STAKEHOLDER IMPACT ON RETURN TO WORK: RTW & COORDINATORS AND HEALTHCARE PROVIDERS

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BACKGROUND
TOPIC

- How do stakeholders in the return to work (RTW) process affect RTW outcomes?

- Focus on two:
  - RTW Coordinators
  - Healthcare providers (HCPs)

- Emphasis on interpersonal and functional components of the role
  - Functional as pertains to RTW (rather than treating for injury)
WORK INJURY COHORT STUDY

- Survey of $n = 869$ injured workers in Victoria
  - Either upper-body musculoskeletal or mental health condition
  - At least two weeks of time loss
    - Requirement to for claim to be managed by WorkSafe Victoria
  - Longitudinal, three survey periods:
    - Baseline (T1): ~ four months post-injury
    - Follow-up (T2): ~ ten months post-injury
    - Follow-up (T3): ~ 16 months post-injury
      - Not much affected T3, excluded from this presentation

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METHODS

- Logistic regression analyses
  - Evaluating impact at baseline (T1) and follow-up (T2) on return to work (RTW) outcomes
  - RTW: being back at work for at least one month

- Adjusting for confounders
  - Confounders selected for theoretical association
  - Filtered for having actual impact on association between main exposure and outcome (threshold: 10%)

- Results reported as Odds Ratio (OR)
  - 1 = 1:1 = same odds; 2 = 2:1 = doubled; 0.5 = 0.5:1 = halved
  - Graphed: OR with 95% confidence interval as error bar
RETURN TO WORK COORDINATORS
RETURN TO WORK COORDINATORS (VICTORIA)

- Employer appointed and based, assist w/ RTW obligations
  - Required
  - Consult w/ injured worker
  - Coordinate w/ other stakeholders
  - Plan RTW

- Evidence suggests successful Coordinators have both managerial and interpersonal skills*

Question: Do interpersonal and functional aspects of the Coordinator role affect RTW outcomes?
- Over and above other workplace factors?
- Over time?

Main exposures: aspects of Coordinator role
- Interpersonal -> stressfulness of interactions
- Functional -> RTW plans
RESULTS:
RETURN TO WORK COORDINATOR
RESULTS: DESCRIPTIVES

**Achieved sustained RTW**
- T1: 45.7%
- T2: 64.5%

**RTW Coordinator interactions**
- Good: 49%
- Poor: 11.1%
- None: 39.9%

**RTW plan**
- Had plan: 51.4%
- No plan: 48.6%
COORDINATOR IMPACT ON RTW OUTCOMES, CRUDE & ADJUSTED

Baseline

Good interaction (ref. no interaction)

Poor interaction (ref. no interaction)

RTW plan (ref. no RTW plan)

Follow-up

Crude

Adjusted
Functional activities benefit shorter-duration claims

Interpersonal activities benefit longer-duration claims

Aligns with research on factors affecting claim duration*
  – Injury-related factors important for shorter-duration claims
  – Psychosocial factors important for longer-duration claims

Complexity in Coordinator impact on RTW

Opportunities to improve Coordinator impact on RTW:
- Reform Coordinator selection and training to consider good interpersonal skills
  - Australian Coordinators feel training is irrelevant*
- Targeted interventions
  - Based on injured worker’s likely trajectory
- Monitor employers’ adherence to obligations
  - Are they planning for RTW (via Coordinator)?
  - Are they appointing Coordinators?

BACKGROUND:
HEALTHCARE PROVIDERS
WHO ARE MAIN HCPs?

Main healthcare provider

- GP/Specialist
- Psychologist
- Psychiatrist
- Physiotherapist
- Occupational therapist
- Chiropractor
- Other
- No HCP
COMPONENTS OF HCP ROLE

- **Main exposures:**
  - Functional: gave estimated RTW date
    - Evidence that expected time to RTW correlated with actual RTW*
  - Interpersonal: stressfulness of interaction
    - Based on findings of RTW Coordinator study, seems important

- **What about impact of treatment?**
  - Injured worker disability, general health, and serious mental illness (SMI) status treated as mediator
    - Included in models to determine direct effect, excluded for total effect
    - Could be considered third path

*Young, A.E., E. Besen, and J.L. Willetts*, *The relationship between work-disability duration and claimant’s expected time to return to work as recorded by workers’ compensation claims managers*. J Occup Rehabil, 2017. 27: p. 284-295.
HCP IMPACT ON RTW OUTCOMES, CRUDE, ADJUSTED, ADJUSTED FOR HEALTH
Possible explanation:

- Effect of injured worker health/disability suggests HCPs main contribution to the RTW process mainly via treatment of injured workers
- Other components of role (interpersonal, functional for RTW) less important
- Doesn’t exclude possibility that HCPs cannot contribute beyond providing treatment
  - Effect may be small; larger samples may be able to detect association
  - E.g., RTW Coordinators still need accurate information about injured worker’s abilities in planning RTW

STRENGTHS & LIMITATIONS

- **Strengths**
  - Longitudinal findings, stronger inference of causality
  - Objective outcome, sustained RTW
    - Versus point-in-time RTW outcome
    - Assessed at two time points
  - Adjustments for other factors

- **Limits**
  - Standard limits of self-report survey
    - Recall bias, etc.
  - Channeling bias
    - Differences between those contacted by Coordinator, given RTW plan, receive healthcare
CONCLUSIONS

- Findings suggest RTW Coordinators make important contributions to RTW process
- HCP impact non-significant when controlling for worker health
  - Could be that HCP’s main contribution is in providing treatment
- Complex associations between RTW stakeholders and RTW outcomes
- Promising opportunities to improve RTW outcomes
  - Particularly among longer-duration (and much costlier) claims