AN INDUSTRY WIDE STRATEGY FOR A CONSENSUS BASED APPROACH TO DISABILITY MANAGEMENT:

The Enhanced Disability Management Program – A Case Study

National Institute of Disability Management and Research™

Acknowledgements

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INTRODUCTION

The scale of the Enhanced Disability Management Program (EDMP) is one important reason for adopting it as the subject of a case study. It currently covers approximately 150,000 workers in four Bargaining Associations and all health authorities across British Columbia's health care system. The aim of this paper is to document the current status of the EDMP which has built on previous initiatives to create an industry wide consensus based approach to keeping people ill or injured connected to the workplace in the health sector in the province of British Columbia. The learning points of two of the previous initiatives that set out to establish effective job retention and return to work programs in health and care facilities using a consensus based disability management (DM) approach are also described.

One of the initiatives which informed the design of, and processes adopted by, the EDMP was implemented by a large health authority and involved close cooperation between management and unions (McAnaney & Williams, 2010; McAnaney, 2011). The other was implemented by eight relatively small long term care providers affiliated to the BC health system (McBeth, 2013). Both projects incorporated a proactive role for unions representing health employees. While they faced different challenges and required different strategies in establishing effective DM policies and procedures, both projects resulted in positive outcomes for workers and the employers.

Conceptions of the extent to which unions need to play an active, advocacy or passive role in the DM process vary across models of DM and jurisdictional boundaries (Westmoreland & Buys, 2004; Harder & Scott, 2005; Gensby et al, 2010; Harder & Geisen, 2012). Early conceptions of DM accepted that DM programs involving joint labour management support had the potential to benefit all active interests including employers, unions and insurers by addressing, at an early stage, the unmet needs of ill or injured workers (Akabas, 1986; Bruyere & Shrey, 1991).

Although these earlier conceptions of DM underlined the potential positive impact of DM on labour relations, the main emphasis was on employers taking more control of the job retention and return to work processes by moving from community based services to workplace based interventions. Positive labour relations was seen as a desirable outcome of the DM paradigm rather than labour being viewed as an essential partner in designing, developing and implementing DM (Shrey, 1996; Shrey & Lacerte, 1997).This approach can be termed employer-led DM (Shrey, 1996; Shrey & Lacerte, 1997; Harder & Geisen, 2012; Langman, 2012). While this approach can be employee-centred, it is based on the employer adopting the lead role.

In non-unionized workplaces an employer-led approach can be associated with a perception that absent workers may be vulnerable to being coerced to return to work before it is appropriate (Trades Union Congress, 2010). Randall and Buys (2012) cited a number of studies that documented the lack of impact

of DM programs where there was no worker involvement and recommended a consensus based approach to DM.

A key principle of a consensus based approach to DM is the requirement for a joint labour management committee which has responsibility for overseeing the development and design of workplace DM programs (National Institute of Disability Management and Research, 2004; Wynne & McAnaney, 2004; Hunt, 2009). This alternative conception of DM to the employer-led model places the active role of unions and other worker representative organizations at the centre at program level.

The International Labour Organization's *Code of practice on managing disability in the workplace* reflects this approach (2001). The International Social Security Association has incorporated a consensus based approach into its return to work guidelines (2012). More recently, active collaboration between unions, senior management and supervisors in DM program development was proposed as a prerequisite for effective implementation (St-Arnaud & Pelletier, 2014). The authors emphasised the need for direct union involvement supported by collective agreements, where relevant, throughout the retention and return to work process. Participation of union representatives in the generation of individual return to work plans was viewed as desirable on a needs basis (St-Arnaud & Pelletier, 2014). The contribution of worker representatives in preparing an absent worker for reintegration was also recommended.

In a survey conducted by the Conference Board of Canada in 2013, unionized workplaces were found more frequently to have formal DM supports for their workers and workers were more likely to be aware of the DM interventions and supports available (Thorpe & Chenier, 2013).

BACKGROUND AND CONTEXT

A number of drivers converged in 2008 to create the basis for a range of return to work and DM initiatives that can be viewed as culminating in the implementation of the EDMP.

The origin of this province-wide initiative can be traced to a decision in 2008 by the BC Minister's Council on Employment for Persons with Disabilities, chaired by the Hon. Claude Richmond, BC Minister for Employment & Social Development at the time. In the context of BC hosting the 2010 Olympics and Paralympics, the committee was tasked with implementing strategies designed to significantly increase employment participation for persons with disabilities. The committee decided on two parallel programs.

The first of these was *Ten by Ten*. This was targeted at city and municipal governments with the objective of increasing overall employment rates of persons with disabilities by a factor of ten by 2010.

The second, and most relevant to the current study, was the Disability Management Excellence Initiative (DMEx) to which $1m CAD was allocated. The DMEx initiative was aimed at employers of all sizes and sectors across BC. Its overall goal was to support workplaces in achieving better job retention and reintegration outcomes for current employees who were at risk of losing their jobs on the grounds of mental or physical health problems. The initiative was intended to reduce the inflow of individuals with mental or physical impairments into the provincial social security system. This approach to reducing the number of disability pension recipients has been recommended by the Organization for Economic Development and Cooperation (OECD) (2003; 2010).

From a practical perspective, funding from the BC government allowed employers to obtain at no cost a *Consensus Based Disability Management Audit* (CBDMA) or *Workplace Disability Management Assessment* (WDMA) (Flach et al, 2006; Hunt, 2009).

A broad cross section of BC employers opted to take advantage of this offer across a range of sectors including banking, transportation, advanced and secondary education, forestry/mining, legal services and health care.

In the health care sector the initiative was adopted by the BC Nurses' Union (BCNU), which was concerned about the impact of long-term health-related work absence on the career and job retention options of nurses, and Vancouver Coastal Health Authority (VCH), which needed to address its rising short-term (STD) and long-term disability (LTD) costs and the additional costs of replacing ill or injured workers.

The Early Intervention and Rehabilitation Program

This collaboration resulted in the establishment of the Early Intervention and Rehabilitation Program (EIRP) (McAnaney, 2011). Based on an audit, using the CBDMA, VCH's existing approach to managing workplace health and long-term absence was evaluated. The management of long-term absence was contracted out to an external agency. The audit identified a number of key areas for improvement including the complexity of the system; low organizational control over processes and procedures; sub-optimal communication with employees and external actors; inconsistent employee participation; incompatible information management systems across the organization; and inaccessible disability costs data. Of particular relevance to the current case study was that while union and management were involved in return to work and duty to accommodate, neither had a strong understanding of the DM process. Based on these findings, a memorandum of agreement established the EIRP, which was implemented between 2009 and 2010.

The EIRP put in place a number of core mechanisms to support safe and timely interventions for employees whose jobs were at risk on health grounds. Some of the more effective strategies included a project coordination committee involving both union and management representatives; a separate joint 'think tank' for resolving problems; a program logic model that made processes and intended outcomes explicit; a program manual that documented the project procedures; a dedicated DM information management system; internal case management services; and a formal transitional work program (McAnaney & Williams, 2010; McAnaney, 2011).

The EIRP project was carefully monitored and a number of significant output and outcome indicators were measured. During the early stages of implementation, referrals to the program increased by 89 per cent in comparison to the previous program, and the number of employees who agreed to participate increased three-fold. Participation rates in the program increased from 69 per cent to 94 per cent. In terms of efficiency, there was a 50 per cent reduction in time to first contact and a 23 per cent reduction in time to return to work. The effectiveness of the EIRP was evident in a number of performance indicators including Duty to Accommodate Requests which reduced by half, return to full duties which increased by a third, and reduced LTD claims accepted. The estimated savings in the first year of operation amounted to over $1.3 million (McAnaney, 2011).

The Health Employers Association of BC (HEABC) DM Project

Between 2011 and 2013, the HEABC, in collaboration with eight affiliate long term care providers, not operated by the provincial health authorities, implemented a pilot project in partnership with WorkSafeBC in order to establish a joint DM and claims management program in participating organizations (McBeth, 2013). This was a particularly interesting initiative because the scale of the participating employing organizations was small. This meant that they were not in a position to establish DM programs in their own right and lacked the knowledge and experience to resolve their return to work challenges. An important tool in establishing the context for the pilot was the WDMA, which was developed as a shorter version of the CBDMA and covers the same domains. It provides a profile of strengths and areas for improvement similar to the CBDMA (McBeth, 2013).

The assessment revealed a number of areas for improvement including restricted information management resources; limited options for long term accommodations; a lack of experience in dealing with impairments; no dedicated, qualified return to work coordinators; and ambiguous lines of responsibility and accountability. In addition, very few return to work procedures were documented, awareness of what was available was low, and it was difficult to find information on disability costs. Nevertheless, WorkSafeBC estimated that the average claims were 15 per cent higher than other long term care facilities in the province and short term duration was 20 per cent higher.

At the core of the pilot project was establishing a shared DM resource for the organizations that offered advice and guidance for managers in managing absence and claims and operated as a central hub for information, documentation and learning. It included a DM manual, modified duties lists for each organization, information packs for employees and workplace and job profiles. External expertise was sourced to provide impairment specific and return to work training. Complex cases were managed by the DM resource. A particularly useful mechanism to support project implementation was the development of a DM Roadmap which specified the main milestones to be met. Working with the unions was an integral component of the project (McBeth, 2013).

The initiative was implemented in two phases using a coaching model. Direct individual claims management support was provided in the early stages of the project in order to build a relationship with the employers and assist them to become familiar with the procedures. Throughout the project less complex cases were gradually transitioned to in-house management as the capacity to respond to these increased. The initial phase focused upon education, moving claims in-house, developing links with collaborating organizations and resolving practical problems to demonstrate the potential impact of the approach.

Based on a mid-term review of objectives, the focus of the project was narrowed to addressing WorkSafeBC claims duration and costs. As a result, more limited and achievable objectives were established including improving communication with funders and suppliers, and specifying more transparent referral procedures. Specifically, the second phase of the project implemented training and awareness raising for staff, built relationships with external actors, agreed early intervention and claims management procedures, and promoted consensus between the organizations and unions on a DM and attendance promotion program. One useful mechanism adopted was to bring representatives of each of the organizations together in small groups to work on specific challenges. In addition, a limited data set on costs and duration was put in place.

Project outcomes were mainly positive in terms of raised awareness among employees, enhanced communication processes with providers and data capture. The management of less complex cases had been taken in-house although continued support was required for more complex cases and there were significant improvements in early intervention and modified duties for less complex cases. Further, participation rates in early intervention programs had increased.

Outcome indicators revealed substantial impact in terms of reduced costs and increased benefits. For example, there was a 12 per cent reduction in costs and 14 per cent reduction in the average days paid. WorkSafeBC surcharges had been eliminated and the organizations were performing at average levels compared to the long term care sector. Financial gains included ratings adjustments estimated at

$580,000 CAD, additional pay saved in the region of $121,000 CAD, sick leave savings of $328,000 CAD and savings of around $83,000 CAD per employer. This was estimated to be a ten fold return on investment (ROI) for employers and overall an almost six fold ROI (including WorkSafeBC contributions) (McBeth, 2013).

Nevertheless, the sustainability of such gains represented a challenge. Even though the performance of the eight employers had improved substantially as a result of the project, the same limiting factors existed as at the beginning of the project simply because these were small organizations. Consequently, the employers required ongoing assistance with more complex cases and with integrating job retention and RTW good practice into their policies and procedures. As a result of the narrow focus on WorkSafe-BC claims, the remit of the DM function needed to be broadened to include all causes of absence. It was recommended that other providers in the long term care sector, and particularly the 152 organizations that are directly under the remit of the health authority, could act as a resource. These organizations have access to data collection facilities, call centres and DM professionals which could be extended to all affiliate organizations.

THE ENHANCED DISABILITY MANAGEMENT PROGRAM (EDMP) – A CASE STUDY IN CONSENSUS

The EDMP is exceptional in its scale. It involves collaboration between all health unions and Health Authority employers across the province of BC, and took over 50 days of bargaining to negotiate the language. According to the Health Employers Association of BC (HEABC) website, the Nurses' Bargaining Association (NBA), the Health Science Professionals Bargaining Association (HSPBA), the Community Bargaining Association and Facilities Bargaining Association are participating from the union side. Employing organizations include all Health Authorities (Vancouver Coastal Health, Fraser Health, Interior Health, Island Health, Northern Health, Providence Healthcare and the Provincial Health Services Authority). Recently, a number of affiliate employers have been incorporated into the initiative (Health Employers Association of BC, n. d.). The explicit aim of the EDMP is to achieve early, safe and sustainable return to work outcomes for injured and ill health employees and a corresponding reduction in long-term disability (LTD) premiums and sick leave utilization.

The Structure of the EDMP

Oversight of the EDMP is assigned to a Provincial Steering Committee (PSC) which is responsible for governance, administration and evaluation. Membership of the (PSC) currently consists of worker and management representatives from each of the health authorities and senior representatives from the NBA

and HSPBA. The main mechanisms for implementation are a set of joint employer/union working groups that oversee the operation of EDMP and work in areas of program promotion, communications, dispute resolution, data analysis, and evaluation.

Each health authority, with the exception of Vancouver Coastal, provides DM support through their workplace health departments utilizing the Healthcare Benefit Trust (HBT). This is a not-for-profit organization that provides group health and welfare benefits to employees in health and social care services on behalf of its employers. It administers the long term disability (LTD) plan which funds early intervention services. It covers approximately 100,000 individuals and their families in BC and the Yukon. Vancouver Coastal Health provides DM support and services through internal resources developed through the EIRP, described earlier.

The affiliate employer group consists of approximately 170 different employer sites. With a few exceptions, the affiliates do not have their own internal DM support. A third party provider was selected to provide professional disability and health management services to the vast majority of the affiliates under the auspices of the EDMP. Approximately 30 affiliate employers use different providers for these services.

EDMP Principles and Benefits

The EDMP is built on two core principles. Firstly, it is a fundamental principle that participation in the program for regular employees is required unless there is a valid reason why this should not be the case. Casual workers and others who self-refer while still at work may also participate, if it is considered appropriate. In such cases, services provided are considered on a case by case basis and at the discretion of the employer. Secondly, the principle of early involvement is central to the way the program operates. This is specified as missing one shift due to illness or injury as a result of a work-related event or five consecutive shifts due to a non-occupational illness or injury.

According to the EDMP employee information pack (2015) the benefits of participation for an employee include:

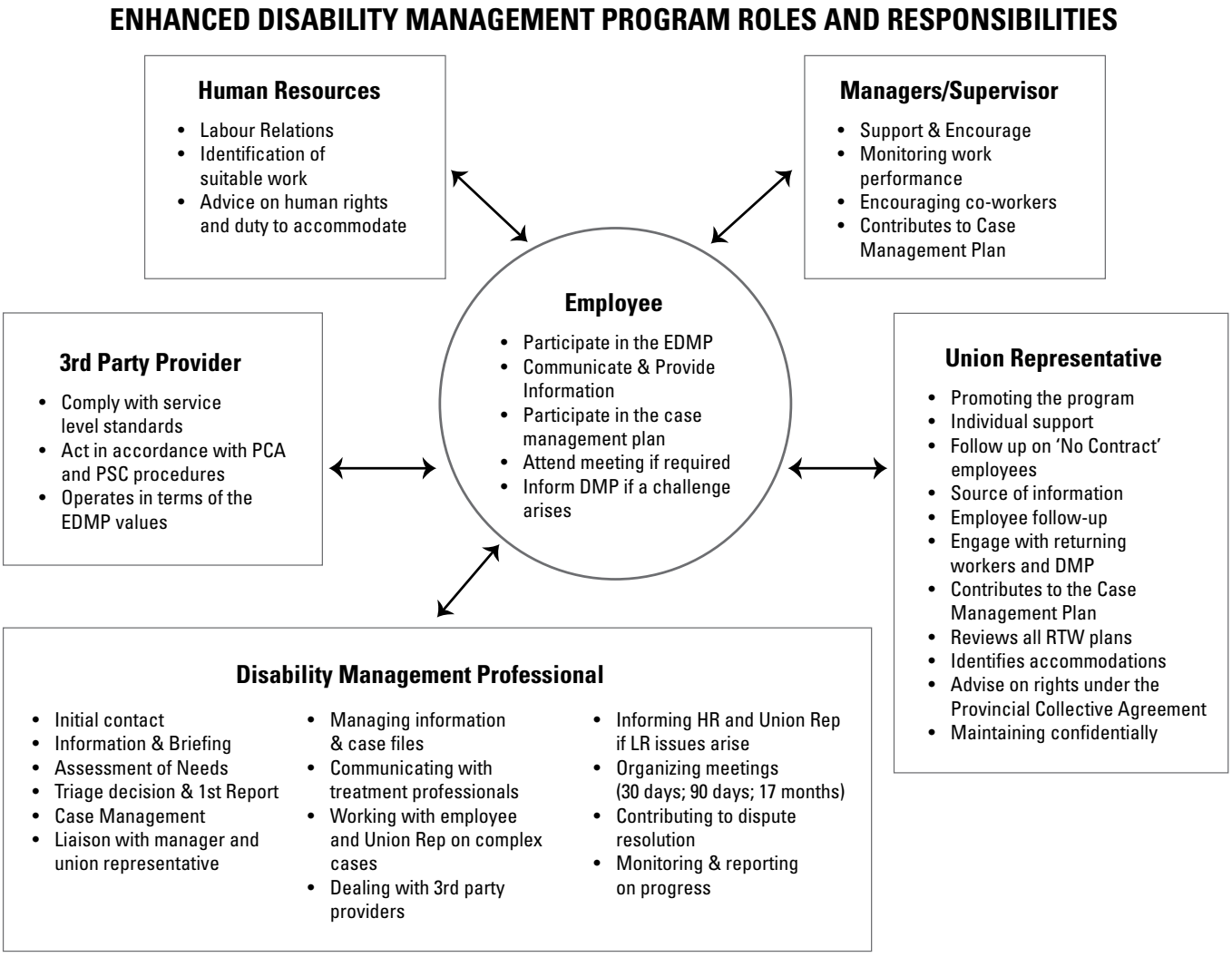
- Receiving supports and interventions which address their medical, personal, workplace and vocational barriers to return to work or stay at work.
- Access to medical and rehabilitation services, if required, at an earlier stage.
- Access to diagnostic services or treatments that would not normally be covered by existing plans.
- The potential to avail of a variety of return to work opportunities including temporary assignments, flexible work options, duty modifications or less strenuous work options.

In return, the employee must participate in the EDMP by providing any information required and communicating with the other individuals involved. Participation in the case management plan is also mandatory as is attendance at meetings and letting the DM professional know if anything changes or any challenges are encountered.

EDMP Roles and Responsibilities

Figure 1 presents the roles and responsibilities of each of the key actors in the EDMP from the perspective of an employee with an injury or illness.

Figure 1: EDMP Roles and Responsibilities from an Employee Perspective



Managers and supervisors mainly play a supportive role to the case management plan by supporting and encouraging the employees, monitoring work performance, getting co-workers to engage with the process and contributing to the case management plan as required. Human resources staff become involved if labour relations issues arise or where it is necessary to identify suitable work if a duty to accommodate is involved.

The third party provider, except in the case of Vancouver Coastal Health, assists in arranging and funding assessments, services, supports or interventions identified in the case management plan (CMP) and deemed necessary. The third party provider is required to comply with both the standards and values of the program and to operate in line with the requirements of the Provincial Collective Agreement (PCA) and the procedures set out by the Provincial Steering Committee. An exception to this is Vancouver Coastal Health (VCH), where VCH determines what assessments, services and supports are required, and the third party provider funds the plan.

Union representatives play a very substantive role in the program. In addition to promoting participation in the program and providing information for employees, union representatives support individual employees throughout the process and work actively with the disability management professional (DMP) on the case management plan, particularly in the case of more complex cases. In addition, union representatives can identify accommodations and advise employees on their rights under the PCA. They also review all RTW plans and follow up with returning employees. Like all parties involved in EDMP, the union representatives are bound by a code of confidentiality. There is a cross-party commitment to confidentiality.

The fundamental resource in terms of expertise and support is the DMP. Ill or injured employees are triaged into the program by the DMP. This involves providing information about the program and briefing potential participants about the nature of the process and what may be expected on their behalf. With the collaboration of the individual, the DMP carries out an assessment of needs in relation to the potential to return to work and then agrees to the next steps in the process. At this point, the DMP issues a report to the union representative. Once the overall objective is agreed, the DMP's primary employee-facing role is to act as case manager, assisting employees with any concerns that arise, liaising with the manager and union representative, communicating with treatment professionals and dealing with third party providers. In more complex cases, the DMP works closely with the employee and union representative throughout the process. If a human resources or labour relations issue arises, the DMP informs both HR and the union representative. If there is a disagreement in the case management plan, the DMP and union representative attempt to resolve the dispute through the dispute resolution process. This process can be escalated up to the EDMP working group, Provincial Steering Committee and finally, to an Arbitrator until it is resolved. Once employees have returned to work, the DMP monitors the

success of the case management plan and is available in the case that additional interventions are required.

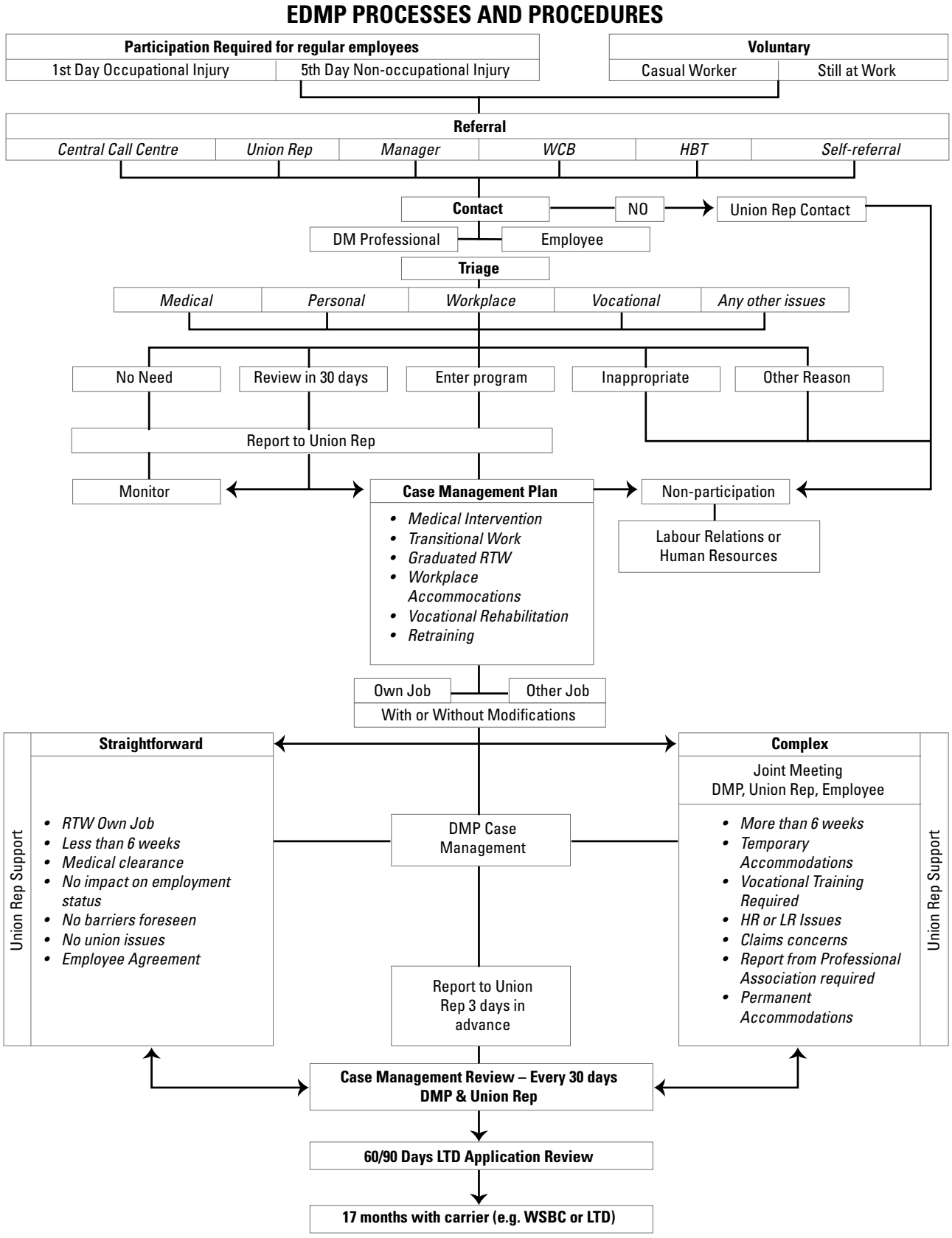
The DMP is also responsible for the administration of the program in terms of information management, taking care of case files, organizing meetings (30 days; 90 days; 17 months) and issuing regular reports on progress with regard to the overall program. As the process has progressed, employers have introduced additional roles such as return to work coordinators who carry out the initial triage and manage straightforward cases.

THE EDMP PROCESS

Figure 2 presents the EDMP from a process perspective and can serve to clarify the roles of the various actors from initial contact to case closure. As described above, regular employees are required to participate in the program and referrals are made after one day of absence in the case of an occupational illness or injury and after 5 days absence for other health conditions. In addition, casual workers and employees who are still at work can volunteer into the program although services provided are at the discretion of the employer on a case by case basis.

While services and supports may vary, it is important to emphasise that under Canadian Human Rights legislation employers have a requirement to accommodate workers with an illness or injury. The EDMP is an important mechanism which assists the employer, the union and the individual to meet their obligations under this act.

Figure 2: EDMP Processes and Procedures



There are multiple referral sources to the program in addition to self-referral. These include the manager, the union representative, Workplace Health Call Centre (occupational injuries), the Healthcare Benefit Trust or a central absence call line, which existed prior to the EDMP in some Health Authorities, although in some cases it has been established as part of the revised process. Initial contact is made by the DMP or an assistant. If contact is difficult to establish or the regular employee does not wish to participate in the program, the DMP informs the union representative who follows up with the employee. This is a key role for the union representative and the experience has been that employees are more open to participating following discussion with the union representative.

The DMP carries out a needs analysis that explores medical, personal, workplace, vocational and any other barriers with a view to deciding the next appropriate step in the process. In the case that a person is considered to be suitable for a case management plan, the person progresses to the next stage of the process. There are a number of reasons why entry into the program may be either postponed or considered to be inappropriate. It could be the case that the DMP and employee agree that there is no requirement for RTW supports or interventions and return to full duties is anticipated imminently (within 30 days). In such cases, the DMP will monitor that the employee has returned to work and, if not, contact them and enrol them in the program. If an employee is unwilling to participate at this stage, this is followed up by the union representative and where required would be forwarded to LR/HR.

For every employee who is admitted to the program, the DMP develops a case management plan (CMP) to meet the agreed intended outcome. This can involve a return to the employee's original job or to an alternative position and may include modifications to the work environment or conditions. The core interventions in a CMP include transitional work options, a graduated return to work, accommodations, vocational rehabilitation or retraining.

A key decision at this point is whether the DMP considers the return to work process to be straightforward or complex. A set of criteria on which to base this decision have been specified. A straightforward return to work is appropriate when the employee agrees with the CMP, has medical clearance to return to his or her original job within a six week period with no impact on job status, and where no barriers or labour relation concerns are evident. In these types of plans the union representative is available to support the employee on a needs basis.

A more complex return to work is considered suitable when the return to work process is likely to exceed six weeks and where additional interventions, such as vocational training, temporary or permanent accommodations, may be necessary.

Other factors that may indicate the need for a more complex CMP include the existence of a HR or labour relations concern, an issue with a claim or professional practice concerns. The CMP in complex cases is initiated through a meeting between the DMP, the employee and the union representative.

Each CMP is reviewed every 30 days by the DMP and union representative. Other key milestones are at 60/90 days where consideration is given to an application for LTD and at 17 months where the meeting is to determine the likelihood of the LTD claim closing within another 6 months and the supports / services that may be necessary. The key question at this point is whether the worker will require a Duty to Accommodate intervention or support.

An important tool developed to support the EDMP is its online resource centre. This performance support tool hosts information about the program and step by step instructions targeted at DMPs, union representatives, managers and ill or injured workers.

CONCLUSIONS

The EDMP has a number of characteristics that makes it an interesting subject of a case study. Firstly, both occupational and non-occupational illness or injury are within its scope without distinctions. Secondly, it is an industry wide initiative that operates across the province between the health employers and health sector unions. Thirdly, it is specifically targeted at promoting the health and productivity of employees and reducing the disability costs to employers. Fourthly, all employees, apart from casual workers and regular employees struggling at work, are required to participate in the EDMP unless they can make a valid argument why this should not be the case. Fifthly, it is an example of how union representatives can play a proactive role at policy, program and individual levels. Finally, it provides a working example of what consensus based DM can look like when its principles are fully embraced by all partners within the system and in organizations.

On these grounds alone it would be fair to conclude that it is a relatively unique initiative in the domain of DM and return to work. However, the EDMP also represents a culmination of a range of initiatives targeted at organizational and system change to enhance job retention and reintegration. It is possible to track its origins directly to the decision by the BC Minister's Council on Employment for Persons with Disabilities to allocate $1m CAD to the Disability Management Excellence Initiative in 2008. Over the eight year period since then, it is possible to track a number of initiatives undertaken by employing organizations and unions in the health sector in BC including the Early Intervention and Rehabilitation Pilot implemented by Vancouver Coastal Health in collaboration with the BC Nurses Union, and the DM pilot initiated by a group of affiliate long term care facilities with the support of the Health Employers Association of BC.

It is legitimate to question the extent to which the lessons learned can be considered transferable across industry or jurisdictional boundaries given the strong commitment to social partnership through collective agreements that is evident in BC. Nevertheless, it is possible to argue that the public sector is strongly

involved in the delivery of health and care services in many countries and that a similar approach to system change could be considered in addressing issues of health, productivity and the costs of absence and disability in the health sector in many jurisdictions.

At the level of organizational change, the potential for generalizing the strategies and mechanisms adopted in the three initiatives could be viewed as being relatively strong. The approaches used to build the capacity of organizations to respond earlier and more effectively to health-related absence, the challenges encountered, and the actions taken to resolve these have relevance to all employing organizations regardless of the legislative and policy context or the industry. Whether an organization is unionized or not, the approaches used to build and maintain consensus during the process of organizational change are relevant.

The main critique that can be directed at this case study is that it includes no information or data on the quantitative and qualitative outcomes across the sector in terms of jobs saved, the creation of temporary or permanent accommodations, the duration and frequency of health-related absence, the impact on short-term and long-term disability costs, and the need for temporary staff. The parties involved in the EDMP are acutely aware of this and substantial effort is being invested in compiling initial performance indicators.

A very robust provincial data warehouse has been created specifically to track data on the EDMP which will allow the parties to conduct a thorough evaluation. In the interim, some lessons are emerging from the process. For example, while the EDMP is based on best practices within consensus based DM, there can be disconnects between principles and practice. Specifically, one fundamental challenge that has arisen is the difference between having such a program and the readiness of the system to respond effectively.

In this regard, the need for formalized stay at work options such as light duties has emerged as a concern. In the absence of guidelines for this, there can be significant barriers to keeping individuals at work or returned to work in a timely manner. There are early indications that long term disability rates (LTD) have increased since the implementation of the EDMP. Two factors that are being explored in this regard are the administrative requirements of the enrollment process and the lack of clear starts and exits to the program which could result in the LTD package and qualification period being activated. However, in the absence of outcome data it is difficult to point to specific components of the EDMP approach that work well or which faced challenges.

In conclusion, the OECD has been advocating for system wide measures to divert workers from needing to register as disabled with disability pension systems. The grounds upon which this recommendation is based are that the exit rate from such systems to employment is less than one per cent annually across OECD member countries and the fiscal burden of increasing disability costs is unsustainable (2003;

2010). The EDMP and its predecessors provide an example of how such system change can be achieved through individual and organizational commitment and effort and the strategic application of the principles of consensus based DM.

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