



Telephonic support to facilitate return to work: what works, how, and when?

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Lead in

There is wide acceptance that work is (generally) good for our health and wellbeing, and that this is true for most working-age people, including those with health problems. A timely return to work for people with health problems, therefore, is a desirable goal.

The Government has proposed a new service to help people with (common) health problems to return to work in a timely manner. Telephonic contact is an attractive approach with the potential to provide targeted delivery of the right support to the right people at the right time, but that begs the question – do such approaches offer the desired advantages? While telephonic methods are increasingly used to deliver various health services, there are important questions around safety, effectiveness, acceptability and relative costs.

The aim of this review was to provide an evidence base for the use of telephonic assessment and support to facilitate timely return to work for people with common health problems.

Recognising that the academic literature on the topic may be limited, documentary evidence was also sought from professional practice and grey literature sources. Data from 83 peer-reviewed academic articles, 10 practice exemplars and 28 grey literature documents were extracted into evidence tables.

Using a best evidence synthesis, high-level evidence statements were developed and linked to the supporting evidence, which was graded to indicate the level of support. The evidence statements are organised to cover four pertinent

areas of telephonic support: assessment and triage; case management; information and advice; return to work. The evidence on important aspects of implementation – safety, acceptability, timing, cost-benefits, required skills – was further explored and interpreted.

Findings

The main findings are summarised below, along with some interpretive commentary. The majority of the findings are supported by evidence both from academic research and from practice exemplars. It is particularly pertinent that the main findings apply to most, if not all, common health problems.

Assessment and triage

There is robust evidence that telephonic approaches can be suitable for assessing clients' needs and can compare favourably to face-to-face methods. The assessment can be used to make decisions about allocation to appropriate care through a triage process.

This means that telephonic methods can be used effectively to assess the clinical, work and participation needs of people with common health problems, and they can be as effective as face-to-face approaches in doing so.

In addition, telephonic methods can be used to allocate people with common health problems to occupational and clinical management pathways through a triage process that is both effective and efficient.

Clearly, the approach used to assess and manage common health problems telephonically must complement the type of problem (e.g. musculoskeletal or mental health), but the underlying principles are the same for all.

When telephonic approaches yield inferior results, the most likely reasons are inadequate (training in) telephonic or clinical skills, poor service design and implementation, and poor adherence. It is crucial that the telephonic personnel (including clinically-trained staff) receive focused training and support that is reviewed on a regular basis, and facilitated by standardised protocols.

Case management

There is robust evidence that telephonic case management can support people with common health problems through care pathways, monitor progress and facilitate return to work. It can contain overall costs by reducing delays and optimising referrals.

The overall effectiveness of the case management process is well established in a variety of settings and for a range of clients, where telephonic first contact is the norm. Nevertheless, careful service design and practitioner training is required to avoid duplication of services through over-escalation to face-to-face assessments.

Specific advantages of telephonic case management include reducing delays, integrating intervention components, optimising referrals, coordinating stepped care and communicating between the key players. This fits well with a stepped-care model: delivering just what's needed, when it's needed.

Telephonic approaches are unsuitable for clients with communication problems and those with complex pre-existing medical conditions in addition to their current common health problem: assessment and triage can identify these cases and move them to a face-to-face approach.

Information and advice

There is adequate evidence that relevant information and advice, including self-management techniques, can be effectively delivered by telephone.

Information and advice in a case management context is seen as a necessary, but not sufficient, part of the overall intervention package. Although generally incorporated into the multifaceted case management process, it is capable of having a positive effect in isolation. In practice verbal advice and information is typically augmented by written information.

Delivery of relevant information by telephone contact can encourage and enhance self-management of common health (and other) problems. There are reports in the grey literature and practice exemplars that very early, carefully focused telephonic self-management intervention alone can be sufficient for a proportion of people to be able to self-manage their health problem, and that this is sustainable.

In respect of occupational outcomes, telephonic delivery of work-focused information and advice is useful to orient the person towards return to work, thus helping to set expectations and aiding decisions about how and when to return.

Return to work

There is robust evidence (notably from practice exemplars) that telephonic interventions can facilitate return to work. Effective approaches incorporate evidence-based concepts of vocational rehabilitation: identifying obstacles to work participation; developing a return-to-work plan; providing work-focused information; coordinating the key players (person – workplace – worker). These can all be facilitated telephonically.

The main aspects of telephonic services that have been shown to be effective for helping return to work are:

- ensuring return to work is asked about in every case;
- promoting self-management approaches as soon as appropriate;
- demedicalising common health problems wherever possible;
- having a monitoring process to avoid serial ineffective treatment;
- integrating line managers into the return-to-work-plan;
- facilitating early referrals into the service.

Aspects of implementation

There is acceptable evidence that telephonic approaches can be delivered safely using personnel with appropriate skills, training and governance.

The safety issue is not so much to do with the telephonic process; rather it is to do with skills and training. While ethical and legal concerns do exist, there is a consensus that those concerns are common to healthcare in general.

There is natural concern that telephonic assessment may overlook serious medical conditions. This seems to arise from a misunderstanding that the telephonic process is intended to replace clinical examination and be diagnostic: it is not. Client safety can be assured if telephonic assessors are appropriately trained and work to a structured protocol.

There is robust evidence that telephonic approaches (if suitably conducted) are generally accepted by service users, and are associated with high levels of satisfaction that equal or exceed those for face-to-face approaches. In addition, telephonic approaches are generally acceptable to health professionals.

Little evidence is available about the extent that people at the workplace find telephonic contact acceptable. However, the practice exemplars indicated that line managers regularly

participate in work-focused interventions, in some cases actually referring into the telephonic service. The main limitation of telephonic approaches is when clients have communication problems of any sort, and this limitation could also apply in communication with the workplace.

There is robust evidence that a biopsychosocial perspective is appropriate for managing common health problems, from both clinical and occupational perspectives. Telephonic approaches based on biopsychosocial principles can lead to cost-benefits and be cost-effective for clinical and occupational outcomes.

The key components for successful interventions directed at occupational outcomes that can be delivered telephonically are:

- early identification of obstacles to work participation;
- developing and coordinating a return-to-work plan;
- taking stepped action;
- getting all players onside.

There is robust evidence that timing is important to achieve desired occupational outcomes: early intervention is consistently associated with a timely return to work.

From the perspective of vocational rehabilitation, there is a window of opportunity from around four to twelve weeks after onset of a common health problem. It is clear that the use of telephonic contact can minimise delays in starting the process.

The evidence actually favours interventions that start sooner than the beginning of the vocational rehabilitation window. In the early days and weeks of absence a 'light touch' intervention may be all that is required, with the intervention being escalated if return to work is delayed. Telephonic case management is suitable to guide this sort of stepped intervention.

Conclusion

Telephonic approaches using assessment and triage, along with coordination of the key players, can be effective at reducing the number of sickness episodes, the number of days lost and the overall cost of a case/claim. Unnecessary healthcare can be reduced, without compromising client satisfaction. The important caveat is that this applies when services are well designed and implemented, and are staffed by professionals who have appropriate training and support.

Central to enhancing return-to-work outcomes is that work is seen as a health outcome, and that work participation is the principal focus for the service: every client is asked about their work to identify obstacles to early return; they are helped to devise a practical and feasible return-to-work plan; there is coordinated action with the workplace. The assembled evidence indicates that when all these components are put together in an efficient manner, with appropriately skilled staff, the service will facilitate timely return to work and demonstrate cost-benefits and cost-effectiveness.