Individuele verzuimbegeleiding. Beoordeling en borging van de professionele kwaliteit
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SUMMARY

OCCUPATIONAL REHABILITATION; ASSESSING AND ASSURING THE PROFESSIONAL QUALITY

In recent years the involvement of Dutch employers with sickness absenteeism has been increased. During the first year of absenteeism wages are no longer covered by social insurance but are to be paid by the employer himself. Also, the employer has to provide for an adequate occupational rehabilitation. With respect to this rehabilitation task professional assistance of an so-called "arbodienst" is compulsory. It is expected that this assistance will contribute to the quality of rehabilitation. However, guidelines for effective procedures of rehabilitation cannot be given. As a consequence the quality of the rehabilitation service provided by an arbodienst is subject to critical review.

In general the absence of standards of good practice can be interpreted as a sign of insufficient professional quality. This quality depends on the abilities of the professionals, the theoretical basis of the field and the methods that are available. Of these the abilities of the occupational physician in the field of occupational rehabilitation are indisputable. Sickness absenteeism has been the subject of much empirical and theoretical research and occupational rehabilitation has been applied since decades. Most of the ingredients for a high level of professional quality are thus available. However, these ingredients are not explicited in terms of methods and standards for good rehabilitation practice. This conclusion can be viewed as the starting point of our study. The main goal of this study is to explore the professional quality of occupational rehabilitation. This exploration is focused on the two main conditions for this quality: the theoretical status of the field and the available methods. The aim is a practical one. Following the exploration of the professional quality criteria of good practice will be derived.

To establish the theoretical status of the field the literature on sickness absenteeism is reviewed. The relevance of this literature is easily stated. It points to the causal factors of absenteeism, which should also be addressed during a (successful) rehabilitation. In the literature several different explanations of sickness absenteeism are found. Some of these differences are due to the theoretical framework that is used, some can be attributed to the application that is intended and others to the category of sickness absenteeism that is studied. The empirical basis of all of these models is weak. Some of the interactions between the variables specified are supported by empirical data, but most of them are not. Finally, none of these models is designed specifically for application in the field of occupational rehabilitation.

Viewing this state of affairs the theoretical base of occupational rehabilitation is questionable. It seems likely that some theoretical notions govern rehabilitation, but the origin of these notions
is unclear. The best guess for the notions in use are those presented in a well-known Dutch model: the load-capacity model. In this model sickness absenteeism is presented as a consequence of a continuing unbalance between the capacities of the employee on the one hand and work demands on the other. This intuitively appealing, but rather simple, model can easily be translated in terms of occupational rehabilitation. However, it reduces rehabilitation to a process with only two options. One option consists of improving the capacities of the employee and the other of reducing the workload. Although these options can be applied in some cases, they fall short in other ones. Not all problems in rehabilitation can be attributed to a simple deficiency in capacities or an overload. As other models show the mechanism of sickness leave is more complex. Presuming that rehabilitation is not limited to certain cases it is plausible that other notions than presented in the load-capacity model are used.

In an attempt to reproduce these more or less implicit theoretical notions an alternative model is proposed. This model can be viewed as an extension of the load-capacity model with relevant concepts of other models. According to this model the total daily load is determined by the load encountered during working and non-working hours. In the normal (healthy) situation this total daily load is in balance with the capacity of the employee. Problems can be expected in case of a factual or a (by the employee) perceived unbalance. This (factual or perceived) unbalance provokes a reaction from the employee. He can react by adapting the workload or the load during non-working hours. Both reactions can range from a simple alteration of the work or non-work activities to a total abolishment of these activities. In case of abolishment of all working activities the employee reports sick. According to the model the choice between the reaction alternatives is dependent of
- the perceived unbalance: The likelihood of sick leave increases with the difference perceived between total load and capacity;
- job characteristics: The likelihood of sick leave decreases with the opportunity to adapt the workload;
- personal environment: The likelihood of sick leave decreases with the opportunity to adapt the load experienced during non-working hours;
- motivation: The higher the motivation the better the available opportunities of adaptation will be used. As a consequence the likelihood of sick leave decreases with the level of motivation.

The concepts of this model of absence behaviour can easily be applied to the process of occupational rehabilitation. This process passes through three logical successive stages. In the first stage the rehabilitation problem is defined. For this purpose a heuristic method based on the absence model can be applied. Using this method four possible conclusions are reached. The first is the traditional and most customary outcome. Viewing the minimal workload and the maximum capacity of the employee it is concluded that a real unbalance exists. In this case the sick report was inevitable and is thus acceptable. The other outcomes might arise when no obvious unbalance between the workload and the capacity is established. The sick report itself is questionable. In this case the subject of rehabilitation is not the workload and neither the capacity of the employee but the sick report itself. Possible underlying problems are:
- A perception problem: the employee overestimates the load or underestimates his capacity.
- A coping problem: the employee is unable to use the adaptation possibilities.
- A motivation problem: the employee refuses to use the adaptation possibilities.
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These behavioural problems should be solved before entering the last stage of rehabilitation. The second intermediate stage in the process of occupational rehabilitation deals with the non-behavioural causes of absenteeism. In this stage the capacity development and the factors influencing this development are monitored and, if necessary, controlled. This stage ends when a sufficient level of capacity is reached. Sufficient in the sense that the work might be conditionally resumed.

The third and last stage in the rehabilitation process deals with the actual reintegration to work. Starting point is the advise of the occupational physician that the work can be resumed if certain conditions in the working environment are met. These conditions are connected with the ability that is reached and, possibly, with factors which impair the health and safety in the long run. Following this advise the work resumption and the accompanying conditions are regularly re-evaluated and, if necessary, adjusted. This re-evaluation can be performed using a method similar to that applied in defining the rehabilitation problem. The end of this third stage and of the rehabilitation process is reached when the balance between work demands and capacity is restored. From this point temporary conditions that facilitated work resumption can be stopped.

The application of the model of absence behaviour clearly demonstrates the limitations of the theoretical base of occupational rehabilitation. The model is explicit about the problems to be addressed in the rehabilitation process, but a (best) method to solve these problems is not provided. The application of theoretical notions is therefore limited to the general structure of the rehabilitation process. This process can be stated in terms of a problem-solving process in which logical rules and theoretical considerations govern the order and subject of the activities, respectively.

The model of absence behaviour and its application in terms of the rehabilitation process are not to be interpreted as a description of the ongoing practice. In practice deviations in thought and process are likely. The presence of these deviations can be interpreted as a measure of professional quality. The higher the professional quality the more similar methods will be applied. This similarity is measured by studying the execution of occupational rehabilitation in a simulated environment. To create a simulated environment a (PC)-computer program is developed. By means of this program the occupational rehabilitation task can be performed at home in a controlled setting. The nature of this simulation program is interactive: the presentation of a case is dependent upon the rehabilitation actions performed. The simulation proceeds as follows. Starting point is an introduction to the case. This introduction consists of some demographic information concerning the employee and a short description of the complaint accompanying the sick report. Following this introduction the rehabilitation task is started. This task is performed by successively selecting a rehabilitation option, including a completion date. Several predefined options are available. The employee may, for instance, be questioned about the reason of sick report, the sickness history, the nature of the sickness complaint, the therapy, the job demands or the personal circumstances. The general physician may be consulted about the therapy and the prognosis. The employer may be contacted to investigate the job demands and the possibilities for job adjustments or an inspection of the work environment may be performed. Finally it is possible to advise a conditional of unconditional resumption of work. By registering the options selected an image of the general process of rehabilitation is obtained. This image consists of a series of rehabilitation actions arranged by completion date.
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In the simulation program a wide range of different cases is presented. These cases differ according to the sort of rehabilitation that can theoretically be expected. Differentiating variables are type of complaint, speed of recovery, job category, absence history, complaint origin, recovery behaviour (of the employee) and reintegration co-operation (of the employer). The type of complaint is defined using three categories: psychological problems, back problems and injuries. For each of the other variables two categories are defined, representing a positive and a negative condition respectively. Based on the 7-point typology formed by these variables 192 different case scenarios are written. Applying a balanced group design these scenarios are systematically distributed resulting in 8 different versions. Consequently per respondent only 24 of these scenarios need to be presented.

About a third of the Dutch population of occupational physicians was invited to participate in the study. Of these 63% did react but only 15% (n=105) did complete the simulation task. Important reasons for non-participation are lack of experience with occupational rehabilitation and practical factors such as lack of time or suitable computer equipment. Accounting for the first reason the actual participation is estimated around 25%. Further analyses of characteristics of participants and non-participants did not show any remarkable differences. Therefore the participants can be viewed as a representative sample of the Dutch population of physicians with experience in the field of occupational rehabilitation.

The analysis of the performance at the simulated occupational rehabilitation task is divided into three steps. Firstly the structure of the rehabilitation process is reviewed, secondly the variations in this process are studied and finally the predictability of the process is considered.

The analysis of the structure shows that occupational rehabilitation can be described as an episodical process. The first episode starts at the beginning of an absence spell. In this "inventory" episode the problem that gave rise to absence is defined: the focus is on the causal factors of absence. The second episode starts when ample information about the causal factors is gathered and continues until actual reintegration in work is considered. In this "recovery" episode the most attention is paid to the recovery of capacity and the opportunities to intervene. The third and last episode starts when the capacity is sufficiently recovered. Sufficient in the sense that the work can at least be conditionally resumed. Typical activities in this "reintegration" episode are monitoring and adapting these conditions for the purpose of facilitating a full resumption of work. These episodes are general in nature: they are observed for every physician and in most cases. Variations in the rehabilitation process do not show in the succession of episodes but in the variables with which each episode can be described. These variables are the episode duration and the episode pattern (of rehabilitation activities performed). Using regression and loglinear analysis the relation between these variables and predefined characteristics of the cases is established. These analyses show variations of the rehabilitation process in relation to:

- **Type of complaint:** In comparison with back problems and injuries, psychological problems give rise to a longer duration of the inventory and recovery episodes and a shorter duration of the reintegration episode. The differences between the episode patterns are restricted to the inventory episode. During this episode for psychological complaints a broad range of rehabilitation activities is used, whereas for other complaints the activities are mostly limited to capacity evaluation.

- **Speed of recovery:** A slower speed gives rise to an increase of duration of each episode. The
amount of increase is relatively small for the inventory episode, modest for the recovery episode and large for the reintegration episode. However, no significant differences between the episode patterns are observed.

- **Reintegration co-operation:** A non-co-operative employer gives rise to an increase of the duration of the reintegration episode, which can be attributed to more attention to the workload and the recovery of capacity.

- **Necessity of absence:** This factor gives rise to the largest differences in duration and pattern of the episodes. Most striking are these for the recovery and the reintegration episode. For cases which are evaluated as of low necessity these latter episodes are almost aborted. The rehabilitation process is compressed in one step on which occasion a quick inventory is followed immediately by an advice to resume work. On the other hand, for high necessity cases the rehabilitation process passes through all episodes and in each episode a broad range of activities is performed. Unlike the factors mentioned above no relation was found with the other predefined factors. In spite of differences in job category, absence history, complaint origin or recovery behaviour a comparable rehabilitation process is followed. In an attempt to predict the rehabilitation process these results are largely confirmed. Using a logistic regression model to predict the rehabilitation options chosen, only four significant predictors are found: type of complaint, speed of recovery, necessity of absence and recovery stage. With these four factors the use of most of the available rehabilitation options can be well predicted. Moreover, application of the logistic model to different groups of participants demonstrates that these factors can be generalised. Participants only differ in the intensity with which rehabilitation activities are employed, but not in the choices that are made.

Reviewing these results it is concluded that only a partial correspondence with the theoretical expectations exists. Firstly the empirical episodes and the theoretical stages are similar in order and content. However, in contrast to these stages the succession of episodes is more gradual. Secondly variations in the rehabilitation process are expected in relation to factors as type of complaint, speed of recovery, reintegration co-operation (of the employer), absence history and recovery behaviour (of the employee). However, variations in the process with only the first three factors were found. Although some of these differences can be attributed to the design of the rehabilitation task, other differences suggest that the professional quality of rehabilitation can and should be improved. Following this suggestion two possible ways of improvement are recommended. The first recommendation is to formulate criteria with which the rehabilitation effort can be evaluated. Based on the results of this study, two empirical criteria - including assessment methods - are proposed: the structure and the content of the rehabilitation process. Using these criteria a certain standard of professional quality can be reached. As a consequence the general level of performance will increase and individual differences will decrease. However, the overall effect on the professional quality of these criteria will be limited: the upper bound of improvement equals the “best practice” of rehabilitation. As the results show this “best practice” can be improved upon if a better use of the existing theory is made. The second recommendation is therefore to integrate theory and method in a general protocol of rehabilitation. An example of such a protocol is presented. This example demonstrates the importance of the problem definition for the quality of rehabilitation. To maximise the effect of rehabilitation an early professional involvement should therefore be customary.
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