

Supporting return to work through appropriate certification:

A systematic approach for Australian primary care

Harry Papagoras ^{1*}

Tania Pizzari ^{1,2}

Paul Coburn ¹

Kevin Sleigh ¹

Andrew M. Briggs ^{1,3}

¹ Health and Disability Strategy Group, Transport Accident Commission and WorkSafe Victoria

² La Trobe Sport and Exercise Medicine Centre, La Trobe University, Victoria

³ School of Physiotherapy and Exercise Science, Curtin University, Western Australia

**Corresponding Author*

Mr Harry Papagoras

Health and Disability Strategy Group

WorkSafe Victoria

222 Exhibition Street

Melbourne, VIC, 3000

Tel: (03) 9940 4264

Fax: (03) 9641 1927

Email: harry_papagoras@worksafe.vic.gov.au

Competing interests: All the authors are employees of, or subcontractors to, WorkSafe Victoria and TAC. No other competing interests are declared.

Abstract

Background: Primary care practitioners play a critical role in supporting return to work (RTW) and minimising the detrimental physical and psychosocial sequelae of unnecessary and prolonged work absence in injured and ill workers. Accurate and consistent certification of capacity is an essential component of this role that has been scrutinised recently given the identified variation in certification between and within professions.

Purpose: This Perspective outlines the importance of correct certification of capacity for injured workers and provides a RTW Flowchart to support systematised and appropriate certification. The Flowchart is aimed at primary care practitioners; e.g. general practitioners or physiotherapists. The Flowchart was developed at the Transport Accident Commission and WorkSafe Victoria as a guide for Australian primary care practitioners when certifying capacity.

Conclusion: A more systemised approach to certification coupled with professional education and support may reduce variations and inaccuracies in certification, improve RTW rates and reduce the increasing burden of disease related to workplace injuries.

Key words: injury, return to work, certification, capacity, primary care

Introduction

Workplace injuries are common in Australia and other countries and are associated with significant personal and societal impacts. The cost of workplace injury in Australia in 2008-09 was estimated at \$60.6 billion (4.8% of GDP) ¹. Musculoskeletal injuries comprise the largest volume of work-related injuries in Australia ² and accordingly, the largest expenditure of worker's compensation claims ³, consistent with international data ⁴. On a global scale, the absolute burden of disease (informed by the Global Burden of Disease Study) of occupationally-related low back pain has increased by 22% between 1990 and 2010, largely driven by population growth and ageing ⁵. In light of systematic review-level evidence linking compensation claims with poor physical and psychological outcome after musculoskeletal injury ⁶ and increasing attention towards the negative influence of a compensation context on outcomes related to persistent pain ⁷, a focus on supporting injured workers effectively and sustainably return to work (RTW) is important. In this context, primary care health professionals have a critical role ⁸, particularly as it relates to correct certification of work capacity ⁹.

The importance of focusing on RTW after an injury / illness is underpinned by evidence suggesting that in general, work is good for health and well being and that unnecessary and prolonged time off work may be harmful physically, psychologically and socially ¹⁰⁻¹². Early support for RTW is also relevant as the longer someone is off work, the less likely they are to ever return to work, irrespective of the severity of the original injury ¹⁰.

A range of physical, psychological, social factors, and in the context of workers compensation, regulatory and legislative and system factors, influence an early, safe and durable RTW following a work-related injury or illness ^{7,13}. Within this milieu, the role of the primary care providers in accurate and consistent certification of capacity is critical, as is interdisciplinary communication between the certifying practitioner and those other practitioners involved in the worker's care.

The aim of this Perspective paper is to outline the role of appropriate certification by primary care health professionals in supporting injured workers return to work and to propose a Flowchart to help clinicians identify and act upon possible barriers to inappropriate certification. While this initiative was developed in Victoria, the principles are applicable to all Australian jurisdictions.

The Certificate of Capacity

The Certificate of Capacity is the communication tool used in workers compensation systems to indicate an injured worker's functional capacity to then enable or restrict RTW. The Certificate facilitates communication between all stakeholders including the worker, the employer, the certifier, other clinicians involved in the worker's care and the insurer. The certificate is a legal document and currently only a medical practitioner is able to issue a certificate of capacity in all states and territories of Australia, other than Victoria. In Victoria, a medical practitioner must complete the first certificate of capacity and subsequent certificates can be provided by a medical practitioner, physiotherapist, chiropractor or osteopath. While certificates vary slightly across jurisdictions, recent iterations ensure all are aimed at identifying a worker's function rather than incapacity. The Certificate of Capacity is the first stage in the RTW process. If an injured worker is certified as "unfit" or with "no capacity for employment", then no RTW can occur, even if the worker currently holds a job and has a supportive employer with suitable duties available.

In a retrospective analysis of Victorian workers compensation data for all injured and ill workers with an accepted workers compensation claim between 2003 and 2010, Collie et al ² reported that 74.1% of general practitioner (GP)-issued Certificates recommended workers were unfit for any work. While severe injuries may necessarily require certification as unfit, workers with less severe injuries that may feasibly have some work capacity, such as musculoskeletal and back injuries, were largely certified as unfit: 68.0% and 77.6%, respectively ². The researchers also identified high variation in

the work capacity recommendations and duration of Certificates issued by GPs. Differences in unfit certification rates have also been identified between primary care disciplines ^{2,14}.

Certifying “unfit” may not accurately reflect true functional capacity and could lead to unnecessary disability and time off work ¹⁵, leading to negative worklessness ⁸. Prolonging incapacity by inappropriately certifying total incapacity may lead to iatrogenic disease ¹⁶. When determining work capacity, clinicians should consider what a worker can, can't and shouldn't do as it relates to their work injury / illness.

When is certifying “unfit” reasonable?

The American College of Occupational and Environmental Medicine identified when work absence was medically necessary as opposed to discretionary or unnecessary work absence ¹⁵. The following summary is based on that position statement:

- Medically necessary “unfit” certification is when an injured worker is totally incapacitated due to hospitalisation or strict bed rest states. It also occurs when being at work, or activity, is medically contraindicated. Time off work under these situations ensures that the injury or illness will not significantly deteriorate, the recovery will not be delayed, and significant harm is not caused to the injured worker, others, or equipment.
- Discretionary “unfit” certification is usually based on incorrect assumptions or a situation. This can occur when the certifier judges the injured worker could go back to work, however, has reservations such as inability to drive, being unsure of what work may be available, or thinking that there may be too much effort to support the injured worker back to work. These factors can usually be resolved with effective communication.
- Unnecessary “unfit” certification may be due to a range of factors such as an inadequate understanding about the compensation system and the health practitioner’s role in certification; waiting for information that may not necessarily change the management;

employer and practitioner ignorance concerning the health benefits of work and their interface with optimal clinical management; and resistance that influences the certifier or other problems that do not relate directly to the injury, such as job dissatisfaction, anger or other psychosocial factors (Box 1) ^{7,17-19}.

Box 1: Practice point

Certification should relate to the injured worker's capacity to safely undertake tasks at work as it relates to the injury, rather than other workplace issues. Notably, certifying "unfit" may not necessarily resolve the incorrect assumption or the situation limiting RTW.

For example, if a clinician deems that the injured worker is "unfit" and has no capacity to work, then consider what they would be doing at home. For example, if they are bed-bound, then it is likely that certifying "unfit" is medically necessary, whereas outside this circumstance then there are various levels of capacity that could facilitate RTW.

Asking "What would the person reasonably be doing at home" is a key question in determining someone's functional capacity and if certifying "unfit" is medically necessary.

Supporting systematised and appropriate certification

A "RTW Flowchart", based on the pivotal role of the certificate of capacity, was developed at WorkSafe Victoria and the Transport Accident Commission (TAC), Victoria, and provides a systematic method to identify and manage RTW barriers and support appropriate certification (Figure 1). The Flowchart was developed in 2016 by the authors, with the first author (HP) leading its development and iterations. This Perspective piece presents the Flowchart in the public domain for the first time. Future work will prioritise the evaluation of the Flowchart in practice and support for wide-scale implementation. The Flowchart is aimed at primary care providers who are responsible for

certification and other providers participating in the injured worker's care. The purpose of the Flowchart is to assist care providers with appropriate certification and identify and act upon any system barriers to potentially inappropriate certification. Using the Flowchart as an adjunct to practice and to guide communication with the injured worker and other healthcare providers participating in an injured worker's care is likely to assist in appropriate certification and supporting the injured worker to return to work.

[insert Figure 1 here]

Once work status is established, the right hand side of the flow chart can be used to support a RTW should it have not yet occurred, and the left hand side can be used to guide the progression back to pre-injury duties as required.

If the worker has not returned to work then a review of how the worker is being certified is required, which may involve liaising with another practitioner currently providing certificates. Where a worker is certified fit, but has not yet returned to work, the employer or employment may be the barrier, which is important information for the insurer to allow the initiation of vocational resources.

Summary and recommendations

Appropriate certification is an important enabler to RTW. A more systematised approach to certification in primary care, accompanied with professional education and support, is likely to be required to improve certification practices to support RTW.

Figure legends

Figure 1: Return to Work flowchart

References

1. Safe Work Australia. Key Work Health and Safety Statistics, Australia. Canberra: Safe Work Australia; 2013.
2. Collie A, Ruseckaite R, Brijnath B, Kosny AA, Mazza D. Sickness certification of workers compensation claimants by general practitioners in Victoria, 2003-2010. *Med J Aust* 2013;199:480-3.
3. Zheltoukhova K, Bevan S, Reich A. Fit for work? Musculoskeletal disorders and the Australian labour market. London: The Work Foundation; 2012.
4. Punnett L, Wegman DH. Work-related musculoskeletal disorders: the epidemiologic evidence and the debate. *J Electromyogr Kinesiol* 2004;14:13-23.
5. Driscoll T, Jacklyn G, Orchard J, et al. The global burden of occupationally related low back pain: estimates from the Global Burden of Disease 2010 study. *Ann Rheum Dis* 2014;73:975-81.
6. Murgatroyd DF, Casey PP, Cameron ID, Harris IA. The effect of financial compensation on health outcomes following musculoskeletal injury: systematic review. *PLoS One* 2015;10:e0117597.
7. Beales D, Fried K, Nicholas M, Blyth F, Finniss D, Moseley GL. Management of musculoskeletal pain in a compensable environment: Implementation of helpful and unhelpful Models of Care in supporting recovery and return to work. *Best Pract Res Clin Rheumatol* 2016;30:445-67.
8. Daly A. Worklessness: can physiotherapists do more? *J Physiother* 2016;62:179-80.
9. Johnston V, Beales D. Enhancing direct access and authority for work capacity certificates to physiotherapists. *Man Ther* 2016.
10. Waddell G, Burton K. *Is Work Good For Your Health And Well-Being?* London: TSO; 2006.
11. Rueda S, Chambers L, Wilson M, et al. Association of returning to work with better health in working-aged adults: a systematic review. *Am J Public Health* 2012;102:541-56.

12. Australasian Faculty of Occupational and Environmental Medicine. Realising the health benefits of work – An evidence update. Melbourne: Royal Australasian College of Physicians; 2015.
13. Foreman P, Murphy G, Swerissen H. Barriers and facilitators to return to work: A literature review. Melbourne: Australian Institute for Primary Care, La Trobe University; 2006.
14. Gosling C, Keating J, Iles R, Morgan P, Hopmans R. Strategies to enable physiotherapists to promote timely return to work following injury. Melbourne: ISCRR and Monash University; 2015.
15. Stay-at-Work and Return-to-Work Process Improvement Committee. Preventing needless work disability by helping people stay employed. *J Occup Environ Med* 2006;48:972-87.
16. Dunstan DA. Are sickness certificates doing our patients harm. *Aust Fam Physician* 2009;38:61-3.
17. Cancelliere C, Donovan J, Stockkendahl MJ, et al. Factors affecting return to work after injury or illness: best evidence synthesis of systematic reviews. *Chiropr Man Therap* 2016;24:32.
18. Ruseckaite R, Collie A, Scheepers M, Brijnath B, Kosny A, Mazza D. Factors associated with sickness certification of injured workers by General Practitioners in Victoria, Australia. *BMC Public Health* 2016;16:298.
19. Mazza D, Brijnath B, Singh N, Kosny A, Ruseckaite R, Collie A. General practitioners and sickness certification for injury in Australia. *BMC Fam Pract* 2015;16:100.

Return to Work (RTW) Flowchart
Identifying and managing RTW barriers
Day 1 and ongoing

Determine if the injured worker is working and, *with a sense of urgency*, identify and manage barriers to RTW and work capacity progression. Use available resources when the management of the barrier is beyond your scope

