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Practices of Return-to-Work Coordinators Working in Large Organizations

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Abstract *Purpose* Although the role of return-to-work coordinators (RTW coordinators) is associated with reducing long-term disabilities, little has been written about their practices. The objective of this study was to clearly identify their tasks and activities and the stakeholders with whom they collaborate. *Methods* A cross-sectional survey was conducted using a web-based self-administered questionnaire. Participant inclusion criteria were as follows: (1) working for a large organization with 500 or more employees; (2) being responsible for managing disabilities and coordinating the return-to-work process; and (3) having been involved in coordinating the return to work of at least one person in the past year. *Results* 195 RTW coordinators completed the questionnaire. The three tasks or activities rated as most important were applying laws, policies, and regulations related to work absences and return to work; contacting the absent worker; and planning the return to work. A nursing or occupational health and safety training background significantly influenced the RTW coordinators' practices. In addition, RTW coordinators collaborated mainly with workers and their supervisors. *Conclusion* Despite a wide variety of contexts and diverging definitions of competencies, a set of common RTW coordination practices appears to exist across industrialized countries. RTW coordinators with a training background in the health field seem better able to assimilate the various dimensions of work disability. Moreover, concerted action was found to be minimal and a far cry from recommendations. The practices defined could serve as a benchmark for describing RTW coordinators' responsibilities in greater detail and allow for cross-organization and cross-country comparisons.

Keywords Rehabilitation · Task performance and analysis · Return to work · People with disabilities · Quebec

Background

In the past two decades, great efforts have been made to improve occupational rehabilitation programs, primarily for individuals with musculoskeletal disorders. This work has led to increasing recognition of the importance of actively involving an in-house company resource in such programs. This resource person would coordinate actions among supervisors, insurers, and healthcare providers in order to facilitate the return to work [1–4]. The person would thus be a pivotal player in concerted action, defined as the pooling of the resources and expertise of various stakeholders to achieve the shared objective of a sustainable return to work [1]. Moreover, the presence and expertise of these professionals—return-to-work coordinators—would help reduce long-term disability [5, 6]. Most of them would take on the role of coordinating the RTW amidst other roles associated with their functions in companies' human resources or occupational health and safety departments [7]. The nature and frequency of RTW coordinators' practices would also vary with the conditions in place. For example, in the Netherlands, the employee

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and employer have to work together to ensure the employee's fastest possible return to work, as both parties are obliged by law to cooperate. If they do not, financial sanctions apply. A representative of a health, safety, and well-being department or of an occupational health physician develops a RTW plan and facilitates the RTW coordination process [8]. In the United States and Canada, while some RTW coordinators have substantial resources and can rely on organizational structures to facilitate their work, others must do the RTW coordination job part-time, often with little support. Also, certification programs may be offered but are not necessarily required by employers [7, 9]. The role is more clearly defined in Australia, where introductory and advanced training courses are given [10] and the occupation of RTW coordinator is structured by "compliance codes" [11]. However, RTW coordination is still in its very early stages in countries such as China, where there is no official policy encouraging workers to return to work [12].

A first major effort to identify RTW coordinator practices was made by Shaw et al. [6]. It was based on a literature review of 22 studies involving interventions designed to reduce work absences associated with physical health problems and including a designated person to facilitate the return to work. The studies were conducted in Australia, Canada, Finland, Norway, the Netherlands, Sweden, and the United States. Of the 29 tasks and activities related to RTW coordination that were identified in the Shaw study by examining the content of the interventions, the following were noted, among others: "meet on site with worker, supervisor, stakeholders," "inventory/ prioritize perceived problems or barriers," and "assign responsibilities to implement job modifications." The authors then grouped each of the tasks and activities under six RTW coordinator competency domains: (1) ergonomic and workplace assessment, (2) clinical interviewing, (3) social problem solving, (4) workplace mediation, (5) knowledge of business and legal aspects, and (6) knowledge of medical conditions.

Gardner et al. [13] continued this work by interviewing researchers who had been involved in the studies included in the Shaw et al. review [6]. Ten groups of essential competencies were identified: (1) individual qualities and traits required (e.g. being positive or flexible), (2) knowledge base (e.g. ergonomic interventions, knowledge of compensation-related legislation), (3) RTW focus and attitude (e.g. not letting oneself be distracted by medical problems and staying focused on the RTW objective), (4) organizational and administrative skills, (5) assessment skills (e.g. assessing job requirements), (6) communication skills (e.g. ability to communicate effectively with all parties involved), (7) interpersonal relationship skills (e.g. ability to develop good relations

with all parties), (8) conflict-resolution skills (e.g. negotiating abilities), (9) problem-solving skills, and (10) RTW facilitation skills (e.g. ability to mobilize all parties involved in the RTW process). According to the researchers interviewed, the RTW coordinator played a very important, if not essential, role in the success of their RTW programs. The results of the interviews also suggested that the coordinator needs particular aptitudes to be able to work in a context involving complex relationship dynamics, such as those between the workplace, insurer, and physician [13].

That same year, Pransky et al. [14] published an article describing the competencies required of RTW coordinators in three countries (Canada, United States, and Australia). Focus groups held with 75 experienced coordinators resulted in a listing of eight common competency groups: professional credibility, communication, conflict management, evaluation, problem-solving, administration, individual personal attributes, and information gathering. An Internet-based survey was then conducted of 148 coordinators to assess the importance they placed on these competencies. The competencies rated as most important included "respecting and maintaining confidentiality," "having ethical practices," "having listening skills," "ability to communicate well verbally… and in writing," "being consistent between what you say and what you do," and "being committed to the goal of early RTW." Among the competencies rated as least important were "ability to provide resources and support for the [worker's] family" and "ability to find out about co-worker responses to the employee being out of work and returning."

In a study conducted in China, Cheng et al. [12] explored several points, including employers' views on activities needed for RTW coordination. The results showed the five following activities to be rated as most important: identifying suitable work tasks for the injured worker's work capacities, understanding the worker's degree of recovery, understanding any disability resulting from the initial injury, reviewing the organizational structure to see if job accommodations are possible, and reviewing the injured worker's medical condition and level of work disability. At the other end of the spectrum, the following activities were deemed least important: being informed about legal responsibilities, meeting with coworkers to understand their views of the injured worker's productivity, and discussing the possibility of flexible working hours.

In another study, conducted in Australia with 25 RTW coordinators responsible for the return to work of injured nurses, James et al. [15] identified certain points made during group discussions to the effect that personal attributes such as the ability to gain people's trust, to be a positive leader and to adequately manage conflicts were

deemed as important, if not more important, than having knowledge of the worker compensation system and the impact of absences on the organization, or than having medical expertise or expertise in ergonomics. Furthermore, good communication skills and the ability to safeguard confidentiality, show empathy and establish a climate of trust were identified as necessary in the context of RTW processes. A similar study published in 2014 [16] and conducted among Australian RTW coordinators involved in the development and implementation of policies and procedures within organizations operating in different sectors, yielded results consistent with those of James et al. [15].

Above all, the available literature highlighted the competencies required of RTW coordinators. However, the competencies were gleaned either from studies of interventions [6] or researchers with knowledge of RTW coordination [13], or were identified by individuals clearly concerned about work absences but not playing a significant role in RTW coordination [12]. Pransky et al. [14], James et al. [15] and Bohatko-Naismith et al. [16] all interviewed RTW coordinators but focused specifically on the importance that the coordinators placed on the various competencies and personal attributes likely to facilitate the RTW process. Lastly, none of the authors [6, 12–14] defined the actual concept of competency, with the result that it sometimes refers to more or less concrete tasks or activities, and at others, to what appear to be personal qualities or aptitudes or to knowledge per se. The definition of the concept of competency used in our project corresponds to that given by Tardif [17], i.e. "the complex knowing of how to act which involves effectively drawing upon and combining a variety of internal and external resources within a group of similar situations" [translation, p. 22]. In connection with this definition, it was agreed that RTW coordinator competencies were characterized by (1) several tasks or activities, (2) collaboration among various stakeholders (the literature suggests that different stakeholders can join in RTW coordination efforts), and (3) a few essential qualities or aptitudes.

To date, no quantitative study has established what RTW coordinators do in concrete terms, or with what frequency and with whom. No detailed and systematic inventory exists of their practices that could possibly serve as a benchmark. The purpose of this study was therefore to identify the tasks and activities performed by RTW coordinators in as much detail as possible, as well as the stakeholders with whom they have to collaborate. It also consisted of establishing which variables influenced the intensity of RTW coordinators' practices, another aspect that has not been studied to date. This objective was pursued in the context of large organizations situated in Québec, Canada, because it was hypothesized that RTW coordinators in these organizations have a stronger and more diversified role than in small and medium-sized organizations. This article does not present the essential qualities or aptitudes of RTW coordinators.

Methods

Ethics Statement

The study was approved by the Research Ethics Committee of the Research Centre of Charles Le Moyne Hospital in Longueuil, Quebec; all participants gave informed consent.

Design of the Study

A cross-sectional survey using an Internet-based self-administered questionnaire was developed using two data sources: a list of tasks and activities derived from the literature [6, 12–14, 18] and the results of three face-to-face interviews with key contact persons working in two large private-sector organizations and one public-sector organization. A first version of the questionnaire was developed using an exhaustive list of tasks and activities and of potential collaborators with RTW coordinators; it was then pretested on the key contact persons interviewed. The latter were asked, among other things, to assess the pertinence and clarity of the questions and answer choices, as well as the time required to complete the entire survey. This first version of the questionnaire was then revised to clarify certain statements and eliminate redundancy. The final version was programmed in SurveyMonkey (SurveyMonkey Inc., Palo Alto) before being sent to potential participants.

The Internet-based survey questionnaire included 49 main tasks and activities. The RTW coordinators were asked the following question: "How frequently do you have to perform the following tasks and activities associated with Competency X?" [translation]. They were asked to respond using a four-point Likert-type scale: often (4), occasionally (3), rarely (2) and never (1). The tasks and activities were grouped under four core competencies established by the researchers involved in the study according to an apparent thematic logic. Competency 1 was named "Adapting your practices to the needs and capacities of the worker who is on work absence and in the process of returning to work" [translation] (20 tasks or activities); Competency 2, "Involving the workplace stakeholders concerned and appropriate external resources in an employee's return-to-work process" [translation] (15 tasks or activities); Competency 3, "Developing practices that comply with laws, regulations, agreements, and procedures related to work absence and return to work"

[translation] (eight tasks or activities); and Competency 4, "Rethinking/Questioning your practices and ideas regarding work absence and occupational health and inviting the various stakeholders in the workplace to do the same" [translation] (six tasks or activities). The legitimacy of grouping the tasks and activities under four core competencies by apparent thematic logic was confirmed through reliability analyses. They revealed appreciable internal consistency for the four core competencies, with Cronbach's alpha coefficients ranging from 0.756 to 0.922.

The stakeholders with whom the RTW coordinators collaborate most were identified essentially through the following question: "How frequently do you have to work with each of the following stakeholders, in connection with Competency [Competency number (1 or 2)]?" [translation]. For each stakeholder considered, they were asked to respond using a four-point Likert-type scale: often (4), occasionally (3), rarely (2) and never (1). Other questions requiring the selection of stakeholders from a checklist were also used, namely "With whom do you usually have to work, in connection with Competency 4, for the two tasks or activities identified below?" [translation] and "Who are your usual contact persons or target groups, in connection with Competency 4, for the tasks or activities listed below?" [translation].

Lastly, the questionnaire contained questions on the RTW coordinators' sociodemographic characteristics (e.g. sex, age group, training background, highest level of education completed) and professional characteristics (e.g. average number of years worked in the field of work-absence management, number of workers under the responsibility of participants for work-absence management). Other questions pertained to the organizations' characteristics (e.g. status of the organization (public/private), percentage of people on work absence, proportion of unionized employees, existence of health services or a health office, use of an external firm for disability management).

Participants and Setting

A list of organizations with 500 or more employees in Québec was drawn up using various Internet sites. A total of 652 private and public organizations were identified. The compliance of this non-probability sample with the inclusion criteria was verified systematically through telephone contact with each organization. These criteria were as follows:

1. working for a large private or public organization with 500 or more employees in Québec;
2. responsible for managing the disabilities and coordinating the return to work of the organization's employees;

3. having been involved in coordinating the return to work of at least one person in the past year, regardless of the reason for the work absence.

When the criteria were met and the target individuals agreed to participate in the study, we sent them an email message containing all pertinent information about accessing the Internet survey. Based on previous online survey experiences [19] and research involving company representatives, a response rate of the order of 30–50 % was anticipated.

Data Collection and Analysis

The Web-based data collection process took place from April to September 2014. The average time required to complete the entire survey was approximately 30 min.

The sociodemographic and professional characteristics of the RTW coordinators and the organizations for which they worked were analyzed and presented in terms of frequencies, means, and standard deviations. Mean frequencies of more than 3.00 corresponded to the most important tasks or activities. Only descriptive frequencies were presented for the stakeholders collaborating with the RTW coordinators. Analyses were performed using PASW Statistics 18 (SPSS Inc., Chicago).

Performance intensity scores (dependent variable) were calculated for the four core competencies by adding up the answers obtained on each task and activity, for each participant. Given the large number of independent variables that could explain the variations in intensity scores, a first step was carried out to reduce the number to be included in the regression models. Depending on the nature of the variables, correlations or t tests were performed on the characteristics of the participants and their organizations. When statistically significant associations were found, the variables were included in the linear regression analyses. A stepwise process was used. The analyses pointed to the variables that best explained the variations in the intensity scores. The R^2-adjusted value was retained to ascertain the proportion of the variance explained by the independent variables retained.

Results

Response Rate

Of the 652 organizations identified, 471 met the inclusion criteria. The main reason for exclusion was the presence of fewer than 500 employees. For 91 organizations, it was impossible to speak with a RTW coordinator to propose the Internet-based survey. Fifty-three organizations refused to

participate due to lack of time for the survey. A total of 327 invitations were therefore sent by email and 195 surveys were completed in their entirety. Relative to the number of eligible organizations, the response rate was 41.4 % (195/471). Relative to the number of invitations sent, the response rate was 59.6 % (195/327). Figure 1 presents a flowchart synthesizing this information.

Participants' and Organizations' Characteristics

Table 1 shows the participants' characteristics, and Table 2, the organizations' characteristics. The typical participant profile was as follows: female (76.7 %), between ages 35 and 54 (64.2 %), with a university diploma (82.6 %), active in the area of disability management for nearly 13 years (12.81 years on average), in her current job for just over 7 years (7.25 years on average), and responsible for between 500 and 1000 employees (32.8 %) or between 1001 and 5000 employees (36.4 %). A majority of the participants worked for private organizations (57.9 %) and for organizations with between 500 and 1000 employees in Québec (53.8 %), in which all or most of the employees were unionized (65.6 %). The work-absence rate reported was generally 6 % or less when

Fig. 1 Flowchart

participants completed the survey (73.2 %), and mental health and musculoskeletal disorders were virtually tied as the most frequent reasons for work absence (47.7 and 46.1 %, respectively). Also, slightly over four participants out of 10 (42.1 %) reported the existence of health services or a health office within their organization, and approximately half (48.2 %) that their organization used an external firm for disability management.

Tasks or Activities Rated as Most or Least Important

Tables 3, 4, 5 and 6 show the tasks or activities rated as most and least important in the RTW coordinators' practices, grouped by the core competency under which they were classified. They also show the mean frequency at which each of these was carried out. Disregarding classification by competency, the five tasks or activities rated as most important in the RTW coordinators' practices were applying laws, policies, and regulations related to work absences and return to work (mean = 3.83/4.00; Competency 3), contacting absent workers (mean = 3.66/4.00; Competency 1), using the medical diagnosis and limitations to plan the return to work (mean = 3.48/4.00; Competency 1), keeping up-to-date on laws, policies, and regulations related to work absences and return to work (mean = 3.46/4.00; Competency 3), and performing various administrative tasks and completing forms (mean = 3.46/4.00; Competency 3).

At the opposite end of the spectrum, the five tasks or activities rated as least important in the RTW coordinators' practices were communicating with the absent worker's family (mean = 1.54/4.00; Competency 2), taking into account cultural differences and their impact on work-absence management (mean = 2.09/4,00; Competency 1), evaluating the impact of the worker's absence on the organization's other workers (mean = 2.33/4.00; Competency 2), advising workers to help them appreciate and focus on their strengths (mean = 2.42/4.00; Competency 1), and selecting health professionals to match the worker's needs (mean = 2.47/4,00; Competency 2). It is worth noting that none of the eight tasks or activities grouped under Competency 3 was rated among the least important.

Predictive Variables for Task or Activity Performance Intensity

Twenty tasks or activities were grouped under Competency 1 ("Adapting your practices to the needs and capacities of the worker who is absent and in the process of returning to work"). The performance intensity scores ranged from 20 to 80 for each of the participants surveyed: the mean was 59.7 (SD = 11.1) and the median was 62.0. Regression
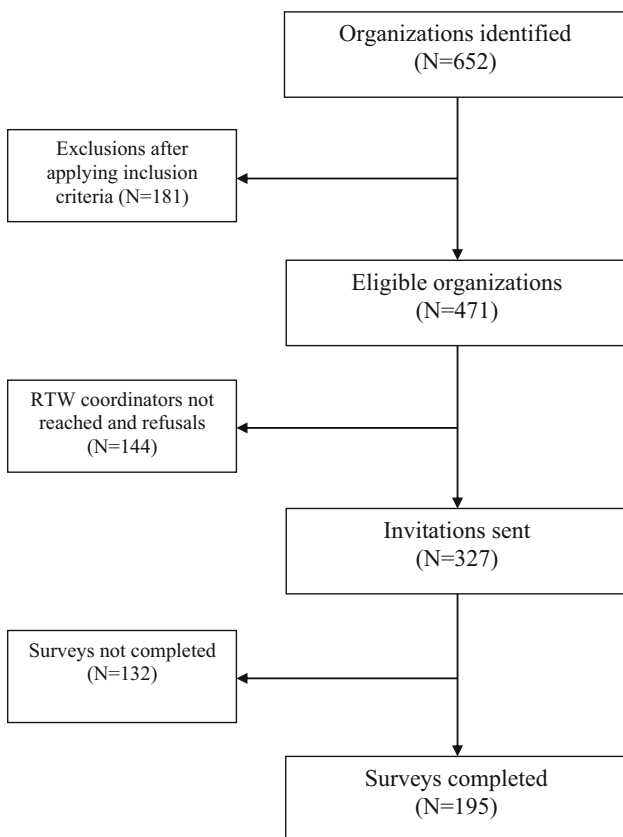
Table 1 Characteristics of the participants (N = 195)

Variables	N (%)
Sex	
Male	45 (23.3)
Female	148 (76.7)
Age groups	
18–34 years	38 (19.7)
35–54 years	124 (64.2)
55 years or over	31 (16.1)
Training background (several possible)	
Human resources	70 (35.9)
Administration	53 (27.2)
Industrial relations	50 (25.6)
Nursing or OHS	52 (26.7)
Other	43 (22.1)
Highest level of education completed	
Secondary or less	8 (4.1)
CEGEP	26 (13.3)
University	161 (82.6)
Average number of years of work in the area of work-absence management (SD)	12.81 (8.59)
Average number of years in current job (SD)	7.25 (6.78)
Number of workers under the responsibility of participants for work-absence management	
More than 5000	13 (6.7)
Between 1001 and 5000	71 (36.4)
Between 500 and 1000	64 (32.8)
Between 200 and 499	36 (18.5)
Fewer than 200	11 (5.7)

analysis showed that three variables explained 19.5 % of the total adjusted variance in this score (F (3, 175) = 15.353, $p = 0.000$): having a nursing or OHS training background (*vs* other fields) (t = −4.095, $p = 0.000$, β = −0.282), having more years of experience in the job held (t = 3.722, $p = 0.000$, β = 0.251), and working for a public organization (vs private) (t = −3.146, $p = 0.002$, β = −0.217).

Fifteen tasks and activities were grouped under Competency 2 ("Involving the workplace stakeholders concerned and appropriate external resources in an employee's return-to-work process"). The performance intensity scores ranged from 15 to 60: the mean was 40.4 (SD = 8.3) and the median was 42.0. Regression analysis showed that two variables marginally explained 6.3 % of the total adjusted variance in this score (F (2, 176) = 6.961, $p = 0.001$): having a nursing or OHS training background (vs other fields) (t = −2.434, $p = 0.000$, β = −0.182) and the increased rate of employees absent from work (t = 2.169, $p = 0.031$, β = 0.162).

Eight tasks and activities were grouped under Competency 3 ("Developing practices that comply with laws, regulations, agreements, and procedures related to work absence and return to work"). The performance intensity scores ranged from 8 to 32: the mean was 27.0 (SD = 4.00) and the median was also 27.0. Regression analysis showed that three variables explained 11.6 % of the total adjusted variance in this score (F (3, 175) = 8.788, $p = 0.000$): the fact that all or most of the employees were unionized (vs a minority or none) (t = −3.335, $p = 0.001$, β = −0.237), the fact that the organization did not use an external firm for disability management (*vs* using such a firm) (t = 2.560, $p = 0.011$, β = 0.182), and a greater number of years of experience in the work-absence management field (t = 2.149, $p = 0.033$, β = 0.152).

Six tasks and activities were grouped under Competency 4 ("Rethinking/Questioning your practices and ideas regarding work absence and occupational health and inviting the various stakeholders in the workplace to do the same"). The performance intensity scores ranged from 6 to 24: the mean was 18.3 (SD = 3.6) and the median was 19.0. Regression analysis showed that two variables marginally explained 8.5 % of the total adjusted variance for this score (F (2, 176) = 9.294, $p = 0.000$): having a nursing or OHS training background (vs other fields)

Table 2 Characteristics of the organizations (N = 195)

Variables	N (%)
Nature of the organization	
Public	82 (42.1)
Private	113 (57.9)
Number of workers that the organization employs in Québec	
More than 10,000	7 (3.6)
Between 5000 and 10,000	11 (5.6)
Between 1000 and 5000	72 (36.9)
Between 500 and 1000	105 (53.8)
Approximate percentage of individuals absent from work when participants completed the survey (N = 179)	
Less than 1 %	37 (20.7)
Between 1 and 3 %	43 (24.0)
Between 4 and 6 %	51 (28.5)
More than 6 %	48 (26.8)
Most frequent reason for work absence	
Musculoskeletal disorders	89 (46.1)
Mental health disorders	92 (47.7)
Other (heart disease, cancer, etc.)	12 (6.2)
Proportion of unionized employees	
All	24 (12.3)
The majority	104 (53.3)
A minority	20 (10.3)
None	47 (24.1)
Existence of health services and a health office	
Yes, exist	82 (42.1)
No, absent	113 (57.9)
Use of an external firm for disability management	
Yes, for all disability files	22 (11.3)
Yes, but for some disability files	72 (36.9)
No	101 (51.8)

($t = -2.566$, $p = 0.011$, $\beta = -0.189$) and the increased rate of employees absent from work ($t = 2.755$, $p = 0.006$, $\beta = 0.203$).

The Stakeholders Collaborating with the RTW Coordinators

Regarding Competencies 1 and 2, approximately seven or eight participants out of 10 reported collaborating often with the absent worker's direct supervisor or manager (75.4 and 83.6 %, respectively) and with the worker him-/herself (74.9 and 79 %). However, relatively speaking, fewer participants reported collaborating often with the human resources advisor (45.1 % and 42.1 %), the insurer representative (36.9 and 36.9 %), health professionals (22.6 and 21.0 %), the union representative (12.3 and 13.8 %), and the absent worker's co-workers (0.5 and 3.6 %). Competency 3 involved the RTW coordinator only and therefore no collaboration with these other stakeholders.

Regarding Competency 4, two tasks or activities involved stakeholder collaborators, while three others involved contact persons or target groups. The participants reported that when it was a matter of analyzing the organization's work-absence management and occupational health and safety practices for optimization purposes or of assessing the organization's performance in terms of occupational health and safety activities or initiatives, they had to collaborate most—regardless of frequency—with direct supervisors or managers (69.7 and 63.6 % respectively for the two tasks or activities) and human resources advisors (66.7 and 55.4 %). However, they reported having to collaborate much less with workers (18.5 and 19.5 %) and union representatives (25.6 and 24.1 %). For tasks or activities that involved raising awareness of prejudices and stereotypes regarding people with disabilities, taking occupational health and safety prevention measures, and promoting occupational health and safety activities or initiatives in the workplace, the participants' main target

Table 3 Tasks and activities associated with competency 1 (N = 195)

	Mean (SD)
Tasks and activities—the most important	
Contacting the absent worker	3.66 (0.65)
Using the medical diagnosis and limitations to plan the return to work	3.48 (0.80)
Evaluating the work environment factors that could hinder the return to work	3.28 (0.80)
Identifying tasks suitable for the worker's capacities	3.28 (0.81)
Monitoring the worker's progress in achieving return to regular work goals	3.28 (0.83)
Having a thorough understanding of the medical terminology	3.27 (0.93)
Clarifying mutual expectations and the nature of the relationship with the worker	3.25 (0.76)
Evaluating the capacities of the worker who has returned to work after an absence	3.15 (0.97)
Identifying the worker's emotional reactions to the absence	3.10 (0.79)
Tasks and activities—the least important	
Understanding cultural differences and how they may impact on work absence management	2.09 (0.91)
Counselling a worker to help him/her appreciate and focus on personal strengths	2.42 (0.94)
Assisting a worker in understanding and coping with stress	2.55 (0.96)
Evaluating the worker's social support system (family, friends, and community relationships)	2.62 (0.97)
Reviewing the workload with the employee	2.65 (0.91)
Recognizing psychological problems (e.g. depression, suicidal thoughts) that require consultation or referrals	2.86 (0.90)
Meeting with the absent worker to show interest in his/her situation	2.90 (0.96)
Analyzing needs for job accommodations	2.91 (0.86)
Analyzing the postures required in the worker's job	2.95 (0.91)
Assisting the worker if his/her condition deteriorates following the return to work	2.96 (0.86)
Identifying the factors that could demotivate the worker regarding his/her rehabilitation	2.99 (0.90)

Competency 1 is "Adapting your practices to the needs and capacities of the worker who is absent and in the process of returning to work"

Table 4 Tasks and activities associated with competency 2 (N = 195)

	Mean (SD)
Tasks and activities—the most important	
Determining whether job accommodations are possible	3.08 (0.79)
Coordinating workplace resources to implement the return-to-work plans	3.04 (0.92)
Collaborating with the insurer so that services are coordinated, appropriate, and timely	3.02 (1.06)
Tasks and activities—the least important	
Communicating with the absent worker's family	1.54 (0.66)
Evaluating the impact of the worker's absence on the organization's other workers	2.33 (0.94)
Selecting health professionals to match the worker's needs (physiotherapists, occupational therapists, psychologists, etc.)	2.47 (1.00)
Communicating with treating practitioners to facilitate return to work planning for workers	2.59 (1.03)
Communicating with the health professionals involved when an employee returns to work	2.59 (0.92)
Participating in the creation of lighter job tasks	2.60 (0.97)
Drafting return-to-work plans	2.79 (1.08)
Stating the nature of a worker's problem when referring him/her to the insurer	2.81 (1.07)
Reporting on the worker's progress to the persons concerned	2.81 (0.96)
Participating in a brainstorming session to find adapted tasks suitable for the worker	2.82 (0.89)
Evaluating the risks related to the work	2.96 (0.95)
Consulting the insurer's representative about the functional capacities, prognosis, and treatment plans for a worker	2.98 (1.08)

Competency 2 is "Involving the workplace stakeholders concerned and appropriate external resources in an employee's return-to-work process"

Table 5 Tasks and activities associated with competency 3 (N = 195)

	Mean (SD)
Tasks and activities—the most important	
Applying laws, regulations, and procedures related to work absence and return to work	3.83 (0.48)
Keeping up-to-date on laws, policies, and regulations related to work absences and return to work	3.46 (0.64)
Performing a variety of administrative tasks and completing forms (e.g. claim forms)	3.46 (0.78)
Informing workers about return-to-work programs	3.44 (0.75)
Pointing workers to the proper bodies (e.g. workers' compensation board)	3.32 (0.77)
Informing the worker about his/her rights under the law	3.26 (0.85)
Writing case note summaries and reports on the return-to-work process	3.11 (0.93)
Taking the worker's seniority, and more generally, collective agreements into account	3.07 (1.16)

Competency 3 is "Developing practices that comply with laws, regulations, agreements, and procedures related to work absence and return to work"

Table 6 Tasks and activities associated with competency 4 (N = 195)

	Mean (SD)
Tasks and activities—the most important	
Keeping up-do-date on occupational health and safety and rehabilitation (reading, continuing education, attending conferences, etc.)	3.30 (0.68)
Implementing prevention measures related to occupational health and safety	3.26 (0.92)
Analyzing the organization's practices in terms of managing work absences and occupational health and safety for purposes of optimization	3.13 (0.83)
Promoting occupational health and safety activities and initiatives in the workplace	3.07 (0.93)
Tasks and activities—the least important	
Evaluating the organization's performance in terms of occupational health and safety activities and initiatives	2.64 (0.98)
Raising the awareness of people in the workplace of prejudices and stereotypes regarding people with work disabilities	2.90 (0.78)

Competency 4 is "Rethinking/Questioning your practices and ideas regarding work absence and occupational health and inviting the various stakeholders in the workplace to do the same"

group was—again, disregarding frequency—direct supervisors or managers (91.3, 85.1, and 83.6 % respectively for the three tasks or activities). The second most important target group was workers (47.2, 84.6, and 82.1 %). Lastly, to a lesser though still significant degree, human resources advisors (38.5, 40.0, and 43.6 %) and union representatives (19.0, 47.7, and 48.2 %) were target groups. Information on work-absence management programs was not collected from stakeholder collaborators or from contact persons and target groups.

Discussion

The results showed that approximately half of the tasks and activities included in the Internet-based survey were carried out frequently (mean of 3.01 or more), with these tasks and activities falling under one or more of the four core competencies. Our list of tasks and activities was more exhaustive than those of both Shaw et al. [6] and Pransky et al. [14]. The face-to-face interviews and the contributions made by the study's interdisciplinary researcher team in fact made it possible to clarify the statements. That being said, the individuals interviewed in big organizations in Quebec, who partly or wholly identified with the role of RTW coordinator, carried out activities that duplicated or overlapped those described by Shaw et al. [6]. However, as previously mentioned, it was difficult to establish a perfect correspondence because the statements were sometimes formulated differently and the concept of competency appeared to vary from one study to another. Regarding the results presenting low performance frequencies, such as "communicating with the absent worker's family" and "evaluating the impact of the worker's absence on the organization's other workers," these concurred with the results obtained by Pransky et al. [14]. In summary, despite

differing contexts, a set of common RTW coordination practices was found to exist across industrialized countries. We drew up a broad inventory that could serve as a benchmark and be tested in other regions and legal contexts. This same benchmark could also serve as a guide for describing RTW coordinators' responsibilities in greater detail, orient and influence organizations' expectations of RTW coordinators, and provide a basis of comparison for use in effectiveness studies.

The regression analyses revealed that the percentage of variance explained was only satisfactory for Competency 1, at 20.8 %. On the other hand, three regression models out of four included the *nursing or OHS training background* variable. This type of background may therefore be a pivotal characteristic for broader deployment of the tasks and activities studied. Bohatko-Naismith et al. [16] also underscored the importance of a health background or, at least, of having a good understanding of medical terminology in order to facilitate RTW coordination. This profile of RTW coordinators with a health background appears consistent with the disability paradigm defined by Loisel et al. [20]. Briefly, the paradigm postulates that a person's work disability is a result of the interaction between his/her characteristics and those of his/her environment. A person with a health training background who is working in a company and is focused on keeping employees at work and healthy has knowledge of work environment systems, the healthcare system, and the individual right from the outset. For this reason, Burton and Conti [21], who reduced disability duration after implementing a disability management program that included RTW coordination, recommended that RTW coordinators have a health training background. Future studies could evaluate the relationships between RTW coordinators' training background and the effectiveness of practices with respect to work-absence duration, number of relapses, and associated costs. From the same perspective, a study documenting the concordance between RTW coordinators' practices and the organizational culture could also be enlightening. In fact, a study by Durand et al. [2] on optimal work-absence management and RTW coordination practices clearly established that in order for such processes to be implemented in companies and accepted by the various stakeholders (employer, employees, and union), they must be built into broader policies aimed at keeping employees healthy. These policies should also undergo periodic evaluation to ensure a fit between the organization's values and RTW coordinators' practices.

Moreover, while many authors identify concerted action as a key driver for rallying the various stakeholders (co-workers, supervisors, union, health professionals) around a common RTW objective [1–4], our results indicate that the RTW coordinators interviewed focussed primarily on the worker-supervisor dyad. Collaboration with the absent worker's co-workers was completely overlooked. Yet studies show that when the problem causing the work absence is specifically a mental health disorder, this collaboration becomes extremely important and facilitates the return to work [1–4].

Strengths and Limitations

The main strengths of this study lie in the substantial sample size (N = 195) and the satisfactory response rate. Also, the direct importing of data from SurveyMonkey to PASW minimized data handling. The fact that participation in the study was voluntary may, however, have pushed the reported frequency of task and activity performance upward. Also, the conversion of task and activity performance frequencies into numerical scores caused some loss of information and detail. Even so, the groupings of tasks and activities all showed substantial internal consistency values, confirming the legitimacy of performing analyses that use intensity scores.

Conclusion

Although RTW coordinators are increasingly identified as a key component in the success of work-absence management programs, there is little literature describing their practices. For the first time, this study quantifies the practices of individuals involved in disability management and RTW coordination within large organizations operating in a variety of industry sectors. RTW coordinators' practices appear relatively homogeneous and generally fit into a set of more varied tasks. Also, while value is placed on concerted action in the scientific literature, RTW coordinators' collaborative effects are largely focused on the worker-supervisor dyad.

Lastly, it would be pertinent to continue this process by describing the realities in small and medium-sized organizations, which employ large numbers of workers in industrialized countries.

Compliance with Ethical Standards

Conflict of interest Marie-José Durand declares that she has no conflict of interest. Iuliana Nastasia declares that she has no conflict of interest. Marie-France Coutu declares that she has no conflict of interest. Michael Bernier declares that he has no conflict of interest.

Ethical Approval All procedures performed involving human participants were in accordance with the ethical standards of the Research Ethics Committee of the Research Centre of Charles Le Moyne Hospital in Longueuil, Quebec.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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