UNDERSTANDING AND MEASURING WORK DISABILITY IN RURAL AND URBAN HEALTHCARE WORKERS IN MANITOBA

QUALITATIVE REPORT
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[1] The boundaries and names for many Manitoba Health Authorities changed in June 2012; Brandon is now in the Prairie Mountain RHA and Central RHA is now part of Southern RHA.

QUALITATIVE REPORT EXECUTIVE SUMMARY

Significance of the study

Important advancements in research and in knowledge creation have been made in the last decade regarding work disability prevention and rural health. However, until now, research into these two areas has been conducted separately. With nearly 20% of the Canadian population living in rural areas (Romanow, 2002) and with work disability presenting increasing economic and social costs (Buckup, 2009; OECD 2010), the lack of knowledge regarding the intersection of these two health areas is a critical knowledge gap. This gap leads to poorly informed policies and practices to advance work disability prevention in rural areas. With a high proportion of healthcare workers in Manitoba working and living in rural settings, rural disparity in work disability outcomes, relative to urban settings, is a critical research priority.

Purpose and objectives

The qualitative study was conducted concurrent with the claims data analyses, and addressed objective three:

> To examine the status of injury prevention and return-to-work policies and programs among acute care hospitals, personal care homes and community health agencies via interviews with key stakeholders including occupational health personnel and union or employee representatives. Questions addressed organizational structures such as joint health and safety committee activities,

policies and practices for disability management including return-to-work programs, onsite work rehabilitation intervention, and ergonomic practices.

Methodology

Participants and Data Collection

In this study, participants were purposively selected for their knowledge and expertise in disability management (DM) policies and practices within the Brandon and Central Regional Health Authorities (RHAs). Eighteen individuals were interviewed and two focus group discussions (n=10) were conducted with managers, program directors, union representatives and workplace safety and health committee members.

Analysis

In the analysis, researchers used the complete transcripts of the interviews and focus group discussions in line-by-line analysis to examine and then code 'meaning units' (words or phrases), which were combined into categories and then into themes. Each transcript was analysed and reviewed by at least two researchers (peer review). All themes were discussed by the entire research team until consensus was reached.

Summary of Themes

Theme 1. Who we are:

- Workers represent full age range
- Professionally or technically certified for their jobs
    - Risk factors perceived to be primarily worker-centred or job-centred

i. Older workers, presenteeism

ii. Physically demanding work tasks – i.e. housekeeping, nurse aide

- Violence against workers – definition unclear re: injury claim

Theme 2. Cooperation and collaboration

- DM is always a team effort

Theme 3. 'We like the rural area'

- Like a family – know and support each other
- Co-workers and managers support each other
- All teams work well together (including insurer)

Theme 4. Celebrations, challenges and hope

*Celebrations "*We are good at:"

- injury prevention
- informed on claims process
- JWSH committees
- RTW/Ergonomics planning

Challenges

- Scheduling meetings with RTW teams
- Staffing re: injured workers and RTW
- Ongoing education re: injury prevention

Hope

- We have the ability to change
- We need to practice innovation, financial management
- We need to improve WCB and health provider involvement

Recommendations for Research and Practice

1. It is recommended that an environmental scan be completed for all health authorities in Manitoba; this should include comprehensive data collection from each RHA on all policies and programs related to DM including injury prevention, health and safety committee practices, work injury and claim process, RTW programs, and job accommodation. It is only with complete and accurate data that stakeholders can form and evaluate policies.
2. More and more, healthcare facilities—especially in the rural areas—are incorporating several functions such as long term care and acute care and home care head office, within one building. This makes it challenging to identify whether the "type of facility" has any bearing on DM success. Researchers and all stakeholders should work together to create accurate descriptors of multi-function healthcare facilities in consistent terms across all RHAs.
3. It is recommended that stakeholders, especially employers and professional associations, track the geographic practice trends of all professional staff; the information would help to plan recruiting strategies and resource management.
4. It is recommended that DM teams explore the use of better and more technology for all team communications.

5. It is recommended that all RHAs outside of Winnipeg continue to place priority on resource recruitment and development including DM coordinators, specialized healthcare providers (such as occupational and physical therapists), physicians and nurses.

OPERATIONAL DEFINITIONS

- Work disability –is defined as the impact of an injury or illness on an individual's ability to perform his or her job tasks. In the context of a Workers' Compensation system, the impact of the injury or illness may result from interaction of multiple systems: workplace, healthcare, insurers, employers, and workers. Work disability may be viewed on a continuum from minor work limitations to complete work absence.
- Work disability prevention- refers to the entire continuum of the prevention and return to work process. The term was sometimes used interchangeably with disability management.
- Work injury rate- this is a frequency that shows the numerator as number of injuries (either or both non-timeloss and timeloss) per 100 or per 1000 workers i.e. 3.3/100
- Disability management (DM) and Return to work (RTW) –Disability management is the term used in much of the current literature that refers to the entire continuum of policy development within a healthcare facility or organization such as the RHA, to the processes and practices in a worker's recovery and return to his or her job. In this study, DM and RTW terms were used interchangeably by study participants.
- Work injuries are injuries occurring at the workplace or within the course of performing one's job duties and are compensable by the Manitoba WCB.
- The definition of Rural is the population outside settlements of 1000 or more with a population density of 400 or more per square kilometer (Statistics Canada, 2009).
- The definition of Urban is derived from the Statistical Area Classification developed by Statistics Canada and reflecting population and proximity to large urban centres.

UNDERSTANDING AND MEASURING WORK DISABILITIES IN RURAL AND URBAN HEALTHCARE WORKERS IN MANITOBA: REPORT ON THE QUALITATIVE ANALYSIS

1. INTRODUCTION

Important advancements in research and in knowledge creation have been made in the last decade regarding both work disability prevention and rural health. However, until now, research into these two areas has been conducted separately. With nearly 20% of the Canadian population living in rural areas (Romanow, 2002) and with work disability presenting increasing economic and social costs for Canada (Buckup, 2009; OECD 2010) the current paucity of knowledge regarding the intersection of these two health areas is a critical knowledge gap. This gap leads to poorly informed policies and practices to advance work disability prevention in rural, remote, and northern areas[i]. While work disability prevention programs are typically developed in urban areas, they are frequently offered in rural areas with little attention given to their suitability to the rural context. Healthcare workers are at high risk for poor return-to-work outcomes due to factors such as workplace violence, high workloads, lack of replacement staff, and in rural facilities, unique rural factors such as distance and isolation.

The purpose of this project was to describe the incidence and impact of work disability for rural and urban healthcare workers in Manitoba, and secondly to develop decision-making tools for prevention of work disability more specifically tailored to rural healthcare facilities. Another purpose was to initiate a tradition of sharing Workers' Compensation Board (WCB) of Manitoba data with the academic environment, to optimize the use of this rich data.

In past studies of healthcare workers, the most common approach to measure rurality has been to use Regional Health Authority boundaries (RHA). One innovative aspect of this project has been the use of a new measure of rurality – the Statistical Area Classification indices (SAC) codes – which are more sensitive measures of rurality than RHA. The project focused on two RHAs of Manitoba – Brandon, an urban area of Manitoba, and Central, a more rural area of Manitoba. Two measures of geographical rurality were used: First, the two RHAs in Manitoba, and second, the more accurate measure of SAC codes. The latter were used primarily in the quantitative analyses.

1.1 PURPOSE

This project was a multi-method project, involving both quantitative and qualitative methods. It involved three phases: 1) Knowledge synthesis, 2) Mixed methods analysis using quantitative and qualitative data, 3) Development and dissemination of decision-making tools. In Phase 2, the quantitative element focused on understanding and developing the database as well as on examining urban-rural differences in work disability indices, with the qualitative element focusing on examining current disability management practices in the two RHAs of interest with focus groups.

It is hoped that by providing a better understanding of the status of disability management and the practices within both rural and urban settings in Manitoba, this project will give greater understanding of the claims data analysis and inform Phase 3 in Knowledge Translation and Exchange (KTE). The Knowledge Translation and Exchange focused on creation of a tool(s) for Disability Management (DM) stakeholders.

1.2 RESEARCH OBJECTIVES

Research objectives include:

1) To create a tradition of sharing claims data in a confidential and secure manner. Historically, there has been little utilization of WCB of Manitoba data by researchers.
2) To examine how rural workers differ from urban workers in work disability outcomes, including duration of work absence, type and cause of injuries, and costs related to work disability among healthcare workers in Manitoba using a recently developed, standardized, and sensitive definition of rurality (Statistical Area Classification, SAC).
3) To examine the status of injury prevention and return-to-work policies and programs among acute care hospitals, personal care homes and community health agencies via telephone interviews with key stakeholders including occupational health personnel and union or employee representatives. Questions would address organizational structures such as joint health and safety committee activities, policies and practices for disability management such as return-to-work programs, onsite work rehabilitation intervention, and ergonomic practices.
4) Through focus groups and stakeholder interviews develop decision-making tools for prevention of work disability specific to rural healthcare employers and employees: i.e. risk assessment for injured workers at high risk for prolonged work absence, recommendations of disability management strategies such as onsite return-to-work and work accommodation interventions, ergonomic practices, and fact sheets with examples of multi-system team solutions for return-to-work.

This qualitative report focuses exclusively on the qualitative element (Objective 3).

2.0 LITERATURE REVIEW

2.1 Rural health and work disability

Healthcare workers are a particularly vulnerable group for poor work disability outcomes: they have higher rates of timeloss claims than workers from any other industrial sector (WorkSafeBC, 2008; AWCBC, 2013), and they have one of the highest proportions of lost work days due to workplace injury or illness. In 2012, the average timeloss injury rate for all-industry sectors was 3.3 per 100 workers, whereas the average timeloss injury rate for healthcare workers was 4.7 per 100 workers (Manitoba WCB, 2012). Across Canada, including Manitoba, the overall work injury rates have decreased since 2000, while the average cost and duration of claims have increased. The decrease in work injury incidence is believed to be due in part to successful prevention efforts.

Rural healthcare workers may differ from urban healthcare workers in that they are older and have lower educational attainment (MacLeod et al., 2004; Timmins & Australian Safety and Compensation Council, 2008). Of particular importance in Manitoba, where distances are substantial, the health of residents in rural communities in Canada is known to decrease as distance to an urban center increases (Ryan-Nicholls, 2004). Differences in work disability outcomes between rural and urban areas in Manitoba remain unknown.

Two studies on workplace musculoskeletal injury rates suggest that rural healthcare workers have a higher incidence of injury than their urban counterparts, ranging from 80% in rural Australia (Smith & Leggat, 2004) to 91.9% in rural Japan (Smith et al., 2003). Closer to home, a British Columbia based study shows that healthcare worker claimants from a primarily rural Health Authority have higher rates of work injury, including musculoskeletal injuries, than healthcare worker claimants from a more urban health authority (Franche et al., 2009).

Two American studies focused on work absence duration (Meyer & Muntaner, 1999; Young, Wasiak, Webster, & Shayne, 2008); only one focused on healthcare workers (Meyer & Muntaner, 1999). The latter study shows that work absence duration among home healthcare workers is more prolonged for rural workers compared with urban workers, and that this more prolonged work absence is associated with higher although non-statistically significant medical costs. Young et al. (2008) suggests that the difference in work absence duration points to a complex interaction between impact of rural work absence duration and healthcare utilization. In Canada, in the British Columbia study, healthcare worker claimants from a rural Health Authority had more prolonged duration of timeloss claims than healthcare worker claimants from a more urban Health Authority.

This limited evidence is suggestive of higher rates of injury and of longer work absences in workers, including healthcare workers, living in rural areas. The studies suggest that injury rates and work absence duration among rural workers, and between rural and urban workers, may vary substantially according to occupational category. Finally, it is apparent that there is limited Canadian data on the topic.

2.2 Risk factors for workplace injury and prolonged work absence.

The most widely recognized and accepted model of work disability has been the one proposed by Loisel et al. (2001). This model views work disability as a function of the interaction between multiple systems – the workplace, healthcare, and insurer systems, as well as the worker/family. It is in synchrony with other models of work disability, which also recognize the multisystem approach to the issue (Franche & Krause, 2002; World Health Organization, 2001). This framework, and critical literature reviews in work disability prevention (Cole & Hudak, 1996; Cole & Rivilis, 2004; Dowd et al., 2010; Krause et al., 2001;

Stewart, Polak, Young, & Schultz, 2012), have guided a literature review focused on the identification of potential risk factors for workplace injury and work absence duration including worker factors, job-level factors, organizational-level factors, disability management policies, the insurance system (i.e. WCB), communication among key stakeholders, access to healthcare, and the rural environment itself. A summary of the literature review on risk factors for workplace injury and prolonged work absence follows.

2.3 Uniqueness of the rural environment

For many workers, the isolation and beauty of rural environments is part of the attraction to rural life (Brockwell, Wielandt, & Clark, 2009; Molinari & Monserud, 2008; Weymouth et al., 2007) and satisfaction with the community can be an important predictor of job satisfaction among rural healthcare workers (Penz, Stewart, D'Arcy, & Morgan, 2008). However, the geography and climate of rural areas can increase the vulnerability of rural workers for poor work disability outcomes, often due to travel on unsafe roads and in hazardous weather conditions (Kmet & Macarthur, 2006; MacLeod, Browne, & Leipert, 1998; Peek-Asa, Zwerling, & Stallones, 2004; Weymouth et al. 2007; Skinner, Yantzi, & Rosenberg, 2009).

2.4 Rural worker factors

In rural healthcare workers, work absence duration and number of episodes of work absence increase in older workers (Alexopoulos, Burdorf, & Kalokerinon, 2003), and among women compared to men (Dellve, Karlberg, Allebeck, Herloff, & Hagberg, 2006; WorkSafeBC, 2008). However, despite the challenging nature of rural nursing practice (MacLeod et al., 1998; MacLeod et al., 2008; MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004; Molinari & Monserud, 2008) rural nurses have lower educational attainment than urban nurses (MacLeod et al., 2004; Timmins & Australian Safety and Compensation Council, 2008)

and limited access to continuing education (Albion, Fogarty, & Anthony Machin, 2005; Molinari & Monserud, 2008; Timmins & Australian Safety and Compensation Council, 2008). Stress is a recurring and important theme for rural healthcare workers (Albion et al., 2005; Lenthall et al., 2009; Timmins & Australian Safety and Compensation Council, 2008), and is associated with a higher likelihood of taking time off work in rural nurses than urban nurses (Timmins & Australian Safety and Compensation Council, 2008). However, current research has found that some rural workforces have a "can-do" work attitude, and may be better at managing work injuries within the context of having job control and flexible work practices (Dean, Hudson, Hay-Smith, & Milosavljevic, 2011).

2.5 Job-level factors.

There is a large overlap between risk factors for prolonged work absence and incidence of workplace injury in the healthcare worker population. High job strain including high physical demands and high workloads is associated with prolonged work absence and incidence of workplace injury especially when combined with low reward (Koehoorn, Demers, Hertzman, Village, & Kennedy, 2006; Shields & Wilkins, 2006). In the United States, direct care nursing has been associated with high injury rates, particularly for homecare workers (Payne & Appel, 2007; Zontek, Isernhagen, & Ogle, 2009); to our knowledge, equivalent studies have not been conducted in Canada.

Low social support at work is associated with work absence and injury incidence (Bourbonnais & Mondor, 2001; Koehoorn et al., 2006; Lysaght, Fabrigar, Larmour-Trode, Stewart, & Friesen, 2012; Verhaeghe, Mak, Maele, Kornitzer, & Backer, 2003). Nevertheless, Lysaght et al. (2012) suggested that injured or disabled workers in healthcare jobs reported higher levels of social support compared to those in other industries, such as business, finance,

and administration. It is not clear whether this finding of high social support translated into better work disability outcomes; although it is a positive indicator of interpersonal support which is associated with shorter work absence duration (Shamian, O'Brien-Pallas, Thomson, Alksnis, & Kerr, 2003, O'Brien-Pallas et al., 2004).

With respect to workplace culture, more respect and support at work was found to be associated with shorter work absence duration in a large sample of Canadian nurses (Franche et al., 2011). In the same study, an organizational culture involving higher levels of autonomy at work, control of work, and improved relationships between nurses and physicians, was also associated with shorter work absence duration.

High workloads in rural nurses are particularly well documented (Lenthall et al., 2009; MacLeod et al., 1998; MacLeod et al., 2004; MacLeod et al., 2008), with rural nursing being described as a "multi-specialist" profession (MacLeod et al., 1998). Long work hours and heavy on-call demands may place rural healthcare workers at increased risk for injury, and may make return to work more challenging (Lenthall, et al., 2009; Weymouth et al., 2007).

Exposure to violence was identified as a major concern for rural healthcare workers in several studies (Alexander & Fraser, 2004; Timmins & Australian Safety and Compensation Council, 2008; Tollhurst et al., 2003a; Tollhurst et al., 2003b; Weymouth et al., 2007). Nurses are concerned about being on call and having to make house calls at night, with inadequate support and protection (Weymouth et al., 2007), including inadequate safety features in buildings (Albion et al., 2005). As well, limited or delayed support following critical incidents, such as violence, are reported in rural healthcare workers (Weymouth et al., 2009). There are, however, conflicting findings regarding frequency of exposure to violence: while in one Australian study, nurses working in remote areas reported higher 12-month incidence of

violence at work than urban nurses (86% versus 43%) (Albion et al., 2005) , another Australian study found equally high rates of violence among both rural and urban paramedics (Verhaeghe et al., 2003). In Canada, in British Columbia, incidence of violence-related timeloss claims for healthcare workers was 31% higher in the more urban Health Authority than in the more rural one (Franche et al., 2009).

2.6. Organizational-level factors.

Organizational-level issues may exacerbate job-level risk factors. Lack of replacement staff is a major source of stress for rural nurses: it hampers their ability to take leave (Lenthall et al., 2009; Weymouth et al., 2007) and increases the workload, which in turn can increase risk of injury and create resentment in coworkers.

Rural healthcare workers are commonly managed by central administrative structures (MacLeod et al., 2008; Molinari & Monserud, 2008; Weymouth et al., 2007), and they report feeling that centrally located administrators fail to understand the challenges of rural nursing, especially the high workload and broad practice scope (MacLeod et al., 2008; Weymouth et al., 2007). When asked to give advice to administrators, rural nurses in Canada stressed the importance of programs/policies developed specifically for rural areas (MacLeod et al., 2008). Rural nurses often feel left out of the decision-making process (Molinari & Monserud, 2008; MacLeod et al., 2008), and perceived distance managers as inaccessible and non-responsive to their concerns (Weymouth et al., 2007).

Within healthcare, rural workers are more likely to work in small facilities, and in occupational categories known to have particularly high injury rates such as community, palliative, or aged care (Timmins & Australian Safety and Compensation Council, 2008).

2.7 Workplace disability management (DM) process

While workplace-based DM processes, such as presence of a dedicated RTW coordinator, communication between healthcare provider and workplace, are critical to support positive disability outcomes (Franche et al., 2005; Friesen, Yassi, & Cooper, 2001; Gardner, Pransky, Shaw, Hong, & Loisel, 2010), no studies were found examining any workplace DM processes in rural settings.

2.8 Compensation systems

Delays in processing claims are associated with longer time to return to work (Sinnott, 2009) and may lead to workers' sense of unfairness that can develop during an unnecessarily long administrative process (Franche et al., 2009). One American study (Sears, Wickizer, Franklin, Cheadle, & Berkowitz, 2003) found time from injury to claim filing was longer in rural areas than in urban areas**.**

2.9 Access to health care.

Delays and difficulty accessing healthcare can affect duration of work absence; challenges with access to healthcare in Canadian rural areas are well documented (Romanow, 2002). Injured workers in rural areas may have difficulty obtaining both trauma and longer-term follow-up care, especially rehabilitation, occupational or physical therapy (Lipscomb, Moon, Li, Pompeii, & Kennedy, 2002; Peek-Asa et al., 1998). Reasons include the requirement to travel long distances, higher client-therapist ratio in rural occupational therapists as compared to urban ones (Boshoff & Hartshorne, 2008).

2.10 Potential solutions.

A return-to-work program that was implemented in rural upstate New York found that by creating a network of providers and dedicated case coordinators at a county level, many of the

access to care problems could be solved for injured workers (Lipscomb et al., 2002). Following implementation of this network, the number of days off work for injured employees decreased, as did the mean number of transitional days required (Lipscomb et al., 2002). Potential avenues for solutions may also be found in technical advances associated with telehealth.

3.0 METHODOLOGY

3.1 Research Design

Because work disability prevention is a complex and multi-layered issue, this research project, Understanding and measuring work injury among urban and rural healthcare workers, employed a mixed methods study design. The qualitative section of the study utilized a descriptive research design using a semi-structured interview guide to meet the project objective of understanding the organization policies and programs that guide the disability management process (Sandelowski, 2000, 2011). A multi-disciplinary team that included researchers from occupational therapy, psychology, population health, sociology and nursing worked with an advisory group with representatives from the Regional Health Authority (RHA) Central, Brandon RHA, Manitoba Nurses Union (MNU), Canadian Union of Public Employees (CUPE), and Workers Compensation Board (WCB).

3.2 Participants

Interview and focus group participants included healthcare facility managers, department and unit supervisors, frontline workers, WCB representatives, directors of health services, union representatives, and human resource personnel. There were 21 female and 7 male participants whose job experience ranged from 6 months to 20 years. Twelve participants worked in Brandon RHA, 13 worked in Central RHA while two union representatives and one

WCB representative served both RHAs. Participants were asked about their knowledge and opinion of disability management policies, programs and practices, focusing on the rural and urban differences.

3.3 Recruitment process

Participants were recruited through poster advertisements, email communications sent from the RHA offices, and through phone calls. Purposive sampling technique was used to recruit a wide range of individuals who had knowledge and/or experience in the area of disability management, including identification of hazards in the workplace, injury prevention, injury claim management, return-to-work and job accommodation.

The research coordinator and assistant sent out posters to the advisory group members who distributed them to different health institutions in Brandon and Central RHAs. There was a slow response from participants. To improve participation response, the research assistant and coordinator contacted healthcare institutions directly. Phone calls to potential participants from these health institutions were made to increase their awareness of the research project, and improve recruitment efforts. Participants chose to either participate in personal interviews or in focus group discussion.

Prior to conducting this study, ethics approval was obtained from the Health Research Ethics Board at University of Manitoba, and from RHA Central. Participants were informed that their participation was voluntary and were assured of confidentiality throughout the study process. Researchers anticipated recruiting 40 participants. However, with the sample of 28 participants data saturation on key research questions like urban and rural differences, injury prevention and disability management was achieved. There were a total of 18 individual interview participants and 5 participants in each of the focus groups (5x2=10).

3.4 Data collection

Recruitment and data collection occurred from February to November 2012. Semi-structured interview and focus group guides were developed using information from the literature and contributions from members of the research team (Appendix 1). Data collection guides included questions on urban and rural differences, the nature and effectiveness of return-to-work and injury prevention programs, effectiveness of workplace safety and health committees, the work environment and culture around disability management and injury prevention. Opportunities were given for all participants to bring forward issues that they found to be significant and may not have been directly addressed in the interview questions. Use of both face-to-face and telephone interview approaches made it convenient for participants and researchers, especially given the distance between healthcare institutions in the two regions and the University of Manitoba (UM). Interviews lasted from 20 to 60 minutes.

Two focus group discussions (FGD) were conducted after completing most of the individual interviews. The first FGD was held at one of the rural health centres. In this FGD, 5 managers and supervisors in acute care, housekeeping, long-term care and infection control were interviewed. These managers and supervisors were all members of the workplace safety and health committee (WSH) in their facility. The second FGD was held at the UM with five members of the advisory group. Running two separate focus group discussions with different types of individuals in terms of their job positions and roles in work injury prevention and management helped to explore issues raised in the individual interviews. These groups were homogenous in the sense that members shared characteristics i.e. all managers or all stakeholders within the advisory group. Having a homogeneous group minimized power

imbalances and promoted a free information-sharing environment. Focus group discussions lasted from 60 to 90 minutes.

3.5 Data analysis

Consistent with descriptive qualitative research design, data analysis occurred simultaneously with data collection. Personal interviews and FGDs were transcribed verbatim. A qualitative data management system, Nvivo version 9.0[1] was used to organize transcripts and for data analysis.

Inductive data analysis followed a multilevel process: Three research team members started coding interviews, using a line by line approach as transcription of other interviews continued. First, each team member coded two interviews separately using an open coding technique then met on numerous occasions to discuss the process and the identification of codes. Journals were kept throughout this process. In this initial coding, the researchers developed a codebook for coding the remainder of the interviews. Any emerging codes were added to the codebook as they emerged. Through the team process of discussion researchers compared, contrasted, and integrated meaningful words or phrases into units, organized codes, grouped them with other similar codes and then linked the codes with higher order patterns that were combined to form themes.

Triangulation of data collection methods (individual interviews and focus group discussions), and data sources (RHAs, WHS, Unions, Managers) were used to enhance the rigour of the research process. Participants came from both urban and rural healthcare agencies. Researchers worked as a team to analyze the data, discussing differences until consensus was achieved. Transcript summaries were checked with participants to ensure

[1] Nvivo 9.0, QSR International, 2012 http://www.qsrinternational.com/products_nvivo.aspx

accuracy and completeness of the information. None of the participants made any significant changes to what they had reported in the interviews or group discussions.

Rigour in this study was ensured through use of triangulation in its data collection methods. Researchers collected qualitative data thorough both independent interviews and focus group discussions. Using these two methods ensured that findings gathered through individual interviews were explored further and validated (Casey & Murphy, 2009). Another way of ensuring rigour was through member checking where participants had the opportunity to review their transcripts and provide feedback on whether they agreed with what was said in the interviews (Sandelowski, 1993). Additionally researchers ensured voluntary participation. Participants had the opportunity of refusing to answer any or all questions. Participants' views were captured and reported through verbatim transcription. The use of a semi structured interview questionnaire allowed participants to respond to questions in ways that were most comfortable for them. Participants' responses guided further probing and flow of the interview process. Probing gave the interviewer the opportunity to get in-depth understanding of participant's responses(Milne & Oberle, 2005).

4.0 RESULTS

Five main themes emerged from the qualitative interviews and FGD data that portray a developmental story of disability management in select rural and urban regions in Manitoba.

Theme 4.1 Who we are

The 18 interview participants and 10 focus group participants included managers, supervisors, frontline workers and a worker's compensation case manager in charge of both

Brandon and Central regional health authorities. Participants described healthcare workers in their respective facilities and RHAs in terms of age, gender balance, and educational qualifications; the interview and discussion guide focused on the disability management program from policy development to injury prevention to RTW.

Healthcare workers within the Brandon and the Central regional health authorities were described as consisting of both young and older workers. In contrast to the researchers' expectations, the number of newer and younger healthcare workers was reported to be increasing in the rural areas. Participants reported that female healthcare employees outnumbered male employees by a considerable margin. Trades and maintenance workers were described as generally in their middle years.

> *Age wise, we have, we sort of go across the spectrum, but the majority, I would say probably a third of our staff are over 50, a third are between 30 and 50, and the other third are between 16 and 30. (Health services director)*
> *Age, A lot of younger people, I would say, a lot of new hires, I see frontline healthcare workers, a lot of newly graduated, whether health care aides, nursing, so seems to me there is a bigger majority between the 20-30 age range, 20-35 for sure. That's my perception. (Nurse)*

All direct patient care staff in the different facilities had some form of post-secondary education with acceptable certification as required for their job and their profession.

Trends of injuries appear to be related to the age of the worker, and the type of job. According to interview participants, the most common type of injury affecting healthcare workers in rural and urban healthcare facilities is back injury. Back injuries are more common among healthcare aides and nurses involved in direct patient care. More specifically, it was reported that injuries occurred most often to those staff involved in lifting, or

transferring patients, to newer employees, and to staff working with aggressive or unpredictable clients. Injuries from aggressive clients were perceived to be on the increase.

Long-term care facilities appear to have a high number of injury cases. The injuries have been more common among older healthcare workers but the trend may be changing with younger workers starting to get more injuries.

> *a lot of the …long term nurses have been out on illnesses, whether it's a surgery or whatever. I say most of those are in their 40's and 50's. I haven't seen as many of the younger staff, but I think part of it is how many years they've been doing this job and, you know, the wear and tear on the body… think from what I see, it's more seasoned [workers who become injured].(Manager).*

Commenting on the injury pattern, another participant from the focus group observed that:

> *For me in long term care it's more the health care aides, because they're providing the direct hands on care, and we have a twelve bed dementia unit, and that's where the injuries are happening for the most part…*n*urses do everything there as well. Lots of lifting and transfers, aggressive patients… generally speaking, newer staff get injured more, get punched more, than an older staff who's had the experience.(Focus Group 1)*

Another nurse commented:

> *I've seen injuries to all levels. All areas, all levels, all ages. It's pretty varied. There's….the nursing units have high numbers on injuries based on the type of work they do, as does housekeeping based on the type of work they do. Back injury would be one of the top ones that I could think of. (Nurse)*

Theme 4.2 DM Teamwork-Collaboration and cooperation

All participants who represented facilities reported they had a DM or RTW team. (Note that most participants used the descriptor of return-to-work (RTW) rather than disability

management (DM) as used by the interviewers). The DM team was comprised of the employer who might be represented by the facility manager or unit supervisor, an insurance representative who represented the insurance covering the worker's injury; i.e. either Manitoba Public Insurance (MPI) or Workers' Compensation Board (WCB), health professional(s) providing care to the injured worker; this included but was not limited to a physician, physical therapist or occupational therapist, as well as the injured worker and his or her union representative. The most common unions represented in these meetings were the Manitoba Nurses Union (MNU), Canadian Union of Public Employees (CUPE), and Manitoba Government and Employees Union (MGEU)

> *As far as I know, there's… an employee comes to the meeting. A rep from their union, as well as HR [human resources] from, like it's usually this person that I was talking about, our workplace safety person, director of workplace safety. And, I don't know, usually our Director of Health Services is involved in that. I don't know if there's four people or if there's more at that meeting. I know they don't involve anyone else who doesn't need to [be there]*.

It was noted that healthcare providers such as physicians, and the WCB representatives frequently did not attend the return-to-work team meetings. Respondents mentioned that although WCB may not have attended in person, they were usually represented by the regional disability management coordinator or the human resource manager. These observations contrasted somewhat with those shared by the WCB case manager who reported that she/he goes out to these meetings and usually meets with the injured worker as well as other members of the disability management team.

> *WCB is involved if it's a WCB injury, of course. We don't get as much contact with them as we really need to have. It's very difficult to get a hold of those case workers to participate in the discussions. They tend to accept the plan that we put together as an*

> *employer, along with the HR rep, with workplace safety and health. [the injury prevention coordinator] is the contact with the WCB case worker, but as direct managers we have very little if any contact with them [WCB case managers].(Focus Group 1)*

The RTW team's main duty is to help injured workers get back to work. The RTW team also ensures that the injured workers receive their benefits and are connected with the right resources such as occupational health and ergonomics programs. In efforts to fulfill their duties, the RTW team described their work as partnerships with:

> *We [RTW team] partner with human resources and the union, with WCB and the employee coming back to work in terms of finding a role for them and making sure they're coming back to a safe environment.* (Nurse)
> *Well I think they [RTW team] work together well, I think the common goal is to get this person back to normal work life and being productive again.* (Manager)

The workplace health and safety (WHS) committees in different facilities in both RHAs, work with managers, injured workers, unions and human resource personnel. The joint WHS (i.e. both labour and management represented) committees are involved in identifying work injury risks, and engage in injury prevention activities. They meet regularly to review policies, review workplace injuries, and deliberate on prevention steps. They are usually not involved in RTW or DM.

> *…[WHS] then work with the rest of the managers to, related to return-to-work and what not, they're aware of the policies and procedures, and the processes involved in having people come back to work after they've had an injury or been away from the workplace for an extended period of time related to a medical issue. And also stay in touch with our human resource department … and the unions as well in our facility so that we're all working together to have the person, the employee, come back to work.* (Focus Group 1)

> *We [WHS] do a walk-through every meeting as well, we walk through the clinic and the workplace just to identify any hazards that may be there and we do communicate with the staff to find out if there's any concern that they want to bring forward.* (Clinic Manager)

Theme 4.3 We like it in the rural area… Mostly we get along and support each other…that's our culture

Facilities in urban and rural areas are similar in terms of the nature of work within the healthcare sector, policy and practice approaches for injury prevention and programs in disability management or return-to-work. The policies for DM were developed for the entire RHA, and applied to all healthcare facilities within the health authority. Each hospital, personal care home, and community agency [tried to] implement the policies for WSH, injury prevention, and RTW strategies. The efficiency and efficacy of the implementation strategies were somewhat dependent on the resources available to each healthcare facility. Differences varied with regard to distance from a major centre, the workplace environment and community environment. For instance, in the rural areas, people know each other more intimately and it is easy to tell when someone is not at work whereas in the urban centres, it is more difficult to keep track of all employees. The lack of anonymity in the rural area also means that other staff members can easily tell when one of their staff is away because they know each other outside the workplace environment.

> *It's pretty hard in this community to not show up to work and not be seen somewhere by someone because everybody knows you. That's a difference between rural and urban. In urban you can get away with that, but here I could drive down the street and see someone and say 'How come you're here drinking beer, aren't you supposed to be at work? (Focus Group 1)*

Staffing differences are often due to the fact that there are fewer potential workers to draw from in the rural areas. The scarcity of workers overall means that rural facilities find it challenging to replace or accommodate an injured staff member. Wherever facilities are short staffed, workers are more likely to get injured. The injured workers are also likely to come back to full duties before they are properly healed because they know no one else is there to take over their duties; this increases their risk for re-injury—(called presenteeism).

> *…it's just so minimally staffed. I have minimally staffed areas and units too, and it's way more difficult. You're trying to accommodate one person with restrictions and there's only two other people to shuffle those tasks around, where in the regional health centre itself it's so large, you've got 60 people doing housekeeping duties …(Focus Group 2)*

Urban areas have an array of health service resources for injured workers who are returning to work. Some specialized services may often be lacking or are limited in rural areas.

> *Workers [who have injuries] who reside in Brandon or close to Brandon have a wider array of supportive therapies in terms of physiotherapy, massage therapy, yoga, swimming, all those kinds of things that would help maybe with recovery, as compared to somebody who lives in K_, which is a very small town with nothing around it. So the differences are you've got more resource availability, and more anonymity.(Manager)*

Despite the aforementioned differences, the rural areas have some unique advantages. For instance, the employees support each other and are often willing to work overtime to help out when someone is injured. Their closeness also helps them to form warm relationships that may be lacking in urban areas. The close relationships may be a positive force for the most part but may add complexity to the RTW process because of confidentiality concerns.

> *I just wanted to add that when you are in a smaller community everybody knows everybody… it's trying to keep so confidential because they don't want somebody to*

> *know that maybe they're suffering from an illness or something, so they're hesitant to share,_...I can't be at the table because this is my sister-in-law, or it's my daughter. So there's that small community family too. We still make it work. (Focus Group 2).*

Participants suggested that differences between urban and rural areas were related to difference in work culture which is driven by policy, management staff and the workers in the different facilities. This was also true for injury prevention and disability management. For instance, some participants suggested that older workers, who might be more likely to work in the more rural areas, found it difficult to learn skills that could reduce their risk of injuries, preferring to stick to the previously-learned ways of doing things.

Support by co-workers and managers.

Participants reported that a substantial part of the rural culture is strong support by co-workers and managers. Presenteeism-or reluctance to report injuries-was found to exist in some areas. Some facility managers reported that workers were reluctant to report injuries because they knew how challenging it was to replace them, especially in the most rural areas. Injured workers and their managers were reported to be generally positive about the goals of returning to work and preventing further injury. Co-workers supported each other:

> *Now my experience with it is that, my other employees are usually very supportive. You know, if it's a new employee and they are not really sure of what steps to take they usually will involve the supervisor immediately to give that employee guidance. You know usually because we are in a healthcare providing facility, everybody is very compassionate and very helpful if somebody gets injured. (Nurse supervisor).*

Some workers were skeptical about WCB and this may be related to experiences of acquaintances or colleagues who had been in the position of injured worker. Despite these

assertions, WCB was perceived by the participants, just like the employer and other employees, to be very supportive of the injured workers.

> *I think a distrust... for whatever reason, whether they've had past negative experiences with an insurance company, ...whether they've had somebody they know, ...a co-worker or family member who has dealt with them [WCB] and has felt as though they were not listened to and were not given appropriate direction and not assisted as much as they felt they should have been. Some people just have an inherent distrust of the Workers Compensation Board system (Nurse).*
>
> *We [WCB] do try to offer as many resources and support as we can, in all those aspects, may they be mental, may they be physical, may they be adjustments with their home life, may they be something physically in their home that they need, we'll support that (Case manager).*

Support of RTW teams:

> *Well, they [RTW team] come to the table to plan out the care, they want the person to work within their restrictions, they want the person to do as much of the program as it's laid out because the ultimate goal is the person's going to get better and come back to work. Encouraging the staff to report any concerns to them, if they're having any difficulty so they can kind of problem solve, they have to do any problem-solving on a day-to-day basis to make adjustments to the program, to make it better for the staff, have the staff provide them with any updated medical as soon as any changes occur. (Nurse)*

Theme 4.4 Celebrations, challenges and hope

The celebrations. A number of programs were perceived to be effective for injury prevention and return-to-work. Programs that "worked well" included Workplace Safety and Health committees, the return-to-work process, the claims process, the Safe Client Handling Injury Prevention Program (SCHIPP), and the ergonomics program.

When asked about the injury claims processes, managers were aware, and felt that workers were conversant with the claims filing process, and implemented the process in a timely manner. Managers reported that in the event of an injury, workers knew whom to contact, which forms to fill, and where to seek healthcare treatment.

Ergonomics programs were discussed in the context of return-to-work and injury prevention. Managers in one of the focus groups expressed that the ergonomics program was evolving within the RHA – as an awareness issue and as a means of intervention. The RHAs have taken positive steps to address ergonomic resources for both injury prevention and return-to-work purposes. For instance, Brandon RHA hired a kinesiologist who performs ergonomic assessments to help with job modification.

With regard to injury prevention, the RHA Central in collaboration with WCB developed and implemented the injury prevention program known as SCHIPP. Participants reported that the SCHIPP program is effective.

> *The SCHIPP program seems to have helped quite a bit…The program also, it's actually a really good program because what it does is it includes the employee throughout that whole program. (Focus Group* 1)

Participants from both RHAs reported that their RTW programs were effective.

> *… we have a very good process as far as return-to-work and coming together as a group and working to ensure that the employee who we're returning back to work is supported and working in a safe environment and working within the restrictions laid out by the healthcare provider. .. there's much benefit in getting people back, getting them engaged in the workplace, it's not just related to physical injury but also to their mental well-being. Getting them engaged with their co-workers, getting them to maintain that routine, I believe it's [RTW Program] very effective. Getting them back so that they're not sitting at home getting into more of a sick role, and it's proven in the*

> *literature, the longer they stay away, out of the workforce, the harder it is for them to come back (Nurse).*

The challenges. Regardless of the success of these programs and processes, some barriers continued to challenge the good intentions of managers and staff. Within the RTW/DM programs and processes, the major challenges seemed to be scheduling, because of the distance required to travel between the site of the workplace and the location of the stakeholders that meet with the RTW team. Expressed by managers from two different facilities:

> *…D. has to come from B., so to have enough time usually try to group things together so they're not coming for one necessarily, but maybe two or three, or maybe stop here in A and also carry on to maybe X or Y, or somewhere else along the way so it's not just a one-purpose trip. So just coordinating schedules over a large geographical area, to me it makes sense that it probably becomes more problematic, more difficult to do…And the other challenge that we're faced with in the timeliness of getting back, is trying to coordinate those meetings between union, employee, manager, third party insurer, and workplace safety and health person from the region..... So it delays everything. I think part of that is distance again.* (Focus Group 2)

Another manager expressed frustration with trying to interpret "light" or "modified" work when such descriptors were listed by the physician as a limitation for performing duties. Thus a confusion or lack of clarity in communication remained as a challenge.

Staffing needs for the RTW/DM programs within the RHA did not appear to be a critical issue although one manager acknowledged that expectations (of the DM) were too high, that one person could not keep up with the work safety and DM responsibilities for the whole region.

> *What does happen though is the person, our workplace person, is that D. is spending a lot of her time doing that, which means she's probably not available to us for help in other workplace safety issues*. (Manager)

Another staffing concern was that many work units (facilities) were small and employed few staff; if more than one person became injured, regular staffing became a critical issue.

> *And sometimes the other challenge is that we might have an area that has a lot of return-to-work, a lot of our injured staff and then trying to juggle how we're going to work those people in. (Nurse)*

A third issue around staffing was expressed as a difference in how the two RHAs managed the RTW program. The Brandon RHA assigned RTW as one of several responsibilities of the human resources staff. By assigning this responsibility to human resource, sometimes there is lack of specialization leading to less priority being given to RTW needs. A fourth issue around staffing is the challenge of monitoring the RTW process for entry level workers in the community:

> *It's actually probably one of the most challenging return-to-works I've done because the person is an entry-level employee, they're not a professional trained employee. They're at a very entry-level, it's a home care attendant. Their co-workers don't work directly with them, they work the shift after them. This person's working on their own out in the community. It's hard to follow-up, it's hard to monitor restrictions and be sure restrictions are followed. So it's been a very challenging one.* (Director).

On a different note, the effectiveness of the SCHIPP program came with challenges as well. It is challenging to keep up with education sessions for new staff, and with contract workers, and refreshment sessions for regular staff. SCHIPP program facilitators also found it

challenging to monitor and maintain the standards for staff to follow partly because it takes longer to accomplish some tasks in a safe manner.

> *…it's hard to educate everybody, hard to get information maybe, because some of the information we have to supplement our program is video related, so some staff need to be able to access the internal internet for our region to be able to get to it and they can't*. (Educator)
>
> *Possibly it's because the time element, like staff have a very limited amount of time to get their work done. I shouldn't say limited, but it's a narrow window to get your work done, so you're always kind of hurrying a little bit. And because of that you sometimes have an injury...* (Focus Group 1)

Last but not the least is the financial demand that comes with implementing new programs and equipment for injury prevention/disability management. For instance, it is sometimes expensive to purchase recommended ergonomic equipment.

> *We had an ergonomist and an occupational health and safety nurse that would come in and say our work stations weren't good for this and that reason and then that becomes a budgetary issue of who gets the nicest desk, how many desks can we buy that look wonderful, and how many chairs can we buy*. (Manager)
>
> *Yes. They want to recommend things that I can't afford. Everybody has an individual need for a chair… And they are expensive, we ought to quit our jobs and go into office furniture manufacturing I'll tell you, because everything costs a million dollars. But I don't know. They definitely…the limitations are that, yes, there's a lot of equipment out there that we would probably all love to have but the employer can't afford it all so we kind of have to go with a generic "your chair is adjustable up and down, and the seat and the back."* (Manager)

The hope. Participants voiced their hope to improve despite the barriers and the challenges. In the area of return-to-work, they mentioned that despite staffing and financial challenges, and

lack of support from managers, there were opportunities to overcome these challenges. They felt that managers could be innovative and find inexpensive ways of working within their budget restrictions. One manager stated:

> *I finally found something that worked, it was inexpensive compared to… the original cost of the eyewash station was supposed to be two grand or something. We found something that we could attach to the taps, for like $250 and worked. It met all of the standards, the standards. It worked. But you have to be inventive and you have to be very careful that you use your dollars wisely because you have a limited amount*. (Focus Group 1)

Managers and supervisors could/should contact injured workers following the injury to express their support. This might improve chances for early return-to-work.

> *Sometimes, that's a gap for me because sometimes you are off and there is no return-to-work for six months and … you just lose sight of who is not right on your doorstep, so at times I think we could be phoning a little bit more and checking in but I just wait for them to roll in with their notes and say she is good to go, set it up.* (DM Manager).

Several participants expressed that a medical representative or a WCB representative was rarely available to sit on the committee to plan or monitor a RTW plan (they suggested that these team members could improve their involvement in the RTW team).

> *I think it does. I don't have any evidence to support that other than they're bigger, they're all there, WCB, their offices are in Winnipeg, so their distance to travel is they're still in the city. I don't know if they have any more active participation or not. But it would be, I think that's a gap that we see regardless, is that they're not present for those meetings*. (Focus Group 1)

5.0 DISCUSSION

This is the first research study to be conducted in Manitoba that explores similarities and differences in disability management among healthcare facilities and workers in both rural and urban healthcare settings. This study used a research team with diverse backgrounds and experiences in occupational health, sociology, psychology and nursing informed, which ensured that study findings were interpreted from different professional and practice frameworks.

5.1 Work disability prevention

As presented in the findings above, disability management policies have been developed and implemented in the two RHAs in line with the work disability prevention (WDP) models presented by Frank and colleagues (1998), Franche and Krause, (2002), Franche and Krause, (2003), Loisel and colleagues (2001), Franche et al. (2005), and Krause and colleagues (2001). The approach to disability management via multi-stakeholder group of worker, healthcare provider, workplace and insurers is a model that has been promoted for more than a decade (Loisel, 2001). Until now, the WDP model has not been evaluated in the Manitoba healthcare sector and has not been evaluated in a rural setting. The current study has established that teamwork and collaboration using some form of the WDP prevention model is regularly practiced in the Brandon and Central RHAs in Manitoba. Even though challenges with scheduling of meetings and the absence of key healthcare providers delayed the whole process of return-to-work especially in the rural areas, there was (and continues to be) a commitment by the DM team to make things work. This is an example of effective application of the WDP model in rural Manitoba. Further research is needed to address how or why the WDP model is working despite the delays in return-to-work process. Moreover, there is need

to address the challenges that delay the return-to-work process. Further evaluative research of the WDP model application in rural health settings is indicated.

As found in other studies **(**Brockwell, et al., 2009; Molinari & Monserud, 2008; Weymouth, et al., 2007), participants in this study affirmed that healthcare workers liked to work in the rural areas. Many participants especially from RHA Central preferred working in the rural area. They like it in the rural area because of the sense of community, working like a family or with family members and feeling supported in cases of work injury. This community culture translates to the work area where workers in rural settings are more supporting of injured workers. Possibly the supportive culture in the rural setting is a factor that can encourage healthcare workers to move and work in the rural areas.

In line with previous research on high workloads in rural areas (Lenthall et al., 2009; MacLeod et al., 1998; MacLeod et al., 2004; MacLeod et al., 2008), participants from rural healthcare facilities in this study spoke of staffing as a challenge that partially contributes to work injury. They talked of situations where injured workers found it difficult to report an injury because their facilities were short staffed and staying off work would mean that the injured worker's colleagues would be overworked.

Participants in this study seem to suggest that a greater number of new graduates and younger nurses are moving to rural healthcare practice areas. As this was not found to be a significant difference in the claims analysis (see **Quantitative Report**), this needs further exploration to determine the accuracy of such a statement.

5.2 Study Limitations

Participants for this study were selected using purposive sampling. Managers, supervisors, frontline workers, occupational health nurses, case managers and human resource

managers participated in the interview or the focus group process. Although this limited the data to the policy and program aspects of DM and did not capture the experience of injured workers, it was felt that policy and program were essential to understanding the processes. All participants were volunteers and most were in a management or supervisory job position, and as such, may have had different views than injured workers.

5.3 Conclusion

The qualitative part of this study provides an understanding of the policies and the practices of disability management and injury prevention in Brandon and Central regional health authorities (RHA) of Manitoba. The managers, supervisors and front line workers shared their knowledge and work experience as far as disability management is concerned. They reported similarities in urban and rural demographics of healthcare workers, RTW/DM policies and programs, teamwork within the RTW/DM committees, and patterns of injury and challenges faced. One key difference between the rural and urban facilities in this study suggested that a high level of support from managers and coworkers was an element of rural workplace culture and therefore more likely to be experienced in rural facilities.

Potential for new policy and practice. A return-to-work program that was recently implemented in rural upstate New York found that by creating a network of providers and dedicated case coordinators at a county level, many of the access to care problems could be solved for injured workers (Lipscomb et al., 2002). Following implementation of this network, the number of days off work for injured employees decreased, as did the mean number of transitional days required (Lipscomb et al., 2002). The researchers in Objective 4 of this study are in process of designing and implementing an innovative web-based Knowledge Transfer

and Exchange (KTE) project to improve communication exchanges among all Manitoba regional health authorities.

6.0 RECOMMENDATIONS FOR RESEARCH AND PRACTICE

6.1 It is recommended that an environmental scan be completed for all health authorities in Manitoba; this should include comprehensive data collection from each RHA on all policies and programs related to DM including injury prevention, health and safety committee practices, work injury and claim process, RTW programs, and job accommodation. It is only with complete and accurate data that stakeholders can form and evaluate policies.

6.2 More and more, healthcare facilities—especially in the rural areas—are incorporating several functions such as long term care and acute care and home care head office, within one building. This makes it challenging to identify whether the "type of facility" has any bearing on DM success. Researchers and all stakeholders should work together to create accurate descriptors of multi-function healthcare facilities in consistent terms across all RHAs in Manitoba.

6.3 It is recommended that stakeholders, especially employers and professional associations, track geographic practice trends and recruitment strategies of all healthcare professions in the rural areas of Manitoba.

6.4 It is recommended that DM teams explore the use of more sophisticated and more technology for all team communications. The KTE phase of this research study will be an innovative strategy to explore the efficacy of a web-based communication system.

6.5 It is recommended that all RHAs outside of Winnipeg continue to place priority on resource recruitment and development including DM coordinators, specialized healthcare providers (such as occupational and physical therapists), physicians and nurses.

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APPENDIX A

KEY INFORMANT INTERVIEW GUIDE

Introduction

Good morning/afternoon/evening. My name is _____. I am a researcher for the "Understanding and measuring workplace injury and disability among rural and urban health care workers in Manitoba" project at the University of Manitoba.

You have been invited to participate in this research study because of your employment and/or key role in the disability management or joint health and safety committee in your facility in Manitoba. Thank you for accepting the invitation to participate in this in-depth interview.

As part of the interview, you will be asked to discuss your understanding of the disability prevention policies and programs in your facility, and differences in disability outcomes between urban and rural settings. We will start by focusing on what is happening in your own facility. Towards the end of the interview, we will move into a discussion of what you see as differences between urban and rural settings.

The purpose of this interview is to examine the status of work related injury prevention and return-to-work policies and programs in personal care homes, hospitals and community health agencies. Later on in this research study, the researchers anticipate working with stakeholders – workers, managers, insurance representatives to develop decision making tools for prevention of work disability for rural and urban health care workers. This interview will take about 20 to 45 minutes. The interview will be audio recorded so that the researchers may accurately write out the issues discussed.

My role in this discussion is to moderate the discussion. I am here to ask questions and record your response. My colleague will take notes while I conduct the interview. You may ask questions about the study or process of the interview before or after the interview.

In order to proceed, I will need your permission, or consent, to participate in this interview. Please read the informed consent form. By signing and dating the form, you consent to participating in this interview. Please remember that participation is voluntary. You may choose not to answer all questions and may stop the interview at any time. (Give participant time to read, sign, and date informed consent form.)

Do you have any questions before we begin?

1. Ice Breaker Interchange

What is your role in the personal care home/community facility/hospital?

2. Main Questions-Topical Areas

Let's begin the interview.

Interview

1. Background information

- Tell me about yourself in terms of your:
    - Position title, age, gender (the interviewer does not need to ask about gender)
    - Expertise in DM
    - Location – RHA,
    - Type of healthcare facility- Personal care home, community, hospital
    - How long you have been working with this health care facility and or in this RHA

2. Joint Health and safety committee (JHSC)

- Are you familiar with your facility's Joint Health and Safety Committee?
- What are the health and safety issues that you often handle?
- How well does the committee work together?
- Which groups are represented in this health and safety committee?
    - What are their roles in regards to disability management?
- What kind of decision-making power does the committee have?
    - How are the different groups engaged in the decision making process?

3. DM policies and/or programs

- Does your organization have a DM and/or return-to-work (RTW) and/or ergonomics policies? (if documented, request a copy)
    - To what extent are these policies implemented?
        - Tell me more about how are they being implemented
    - In describing these policies, how do they incorporate the following aspects in disability management?
        - the workplace,
        - accessibility of employees to healthcare services,
        - insurer-WCB,
        - Worker (employee)?
    - What is the level of the supervisor involvement in the implementation of these policies and programs?
    - How do employees, the healthcare facility/administration and WCB perceive these policies and programs?
- Does your organization have a DM program such as a return-to-work (RTW) and/or Stay-at-work (SAW) program?
    - If so, tell me more about it. How does it work?
    - How would you describe its effectiveness?

  - What are some of the limitations of this program?
  - Who delivers the program – is it offered in-house or by a third party?
  - How does your facility work with health care providers (where injured workers seek health care services) in promotion of RTW policies?
  - Who funds the RTW and or SAW program?

- Does your organization have an onsite work rehabilitation program?
  - If so, tell me more about it. How does it work?
  - How would you describe its effectiveness?
  - What are some of the limitations of this program?
  - Who delivers the program – is it offered in-house of by a third party?
  - Who funds the rehabilitation programs?

- Does your organization have an ergonomics program?
  - If so, tell me more about it. How does it work?
  - How would you describe its effectiveness?
  - What are some of the limitations of this program?
  - Who delivers the program – is it offered in-house of by a third party?
  - Who funds the ergonomics program?

- Has there been any evaluation or review of these policies and/or programs?
  - If so, please tell me more about the evaluation and/or review.
    - What recommendations were made?
  - If not, do you feel that these policies and/or programs need an evaluation and/or review?
  - If yes, what suggestions or recommendations do you have?

- How does your facility work with other healthcare providers, WCB and employees in seeking to reduce work disability issues?
  - If the facility works with other health care providers, WCB, and employees, are there any specific programs in place for this form of collaboration?
    - If so, tell me more about them
  - What are the benefits/significance of working with other healthcare providers, WCB and employees in seeking to reduce work disability issues?
  - What are the challenges of working with other health care providers, WCB and employees in seeking to reduce work disability issues?

4. Workplace culture and disability management

- How is the workplace culture with respect to work disability prevention and disability management?
  - Is the workplace culture supportive of the implementation of DM policies?
    - Tell me more about this

  - How do co-workers respond to disability management programs and policies?
  - Is there anything in the policy that supports the legitimacy of the injury?
  - How do supervisors, co-workers typically perceive the legitimacy of disability or injury claims by employees?

- What is the culture and what are the philosophies around reporting work place injuries to WCB?
  - Who is responsible for filing disability claims?
  - How often is the manager involved in filing these claims?
  - Are there cases of delay in filing disability claims?
    - If so, how often?
    - If so, what plans are in place to prevent future delays?
  - How would you rate the frequency of work place injuries in your facility?

- What form of accommodation is provided for injured workers?
  - Tell me more.
  - What is the process around obtaining an accommodation?
    - How long does this process take?

5. Length of time off work and staff support

- How long does it take to know that a staff is off work before the manager is aware and takes the appropriate steps?
  - What happens if an employee is off work for more than three weeks?
  - Is there a system in place that can help to identify which staff is off work and for how long?
  - How often is the manager informed about the staff who is off work?
  - Who takes the initiative to contact and follow up with the staff?

- What steps are taken to support staff/staffs that are off work due to work place injury?
  - Do we have systems in place to support staffs that are off work due to injury?
    - Tell me more about these systems
  - Is there early supportive contact?
    - If yes, how is this done?
  - Besides the early contact, is there any other person who makes contact with the worker?
    - Tell me more about the nature of this contact.
    - Do you have a case manager?

- At what point are the case manager, health and safety committee, and/or third party involved?
- Is the case manager part of the management, or third party?
- If a third party is involved, what services is the third party asked to provide?

6. Role of unions in DM

- How do unions interact with management and workers in DM?
  - Tell me more about this interaction
- What is the interaction between the union representative, the worker, case managers and healthcare provider?
  - Tell me more about this
- What are the traditions about having unions involved?
  - Are injured workers informed of the involvement of the unions?
  - It is often reported that the unions are there to support the worker; do you see this as being the case in the work injury and disability?
- What is the experience of union representation in promoting workplace safety and injury prevention?
- Does the involvement of the unions affect the process of disability prevention and management
  - If so, tell me more
- Does the involvement of the unions affect the length of time in processing an injury claim?
  - If so, tell me more

7. Healthcare workers

- What are the demographics of your healthcare workers?
  - Would you say they are more elderly or younger age-wise?
    - Why do you think this is so?
  - How would you describe their education levels?
    - Why do you think this is so?
- How would you describe their disability outcomes?
  - Tell me more about this.
- How does the age and educational levels of the healthcare workers contribute to their disability outcomes in terms of injury rates, participation in return-to-work programs, the type and cause of injury, their ability to use injury prevention programs, and time spent out of work?
  - Why do you think that way?
- Do you think that the disability outcomes, age and educational levels affect the recruitment and retention of workers?
  - Why do you think this is so?

- Do you have any suggestions for overcoming this? (if disability outcomes, age and education levels affect recruitment of healthcare workers)
- Do you think that your disability management policies and programs affect recruitment and retention of workers?
    - Why do you think this is so?

8. Urban vs. Rural settings

- Do you consider your facility as urban or rural?
- It is perceived that rural health care systems differ from the urban health care systems as far as workers disability prevention is concerned, what is your take on this?
    - Why do you think this is so?
- How do you think the work-related injuries here differ from those in facilities in a more (rural/urban) setting?
- How do you think the RTW programs here differ from those in facilities in a more (rural/urban) setting?
- How do you think the work absence duration in your facility (rural/urban) compares with rate in other facilities that are considered more (rural/urban)?
- How do you compare the similarities/differences in DM policies between your facility (rural/urban) and those of other facilities that are more (rural/urban)?
    - If there are any differences: (ask) tell me some of these differences
    - Do you think it is necessary to have (or not to have) these differences?
- How do you compare the age and education levels of health care workers in your facility (urban/rural) with those of health care workers in facilities that are considered more urban/rural?
    - Why do you think this is so?

9. Are there any other issues or concerns you would like to talk about?

FOCUS GROUP DISCUSSION GUIDE

1. Background information

- Tell me about yourself in terms of your:
    - Position title, age, gender (the interviewer does not need to ask about gender)
    - Expertise in DM
    - Location – RHA,
    - Type of healthcare facility- Personal care home, community, hospital
    - How long you have been working with this health care facility and or in this RHA

2. Joint Health and safety committee (JHSC)

- Are you familiar with your facility's Joint Health and Safety Committee?
- What are the health and safety issues that you often handle?
- How well does the committee work together?
- Which groups are represented in this health and safety committee?
    - What are their roles in regards to disability management?
- What kind of decision-making power does the committee have?
    - How are the different groups engaged in the decision making process?

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- Does your organization have a DM and/or return-to-work (RTW) and/or ergonomics policies? (if documented, request a copy)
    - To what extent are these policies implemented?
        - Tell me more about how are they being implemented
    - In describing these policies, how do they incorporate the following aspects in disability management?
        - the workplace,
        - accessibility of employees to healthcare services,
        - insurer-WCB,
        - Worker (employee)?
    - What is the level of the supervisor involvement in the implementation of these policies and programs?
    - How do employees, the healthcare facility/administration and WCB perceive these policies and programs?
- Does your organization have a DM program such as a return-to-work (RTW) and/or Stay-at-work (SAW) program?
    - If so, tell me more about it. How does it work?

  - How would you describe its effectiveness?
  - What are some of the limitations of this program?
  - Who delivers the program – is it offered in-house or by a third party?
  - How does your facility work with health care providers (where injured workers seek health care services) in promotion of RTW policies?
  - Who funds the RTW and or SAW program?

- Does your organization have an onsite work rehabilitation program?
  - If so, tell me more about it. How does it work?
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  - If so, please tell me more about the evaluation and/or review.
    - What recommendations were made?
  - If not, do you feel that these policies and/or programs need an evaluation and/or review?
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    - Is the workplace culture supportive of the implementation of DM policies?
        - Tell me more about this
    - How do co-workers respond to disability management programs and policies?
    - Is there anything in the policy that supports the legitimacy of the injury?
    - How do supervisors, co-workers typically perceive the legitimacy of disability or injury claims by employees?

- What is the culture and what are the philosophies around reporting work place injuries to WCB?
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    - How often is the manager involved in filing these claims?
    - Are there cases of delay in filing disability claims?
        - If so, how often?
        - If so, what plans are in place to prevent future delays?
    - How would you rate the frequency of work place injuries in your facility?

- What form of accommodation is provided for injured workers?
    - Tell me more.
    - What is the process around obtaining an accommodation?
        - How long does this process take?

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- How long does it take to know that a staff is off work before the manager is aware and takes the appropriate steps?
    - What happens if an employee is off work for more than three weeks?
    - Is there a system in place that can help to identify which staff is off work and for how long?
    - How often is the manager informed about the staff who is off work?
    - Who takes the initiative to contact and follow up with the staff?

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    - Do we have systems in place to support staffs that are off work due to injury?
        - Tell me more about these systems

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  - If yes, how is this done?
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  - If a third party is involved, what services is the third party asked to provide?

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  - Tell me more about this interaction
- What is the interaction between the union representative, the worker, case managers and healthcare provider?
  - Tell me more about this
- What are the traditions about having unions involved?
  - Are injured workers informed of the involvement of the unions?
  - It is often reported that the unions are there to support the worker; do you see this as being the case in the work injury and disability?
- What is the experience of union representation in promoting workplace safety and injury prevention?
- Does the involvement of the unions affect the process of disability prevention and management
  - If so, tell me more
- Does the involvement of the unions affect the length of time in processing an injury claim?
  - If so, tell me more

7. Healthcare workers

- What are the demographics of your healthcare workers?
  - Would you say they are more elderly or younger age-wise?
    - Why do you think this is so?
  - How would you describe their education levels?
    - Why do you think this is so?
- How would you describe their disability outcomes?
  - Tell me more about this.
- How does the age and educational levels of the healthcare workers contribute to their disability outcomes in terms of injury rates, participation in return-to-work

programs, the type and cause of injury, their ability to use injury prevention programs, and time spent out of work?
    - Why do you think that way?
- Do you think that the disability outcomes, age and educational levels affect the recruitment and retention of workers?
    - Why do you think this is so?
- Do you have any suggestions for overcoming this? (if disability outcomes, age and education levels affect recruitment of healthcare workers)
- Do you think that your disability management policies and programs affect recruitment and retention of workers?
    - Why do you think this is so?

8. Urban vs. Rural settings

- Do you consider your facility as urban or rural?
- It is perceived that rural health care systems differ from the urban health care systems as far as workers disability prevention is concerned, what is your take on this?
    - Why do you think this is so?
- How do you think the work-related injuries here differ from those in facilities in a more (rural/urban) setting?
- How do you think the RTW programs here differ from those in facilities in a more (rural/urban) setting?
- How do you think the work absence duration in your facility (rural/urban) compares with rate in other facilities that are considered more (rural/urban)?
- How do you compare the similarities/differences in DM policies between your facility (rural/urban) and those of other facilities that are more (rural/urban)?
    - If there are any differences: (ask) tell me some of these differences
    - Do you think it is necessary to have (or not to have) these differences?
- How do you compare the age and education levels of health care workers in your facility (urban/rural) with those of health care workers in facilities that are considered more urban/rural?
    - Why do you think this is so?

9. Are there any other issues or concerns you would like to talk about?

[i] "Rural, remote, and northern" relate to separate yet overlapping constructs; for simplicity, we use the term rural to refer to all three concepts