

Disability Management Practices in Ontario Health Care Workplaces

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Abstract *Background:* Workplace disability management programs are important in managing injury and disability. *Methods:* A stratified random sample of 188 employers in health care workplaces (71 hospitals, 48 nursing homes, 42 private clinics, and 27 community clinics) completed a mailed Organizational Policies and Practices (OPP) questionnaire. The OPP asked questions about eight workplace disability management practices. This article compares disability management practices across the four types of health care workplaces. *Results:* A one-way analysis of variance for each of the eight practices demonstrated significant differences across facility types for all practices, except ergonomic practices. For unionized versus non-unionized workplaces, there were significant differences in all practices, except ergonomic practices. For workplaces with formal policies versus those without policies, there were significant differences in all practices, except people-oriented culture and safety diligence. *Conclusion:* Variations in disability management practices in health care workplaces need to be addressed to provide more effective prevention and treatment of work-related injuries and disability.

Keywords Disability management · Organizational behavior · Health care · Surveys · Organizational policies and practices · Rehabilitation

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Introduction

Timely return to work following work-related musculoskeletal injuries and the high costs of work disability associated with these injuries have become critical issues for employers [1–3]. In particular, workers in the health care sector have a high incidence of on-the-job-injuries [4–7]. From 1999 to 2003, in the health care sector in Ontario the proportion of lost claims data resulting from these injuries varied from 7.0% to 9.4% [8]. In 2000, health care workers were one and a half times more likely to miss work because of illness and disability than workers in other sectors [4, 5]. Nurses have been recognized as having a high incidence of manual handling associated injuries, especially of the back [7, 9, 10]. Nurses also are at risk for needle-stick injuries, infections, illnesses, and workplace abuse [4, 11, 12]. Restructuring, downsizing, and an increased number of older people requiring health care services have placed greater demands on the health care sector and have led to fewer jobs, job insecurity, longer working hours, and higher patient-staffing ratios [7, 13–15].

The return of injured workers to their job is determined by a complex interaction of numerous factors including the characteristics of the individual worker, the characteristics of the injury, the job, the workplace, the broader social, economic, and legislative environment, the compensation system, and the interaction of all stakeholders in the disability process [16–20]. Organizational factors such as the presence and effectiveness of joint management and labour committees in health and safety [21], organizational climate [22, 23], employer participation [24], and control over one's job demands [25, 26] also are important in returning injured workers to work. In a recent systematic review of the quantitative literature, Franche et al [27] found that work disability duration was significantly reduced by the following intervention components: worker accommodation offers, contact between the health care provider and the workplace, early contact with the worker by the workplace, ergonomic work site visits, and the presence of a return to work coordinator.

In an effort to prevent and manage work-related injuries, employers have implemented disability management programs to lower disability costs, protect the employability of workers, and promote safe and timely return to work [17, 28, 29]. Disability management programs are proactive, workplace-based approaches to: (a) prevent work disability from occurring; (b) provide early intervention for health and disability factors; and (c) encourage access to rehabilitation to promote safe and timely return to work [19, 30]. These programs have been shown to be effective in preventing, reducing, and managing workplace injuries, as well as returning injured workers to work [30–34]. Disability management programs may include modified work programs, reduced hours, vocational rehabilitation, integrated pro-active return to work programs, medical case management, and employee-supportive communication among employers [1, 30, 33–35].

Much of the literature on managing disability in the workplace has occurred in the manufacturing industry and in workplaces that have more than 100 employees [29–31]. In a cross-sectional study of 220 Michigan firms, Habeck and colleagues [31] used a 95-item questionnaire to examine the relationships among disability management practices with the incidence and duration of Workers' Compensation injury claims. They found that employers who were higher performers in safety diligence, pro-active return to work programs, and people-oriented culture had lower claim rates and duration. Using the data set from the Habeck et al study [31], Amick et al [36] shortened Habeck et al's 95-item instrument to a 52-item Organizational Policies and Practices (OPP) questionnaire.

This article presents data on the use of the revised 52-item OPP with a sample of employers in the Ontario, Canada health care sector. Data collected as part of a larger study [37] provided the opportunity to further examine workplace policies and practices in health care workplaces. The research questions were: (1) What disability management practices are available in Ontario

health care workplaces (i.e., hospitals, nursing homes, private clinics, and community clinics)? and (2) Are there variations in these practices among the facility types depending upon workplace characteristics such as being unionized, having formal disability management policies, purchasing external disability management services, and size. The variations in OPPs would highlight workplaces that required assistance in improving disability management activities, as well as information on the specific practices to improve.

The purpose is two-fold. First, to identify disability management practices across four types of health care workplaces. Second, to examine variations in practice by workplace characteristics (i.e., being unionized, having formal disability management policies, purchasing external disability management services, and size) among the facility types.

Materials and methods

Workplaces

Three hundred and thirty-six health care workplaces in Ontario, Canada were randomly selected from a list of health care workplaces provided by the Ontario Workplace Safety and Insurance Board. To obtain a representative sample, these workplaces were stratified according to facility type (i.e., hospitals, nursing homes, private clinics, and community clinics) and size (small = less than 20 employees; medium = 20 to 100 employees; and large = greater than 100 employees). Workplaces were sampled separately from each strata. Some examples of private clinics were physician, dental, and radiology clinics whereas community clinics were workplaces that provided nursing and other services to individuals in the home.

Survey instrument

The 52-item OPP questionnaire [36, 37] was used. The OPP asks employers to rate each item on a 5-point Likert scale (1 = 0% or never) to 5 (100% or always) the extent to which their workplace achieves the following practices: (1) safety diligence – examines strategies and methods used to achieve workplace safety (7 items); (2) safety training – considers employee and supervisor safety training at the workplace (4 items); (3) ergonomic practices – addresses approaches to designing work environments and work tools to accommodate individual physical differences (8 items); (4) disability case management – examines how administration handles injury and illness cases when they occur (6 items); (5) return to work – addresses approaches to managing return to work when injuries or illnesses occur (8 items); (6) safety leadership – considers the role of management in supporting health and safety practices (7 items); (7) people-oriented culture – examines how management supports a positive workplace environment (9 items); and (8) joint health and safety climate – addresses policies about joint health and safety and management's shared involvement in safety issues (3 items). The OPP questionnaire has been shown to have good internal consistency (Cronbach's $\alpha = 0.95$) and discriminant validity [37]. A copy of the OPP questionnaire can be obtained from Dr. Amick at www.benamick.com

Demographic questions also were included in the survey. They were: (1) How many full-time employees work at your workplace? (2) How many part-time employees work at your workplace? (3) Are your employees members of unions? (4) Does your workplace have formal disability management policies in place? (5) Does your workplace purchase disability management services from outside sources? and (6) If your workplace purchases disability management services,

what services are purchased? A cover letter explaining the purpose of the study and asking the employer or employer representative to complete the survey was attached to the questionnaire.

Procedures

The study was approved by the Research Ethics Board, McMaster University, Hamilton, Ontario, Canada. Prior to mailing the questionnaire, a telephone call was made to each workplace to introduce the survey, and to obtain, if possible, the name of the contact person who would complete the OPP questionnaire.

The OPP questionnaire was mailed to 336 employers or employer representatives (human resources managers, supervisors/managers) in health care sector workplaces in Ontario. The survey sample consisted of 101 hospitals, 86 nursing homes, 101 private clinics, and 48 community clinics (336 workplaces). Four weeks later, a second questionnaire package was sent to non-respondents, including a reminder letter to complete the survey. Approximately five weeks later, another reminder letter was sent to the non-respondents. This resulted in a total of two rounds of follow-up OPP questionnaires and reminder letters that were mailed or faxed to non-respondents. To increase the response rate, at least two follow-up telephone calls were made to each workplace. Thank you letters were mailed to all respondents.

A total of 188 out of 336 (56%) employers in health care workplaces responded. Seventy-one out of 101 hospitals (70%), 48 out of 86 nursing homes (56%), 42 out of 101 (42%) private clinics, and 27 out of 48 (56%) community clinics returned completed questionnaires. Response rates varied significantly by the type of health care facility ($\chi^2 = 16.90$, $df = 3$; $P = 0.007$). Of the 188 health care workplaces that responded, 43 were small workplaces, 46 were medium workplaces, and 93 were large workplaces. Six facilities did not report their size.

Analysis

To avoid the risk of a type II error when performing multiple statistical analyses, the critical value for statistical significance was set at $P = 0.01$ for all analyses.

Chi-square analyses were used to determine if the response rates differed for the four types of health care workplaces and if other categorical characteristics varied across respondents by health care facility type. Mean scores (varying between 1 and 5) were computed for each of the eight subscales in the OPP for each of the facility types. Floor and ceiling effects were examined by determining the percent of responses that clustered at “1” and “5,” respectively. Eighty percent or higher endorsement indicates a floor or ceiling effect [38]. Ceiling effects were examined to determine if social desirability occurred [38]. Social desirability is a tendency for people to present themselves in a social desirable manner to achieve the approval of others [39]. Floor effects are examined to detect items that are not relevant and should not be included in the scale [38]. A series of box plots by facility type were performed to examine the normality of the OPP scores [40]. Cronbach’s alphas were computed to determine the internal consistency of both the total OPP and the OPP subscales [38]. An acceptable level of Cronbach’s alpha is 0.7 [41]. Inter-subscale correlations (Pearson correlation coefficients) were calculated to examine the association among the OPP subscales [38].

A multivariate analysis of variance (MANOVA) was conducted to compare the eight disability management practices among the four health care facility types. MANOVA, which is an extension of a one-way univariate analysis of variance (ANOVA), is appropriate to compare multiple dependent variables among three or more groups [42]. Since the MANOVA was significant ($F(24,514) = 5.95$; $P = 0.000$), a one-way ANOVA for each of the eight OPP subscales was

conducted to determine which practices had the largest mean differences among the health care facility types. For the significant ANOVA results, a series of post-hoc paired mean comparisons (Scheffe's test) were performed to determine which activities were significantly different between facility pairs [43].

One-way ANOVAs also were performed to examine mean practice differences for each of the disability management practices among the facility types in relation to being unionized, having formal disability management policies, purchasing external disability management services, and workplace size.

Results

There were statistically significant differences among the facility types with regard to being unionized ($\chi^2 = 98.87$, $df = 3$; $P = 0.000$), and having formal disability management policies in place ($\chi^2 = 29.06$, $df = 3$; $P = 0.000$), but not with regard to purchasing external disability management services ($\chi^2 = 0.78$, $df = 3$; $P = 0.85$). There was a significant association between being unionized and having formal disability management policies ($\chi^2 = 25.21$, $df = 1$; $P = 0.000$). Since there was not a statistically significant difference in purchasing external disability management services across the facility types, we did not perform any further analysis on this workplace characteristic.

The item responses were well distributed and did not exhibit floor or ceiling effects. A series of box plots by facility type revealed few departures (outliers) from a normal distribution, confirming that the items were normally distributed. Cronbach's alpha for the total OPP for all facility types was 0.94, indicating high internal consistency. Cronbach's alphas for each facility type also were high (0.95 for hospitals; 0.95 for nursing homes; 0.90 for private clinics; and 0.93 for community clinics). Cronbach's alphas for each of the eight subscales for all facility types (Table 1) varied from 0.69 (safety training) to 0.93 (return to work). When the items in each of the subscales were removed sequentially, the recalculated alphas dropped minimally, suggesting that each item makes a unique contribution to the subscale. Inter-subscale correlations (Pearson correlation coefficients) varied from low to moderate ($r = 0.12$ – 0.69), suggesting that most subscales were measuring different and unique aspects of disability management.

The characteristics of the respondent workplaces across the health care facility types are shown in Table 2. A small number of private clinics (10%), in comparison to the other facility types (96%

Table 1 Cronbach's Alphas for the subscales in the organizational policies and practices questionnaire in health care workplaces in Ontario, Canada

Practices	Number of items in each subscale	Alpha	Spearman Brown for 52-item scale ^a
Safety diligence	7	0.76	0.96
Safety training	4	0.69	0.97
Ergonomic practices	8	0.82	0.97
Disability case management	6	0.90	0.99
Return to work	8	0.93	0.99
Safety leadership	7	0.90	0.99
People-oriented culture	9	0.88	0.98
Joint health and safety climate	3	0.89	0.99

^aSpearman Brown was used to adjust for the unequal number of items in each subscale of the Organizational Policies and Practices questionnaire

Table 2 Workplace characteristics in health care workplaces in Ontario, Canada ($n = 188$)

	Hospitals ($n = 71$) mean (SD)	Nursing Homes ($n = 48$) mean (SD)	Private Clinics ($n = 42$) mean (SD)	Community Clinics ($n = 27$) mean (SD)
Number of full time employees	2102.07 (1255.18)	80.44 (140.12)	5.77 (9.35)	61.58 (109.45)
Number of part time employees	739.84 (998.17)	72.02 (102.72)	15.35 (53.55)	52.96 (62.30)
	<i>n (%)</i>	<i>n (%)</i>	<i>n (%)</i>	<i>n (%)</i>
Employees are members of unions ^a				
Yes	68 (96)	38 (79)	4 (10)	16 (59)
No	1 (1)	10 (21)	38 (90)	11 (41)
Missing	2 (3)			
Workplace has formal policies ^a				
Yes	55 (77)	32 (67)	14 (33)	15 (56)
No	8 (11)	10 (21)	23 (55)	7 (26)
Missing	8 (11)	6 (12)	5 (12)	5 (18)
Workplace purchases disability management services				
Yes	17 (24)	09 (19)	8 (19)	6 (22)
No	46 (65)	32 (67)	31 (74)	16 (59)
Missing	8 (11)	7 (14)	3 (7)	5 (19)
Disability management services that are purchased ^b				
Physical demands analysis	2 (n/a)	0 (n/a)	0 (n/a)	1 (n/a)
Functional abilities evaluation	2 (n/a)	0 (n/a)	0 (n/a)	0 (n/a)
Independent medical evaluations	17 (n/a)	2 (n/a)	3 (n/a)	1 (n/a)
Short/long term insurance carriers	1 (n/a)	4 (n/a)	8 (n/a)	1 (n/a)
Rehabilitation services	3 (n/a)	2 (n/a)	0 (n/a)	1 (n/a)
Workplace Safety and Insurance Board				
Employee assistance program	1 (n/a)	0 (n/a)	0 (n/a)	0 (n/a)
Not applicable	40 (n/a)	31 (n/a)	24 (n/a)	16 (n/a)
Missing	4 (n/a)	9 (n/a)	7 (n/a)	7 (n/a)

Note. n/a, not applicable.

^aAll P values = 0.000 using χ^2 test.

^bWorkplaces could provide more than one answer.

for hospitals; 79% for nursing homes; 59% for community clinics) were unionized. Similarly, a small number of private clinics (33%) had formal policies in place (77% for hospitals; 67% for nursing homes; 59% for community clinics). Overall, a low number of health care workplaces (20%) reported purchasing external disability management services (24% for hospitals; 19% for nursing homes; 19% for private clinics; and 22% for community clinics).

Mean scores for the total sample as well as for each facility type are displayed in Table 3. The total sample rated ergonomic practices the lowest (3.5) while safety diligence, and joint health

Table 3 Mean scores (and Standard Deviations) and multivariate analysis of variance for the organizational policies and practices (OPP) questionnaire in health care workplaces in Ontario, Canada

Practices	Total Sample (<i>n</i> = 188)	Hospitals (<i>n</i> = 71)	Nursing Homes (<i>n</i> = 48)	Private Clinics (<i>n</i> = 42)	Community Clinics (<i>n</i> = 27)	<i>F</i> (3,184)	<i>P</i>
Return to work	3.7 (0.9)	4.0 (0.7)	3.9 (0.8)	2.9 (1.0)	3.5 (1.0)	17.34	0.000
Disability case management	4.1 (1.9)	4.3 (0.7)	4.3 (1.0)	3.2 (1.4)	4.1 (0.8)	16.61	0.000
Safety leadership	4.0 (0.9)	3.9 (0.9)	4.4 (0.6)	3.5 (1.2)	4.1 (0.7)	9.24	0.000
Joint health and safety climate	4.2 (1.0)	4.3 (0.8)	4.4 (1.0)	3.6 (1.3)	4.2 (1.0)	7.30	0.000
Safety diligence	4.2 (0.5)	4.0 (0.6)	4.4 (0.5)	4.2 (0.5)	4.4 (0.5)	7.04	0.000
People oriented culture	3.8 (0.6)	3.6 (0.6)	3.9 (0.6)	4.0 (0.8)	4.0 (0.4)	5.34	0.001
Safety training	4.0 (0.8)	4.1 (0.6)	4.3 (0.7)	3.7 (1.1)	3.9 (0.9)	4.79	0.003
Ergonomic practices	3.5 (0.8)	3.5 (0.7)	3.6 (0.7)	3.6 (0.9)	3.5 (0.6)	0.22	0.88 (ns)
Total OPP ^a	3.9 (0.5)	4.0 (0.5)	4.1 (0.5)	3.6 (0.6)	4.0 (0.5)	<i>F</i> (24,514) ^b 5.95	0.000

Note. Scores are based on the 5-point scale (never = 1; always = 5); ns, not significant.

^aTotal OPP = Organizational Policies and Practices Questionnaire and is based on 52 items.

^bMultivariate *F* statistic.

and safety climate were both rated the highest (4.2). The overall disability management scores were lowest for private clinics (3.6) and highest for nursing homes (4.1). Private clinics had low scores for return to work (2.9) and disability case management (3.2), while hospitals had high scores for these two practices (4.0 for return to work and 4.3 for disability case management).

The MANOVA (Table 3) showed that there were statistically significant differences in disability management practices across the facility types ($F = (24,514) = 5.95; P = 0.000$). A one-way ANOVA for each practice showed that among the health care facility types there were statistically significant differences in all practices, except ergonomic practices. Post-hoc mean paired comparisons (Scheffe's test) confirmed these findings.

For unionized versus non-unionized workplaces (Table 4) there were statistically significant differences in all practices, except ergonomic practices. This table shows that unionized workplaces scored high on all practices, except people-oriented culture and safety diligence.

Workplaces with formal policies in comparison to those without policies (Table 5) demonstrated statistically significant differences in all practices, except people-oriented culture and safety diligence. As can be seen in this table, workplaces that had formal policies scored high in all practices.

As for workplace size (Table 6), there were statistically significant differences in all practices, except ergonomic practices. Large workplaces scored high in return to work and disability case management practices; medium sized workplaces scored high in joint health and safety climate, safety training, safety diligence, and safety leadership practices; and small workplaces reported high scores in people-oriented culture and ergonomic practices.

Discussion

This study showed that there were significant differences among the four types of health care facilities in all disability management practices, except ergonomic practices. Overall, the employers rated themselves as achieving high levels of safety diligence (mean = 4.2), and joint health

Table 4 Analysis of variance for disability management practices in health care workplaces by unionization in Ontario, Canada

Practices	Unionized (<i>n</i> = 126)	Non-unionized (<i>n</i> = 60)	<i>F</i> (1,184)	<i>P</i>
Return to work	3.94 (0.68)	3.02 (1.04)	51.61	0.000
Disability case management	4.29 (0.71)	3.53 (1.24)	27.37	0.000
Joint health and safety climate	4.33 (0.71)	3.76 (1.24)	15.74	0.000
People-oriented culture	3.70 (0.62)	4.04 (0.62)	12.0	0.001
Safety training	4.16 (0.68)	3.77 (1.03)	8.94	0.003
Safety leadership	4.07 (0.77)	3.67 (1.11)	8.36	0.004
Safety diligence	4.11 (0.55)	4.29 (0.5)	4.63	0.03
Ergonomic practices	3.54 (0.68)	3.54 (0.88)	0.0003	0.98 (ns)
Total OPP ^a	4.02 (0.48)	3.70 (0.59)	14.74	0.000

Note. Values shown are mean scores with standard deviation in parentheses; ns, not significant.

^aTotal OPP = Organizational Policies and Practices Questionnaire and is based on 52 items.

and safety climate practices (mean = 4.2) and low levels of ergonomic practices (mean = 3.5). These findings may suggest that the employers perceived themselves as carrying out good safety practices and that they have integrated both safety diligence, and joint health and safety climate activities into their safety policies. A possible explanation for the finding that the employers assigned low ratings to ergonomic practices may be associated with how the workplace defined ergonomics. For instance, some may have seen ergonomic practices as being an integral component of safety diligence while others may have considered it to be a separate entity.

There was a significant difference among the facility types with regard to being unionized. This finding was not surprising as private clinics (physician offices, dentist offices), in comparison with hospitals, are traditionally not unionized. Our study showed that only 10% of private clinics, in comparison to 96% of hospitals and 79% of nursing homes, were unionized.

The finding that there was a significant difference among the facility types with regard to having formal policies may be due to the high incidence of work-related injuries in hospitals and nursing homes [5, 44]. Workplaces with formal policies may have more written health and

Table 5 Analysis of variance for disability management practices in health care workplaces by having formal policies in Ontario, Canada

Practices	With formal policies (<i>n</i> = 116)	No formal policies (<i>n</i> = 47)	<i>F</i> (1,161)	<i>P</i>
Disability case management	4.38 (0.73)	3.43 (1.27)	35.63	0.000
Safety leadership	4.22 (0.68)	3.33 (1.24)	33.52	0.000
Return to work	3.93 (0.80)	3.14 (1.10)	26.02	0.000
Safety training	4.22 (0.72)	3.60 (1.06)	18.14	0.000
Joint health and safety climate	4.32 (0.80)	3.74 (1.17)	13.27	0.000
Ergonomic practices	3.69 (0.63)	3.26 (1.00)	10.91	0.001
People-oriented culture	3.82 (0.61)	3.79 (0.83)	0.086	0.77 (ns)
Safety diligence	4.18 (0.56)	4.18 (0.63)	0.0001	0.99 (ns)
Total OPP ^a	4.10 (0.45)	3.56 (0.64)	35.87	0.000

Note. Values shown are mean scores with standard deviations in parentheses; ns, not significant.

^aTotal OPP = Organizational Policies and Practices Questionnaire and is based on 52 items.

Table 6 Analysis of variance for disability management practices in health care workplaces by size in Ontario, Canada

Practices	Small workplaces (<i>n</i> = 43)	Medium workplaces (<i>n</i> = 46)	Large workplaces (<i>n</i> = 93)	<i>F</i> (2,179)	<i>P</i>
Return to work	2.83 (0.98)	3.74 (0.92)	3.97 (0.64)	29.41	0.000
Disability case management	3.37 (1.28)	4.17 (0.87)	4.27 (0.71)	14.70	0.000
Joint health and safety climate	3.61 (1.31)	4.49 (0.56)	4.28 (0.77)	12.26	0.000
People-oriented culture	4.10 (0.74)	3.98 (0.31)	3.61 (0.65)	11.74	0.000
Safety training	3.54 (1.15)	4.28 (0.65)	4.12 (0.63)	11.14	0.000
Safety diligence	4.21 (0.51)	4.40 (0.46)	4.03 (0.54)	7.73	0.001
Safety leadership	3.57 (1.15)	4.30 (0.79)	3.96 (0.80)	7.59	0.001
Ergonomic practices	3.60 (0.87)	3.56 (0.71)	3.51 (0.71)	0.20	0.82(ns)
Total OPP ^a	3.60 (0.58)	4.11 (0.49)	3.97 (0.49)	11.98	0.000

Note. Values shown are mean scores with standard deviations in parentheses; ns, not significant.

^aTotal OPP = Organizational Policies and Practices Questionnaire and is based on 52 items.

safety policies to ensure that these injuries are dealt with appropriately. Cunningham and James [45] found that workplaces with written policies, compared to those without written policies, had a significant decrease in absences and were more likely to use proactive measures, such as making adjustments to working hours, transferring employees to other work, and having light duty opportunities.

There were no significant differences among the facility types with regard to purchasing external disability management services. This may be because health care facilities (especially larger facilities such as hospitals) are more likely to have disability management resources available, and consequently, they do not have to purchase them.

There was a significant association between being unionized and having formal disability management policies. A possible explanation is that unions have become more knowledgeable and proactive in terms of pushing for formal disability management practices into their workplaces [46, 47].

For workplaces that were unionized versus those that were not, there were statistically significant differences in all practices, except ergonomic practices. Unionized workplaces scored themselves high in all practices, except people-oriented culture and safety diligence. People-oriented culture has been connected with reducing costs related to lost time injuries [48, 49]. Safety diligence is an integral aspect of disability management programs [16, 50, 51]. Given the importance of both people-oriented culture and safety diligence in disability management programs, workplaces need to focus more on enhancing these practices.

For workplaces that had formal disability management policies versus those without policies, there were statistically significant differences in all practices, except people-oriented culture and safety diligence. Workplaces with formal policies scored themselves high in all practices. For employers to promote a safe workplace environment, they need to establish how it will be done, and consequently, they developed formal written policies and procedures. In addition, health care workplaces that are subject to accreditation, such as hospitals and nursing homes, would have to demonstrate that they have written relevant policies in place as part of the accreditation process. A people-oriented work culture suggests a positive environment in which management acknowledges employees and responds to their needs.

For large, medium, and small workplaces, there were statistically significant differences in all practices, except ergonomic practices. Large workplaces rated themselves as having high return to work and disability case management practices, while small workplaces reported having high people-oriented culture practices. This finding is not surprising given that large facilities (such as hospitals) tend to have more resources available (human resources/disability management professionals) to carry out return to work and disability case management activities. It has been shown that small workplaces seem to be less effective in managing work-related injuries [52, 53] which may be attributed to their limited resources to implement disability management programs. It could be argued that small workplaces have less ‘red tape’ and more informal communication which would contribute to a people-oriented work culture.

Cronbach’s alpha for the overall OPP for all health care workplaces was very high at 0.94, demonstrating good internal consistency and homogeneity. In addition, Cronbach’s alphas for each subscale for all workplaces were high (all were above 0.7, except for safety training at 0.69 which is almost acceptable).

Limitations of the study

It is possible that when the employers were completing the OPP, they may have been influenced by Ontario provincial legislation. For instance, it is mandatory for workplaces with more than 20 employees to have joint health and safety management committees to address the concerns of health and safety, injury prevention, return to work, and disability case management [54]. In addition, the requirements to provide early and safe return to work and reasonable accommodation are major aspects of “Duty to Co-operate in Return to Work” and “Duty to Accommodate” legislation [55]. This legislation states that workers must cooperate with the return to work process and allows them to request accommodation if it is reasonable to expect that the accommodation will allow them to perform the job. Employers are responsible for cooperating with return to work requests and providing the necessary accommodation. These activities are further mandated by the Ontario Human Rights Code [56] and the Canadian Human Rights Act [57].

The data came from self-reports by employers or employer representatives. Further studies with employees who sustained a work-related injury or disability within the health care sector are needed to obtain their perceptions of how disability is prevented and managed. Since both employer and employee ratings of the OPP questionnaire have been shown to predict injury incidence, work disability, and return to work status [58–60], further investigations with regard to employer-employee agreement about disability management practices within the health care sector are necessary.

The response rate for the overall sample was 56%. Response rates for the hospitals, nursing homes, private clinics, and community clinics workplaces were 70%, 56%, 42%, and 56%, respectively. The desirable response rate of 70% [61] was achieved for hospitals but not for nursing homes, private clinics, and community clinics. We did attempt to increase the response rates by sending out two rounds of follow-up reminder letters and phone calls, as well as the mailing and faxing of additional OPP questionnaires to the non-respondents. Several respondents stated that they were too busy to complete and return the surveys, or were not interested in the study. Many of the smaller workplaces reported that they did not have any disability management programs in place, and therefore, felt that the study was not relevant to them. The low response rates, especially in the private clinics (42%), limit the generalizability of the results. Further studies incorporating larger sample sizes with employers in the health care sector in various facilities need to be conducted to determine if similar results are found.

Conclusion

This study is a significant contribution as it is the first to systematically identify and examine workplace disability management practices in the Ontario health care sector. Developing and monitoring disability management programs to determine how disability is prevented and managed is essential in promoting successful and early return to work, and in reducing the costs of lost time claims. This research demonstrates that overall, health care workplaces apply appropriate disability management practices in their work settings, even though there are variations in these activities. Our findings show that organizational policies and practices may be influenced by various workplace characteristics such as union involvement, having formal policies, and workplace size. Given the impact of a comprehensive disability management program on decreasing and minimizing work-related injuries and disability, those facilities that do not have appropriate practices for managing disability should receive further assistance. Employers, human resources, unions, rehabilitation providers, and policy makers need to address the variations in disability management practices in health care workplaces in order to provide more effective prevention and treatment of work-related injuries and disability.

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