. If feedback is to be provided by the recovery managers, the resources need to be available for these individuals to do this. Workers need to know that they are appreciated for their efforts, not only in their day to day work activities, but particularly if they are working in pain, discomfort, with guilt, and/or in fear of re-injury or medical set-back.

In concluding, there is no doubt that as the costs associated with sickness and injury related absenteeism continues to rise, the need to explore the issues to find solutions will also rise. Due to the variety of stakeholders and varying interests, there is even a greater need to ensure that occupational health research is objective and of sound scientific rigor.

REFERENCES

Armstrong, T.J., Haig, A.J., Franzblau, A., Keyserling, W.M., Levine, S.P., Martin, B.A., Ulin, S.S., & Werner, R.A. (2000). Medical and rehabilitation in the workplace: emerging issues. *Journal of Occupational Rehabilitation. 10(1),* 1-6.

Ballard, T.J, Corradi, L., Lauria, L., Mazzanti, C., Scaravelli, G., Sgorbissa, F., Romito, P., & Verdechia, A. (2004). Integrating qualitative methods into occupational health research: a study of women flight attendants. *Occupational and Environmental Medicine.* 61, 163-166,

Baril, R., Clarke, J., Friesen, M., Stock, S., Cole, D., & the Work-ready group. (2003). Management of return-to-work programs for workers with musculoskeletal disorders: a qualitative study in three Canadian provinces. *Social Science & Medicine. 57,* 2101-2114.

Bearwood, B.A., Kirsh, B., & Clark, N.J. (2005). Victims twice over: perceptions and experiences of Injured Workers. *Qualitative Health Research, 15,* 30-48.

Bull, N., Riise, T., & Moen, B.E. (2002). Work-related injuries and occupational health and safety factors in smaller enterprises-a prospective study. *Occupational Medicine, 52,* 70-74.

Burton, W.N., & Conti, D.J. (2000). Disability management: corporate medical department management of employee health and productivity. *Journal of Occupational and Environmental Medicine, 42,* 1006-1012.

Carmona, L., Faucett, J., Blanc. P.D. & Yelin, E. (1998). Predictors of rate of return to work after surgery for carpal tunnel syndrome. *Arthritis Care & Research, 11,* 298-305.

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada. (1998 with 2000, 2002 and 2005 amendments) *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.* Retrieved December 8, 2005, from http://www.pre.ethics.gc.ca/english/policystatment/goals.cfm.

Cole, D.C., Mondloch, M.V., & Hogg-Johnson, S. (2002). Listening to injured workers: How recovery expectations predict outcomes-A prospective study. *Canadian Medical Association Journal, 166*(6), 749-754.

Curtis, J. (2004). Integrating disability management into strategic plans: Creating Healthy Organizations. *AAOHN Journal, 52* (7), 298-301.

Department of Human Resources, Eastern Health Regional Authority (2006). Unpublished raw data

Driver, D.F. (2006). Occupational and physical therapy for work-related upper extremity disorders: how we can influence outcomes. *Clinical Occupational and Environmental Medicine.* 5 (2), 471-82.

Franche, R.L., Cullen, K., Clarke, J., Irvin, E., Sinclair, S., Frank, J. & The Institute for Work & Health (IWH) Workplace-Based RTW Intervention Literature Review Research Team (2005). Workplace-based return-to-work interventions: A systematic review of the quantitative literature. *Journal of Occupational Rehabilitation, 15* (4), 607-631.

France, R.L., Cullen, K., Clarke, J., MacEachen, E., Frank, J., Sinclair, S., & Reardon, R. (2004). Workplace-based Return-to-Work Interventions: A Systematic Review of the Quantitative and Qualitative Literature-Summary. Institute for Work & Health. Retrieved April 29, 2007 from http://www.iwh.on.ca/sr/wd_rtw_interventions.php

Feeny, A., North, F., Head, J., Canner, R., & Marmot, M. (1998). Socioeconomic and sex differentials in reason for sickness absence form the Whitehall II Study. *Occupational and Environmental Medicine, 55* (2), 91-98.

Fisher, T.F. (2003). Perception differences between groups of employees identifying the factors that influence a return to work after a work-related musculoskeletal injury. *Work, 21*, 211-220.

Friesen, M.N., Yassi, A., & Cooper, J.(2001). Return-to-work: The importance of human interactions and organization structures. *Work, 17,* 11-22.

Gard, G. & Larsson, A. (2003). Focus on Motivation in the Work Rehabilitation Planning Process: A Qualitative Study From the Employer's Perspective. *Journal of Occupational Rehabilitation, 13* (3), 159-167.

Gatchel, R.J., Polatin, P.B., Noe, C., Gardea, M., Pulliam, C., & Thompson, J. (2003). Treatment and cost-effectiveness of early intervention for acute low-back pain patients: a one year prospective study. *Journal of Occupational Rehabilitation, 13*(1), 1-9.

Hansen, A., Edlund, C., & Henningsson, M. (2006). Factors relevant to a return to work: A multivariate approach. *Work, 26,* 179-190.

Harkness, E.F., MacFarlane, G.J., Nahit, E., Silman, A.J., & McBeth, J. (2004). Mechanical injury and psychosocial factors in the work place predict the onset of widespread body pain: a two-year prospective study among cohorts of newly employed workers. *Arthritis Rheumatology.* 50(5), 1655-64.

Hewitt and Associates (2004, February). *Disability Management Guidelines.* St. John's, NL: Morandini, R.

Hogg-Johnson, S., & Cole, D.C. (2003). Early prognostic factors for duration on temporary total benefits in the first year among workers with compensated occupational soft tissue injuries. *Occupational and Environmental Medicine, 60,* 244-253.

Kirsh, B. & McKee, P. (2003). The needs and experiences of injured workers: A participatory research study. *Work, 21,* 221-231.

Krause, N., Dasinger, L.K., Deegan, L.J., Rudolph, L., & Brand, R.J. (2001). Psychosocial job factors and return-to-work after compensated low back injury: a disability phase-specific analysis. *American Journal of Industrial Medicine, 40,* 374-392.

Krause, N., Frank, J.W., Dasinger, L.K., Sullivan, T.J., & Sinclair, S.J. (2001). Determinants of duration of disability and return-to-work after work-related injury and illness: Challenges for future research. *American Journal of Industrial Medicine, 40,* 464-484.

Krause, N., Ragland, D., Fisher, J., & Syme, S.L. (1998). Psychosocial job factors, physical workload, and incidence of work-related spinal injury: a 5-year prospective study of urban transit operators. *Spine, 23,* 2507-2516.

Lancourt, J. & Kettelhut, M. (1992). Predicting return to work for lower backpain patients receiving worker's compensation. *Spine, 17,* 629-640.

Loisel, P., Lemaire, J., Poitras, S., Durand, M.J., Champagne, F., Stock, S., Diallo, B., & Tremblay, C. (2002). Cost-benefit and cost-effectiveness analysis of a disability prevention model for back pain management: a six year follow up study. *Occupational and Environmental Medicine, 59,* 807-815.

MacKenzie, E.J., Morris, J.A., Jurkovich, G.J., Yasui, Y., Cushing, B.M., Burgess, A.R., Delateur, B.J., McAndrew, M.P., & Swiontkowski, M.F. (1998). Return to work following an injury: The role of economic, social, and job-related factors. *American Journal of Public Health, 88,* 1630-1637.

Maunsell, E., Brisson, C., Dubois, L., Lauzier, S., & Fraser, A. (1999). Work problems after breast cancer: an exploratory qualitative study. *Psycho-oncology,* 8, 467-473.

McGrail, M.P., Calasanz, M., Christianson, J., Cortez, C., Dowd, B., Gorman, R., Lohman, W.H., Parker, D., Radosevich, D.M. & Westman, G. (2002). The Minnesota health partnership and coordinated health care and disability prevention: the implementation of an integrated benefits and medical care model. *Journal of Occupational Rehabilitation, 12,* 43-54.

McLellan, R.K., Pransky, G., & Shaw, W.S. (2001). Disability management training for supervisors: a pilot intervention program. *Journal of Occupational Rehabilitation, 11,* 33-41.

Murdick, N.R. (1998). Predictors of disability among midlife men and women: Differences by severity of impairment. *Journal of Community Health, 13,* 70-84.

Murray, M., & Chamberlain, K. (1999). *Qualitative Health Psychology: Theories and Methods.* London: SAGE Publications Ltd.

Rose, S.L., & Pietri, C.E. (2002). Workers as research subjects: a vulnerable population. *Journal of Occupational and Environmental Medicine, 44,* 801-805.

Sager, L. & James, C. (2005). Injured workers' perspectives of their rehabilitation process under the New South Wales Workers Compensation System. *Australian Occupational Therapy Journal, 52,* 127-135.

Shaw, L., Segal, R. Polatajko, H., & Karburn, K. (2002). Understanding return to work behaviors: promoting the importance of individual perceptions in the study of return to work. *Disability and Rehabilitation, 24 (4),* 185-195.

Shaw, W.S., Feuerstein, M., Miller, V.I., & Wood, P.M. (2003). Identifying Barriers to Recovery from Work Related Upper Extremity Disorders. *AAOHN Journal 51(8),* 337-346.

Shaw, W.S., Robertson, M.M., McLellan, R.K., Verman, S., & Pransky, G. (2006). A controlled case study of supervisor training to optimize response to injury in the food processing industry. *Work, 26,* 107-114.

Shaw, W.S., Robertson, M.M., Pransky, G., & McLellan, K. (2003). Employee Perspectives on the Role of Supervisors to Prevent Workplace Disability after Injuries. *Journal of Occupational Rehabilitation, 13,* 129-142.

Shrey, D. (2000). Worksite Disability Management Model for Effective Return-to-work Planning. *Occupational Medicine, 15,* 789-801.

Silverman, D. (2005). *Doing qualitative research.* London: SAGE Publications Ltd.

Staal, J.B. Hlobil, H., van Tulder, M.W., Waddell, G., Burton, A.K., Koes, B.W., & van Mechelen, W. (2005). Occupational health guidelines for the management of low back pain: an international comparison. *Occupational and Environmental Medicine, 60,* 618-626.

Svensson, T., Karlsson, A., Alexanderson, K., & Nordqvist, C. (2003). Shame-Inducing Encounters. Negative Emotional Aspects of Sickness-Absentees' Interactions with Rehabilitation Professionals. *Journal of Occupational Rehabilitation, 13,* 183-195.

Väänänen, A. (2005). Psychosocial determinants of sickness absence. A longitudinal study of Finnish men and women. People and Work. Research Reports 67. Helsinki, Finland: University of Tampere, Finnish Institute of Occupational Health.

Williams, R.M., & Westmorland, M. (2002). Perspectives on workplace disability management: A review of the literature. *Work 19,* 87-93.

Yassi, A., Tate, R., Cooper, J.E., Snow, C., Vallentyne, S., & Khokhar, J.B. (2002). Cost-benefit and cost-effectiveness analysis of a disability prevention model for back pain management: a six year follow up study. *Occupational and Environmental Medicine, 59,* 807-815.

Zwerling, C., Daltroy, L.H., Fine, L.J., Johnston, J.J., Melius, J., & Silverstein, B.A. (1997). Design and Conduct of Occupational Injury Intervention Studies: a review of evaluation strategies. *American Journal of Industrial Medicine, 32*, 164-179.

APPENDIX A
Interview guide: recovery managers

Questions guide-recovery managers

1. What is your professional background?

2. How long have you been doing this type of work?

3. What kinds if injuries/illness do you typically see?

4. Can you please describe how you use the guidelines?

5. What do find useful/not useful?

6. Tell me what is the first thing you do when you call an injured/ill worker.

7. What are the common issues you see are hindering his/her return

8. How can the guidelines help address these issues?

9. Are there any changes you would like to see and if yes, what are they and why?

APPENDIX B
Interview guide: workers

Questions guide: workers

1. Can you please tell me about your injury/illness?
2. What was the first thing that happened?
3. Who contacted you to address return to work issues?
4. What were some of the issues that you had concerns about returning to work?
5. Were those issues addressed in you return to work plan?
6. If yes how, if no, why do you think they were not addressed?
7. Based on your experience with returning to work after a period of injury/illness, how do you think the process could be improved?

APPENDIX C
Interview guide: supervisors

Questions guide-supervisors

1. How long have you been a supervisor? Can you tell me a little bit about your role as a supervisor (i.e. the number of people you supervise, site(s), program(s), etc.).

2. Can you describe what you know about recovery management?

3. What is your experience with recovery management?

4. What kinds of challenges do you face as a supervisor when asked to accommodate an ill/injured worker who has been off for period of time?

5. How do you address those challenges?

6. What resources do you know of, can you access when return to work of the worker is not progressing?

7. Are there any changes to the process you would like to see and if yes, what are they and why?

APPENDIX D
Supporting letter from Wellness Advisory Committee

HealthCare
Corporation of St. John's

November 12, 2004

RE: Evaluating the effectiveness of the Recovery Management Program at the Health Care Corporation of St. John's

To Whom it May Concern,

Please be advised that this study has been reviewed and is supported by the Wellness Advisory Committee of the Health Care Corporation of St. John's. The Committee was provided with a presentation on the rationale, methods, and implications of the study, by the principle investigator on November 8, 2004 and had the opportunity to discuss and clarify any concerns relating to this study. It is our understanding that this is a qualitative study which will describe the perspectives of the workers and the recovery managers, who participate in recovery management. This study will also look at the cost effectiveness of recovery management. It is also our understanding that the results of this study will be presented to us when completed.

Sincerely,

Chair, Wellness Advisory Committee
Health Care Corporation of St. John's

Corporate Office
Waterford Bridge Road, St. John's, Newfoundland, Canada A1E 4J8 Tel. (709) 777-1300 Fax (709) 777-1302 or 777-1303
Website: www.hcrsj.nf.ca
SITES: General Hospital • Janeway Child Health Centre/Children's Rehabilitation Centre • Dr. Leonard A. Miller Centre
St. Clare's Mercy Hospital • Sir Walter Templeman Health Centre • Waterford Hospital

APPENDIX E
Approval by the Human Investigation Committee

Memorial
University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

February 7, 2005

Reference #04.231

Ms. K. Larouche
C/o Dr. M. Murray
Community Health
Faculty of Medicine
2nd Floor, Health Sciences Centre

Dear Ms. Larouche:

This will acknowledge your correspondence dated February 4, 2005, wherein you clarify issues provide a revised consent form for your research study entitled **"Evaluating the effectiveness of a recovery management program at the Health Care Corporation of St. John's".**

At the meeting held on **January 20, 2005**, the initial review date of this study, the Human Investigation Committee (HIC) agreed that the response and revised consent form could be reviewed by the Co-Chairs and, if found acceptable, full approval of the study be granted.

The Co-Chairs of the HIC reviewed your correspondence, approved the revised consent form and, under the direction of the Committee, granted *full approval* of your research study. This will be reported to the full Human Investigation Committee, for their information at the meeting scheduled for **February 17, 2005.**

Full approval has been granted for one year. You will be contacted for annual update before **January 20, 2005.**

Modifications of the protocol/consent are not permitted without prior approval from the Human Investigation Committee. Implementing changes in the protocol/consent without HIC approval may result in the approval of your research study being revoked, necessitating cessation of all related research activity. Request for modification to the protocol/consent must be outlined on an amendment form (available on the HIC website) and submitted to the HIC for review.

St. John's, NL, Canada A1B 3V6 • Tel: (709) 777-6974 • Fax: (709) 777-7501 • email: hic@mun.ca • www.med.mun.ca/hic

For a hospital-based study, it is your responsibility to seek the necessary approval from the Health Care Corporation of St. John's and/or other hospital boards as appropriate.

This Research Ethics Board (the HIC) has reviewed and approved the application and consent form for the study which is to be conducted by you as the qualified investigator named above at the specified study site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Human Investigation Committee currently operates according to the Tri-Council Policy Statement and applicable laws and regulations. The membership of this research ethics board complies with the membership requirements for research ethics boards defined in Division 5 of the Food and Drug Regulations.

Notwithstanding the approval of the HIC, the primary responsibility for the ethical conduct of the investigation remains with you.

We wish you every success with your study.

Sincerely,

John D. Harnett, MD, FRCPC
Co-Chair
Human Investigation Committee

Richard S. Neuman, PhD
Co-Chair
Human Investigation Committee

JDH;RSN\jjm

C Dr. C. Loomis, Vice-President (Research), MUN
Mr. W. Miller, Director of Planning & Research, HCCSJ

APPENDIX F
Approval by the Human Investigation Committee for continuation of research

Memorial
University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

January 9, 2006

Reference #04.231

Ms. K. Larouche
C/o Dr. M. Murray
Community Health
Faculty of Medicine
2nd Floor, Health Sciences Centre

Dear Ms. Larouche:

Thank you for taking the time to complete the annual update form for the research study entitled "**Evaluating the effectiveness of a recovery management program at the Health Care Corporation of St. John's**".

The Chairs of the Human Investigation Committee have reviewed your annual update form and have granted approval of this study until **January 20, 2007**, at which time you will be contacted for another update. This will be reported to the full Human Investigation Committee, for their information, at a meeting scheduled for **January 19, 2006.**

Sincerely,

Richard Newman, PhD
Co-Chair
Human Investigation Committee

John Hamett, MD, FRCPC
Co-Chair
Human Investigation Committee

RN;JHjd

APPENDIX G
Approval by the Research Proposal Approval Committee

105

HealthCare
Corporation of St. John's

February 16, 2005

Kim Larouche
2 Byron Street
St. John's, NL
A1B 3B7

Dear Ms. Larouche :

Your research proposal *"HCC # 04.231 - Staff and employee perceptions of the Recovery Management Program at the Health Care Corporation of St. John's"* was reviewed by the Research Proposals Approvals Committee (RPAC) of the Health Care Corporation of St. John's at its meeting on February 24, 2004 and we are pleased to inform you that the proposal has been approved.

This approval is based on the understanding that it has the necessary funding and that it is being conducted as outlined in the approved research proposal. Additionally, the Committee requires a progress report to be submitted annually and upon completion of the project, the committee would appreciate receiving copies of any published articles, abstracts or conference presentations. This information would be used to facilitate knowledge dissemination within the Health Care Corporation of St. John's.

If you have any questions or comments, please contact Lynn Purchase, Manager of the Patient Research Centre at 777-7283.

Sincerely,

Mr. Wayne Miller
Director, Planning and Research
Chair, RPAC Committee

cc: Ms. Lynn Purchase, Manager, Patient Research Centre
Dr. M. Murray, Community Medicine, MUN

APPENDIX H
Consent to participate-recovery managers

October 2003

Faculty of Medicine, Schools of Nursing and Pharmacy of Memorial University of Newfoundland; Health Care Corporation, St. John's; Newfoundland Cancer Treatment and Research Foundation

Consent to Take Part in Health Research

TITLE: Staff and employee perceptions of a Recovery Management program at the Health Care Corporation of St. John's.

INVESTIGATOR(S): Kim Larouche

SPONSOR:

You have been asked to take part in a research study. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

As the researcher, I will:

- **discuss the study with you**
- **answer your questions**
- **keep confidential any information which could identify you personally**
- **be available during the study to deal with problems and answer questions**

If you decide not to take part or to leave the study this will not affect your work situation and role as a recovery manager with the Health Care Corporation of St. John's.

1. Introduction/Background:
In February 2004, the HCCSJ implemented a recovery management policy, in part to manage the increasing costs of injury/illness related absences but also to provide workers with added support with return to work, in the event of an injury/illness. This study is designed to obtained information from both the individuals who would be involved in receiving the assistance of a recovery manager and the recovery managers themselves.

2. Purpose of study:
The purpose of this study is to gain the input from stakeholders of the Recovery Management program and to document common issues, with the ultimate goal of improving the program.

3. Description of the study procedures and tests:
If you agree to participate, you will be asked to answer a series of questions developed by myself. Some questions will provide with a choice of answers the majority of the questions will involve you providing your own thoughts on the question. I will schedule only one time to meet with you, at your convenience.

4. Length of time:
The interview should take no longer than 30 minutes.

5. Possible risks and discomforts:
There are no physical, emotional or socials risks associated with this study however it might be inconvenient for some to schedule time in their workday to participate in the interview.

6. Benefits:

It is not known whether this study will benefit you directly, but it will provide you with an opportunity to have some input in the recovery management program.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells me that you understand the information about the research study. When you sign this form, you do not give up your legal rights. As a researcher involved in this research study, I still have legal and professional responsibilities.

8. Questions:

If you have any questions about taking part in this study, you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Office of the Human Investigation Committee (HIC)
Email:

Signature Page

Study title: Staff and employee perceptions of the Recovery Management Program at the Health Care Corporation of St. John's

Name of principal investigator: Kim Larouche

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent [and information sheet].	Yes { }	No { }
I have had the opportunity to ask questions/to discuss this study.	Yes { }	No { }
I have received satisfactory answers to all of my questions.	Yes { }	No { }
I have received enough information about the study.	Yes { }	No { }
I understand that I am free to withdraw from the study	Yes { }	No { }

- at any time
- without having to give a reason
- without affecting my work status or my role as a recovery manager with the Health Care Corporation of St. John's.

I understand that it is my choice to be in the study and that I may not benefit.

Yes { } No { }

I agree to take part in this study.	Yes { }	No { }
I understand that my interview will be audio-taped.	Yes { }	No { }

_____ _____

Signature of participant Date

_____ _____

Signature of witness Date

To be signed by the investigator:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____

Signature of investigator Date

Telephone number: _____

APPENDIX I
Consent to participate-workers

October 2003

Faculty of Medicine, Schools of Nursing and Pharmacy of Memorial University of Newfoundland; Health Care Corporation, St. John's; Newfoundland Cancer Treatment and Research Foundation

Consent to Take Part in Health Research

TITLE: Staff and employee perceptions of the Recovery Management program at the Health Care Corporation of St. John's.

INVESTIGATOR(S): Kim Larouche

You have been asked to take part in a research study. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

As the researcher, I will:

- **discuss the study with you**
- **answer your questions**
- **keep confidential any information which could identify you personally**
- **be available during the study to deal with problems and answer questions**

If you decide not to take part or to leave the study this will not affect your work situation, worker's compensation benefits you may receiving or may receive in the future.

6. Introduction/Background:
In February 2004, the HCCSJ started a recovery management policy, in part to manage the increasing costs of injury/illness related absences but also to provide workers with added support with return to work, in the event of an injury/illness. This study is designed to obtained information from the individuals who would be involved in receiving the assistance of a recovery manager, the recovery managers themselves and the supervisors who accommodate the workers back in the workplace.

7. Purpose of study:
The purpose of this study is to gain the input from all involved in the Recovery Management program and to find common issues, with the goal of improving the program.

8. Description of the study procedures and tests:
If you agree to participate, you will be asked to answer a series of questions developed by myself. Some questions will provide with a choice of answers the majority of the questions will involve you giving your own thoughts on the question. I will schedule only one time to meet with you, whenever is best for you.

9. Length of time:
The interview should take no longer than 30 minutes.

10. Possible risks and discomforts:
There are no physical, emotional or socials risks associated with this study however you might need to take some time in your workday to participate in the interview.

11. Benefits:
It is not known whether this study will benefit you directly, but it will provide you with a chance to have some input in the recovery management program.

12. Liability statement:
Signing this form gives us your consent to be in this study. It tells me that you understand the information about the research study. When you sign this form, you do not give up your legal rights. As a researcher involved in this research study, I still have legal and professional responsibilities.

13. Questions:
If you have any questions about taking part in this study, you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Office of the Human Investigation Committee (HIC)
Email:

Signature Page

Study title: Staff and employee perceptions of the Recovery Management program at the Health Care Corporation of St. John's

Name of principal investigator: Kim Larouche

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent [and information sheet].	Yes { }	No { }
I have had the opportunity to ask questions/to discuss this study.	Yes { }	No { }
I have received satisfactory answers to all of my questions.	Yes { }	No { }
I have received enough information about the study.	Yes { }	No { }
I understand that I am free to withdraw from the study	Yes { }	No { }

- at any time
- without having to give a reason
- without affecting my work status, any worker's compensation benefits I may be receiving now or in the future

I understand that it is my choice to be in the study and that I may not benefit.	Yes { }	No { }
I understand that my interview will be audio-taped.	Yes { }	No { }
I agree to take part in this study.	Yes { }	No { }

_____ _____

Signature of participant Date

_____ _____

Signature of witness Date

To be signed by the investigator:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____

Signature of investigator Date

Telephone number: _____

APPENDIX J
Consent to participate-supervisors

October 2003

Faculty of Medicine, Schools of Nursing and Pharmacy of Memorial University of Newfoundland; Health Care Corporation, St. John's; Newfoundland Cancer Treatment and Research Foundation

Consent to Take Part in Health Research

TITLE: Staff and employee perceptions of a Recovery Management program at the Health Care Corporation of St. John's.

INVESTIGATOR(S): Kim Larouche

You have been asked to take part in a research study. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

As the researcher, I will:
- **discuss the study with you**
- **answer your questions**
- **keep confidential any information which could identify you personally**
- **be available during the study to deal with problems and answer questions**

If you decide not to take part or to leave the study, this will not affect your work situation and role as a supervisor with the Health Care Corporation of St. John's.

1. Introduction/Background:

In February 2004, the HCCSJ implemented a recovery management policy, in part to manage the increasing costs of injury/illness related absences but also to provide workers with added support with return to work, in the event of an injury/illness. This study is designed to obtained information from the individuals who would be involved in receiving the assistance of a recovery manager , the recovery managers themselves and the supervisors who accommodate workers back in the workplace.

2. Purpose of study:

The purpose of this study is to gain the input from stakeholders of the Recovery Management program and to document common issues, with the ultimate goal of improving the program.

3. Description of the study procedures and tests:

If you agree to participate, you will be asked to answer a series of questions developed by myself. Some questions will provide with a choice of answers the majority of the questions will involve you providing your own thoughts on the question. I will schedule only one time to meet with you, at your convenience.

4. Length of time:
The interview should take no longer than 30 minutes.

5. Possible risks and discomforts:
There are no physical, emotional or socials risks associated with this study however it might be inconvenient for some to schedule time in their workday to participate in the interview.

6. Benefits:
It is not known whether this study will benefit you directly, but it will provide you with an opportunity to have some input in the recovery management program.

7. Liability statement:
Signing this form gives us your consent to be in this study. It tells me that you understand the information about the research study. When you sign this form, you do not give up your legal rights. As a researcher involved in this research study, I still have legal and professional responsibilities.

8. Questions:
If you have any questions about taking part in this study, you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Office of the Human Investigation Committee (HIC) at 709-777-6974
Email: hic@mun.ca

Signature Page

Study title: Staff and employee perceptions of the Recovery Management Program at the Health Care Corporation of St. John's

Name of principal investigator: Kim Larouche

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent [and information sheet].	Yes { }	No { }
I have had the opportunity to ask questions/to discuss this study.	Yes { }	No { }
I have received satisfactory answers to all of my questions.	Yes { }	No { }
I have received enough information about the study.	Yes { }	No { }
I understand that I am free to withdraw from the study	Yes { }	No { }

- at any time
- without having to give a reason
- without affecting my work status or my role as a supervisor with the Health Care Corporation of St. John's.

I understand that it is my choice to be in the study and that I may not benefit.

	Yes { }	No { }
I understand that my interview will be audio-taped	Yes { }	No { }
I agree to take part in this study.	Yes { }	No { }

_____ _____

Signature of participant Date

_____ _____

Signature of witness Date

To be signed by the investigator:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____

Signature of investigator Date

Telephone number: _____

APPENDIX K
Supporting letter from the Newfoundland and Labrador Association of Public Employees

NAPE

Newfoundland & Labrador Association of Public & Private Employees

330 Portugal Cove Place
P.O. Box 8100
St. John's, NL
A1B 3M9

Tel. (709) 754-0700
Fax (709) 754-0720
Toll Free 800 563-4442
www.nape.nf.ca

Incorporated in 1977

August 10, 2005

330 Portugal Cove Place
P.O. Box 8100
St. John's NL A1B 3M9

RE: Staff and Employee Perspectives of the Recovery Management Program at the Health Care Corporation of St. John's

To All Potential Participants of the Above Study:

This is to advise you that this study has been reviewed and is supported by NAPE. Your participation in this study will provide valuable information on recovery management, from the perspective of workers. The results of this study could potentially lead to positive changes in the process of recovery management.

I hope that you will participate in this study.

Sincerely,

Austin Delr
EMPLOYEE RELATIONS OFFICER

AD:bw

APPENDIX L
Supporting letter from the Newfoundland and Labrador Nurses Union

NEWFOUNDLAND AND LABRADOR NURSES' UNION

P.O. BOX 416 - ST. JOHN'S, NL - A1C 5J9 - TELEPHONE (709) 753-6861 - 62
TOLL FREE 1-800-563-5110
FAX (709) 753-1210
E-MAIL ADDRESS nlnu@nlnu.nf.net
WEB SITE www.nlnu.nf.ca

March 22, 2005

To All Potential Participants:

RE: Staff and Employee Perspectives of the Recovery Management Program at the Health Care Corporation of St. John's

This is to advise you that this study has been reviewed and is supported by the Newfoundland and Labrador Nurses' Union. Your participation in this study will provide valuable information on recovery management, from the unique perspective of front line workers. The results of this study could potentially lead to positive changes in the process of recovery management. I encourage you to participate in this study.

Sincerely,

Debbie Forward

Debbie Forward,
Provincial President

/dmw

APPENDIX M
Supporting letter from the Association of Allied Health Professionals

123

Association of Allied Health Professionals
The Dorset Building, 6 Mount Carson Avenue, Mount Pearl, NL A1N 3K4
tel: 709-722-3333 Fax: 709-722-1907 Toll Free: 1-800-726-2247
Website: www.aahp.nf.ca

Representing Allied Health Professionals in Newfoundland & Labrador since 1975

- Audiologists
- Dietitians
- Genetic Counsellors
- Kinesiologists
- Mental Health Counsellors
- Occupational Therapists
- Orthoptists
- Orthotists
- Pasture Care Clinicians
- Pharmacists
- Physiotherapists
- Prosthetists
- Psychometrists
- Psychologists
- Respiratory Therapists
- Sexologists
- Social Workers
- Speech Language Pathologists
- Technology Resource Consultants
- Workplace Wellness Program Co-ordinators

April 7, 2005

Ms. Kim Larouche
Master's of Science Candidate
Division of Community Health
Faculty of Medicine
Memorial University of Newfoundland
Prince Philip Drive
St. John's, NL

Dear Ms. Larouche:

This is to advise that at its meeting on April 1, 2005, the AAHP Executive gave its support for your study in the recovery management at the Health Care Corporation St. John's.

Should further documentation be required, please feel free to contact our office.

Yours truly, Best Wishes !

Sharon King
Administrative Director

APPENDIX N
Letter from Human Resources and Development

Date_____

Dear _____

You have been selected to participate in a study that is looking at the recovery management program at the Health Care Corporation of St. John's. The purpose of this study is gain the input from workers, supervisors and recovery managers, who have participated in recovery management, or used the recovery management program to facilitate return to work. This study has been reviewed and approved by the Human Investigations Committee at Memorial University, as well as the Research Proposal Approval Committee of the Health Care Corporation of St. John's.
In addition, this study has been reviewed and approved by the Wellness Advisory Committee of the Health Care Corporation of St. John's, and your respective union (See attached letters of support).
For this study you will be asked to discuss your participation in the recovery management program, and subsequent return to work. You will be able to decide what you wish to discuss and what you would not like discuss but your responses will remain anonymous to protect your confidentiality. Your interview with the principle investigator will be audio-taped.

If you wish to participate, please contact the principle investigator in the one of the following ways:

1. Address : See attached response letter with self-addressed stamped envelope
2. Phone: 728-4638
3. e-mail: klarouche@nf.sympatico.ca

A response is needed prior to (insert appropriate date).

Thank you for your time and consideration.

Sincerely,

_____
Human Resources and Development
Health Care Corporation of St. John's

APPENDIX O
Amendment approval from the Human Investigation Committee

Memorial University of Newfoundland
Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

ENTERED APR 1 6 2005

April 5, 2005

Reference #04.231

Ms. K. Larouche
C/o Dr. M. Murray
Community Health
Faculty of Medicine
2nd Floor, Health Sciences Centre

SHIPPED APR 0 6 2005

Dear Ms. Larouche:-

This will acknowledge your completed amendment form dated March 24, 2005 wherein you provide an amendment, question guide for supervisors, revised supervisors consent form and revised workers consent form for your research study entitled "Evaluating the effectiveness of a recovery management program at the Health Care Corporation of St. John's".

The Chairs of the Human Investigation Committee have reviewed your correspondence, approved the amendment, question guide for supervisors, revised supervisors consent form and revised workers consent form, as submitted. This will be reported to the full Human Investigation Committee, for their information, at the meeting scheduled for April 14, 2005

This Research Ethics Board (the HIC) has reviewed and approved the amendment, for the study which is to be conducted by you as the qualified investigator named above at the specified study site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Human Investigation Committee currently operates according to the Tri-Council Policy Statement and applicable laws and regulations

Sincerely,

John Harnett, MD, FRCPC
Co-Chair
Human Investigation Committee

Richard Neuman, PhD
Co-Chair
Human Investigation Committee

RN;JH/jd

C Dr. C. Loomis, Vice-President (Research), MUN
Mr. W. Miller, Director of Planning & Research, HCCSJ

St. John's, NL, Canada A1B 3V6 • Tel.: (709) 777-6974 • Fax: (709) 777-8776 • email: hic@mun.ca • www.med.mun.ca/hic

APPENDIX P
Contact reply forms

Contact Reply Form

RE: Staff and employee perspectives on the Recovery Management Program at the Health Care Corporation of St. John's

PRINCIPLE INVESTIGATOR: Kim Larouche

Date:_____

I, _____ am interested in participating in this study.

NAME: _____

PHONE:_____

E-MAIL:_____

_____
Participant Signature