WORKPLACE REHABILITATION: MANAGING FUTURE RISKS BY MANAGING PEOPLE *WELL*

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Abstract

Of course we must prevent injuries as a first line defence against crippling costs and the loss of valuable workers, but we can do much more to manage the risks associated with workplace injury and illness. To be serious about risk management, employers must identify, assess and manage workers with injuries and illnesses that have the potential to lead to long-term incapacity, high costs (workers' compensation premiums and other indirect expenses) and litigation. Managing injured/ill workers in a positive and timely way can lead to early return to productive employment and huge savings in future costs.

Workplace rehabilitation is about managing people *well*. It is about encouraging incapacitated workers to be well by creating opportunities and incentives for them to recover their health and return to productive work at the earliest possible time. It should be an integral part of an organisation's OHS and HR system.

This paper explores what organisations need to do to implement effective injury management systems. It presents international and Australian research as well as local case studies to illustrate barriers and solutions to workplace rehabilitation and benefits being realized in Queensland workplaces.

Introduction

The worker's compensation system in Queensland now places a responsibility for rehabilitating injured workers squarely with the employer. Employers who fail to meet this responsibility can incur substantial penalties from WorkCover. Employers with 30 or more workers at a workplace are also required to have a trained rehabilitation coordinator on staff and a workplace rehabilitation policy and procedures accredited by WorkCover. Again penalties apply for failure to comply. In addition, substantial increases in premiums can occur if an employer fails to reduce compensation costs by assisting with early return to work (RTW).

The new experience based premium system ensures that an employer's claims experience is directly reflected in their premium over a period of several years as an incentive to control the costs of injuries. The degree to which claims experience influences a premium depends on the size of the organisation. Some larger employers with poor claims experience will see a threefold increase in premiums this year in the transition to an experienced based system, but estimates are that premiums can be reduced by 75% by improvements in claims cost performance.

There are substantial social and community reasons to control costs associated with workplace injury and illness. Workers' compensation premiums in Queensland cost employers $625.98 million in 1996-97 (WorkCover Annual Report 1996-97. If we don't get our workers' compensation fund into a healthier condition, employers' may be faced with further increases in premiums and surcharges. This will increase the cost of doing business and reduce job creation opportunities. This will increase the cost of goods and services and we will all carry the greater tax and social burden of unemployed and disenfranchised workers.

Rather than seeing workplace rehabilitation as an extra burden, employers should regard it as an opportunity to control costs, reduce absenteeism, improve workplace relations, and retain skilled and loyal workers. Employers can improve their competitive edge by managing incapacitated workers with positive strategies consistent with other human resource, OHS and quality management systems.

A Cautionary Tale

Sam was a process worker in his late 40s who worked for Acme Foods for 14 years. One morning, he was helping unload pallets in the cool storage area, not his normal job. It was cold and his fingers were numb. He fumbled with a heavy carton and felt a sharp pain in his left shoulder and neck. He continued to work despite the pain and then went to first aid for some Panadol saying he had a headache. He knew Acme didn't like people claiming injuries at work.

Back on the line, his symptoms got worse. After work, Sam went to his doctor. He was given a certificate for two weeks off and some medication. The doctor told him that it was a soft tissue injury, but because of his age it might take some time to heal and he would have to avoid repetitive and heavy tasks with the left arm for a while. Next day, Sam took his medical certificate to work and asked about workers' compensation. His supervisor expressed doubts about the injury and criticised Sam for not reporting the incident straight away. He told Sam that he'd better go home and have a long think about his claim and his future with Acme Foods.

Sam became anxious and was angry with his supervisor for not believing him. He went to the union who helped him submit a workers' compensation claim. Their legal advice was that he had a good damages case against Acme for failing to provide training, gloves and a safe system of work. But Sam's priority was to get back to work and for things to go back they way they were. He rested at home but heard nothing from his employer.

After two weeks, Sam's pain was a bit better and he approached his employer about suitable duties. He was not fit to perform his own job because of the repetitive arm movements involved. The supervisor told him there were no light duties and to come back with a full clearance.

Sam was distraught and went to the union again. They advocated on his behalf with WorkCover, but due to Acme's delay submitting the employer report form, it was four weeks from the accident before he got paid. He still had pain and feared he might never be pain-free. It took another three weeks for Acme to come up with "suitable" duties

Eight weeks after the injury, Sam started back at work - sorting through damaged goods in a small cold back room of the main plant. Before long, his pain got worse and spread over the upper half of his back. His medication made him nauseous and he was exhausted from lack of sleep. He felt humiliated coming to work. He became depressed. After a week, Sam went off work again and saw a solicitor about his damages claim.

Sam remained incapacitated and three years later was awarded $150 000 in damages. Most of this went in legal fees and bills. He tried to find another job but his age, lack of education and his injury went against him. He had to sell the house. The pain in his neck and back never did really go away. Centrelink eventually granted him a disability pension.

Acme paid highly for their failure to rehabilitate Sam and to take preventative action. Other workers were injured in the same area and there were ongoing industrial problems. Acme's workers' compensation premiums went up the year after Sam's injury and continued to rise over the next four years. They had to cut back on staff and, with production delays due to disputes, absenteeism and sloppy work practices, had trouble meeting customer deadlines. Eventually management decided that they better have a closer look at how they were managing workplace injuries, OHS and their people.

The Moral of the Story

Employers can no longer afford to blame the victim or hope an injured worker will get better or go away. Injured workers who are *ill* managed are encouraged to be "ill" by the employer's failure to acknowledge what has happened to them and their value to the organisation. They become anxious about the future

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This story is fictitious. However, the scenario is compiled from many years experience as a rehabilitation

and if employers fail to alleviate their job uncertainty, relationships can deteriorate, legal advice may be sought and the chances of a successful outcome diminish.

Workplace Rehabilitation is a Tool

Like any tool, workplace rehabilitation needs to be used skillfully to achieve its desired results.

In a survey of 220 Michigan employers, Habeck (1992) found employers at risk of incurring high compensation costs were passive *vs* active, sporadic *vs* consistent and aggressive *vs* assertive in their prevention and injury management approach. Barriers to effective rehabilitation included:

- time delay from disability to intervention
- poor RTW planning and failure to involve the injured worker
- limited RTW options
- failure to make reasonable accommodations (e.g. job modifications)
- failure to address psychological reactions to disability
- company benefits/policies that encourage disability.

Shrey (1996) described the common elements of successful disability management programs in industry as including:

- early intervention and RTW philosophy
- joint labour-management commitment and involvement
- multidisciplinary interventions (medical, vocational, psychological, ergonomic, engineering)
- case management
- effective prevention strategies
- employee education and involvement
- policies and procedures which support accommodations/modifications
- accountability of all parties
- management information systems for program evaluation

Tips for Success

1. Real management commitment

Clear statements of commitment in policy documents are important symbols to the workforce that management is serious about assisting workers who are injured. But symbols will never be enough.

Management needs to identify structural barriers to RTW; strengthen incentives to participate; adequately resource the rehabilitation system, provide opportunities for consultation; encourage supervisors to identify suitable duties and flexible work practices; gain support from local health services; and integrate rehabilitation with sound prevention and health promotion strategies (Cornally 1986; Tate, 1992; Kenny, 1995; Wood et al, 1995).

2. A rehabilitation coordinator (RC) who can communicate with authority and sensitivity

RCs in Queensland are required to complete a statutory three day training course by a training provider accredited by WorkCover. The RC is responsible for liaising with injured workers; facilitating identification of suitable duties; development of RTW plans; obtaining medical approval; coordinating the implementation and monitoring of RTW programs; and in many cases for the development, accreditation, implementation and evaluation of the organisation's workplace rehabilitation system. WorkCover (1997) suggests that employers select RCs who have:

- ✓ high level skills in written and verbal communication
- ✓ good organising skills
- ✓ the credibility needed to deal with all levels of staff
- ✓ a sound understanding of the business's systems, operations and circumstances – in particular, human resource management and industrial relations matters, payroll procedures, and cultural factors."

For most organisations, the RC role is not a full-time job and the person appointed performs the functions in addition to other responsibilities. Whilst the role can effectively be performed at different levels in an organisational structure depending on culture and decision-making processes, it is important the RC not only has the responsibility but the authority to perform the role. This requires credibility with all levels in the organisation, and the ability to communicate and negotiate to gain the support of management, supervisors, co-workers, doctors, unions and WorkCover. They also need to establish rapport with an injured worker, involve them in the RTW process and identify possible barriers to success. This can require high level interpersonal and listening skills.

3. Early intervention as standard practice

Length of time off work following injury represents the most significant workers' compensation cost and, if prolonged, is one of the biggest threats to rehabilitation and recovery. Duration of incapacity can be reduced substantially by early RTW programs which accommodate an injured worker's restrictions and encourage upgrading to normal duties.

A workplace rehabilitation system provides employers with a process by which they can arrange early worker contact, liaison with treating health professionals and development of RTW plans which encourage recovery at work. Early intervention has been shown in Australia and overseas to improve the cost effectiveness of rehabilitation by increasing RTW rates, decreasing the length of rehabilitation programs and lowering rehabilitation costs (e.g. Gardner, 1991; Tuziak, 1991; Wood, Morrison & MacDonald, 1995; Industry Commission Report, 1994).

For example, in a study of the on-site rehabilitation programs across three sites in Victoria (a paper mill, a steel mill and a container manufacturing plant), Strautins and Hall (1989) found that 90% of workers referred within a week of injury returned to work while only 66% of those referred after a month did so. The later the referral, the longer the RTW process took.

4. Provision of suitable duties

Suitable duties are the vehicle by which early RTW can be achieved. They enable workers to focus on RTW as a goal, to improve and maintain work fitness, to maintain work skills and workplace relationships, and to counter feelings of loss and uncertainty.

Under the WorkCover Qld Act 1996, employers have an obligation to provide suitable duties which have regard to the injured worker's incapacity, age, education, skills and experience; the pre-injury job; medical information; the rehabilitation plan; workplace rehabilitation procedures; location of the duties and other relevant matters (Section 46). Suitable duties should be individualised, goal-directed, time-limited, meaningful and approved by the treating doctor. If it is not possible to identify suitable duties, WorkCover may provide assistance with redeployment to a new employer.

Many organisations report difficulty in identifying suitable duties. Kenny (1996) reported that common reasons given for failing to supply suitable duties included the nature of work performed; organisation too small; limited skills of injured workers; type of injury; suitable duties not productive and disruptive to the work process. These can be very real issues, but organisations doing well with rehabilitation manage to overcome them. Ways of finding duties suitable for a worker's rehabilitation and reasonable to the employer include comprehensive job and task analysis, consultation with staff at all levels and creative solutions to job redesign. Professional expertise can be purchased if necessary to help with this.

5. Understanding the key role of supervisors

Whilst the supervisor is acknowledged as a key player in the rehabilitation literature, little attention is given to their actual role. One study conducted in the Polaroid Corporation, (Gates, Akabas and Kantrobwitz, 1996) concluded that supervisor was vital in accurately identifying problems caused by the disabling condition (including interference with job performance); developing appropriate accommodations and monitoring their effectiveness; and ensuring sensitive communication between the disabled worker and co-workers.

Supervisors are for a large part responsible for operationalising a RTW plan. They identify options for and implement suitable duties programs; gain commitment from co-workers; arrange relief staff; train, supervise and support the injured worker; monitor progress; and ensure health and safety of the injured worker and all other people on-site. They do this in addition to ensuring that production targets and service standards are met.

Supervisors need adequate resources and training to fulfill this role effectively. They require knowledge and skills, a positive and supportive attitude, management support for flexible and creative solutions for suitable duties, and expert assistance with complex cases.

6. Integrate medical management into the system

Workers' compensation is a medico-legal process. Treating doctor approval of suitable duties is a legal necessity under WorkCover, but medical support for early RTW is also an important tool for reassuring and motivating the worker. Early contact with the doctor to provide information about work options and to obtain information to develop a safe RTW plan is most important.

Organisations who are doing well with rehabilitation do much more than this (see case studies below). The engagement of local or in-house medical services is a key element of many successful rehabilitation strategies. Organisations can use preferred or in-house doctors in the workplace to advise on restrictions, assist in identifying suitable duties, communicate with the treating doctor as well as to implement preventative health strategies. An injured worker has the right to be treated by their own doctor, but it is rare for a worker to refuse to see the preferred/in-house doctor for a consultation. Worker resistance can be alleviated by the doctor having a visible presence on-site by regular visits and discussions with workers to develop familiarity.

7. Risk assess and utilize expert assistance where necessary

A commonly used ratio is that 20% of workplace injuries account for 80% of the costs (e.g. Habeck, 1992). In NSW in 1990-92, 9% of injuries accounted for 41% of costs (Kenny, 1996). Only a small proportion of injuries require comprehensive rehabilitation intervention. Ganora (cited in Cornally, 1986) suggested that 80% of injuries need little more than minor task/environment modification, 15% require more assistance to achieve RTW, and only 5% would be unable to continue in their work role. These percentages will vary between organisations depending on the nature of the industry and workforce factors such as age.

The occurrence of an injury presents a decision point in terms of whether rehabilitation will required. In some cases, the need for rehabilitation will be obvious due to the severity or nature of the injury, but in others it may not be. Employers need to quickly identify and analyse the risks associated with failure to provide rehabilitation, and I would suggest that when in doubt, rehabilitate. The potential savings from early intervention will often outweigh the costs.

In some cases, professional advice may be necessary. The judicious use of expert rehabilitation providers/consultants can complement employer efforts in cases where the injury is severe or complex, where it is difficult to find suitable duties, if a program has become stalled, if conflict develops between worker and workplace, or if a doctor or WorkCover recommends it. Providers, like other services, vary in experience, responsiveness and quality of service delivery. Given the potential to impact on outcome, selection of a reputable provider/consultant should be given serious attention.

8. Embed rehabilitation in OHS but beware of conflicts

Rehabilitation should be seen as a natural extension of occupational health and safety in a risk management framework. Risk assessment and accident investigation activities can contribute to job analysis for later identification of suitable duties for injured workers. Implementation of risk control strategies can reassure injured workers (and others) that steps have been taken to prevent further injuries, demonstrating good will on behalf of the organisation. Suitable duties programs should be risk assessed in terms of worker and co-worker safety. The same consultative processes for OHS can be used for

Many RCs in Queensland also have workplace health and safety responsibilities. These roles can dovetail well but Workplace Health and Safety Officers (WHSOs) who are also RCs should be aware to the potential for role conflict. If an investigation reveals that an injured worker contributed to the accident, damages awarded to the worker can be significantly reduced. If information about accident causation is revealed during the rehabilitation process, the RC may feel constrained by the confidentiality requirements of the WorkCover legislation. These issues could prevent the RC developing or maintaining a relationship of trust with the worker, whilst at the same time fulfilling their WHSO responsibilities.

Sensitivity to such potential conflict should help to identify the rare occasions when a problem might emerge. Separation of the roles might be possible in those cases by delegation to other accredited personnel or enlisting external support (e.g. Division of Workplace Health and Safety, WorkCover, professional OHS or rehabilitation providers).

Good news stories from Queensland workplaces

Following case studies are of organisations achieving success with rehabilitation in Queensland. These stories, collected from RCs during July 1998, represent a few examples of how workplace rehabilitation is being used to manage unplanned absence due to ill-health and injury with positive results in future cost reductions and workplace relations.

A regional meatworks

The plant employs 540 workers on three shifts. The work is high risk: 95% of workers use knives and the work is heavy, labour intensive and repetitive. Their success with injury management (implemented in 1996) is demonstrated by the 68% reduction in average injury cost from $1300 in 1994/95 to $409 in 1997/98, a 68% reduction in days lost per year from 1700 to 550, and an 82% reduction in premium from $3 million to an expected $540 000 this year.

The system was introduced following consultation with the unions and the safety committee. Some initial hesitancy by workers was evident but when they saw workmates recovering quickly from injury and being able to maintain their income, acceptance of the process improved.

The injury management process is integrated in OHS procedures with actions and expectations clearly stated in relation to accident investigation, prevention, application for workers' compensation, identification of workers with three days lost time or more and the RTW process. Workers are instructed in the importance of early reporting and can be subject to disciplinary action they delay in this area. All jobs have been evaluated and documented for possible suitable duties. Rehabilitation plans are drawn up in the form of a contract between worker and company. Workers on suitable duties receive their normal rate of pay.

The safety officer undertakes the RC role, along with first aid. He told me their approach was to "treat our workers like athletes". A local doctor trained in sports medicine attends the plant three days a week and a physiotherapist is employed full-time. A gym facility is provided on-plant and workers on rehabilitation are encouraged to attend this in work time. A sports medicine specialist in Brisbane is used for consultation on difficult cases.

An open cut coal mining company

The company introduced the workplace rehabilitation program in late 1991. Initially the union was resistant, maintaining that injured workers should stay at home "until they were 100%" but support was forthcoming when Workers' Compensation Board (WCBQ) accreditation was sought and the company agreed to cover non-work injuries and illness as well as compensable conditions. Support for the program was also obtained from the 17 doctors in the region as a result of visits by the RC to explain the company's rehabilitation policy.

The assistance of WorkCover Account Managers who provided contacts willing to provide information for the

One of the measures used to evaluate the program is the number of days of suitable duties worked, on the basis that if an incapacitated worker is not on suitable duties they are at home costing the company in sick leave or workers' compensation. In 1993, 195 suitable duties days were recorded (21 work-related, 174 non-work related). In 1997, 940 suitable duties days were recorded (415 work-related, 525 non-work related). In only two cases, suitable duties could not be provided due to the severity of the injury.

The safety superintendent is the RC and a rehabilitation committee is in place. Contact is made with the injured worker in the first 24 hours following injury. Soon after, the RC visits the treating doctor with the worker or phones with the worker present. A "communication" meeting facilitated by the RC is held with the worker, supervisor/superintendent, and a union-nominated workgroup member. Duties are agreed to based on doctor's advice and are documented with a set review date. Workers on rehabilitation don't work overtime but can attend physiotherapy during work time. The RC stressed the importance of having one person coordinating the rehabilitation program to provide continuity and consistency for the injured worker.

An exemplary case was a worker on a waiting list for a kidney transplant (non-compensable). The RC arranged a meeting with the renal specialist in Brisbane, along with the worker, his wife, union representatives and the hospital social worker. Suitable duties were determined and the worker RTW for four months while waiting for the transplant. Soon after the surgery, the renal specialist contacted the RC to praise the program, indicating that being at work had reduced the man's anxiety and helped in his post-surgical recovery.

A Food Manufacturer

The company employs 150-180 employees during summer and 180-250 employees during winter. The company made a critical decision in 1995 with the assistance of WCBQ, to actively manage injuries and possible damages cases against the company. In 1994/95, their statutory claims (77 in total) cost over $200 000, with an average claims cost of $2628. In 1997/98, statutory claims (38 in total) have cost just over $30 000, with the average cost down to $792.

A management plan was developed and included raising the profile of workplace safety, providing preventative training, a workplace rehabilitation program, and appointment of a company medical advisor. All employees participated in formulating the workplace rehabilitation policy and procedures which was then approved by WCBQ.

A company doctor now makes regular visits to the worksite to walk through and discuss questions or concerns with workers. The doctor assists with the development of RTW plans and has an important role in communicating with treating health professionals. There are two trained RCs on-site, one being the Training and WHS Manager. He believes his level of authority is important for gaining support from other managers, and that dealing with the personal consequences of injury strengthens his resolve to prevent injuries from occurring.

Since the program started, suitable duties have been able to be identified in every case. Where necessary, a rehabilitation team is established (including the supervisor, the worker, a union representative, a co-worker and the RC) to identify suitable duties, to arbitrate on any in-house disputes arising out of the program and to monitor a worker's RTW. The aim is always to return to worker to their pre-injury job, but if opportunities arise which would enable the worker to extend their skills in another area while on rehabilitation, this is considered.

The process is outlined in an example of a process worker who twisted his ankle. The RC took the worker to the doctor and for X-rays. Before taking him home, the RC helped him complete the accident and compensation forms. Next day, the RC called the worker who agreed to see the company doctor. The RC transported him to the company doctor the following day. A RTW plan was formulated and treating doctor approval obtained. The worker started suitable duties after two days off work. He was reviewed each day by the RC, after the first day by his treating doctor, and went back to normal duties after one week.

Conclusion

Workplace rehabilitation is about managing people *well*. It is about applying the principles of good human resource management to workers who are incapacitated for work in some way. The focus shifts from what they *can't* do to what they *can* do and what they have to offer to the organisation during their recovery and as valued employees longer-term. Workplace rehabilitation can help injured workers recover their capacity to work by providing opportunities to regain work fitness, maintaining skills and confidence and preventing the destructive negative emotions associated with perceptions of being poorly treated by employers.

Workplace rehabilitation is a risk management strategy that can be seen as an extension of an organisation's OHS system. Whilst prevention should always the ultimate goal, injury management systems should be designed, implemented and resourced just as well as OHS systems if an organisation is serious about controlling future costs.

The strategies outlined in this paper are not exhaustive but provide some suggestions for effective injury management programs. We can always learn from what others are doing by taking and tailoring what is relevant to our own situation. The author is continuing to gather stories about programs that work and welcomes any contributions to the collection.

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