DISABILITY MANAGEMENT PILOT PROJECT

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A. Executive Summary

A two-year disability management (DM) pilot project was initiated as a partnership between eight lower mainland Residential Care employers, WorkSafeBC and HEABC. The purpose of this project was to provide the participating employers a shared Health & Disability Claims Coordinator with the expertise to deliver both program development and claims management services.

The group contracted a Certified DM Professional to carry out the above mentioned services on secondment from the Fraser Health Authority, Workplace Health, effective February 4, 2011.

Funding: Expenses for this project were covered primarily through a cost share between WorkSafeBC and the participating employers with additional funding as well as administrative support provided by HEABC. Each employer was required to contribute $8,000 per year over the two year project. Individual site based DM related costs were also born by the employers. WorkSafeBC also provided $50,000 per year in funding.

Participating employers: Broadway Pentecostal Lodge, Fair Haven United Church Homes, Finnish Home/Manor, George Derby Centre, Haro Park Centre, Little Mountain Residential Care and Housing Society, New Vista Society and The Salvation Army Buchanan Lodge.

Vision: Collaborative development and implementation of a comprehensive DM program to enhance return to work and stay at work programs for participating employers.

Mission: Delivery of a DM program that is committed to providing a planned, safe and timely return to productive and meaningful employment for employees disabled through occupation or non-occupational injury or illness. The goal of the program is to minimize the impact of illness and injury on the individual and the workplace.

Deliverables:

a) Introduction of a "best practice" DM program at each of the participating employers to include the following services:

    1. Coordination and delivery of return to work programs
    2. WorkSafeBC/LTD claims management
    3. Cooperation with external providers who would provide employers with a comprehensive menu of services related to DM
    4. Assistance with duty to accommodate requests
    5. Attendance promotion education; and program evaluation

b) Provision of a shared "hands on" DM specialist available to work with employers and employees individually to carry out the function described in Part a) above.

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c) Comprehensive metrics and evaluation tool to track progress.

d) Development of a plan to communicate the project results to HEABC affiliate member organizations.

e) Twelve-month progress reports that include program status reports measured against the work plan and budget.

Context of project: HEABC has approximately 260 member employers providing health care services, with approximately 100 who operate long-term care (LTC) facilities in affiliation with BC health authorities. Injury, illness and related absence rates are high in this sector. A review of WorkSafeBC records shows that there are well over 2,600 occupational injuries requiring time loss and well over 110,000 work days lost each year in long-term care. The long-term care classification unit (766011) has one of the highest WorkSafeBC payment rates in the Service sector and is the highest under Health Care and Social Assistance. Costs, both human and monetary, are also high in relation to long term disability and sick experience. Participation rates for early intervention services are low in this sector.

Despite these challenges, very few affiliate employers have a dedicated human resources or DM function, most having limited or non-existent human resources with the expertise to provide an effective DM program. These functions are typically handled by someone at the employers with another primary role and are therefore run off the corner of an already crowded desk.

The purpose of the project at its outset was to implement a best practice “hands on” DM program for a group of eight long-term care employers and to use the results to demonstrate the potential return on investment associated with effective DM by communicating them to all HEABC affiliate organizations.

Key outcomes:

- The implementation of a hands-on disability management resource created a positive return on investment with a conservative estimate of $668,168 in annual savings for the project group (based on comparing 2012 figures to 2010 figures). This averaged out to $83,521 in savings per employer. As the investment cost per employer was over $14,000 per year (combined employer and WorkSafeBC contributions), the return on investment was over five-fold.

- Fourteen per cent reduction in WorkSafeBC per claim duration and a 12 per cent reduction in cost per claim despite an increase in these values for the Classification Unit (CU) using comparable values.

- Development and sharing of enhanced claims management tools and processes tailored to the affiliate employer.

- Improvements noted in leading indicators of positive change in disability management including: increased stakeholder knowledge and engagement, enhanced Affiliate specific tools and resources and increased alignment with external stakeholders.

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- Identification of key challenges in the implementation of DM programming with resulting recommendations provided.

Key findings and recommendations:

- There are limited resources at the employer level to manage ongoing DM programming, and differing staffing structures and resources at each employer make process implementation challenging. Ongoing dedicated DM resources for affiliate employers is recommended. Pilot project employers recommended that other employers be canvassed to determine whether they wish to provide financial support for continuing this resource.
- Ongoing and demonstrated support of senior management is vital to the success of DM programming in this setting.
- Further development of DM programming must include education and more robust consultation with injured workers to ensure durability (e.g. Focus groups with injured workers, managers and unions).
- Continue to develop and promote timely return to work/stay at work processes with frontline staff and managers.
- Increased opportunity to share and distribute experience across small employer sites can help to address inexperience at individual sites. The small sample sizes involved in disability management within each pilot employer presented ongoing challenges with acquiring and retaining knowledge and experience.
- Limited access to statistical data prevented a more comprehensive evaluation of the program. More robust and consistent data collection (objective and subjective) is required in order to better evaluate further DM initiatives.
- Affiliate employers do not yet have access to many of the resources developed elsewhere in their industry. Sophisticated DM resources exist in health care including data collection systems, call centers and DM practitioners though these assets have not made their way to the affiliate environment. Leveraging these resources (data collection, call centers, DM practitioners) to allow access in an affiliate environment would benefit the industry as a whole, particularly if classification unit rates for the industry can be lowered.
- Ongoing efforts should be exercised to increase alignment and improve communication with external parties (e.g. WorkSafeBC) and pursue strategic initiatives specific to affiliate long-term care employers.
- Encourage WorkSafeBC to investigate the return on investment of enhancing claims management in the pending stage.

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- Encourage WorkSafeBC to conclude the development of the health care roadmap (using the construction roadmap as a basis) and make it available to employers.
- Consider the establishment of an industry coordinator(s) in DM for affiliate employers.

B. Approach

DM requires the development of systems based policies and procedures. In turn, this project involved the consideration of many aspects of employers' infrastructure. DM processes affect policy features with a direct connection to injury and illness such as sick use and first aid reporting but also have attachments to indirect factors such as staffing structure, budget, data collection, payroll coding and organizational models.

In order to address some of these complexities, a coaching model for the project was adopted and the project employers were provided with ongoing individual claims management assistance coinciding with process and/or program development. Initially this strategy served to help build rapport with the employer contacts while allowing the DM professional the opportunity to become familiar with current practices and resources. As the project progressed, this arrangement transitioned so that the more straightforward return to work or claims management tasks were handled in-house and the DM professional worked to reinforce or fine-tune established processes and assist with more complex scenarios.

The project was structured as a pilot with expectation for variations in performance by the participating employers. This structure allowed for the leveraging of these variations to support implementation of best practices and allowed for adjustments to be made to the project goals. These adjustments can be seen throughout the project timeline and are reflected in the final project outcomes.

The employers involved in this project deserve a great deal of credit for taking on this challenge. They have recognized the value in establishing more efficient and effective processes to assist ill and injured employees and have taken the initiative to make this a priority over the last two years. This pilot project is a direct result of their efforts and while further work is necessary, there are notable successes in these project outcomes both offering an immediate return on investment and in laying groundwork for further human and financial gains.

This project follows a number of others including partnerships with Healthcare Benefit Trust, the National Institute of Disability Management and Research (NIDMAR), REACH Professional Management and Occupational Health and Safety Agency for Healthcare (OHSAH). The details of these ventures are included in the funding proposal for this DM project which is appended. As the outcomes and recommendations were used in the approach developed for this project, it is hoped that the outcomes of the initiatives undertaken here help to facilitate further development of DM in the affiliate environment as well as in long-term care in general.

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C. Project Timeline

February 4, 2011 through February 1, 2013

Segment Timelines:

February 2011 to July 2011: Foundation

The early stages of the project focussed on outlining the foundation on which the DM program would be set. Meetings were arranged with each employer and its representatives to go over current practices and documentation – where available – and to discuss specific goals for the project. An effort was made to get a sense of work site culture including current health and safety programs and wellness initiatives, adopted standards of care for each employer, etc.

Data and existing tools were reviewed and a metrics template – the goal of which was to track and evaluate occupational injury and illness as well as sick related absences – was developed with the input of the employer group. In order to establish a baseline, requests were provided to the employer group to provide historical data regarding sick leave (number of sick hours used, sick cost, number of absences greater than one week, as well as a breakdown of these statistics by department and month/quarter), Long-term disability (LTD) related absences (number of claims, average duration of claims, number of claims past definition date) and any WorkSafeBC information that may have been collected.

A DM program implementation manual had previously been developed for one of the project group employers through a joint effort with NIDMAR. The initial assumption was that this document would serve as a template, if not just be adopted entirely, as a DM Program Manual for the remaining employers. The document was reviewed and provided to employers with requests for their feedback.

At the outset there were a number of conditions that became apparent:

- Employers' level of knowledge in relation to their rights, legal roles and responsibilities related to return to work and claims management was not sufficient to allow them to take on DM tasks in an efficient way. For example, there were frequent questions about what kind of medical could be or should be requested from an employee away from work due to injury or illness. Without this knowledge, it can be difficult to assess the appropriate benefits that may be available to a worker and then to refer them to proper programs or services.
- Knowledge of systems such as WorkSafeBC claims management, the early intervention program (EIP) and LTD claims processes also required upgrading.

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- There was a heavy reliance on third parties, mostly WorkSafeBC or insurance companies (ICBC, Great West Life), to manage claims and employee absences. Despite the reliance on these organizations to monitor claims, very little information was provided to them about the specifics of each employers working environment or return to work opportunities.
- Roles and responsibilities with regard to DM were not well defined within the organizations and processes were inconsistent.
- Employers did not have consistent or reliable systems in use for tracking claims, WorkSafeBC and/or sick use/cost or LTD claim status.
- Due to the size of these employers, sample size in any particular area (WorkSafeBC claims, EIP referrals, LTD claims) was low. This contributed to an inability to acquire experience with particular processes.

These subjective findings were consistent with outcomes in a series of Workplace Disability Management Assessments (WDMA) that had been completed as a component of an initiative sponsored by the Healthcare Benefit Trust in 2009. Six of the eight project employers had participated in this assessment along with 10 other continuing care employers. The aggregate report from this initiative (Summary Report – Workplace Disability Management Assessment, Sept 8, 2009) was used in developing the approach for the pilot.

The following observations were noted in the WDMA report:

Consistent areas of strength:

- Positive relationships between organization and unions
- Functioning JOSH Committee
- Occupational ergonomics are available in some facilities
- Some statistical data available
- Positive efforts to enhance employee health and wellness
- Motivation exists to action recommendations

Consistent areas of need noted:

- Greater responsibility, accountability and authority required within DM processes
- Workplace culture and policy development
- Increased knowledge and skill of the parties involved in DM processes

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- Disability cost benefit data
- Documented and consistent in-house case management procedures
- Established transitional or modified work options

Based on this early information, focus was placed on enhancing DM related education, transitioning the management of claims and other absence related injuries and illnesses to an employer level practice (with less reliance on third party insurance companies) and enhancing collaboration with external parties with a role in these activities.

Establishing Tools and Resources - Key Developments:

- Privacy statements signed at all employers and authorizations established to allow communications with outside organizations such as Great West Life and WorkSafeBC
- Union contacts established
- Metrics template completed
- SharePoint site established as an information hub
- Roundtable added to regular project group meetings and bi-weekly conference calls arranged to facilitate sharing of experience across employers
- Manager tools established such as "When to refer an employee to DM" to begin to outline roles and responsibilities
- Gap analysis tool developed based on WDMA reports
- Data collected from WorkSafeBC, LTD actuarial, (Health Sector Compensation Information System (HSCIS)
- Planning initiated for an education session on the basics of DM: "Disability Management 101"

August 2011 to January 2012: Development and Education

The second quarter of the project was significant in establishing renewed direction and a more manageable set of goals for the project. Initial outcomes were measured and the scope of focus was narrowed considerably. While efforts were continued in managing non-occupational injury and illness, the primary focus was set on reducing duration and cost of WorkSafeBC claims by the end of the period.

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Initiatives included a "Disability Management 101" session, ongoing education through hands on claims management guidance and increased awareness of external education sessions offered through NIDMAR and the Employers' Advisors Office (EAO). Presentations were delivered by representatives from the EAO, Great West Life (GWL) and Healthcare Benefit Trust (HBT). The goals of these sessions were to increase knowledge and skill for the employer representatives for the DM program in the workplace.

Meetings were arranged with union representatives and efforts were made to increase alignment with external stakeholders. These included collaboration with Great West Life, HBT and EAO with each site being provided with a single point of contact; the development of joint processes and/or file reviews were conducted. An enhanced referral process to early intervention services, including employer-based triage, was developed. This subsequently resulted in increased employee participation rates. A documented claims management process for ICBC claims was also developed and distributed. Employers were registered as having modified duties available within WorkSafeBC's CMS (claims management system) in order to ensure employees had early return to work opportunities with time loss claims. Use of the WorkSafeBC Employer Portal was also reviewed to enhance claims information access. Employers' access to GroupNet through GWL was confirmed and usage reviewed. Efforts were made to arrange for access to WorkSafeBC Nurse Advisors within the pending claim stage but were unsuccessful.

Many of the struggles regarding data collection, which remained a challenge throughout the project, became apparent in this second quarter. The workload associated with completion of the metrics template proved to be too high and its return was poor at all but two sites. Adaptations were made to the collection system to reduce this workload. Employers were provided with a narrower set of parameters, for example, number and types of claims, types of accommodations or interventions offered to enhance return to work/stay at work, and sick hours, etc. Again this presented some challenges. Although some sites were tracking various aspects of illness and WorkSafeBC incidents and resulting claims, the systems used for this purpose were not consistent and could not be compared in a cumulative way through the project group. Employers did not have the dedicated resources available to establish these systems.

The development of an Attendance Promotion Program (APP) was also a major focus. Current APP models were reviewed in both health authority and affiliate environments and regular consultations with unions were arranged to gather their feedback. Education sessions were delivered to both management level employer representatives and all remaining staff with largely positive feedback in both venues. By the end of this period, the structure for the program – including the data requirements to run it – had been established.

Program implementation road maps for both the DM program and APP were developed during this stage in an effort to create more standardization and durability for them both.

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DM Road Map Summary

- Reaffirm commitment and support to the project and DM Program (commitment letter)
- Establish an employer based program development team/DM Committee
- Designate a person within each employer with accountability for DM programming
- Workplace report card
- Policy and procedure development
- Assess job tasks and establish modified duties
- Review return to work procedures
- Announce program
- Evaluate program

An interim project report was planned for delivery at the end of the first year, with evaluation of performance to be obtained, in part, through data to be provided by WorkSafeBC. This data would provide the first objective evaluation of the project and the report format was eventually adopted as a tracking tool to be used for the remainder of the project.

Focus shift: In reaction to a number of factors including the need to evaluate efforts within the project and the resources available within each employer, the scope of the project was narrowed at this stage to focus on two specific aspects of WorkSafeBC claims: claim duration and claim cost. To assist with this, employers began submitting all WorkSafeBC Form 7s (Employer's Report of Injury or Occupational Illness) to HEABC where the details were entered into a tracking system.

August 2011 to January 2012 - Key Developments:

- "Disability Management 101" education delivered
- Various enhancements to alignment with external parties
- HBT early intervention services referral guidelines developed
- ICBC claim management guidelines developed
- DM program and attendance promotion program development road map
- Attendance promotion program development completed
- First stages of data tracking for WorkSafeBC claims implemented

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- Shift focus of project to WorkSafeBC time loss claims, specifically per claim duration and cost
- Form 7 tracking system with administrative support from HEABC

February 2012 to July 2012: Implementation

With renewed commitments from each of the employers and a narrowed focus on WorkSafeBC claims (duration and claim cost) the DM road map was used as a guideline for program development and implementation. Efforts were ongoing to manage claims while transitioning accountability for DM into the workplace. The project employers were assigned to sub-committees who were then tasked with activities such as adaptation of modified duties lists to the affiliate environment, development of a "best practice" DM program package to be provided to ill and injured employees and physician/rehab provider packages to assist outside providers by providing DM specific information regarding each workplace.

Education continued as a number of musculoskeletal injury (MSI) and body mechanics sessions were offered. Employers were also provided with training specific to completion and submission of Form 7s.

Meetings took place with WorkSafeBC regarding the potential to develop a package that was originally developed for the construction industry (construction injury management road map) to a health care specific version. This was initially met with enthusiasm and an initial draft with some graphical changes was produced but further development did not occur. The construction package was launched in conjunction with a Nurse Line which gave employers direct access to a Nurse Advisor at WorkSafeBC who was available to assist with return to work planning.

Subjectively, significant gains were noted in employers' ability to assist their injured employees and in claims management in general. There was also a noted increase in the number of resources that the employers themselves brought back to the project group to be shared.

February 2012 to July 2012 - Key Developments:

- Renewed project commitment statements from all employers
- Monthly data tracking report established
- Sub-committee implementation to enhance site based program development and shift accountability back to the employers themselves
- DM Program introduction package for employees
- Physician and rehabilitation provider information
- Affiliate-specific modified duties sheets for most positions
- Form 7 and GWL/LTD presentations

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- MSI education provided
- Project presentation at HEABC AGM

August 2012 to January 2013: Follow up and Evaluation

The establishment of ongoing stats reports (provided by WorkSafeBC) allowed for more consistent and, in some cases, anticipatory monitoring and evaluation of both individual absences and of project performance. For the first time, file reviews included review of a consistent set of statistics regarding WorkSafeBC claims and some trending was possible. The benefits of the reports were inhibited by their late establishment but they did result directly in the rebate of an estimated $35,536 in claims costs and 158 charged lost days in the final project month alone through claims appeals and cost relief. Efforts through this period continued in regard to absence management, documentation, establishment of modified and transitional work opportunities for injured employees and timely information exchange.

Follow-up with WorkSafeBC continued in relation to pursuing the development of a road map that was based on the construction one and modified for health care/affiliates and in relation to establishing consistent points of contact (Nurse Advisors – Now called Return to Work Specialists, and Case Managers). WorkSafeBC will need to allocate resources to both initiatives should they be pursued further.

In order to build on earlier early safe return to work initiatives, employers began to offer selective light employment almost immediately post incident using both the modified duties sheets and the modified work offer form included in the construction road map. These had the dual benefit of ensuring that employees were aware immediately of the opportunities to stay at work and decreasing workload for employers in that communication with physicians and the collection of medical information was more efficient.

At this stage, most employers were handling all aspects of their more “straightforward” return to work cases while ongoing support continued to be required for the more complex cases.

Conversation returned to the implementation of cultural assessments and ongoing staff education in order to enhance the durability of various initiatives. DM Committees were established and initial meetings also occurred with some employers.

DM reference materials that were developed were catalogued in a program binder which was later transferred to a USB flash drive and provided to all employers as an ongoing resource.

August 2012 to January 2013 - Key Developments:

- Final project data evaluations
- Established data report for file reviews resulting in key cost relief and claim appeal decisions
- DM program binder and resources (later transferred to USB)

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- Lobby for direct contacts for affiliate sites (WorkSafeBC)
- Modified work offer process review

D. Project Outcomes

Outcomes and Successes

WorkSafeBC:

The project group as a whole experienced a reduction of 12 per cent in cost per claim and a reduction of 14 per cent in the average number of paid days per claim when comparing 2010 values to 2012 values. Data to assess these factors was taken from funds paid out within the specific period being assessed. This means that the claims costs paid out per 2012 claim were experienced between January 1 and December 31 of 2012. It is understood that these do not necessarily represent the full costs of claims as, in many cases, claims span well over a year or more. Also, LTD payments, WorkSafeBC pension payments and other costs savings have not been added to the claims savings. The scope of the assessment was kept narrow in order to offer some stability to the statistics generated over the short duration of the project and in an effort to ensure that the outcomes measured could be affected by the interventions offered.

It can be difficult to establish a direct savings correlation to claims cost reduction due to the complexities of the WorkSafeBC experience rating and assessment system. A savings of $100 in claims costs does not equate to $100 savings to the employer. In order to establish return on investment some assumptions have to be made and it becomes more useful to look at trends.

WorkSafeBC determines the cost of coverage to the employer (the assessment) in part based on their performance in comparison to similar employers. These employers are grouped into a Classification Unit (CU), in this case long-term care, CU #766011. At the outset of this project, the eight project employers' average per claim cost and duration sat significantly higher than the Classification Unit average.

Year 2010	Average cost per claim	Average claim duration (STD days paid)
Project Employers	$4,377	36
Classification Unit	$3,835	30

Where this scenario exists the outcome is an experience rate adjustment for the employer ultimately resulting in a surcharge in their WorkSafeBC rates. Six of the eight employers were operating at a surcharge resulting in a total of $327,067 in excess cost in 2010 alone.

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Through the two-year project, claim values were reduced, bringing the employer group in line, in fact slightly below, the CU average.

Year 2012	Average cost per claim	Average claim duration (STD days paid)
Project Employers	$3,866	31
Classification Unit	$4,102	31

The long-term care CU consists of 343 employers including 152 sites that are health authority owned and operated. This is worth noting as there are significantly more resources and established DM programming available to these 152 sites. WorkSafeBC statistics show a reduction of 24 per cent (15 days) for the 152 owned and operated sites between 2010 and 2012 while a 2 per cent (1 day) drop was experienced during this same period for all other employers in the CU. These facts add to the accomplishment of the project employers in bringing themselves in line with the CU as a whole.

Where the pilot employers are able to maintain these values – or keep their claim values in line with the CU – it is assumed that those employers previously operating at a surcharge would trend toward an experience rating adjustment of zero. Using historical numbers as a reference, specifically the years 2010 and 2011, this rating adjustment would have resulted in a potential savings of $327,067 and a $253,572 respectively or $580,639 in total assessment costs across two years. Further savings would be realized where employers could reach a merit status in their experience rating as was noted for two of the employers in the project group.

Additional direct and indirect costs associated with WorkSafeBC claims are experienced through a 10 per cent top-up of the WorkSafeBC benefit payable to employees on claim and in backfilling employees for their missed shifts.

Workers with compensable time loss claims are paid their full net pay by the employer despite the fact that the employer is only reimbursed 90 per cent of net pay by WorkSafeBC. Worker replacement must also be considered as this represents an additional wage that would not be paid if the WorkSafeBC claim were not to have occurred. The average wage rate of employees at these eight employers is $24.27 (HSCIS data Q2, 2012). If we consider an average 7.5 hour shift at this rate and 100 per cent backfilling, this represents an additional cost of approximately $200 per day ($182/day for backfilling and the 10 per cent net pay premium, or $182 x 1.10).

In 2012, the project group experienced an average reduction of five days per claim over 121 total claims. Using this data the five-day decrease resulted in $121,000 in cost reduction ($1,000 per claim) estimated for the 2012 calendar year.

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Further indirect costs of disability (occupational or non-occupational) include: loss of productivity (care), overtime pay, retraining and effects on morale. These have not been quantified within this project.

Sick Leave:

When comparing 2012 against 2010 values for sick time costs, savings were also noted. The project group experienced reductions in sick leave cost per FTE of an average of 4 per cent in the first year (2010 vs. 2011) and 9 per cent in the second (2010 vs. 2012). This equates to an aggregate savings of $108,208 in 2011 and $220,101 in 2012, or $328,309 across the two-year period.

Summary:

Summarizing the above, the key outcomes and successes include the following:

- Projected cost savings of $580,639 in WorkSafeBC assessment costs over two years.
- A 14 per cent (five-day) average reduction in per claim duration and a 14 per cent ($591) average reduction in cost per claim for the project group*. This reduction was noted despite an increase in the CU average of 3 per cent (1 day) in per claim duration and 7 per cent ($267) in per claim cost through the same period (2010-2012).
- Claims values were brought in line with CU averages.
- Related indirect cost savings of $121,000 in 2012 due to the avoidance of net pay and staff replacement costs for WorkSafeBC absences in comparison to 2010.
- Reductions noted in sick time costs of $328,309 in two years
- Combining the estimated annual savings of $327,067 in WorkSafeBC assessment surcharge costs estimated for 2012 in comparison to 2010, $121,000 in 2012 staff replacement costs, and an savings of $220,101 in 2012 sick time costs in comparison to 2010, the estimated annual savings in hard costs while in this pilot project was: **$668,168** for the project group, or an average of **$83,521 per employer**.
- As each employer invested $8,000 per year in this pilot, this represents approximately a ten-fold return on their investment per year. With WorkSafeBC contributing $50,000 per year, the combined cost of the pilot was $114,000 per year, and this represents **more than a five-fold return on the total investment.**
- Enhanced absence and claims management was achieved through transition from medical case management to site-based claims management.
- A tool-kit of resources for staff and managers to assist in navigating DM processes (see appendix B for list of tools and resources) was developed and enhanced.

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- A number of DM focused education sessions were developed and delivered. These were well received with high satisfaction results.
- The autonomy of employers in addressing DM processes was increased.
- There was a positive impact on related early intervention services with HBT under the collective agreements, whereby employee participation rates in EIP increased from 30 per cent to 100 per cent through the implementation of a more efficient referral process.
- Affiliate-specific return to work and stay-at-work tools were developed including documented modified duties sheets and physician and rehabilitation provider packages (see appendix B).
- A detailed and well founded attendance promotion program was developed for use in an affiliate environment. This includes a basic road map for implementation.
- Collaboration with external providers (WorkSafeBC, LTD, HBT, etc.) was enhanced.

* Data provided through WorkSafeBC Business Information & Analysis. Claims costs indicated are paid during the assessed period.

E. Key Findings and Recommendations

Key findings and challenges noted in the pilot project:

- There are limited resources at the employer level to manage ongoing DM programming
- Differing staffing structures and resources at each employer make process implementation challenging
- Limited access to statistical data prevents more comprehensive evaluation
- Small sample sizes make employer specific trending or performance evaluation difficult and present ongoing challenges with acquiring and retaining knowledge and experience
- There is limited sharing of DM experiences and best practice outcomes across employers
- Affiliate employers possess limited opportunities for long-term accommodation.
- Affiliate employers do not yet have access to many of the resources developed elsewhere in their industry and it was noted that their alignment with the larger health authorities actually prevented, or has hindered, access to newly developed initiatives within the WorkSafeBC system that may be of significant assistance (e.g. access to return to work specialists).

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Based on the key findings and challenges, the following recommendations are offered:

WorkSafeBC

- Recognition of long-term care (and other affiliate) employers as employing a significant cohort of employees and as being unique within the health care sector with priority placed on strategic implementation specific to their environment.
- Ongoing efforts should be exercised to increase alignment and improve communication. In order to further improve their own management of workplace injuries, employers would benefit from consistent contact points (e.g. return to work specialists) and collaboration as has been experienced within the health authorities and in industries such as construction.
- Consider cost/return on investment investigation into enhancing claims management in the pending stage. For example, allowing employer access to Nurse Advisor/Return to Work Specialist to assist with more timely return to work planning.
- Continued evaluation of project employers' performance beyond the conclusion of the project. While benefits were noted in applying a "hands on" resource through this two year term, attention should be paid to the durability of these benefits once that resource is removed.
- Conclude development of the health care roadmap (using the construction roadmap as a basis) and make it available to employers.

Employers

- Affiliate employers require ongoing dedicated DM resources. While employers demonstrated the desire and ability to take on accountability for some aspects of DM, specifically within the realm of claims management, the relatively small claims exposure and resulting slow gain in experience within most sites indicates that they require ongoing assistance with more complex disabilities. They also need assistance with the establishment of best practices in relation to policy development and prevention.
- Continue to develop and promote timely return to work/stay at work processes with frontline staff and managers.
- Continue to develop disability cost benefit data. For example, while it is noted that employers began to recognize the importance of an early return to work program using self-funded return to work plans, the return on this investment is not known as the cost of these plans is not readily available. The ability to show an investment return can be a major factor in both establishing senior management support and replicating program success in other facilities. This may in part be achieved via the system recommendation below on leveraging resources.
- Ensure continued senior management support of DM is demonstrated throughout organizations. Efforts to implement change in processes will not occur, or will be significantly hampered, where

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the DM practitioner is not provided with the authority necessary to direct these changes. Further, as each affiliate employer is its own unique entity, additional challenges may be faced in garnering uniform support for group projects in the affiliate environment.

- Implementing effective DM practices requires a shift not only in practice but workplace culture. Further development of DM programming must include education and more robust consultation with injured workers to ensure durability. Focus groups with injured workers, managers and unions would serve this purpose as would further implementation and follow up with DM committees.
- While employers have demonstrated the ability to benefit from an ongoing resource for DM, the durability of these benefits is uncertain without ongoing coordination. The pilot project employers suggested that other employers in the industry be canvassed to determine whether they wish to provide financial support for an ongoing resource.

System

- Explore the leveraging of existing resources, e.g., data collection, call centers, disability management professionals for affiliate employers. These resources are often well established and sophisticated and affiliate employers, with coordination, would benefit from accessing them (although costs may be incurred). This may be particularly of interest to the health authorities as their long-term care sites are part of the same classification unit, and whatever initiatives bring down the cost of the affiliate assessments will have the effect of bringing down the cost of the broader classification unit.
- Consider the establishment of an industry coordinator(s) in DM for affiliate employers. Such a role could address issues that include the following:
    - Variations in knowledge and experience levels between small employers. A coordinator could work collaboratively with the employers to share learning experiences and best practices that otherwise occur intermittently in a small employer.
    - Education and the continuous development of resources and best practices.
    - Understanding policy changes (e.g. By WorkSafeBC) and technical industry processes (e.g. accommodation guidelines or how to secure relief of costs), and develop/maintain effective working relationships with key contacts in the industry.

It is recognized that while this pilot was initiated with the vision to implement a full scope DM Project, the outcome became more focussed in claims management. While challenges were anticipated, the initial deliverables proved overly ambitious and adjustments were made. The focus on claims management provides a foundation for broader DM programs while offering opportunities for skill development through coaching, review and adjustment. This approach has been shown to be effective in other environments and has had success here. Effective DM is not, however, limited to an employer's

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ability to effectively handle claims; further work will be required to build upon these successes and move toward an effective and collaborative DM program. The successes achieved so far can serve as solid building blocks toward larger program goals, resulting in more durable DM development.

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F. Appendices

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2. Tools and Resources

Disability Management Program Resources Binder Table of Contents:

1. DM Program Manual
    a. DM Policy Development Manual
    b. Sample Policy Statement
    c. DM Program Implementation Road Map
    d. DM Program Audit sheet

2. Job Demand Analysis (JDA)
    a. JDA Tool Kit
    b. Sample JDA reports: Care Aide, LPN, RN, etc.
    c. Modified Duties Sheets: RCA, Bath Team RCA, LPN, RN, Cook, Dietary Aide, Housekeeping, Activity Worker (affiliate specific)

3. Employee and Physician Package
    a. DM Program Introduction Package
        i. Employee Letter RTW Program Intro
        ii. Letter to Physician
        iii. Medical Questionnaire
        iv. Physician Recommendation Form
        v. Fee Guide for physician services
    b. WSBC Construction Injury Management Road Map
        i. Modified Work Offer
        ii. Physician and Worker Letter
        iii. Injury Management Road Map

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iv. Guidelines for Modified Work

4. Providing Medical Information Guidelines

5. WSBC Claims Process Information
   a. Claims Overview
   b. Monitoring WSBC Claims Guidelines
   c. WSBC Claims Review and Appeal Guide
   d. Protest Letters
   e. Bill 14 (Mental Health Disorder) Policy Chance Information

6. Gradual Return to Work (GRTW) Tool Kit
   a. Step by Step RTW Handout
   b. Consent for Release of Personal Information
   c. GRTW Planner
   d. Rehabilitation Provider Information Form
   e. Occupational Rehabilitation (O.R. 1/2) Provider Information Form
   f. Sample RTW Program
   g. Selective Light Employment Guidelines
   h. Feedback Forms
   i. Form 7 Reference Guide

7. ICBC Claim Management
   a. Arranging an ICBC GRTW (Step by Step Guideline)
   b. ICBC Reimbursement Agreement

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c. Physician Info Letter – GRTW Plan Required

8. Early Intervention Services (EIS)
   a. Early Intervention Services Referral Guideline
   b. Process Flowchart
   c. Referral Forms

9. Long Term Disability (LTD)
   a. LTD Claims Process Overview
   b. Information for New Claimants (BCNU)

10. Education and Training Materials
    a. Disability Management 101 (PowerPoint)
    b. Form 7 Tips and Tricks (PowerPoint)
    c. Various additional resource materials

11. Attendance Promotion
    a. Attendance Promotion Program Leadership Guide (Program Manual)
    b. Sample: Staff Education Sessions: APP (PowerPoint)
    c. APP Education Leadership or Joint Training (PowerPoint)
    d. Varied Supporting Literature

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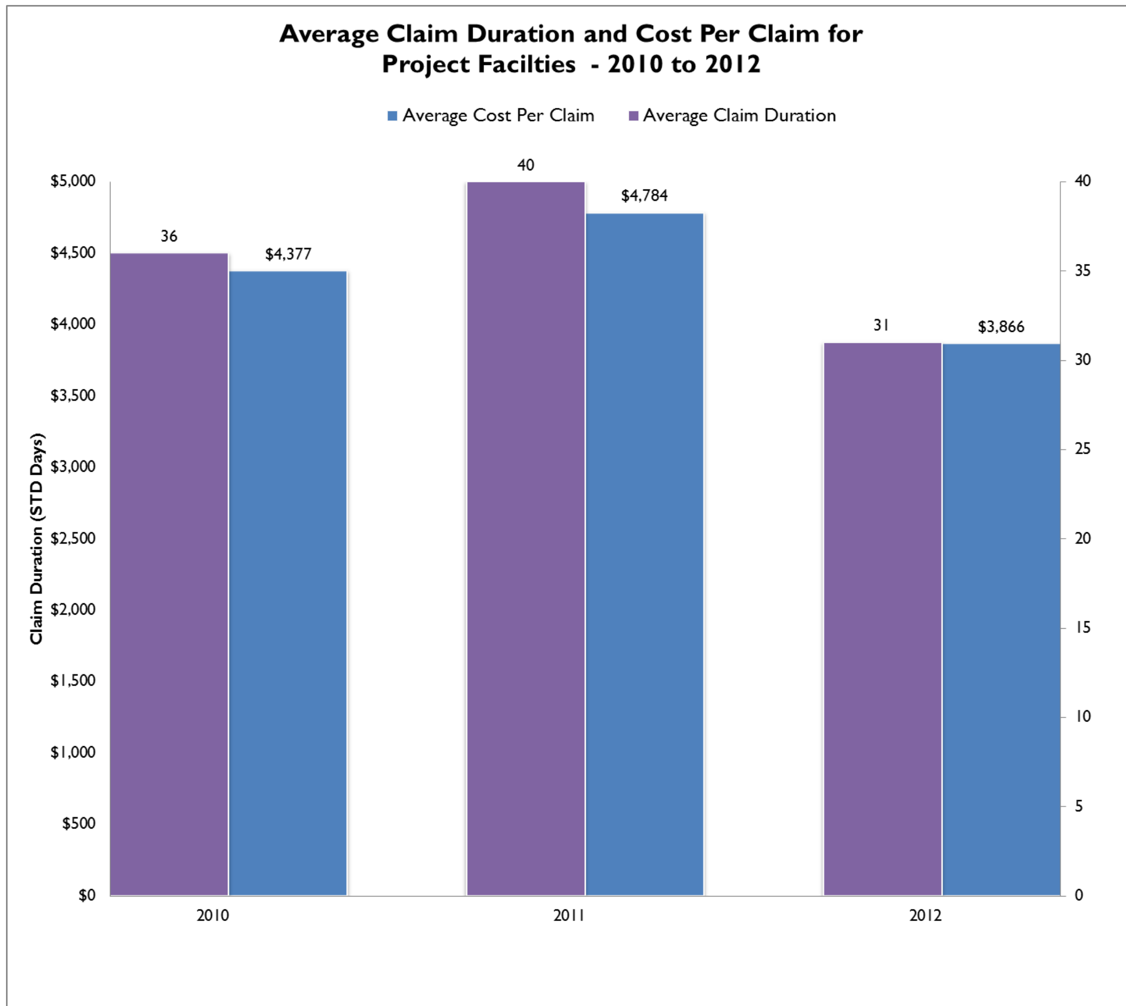
3. Claims Statistics (WorkSafeBC)

Data Sources: BIA Data Mart as of January 2013



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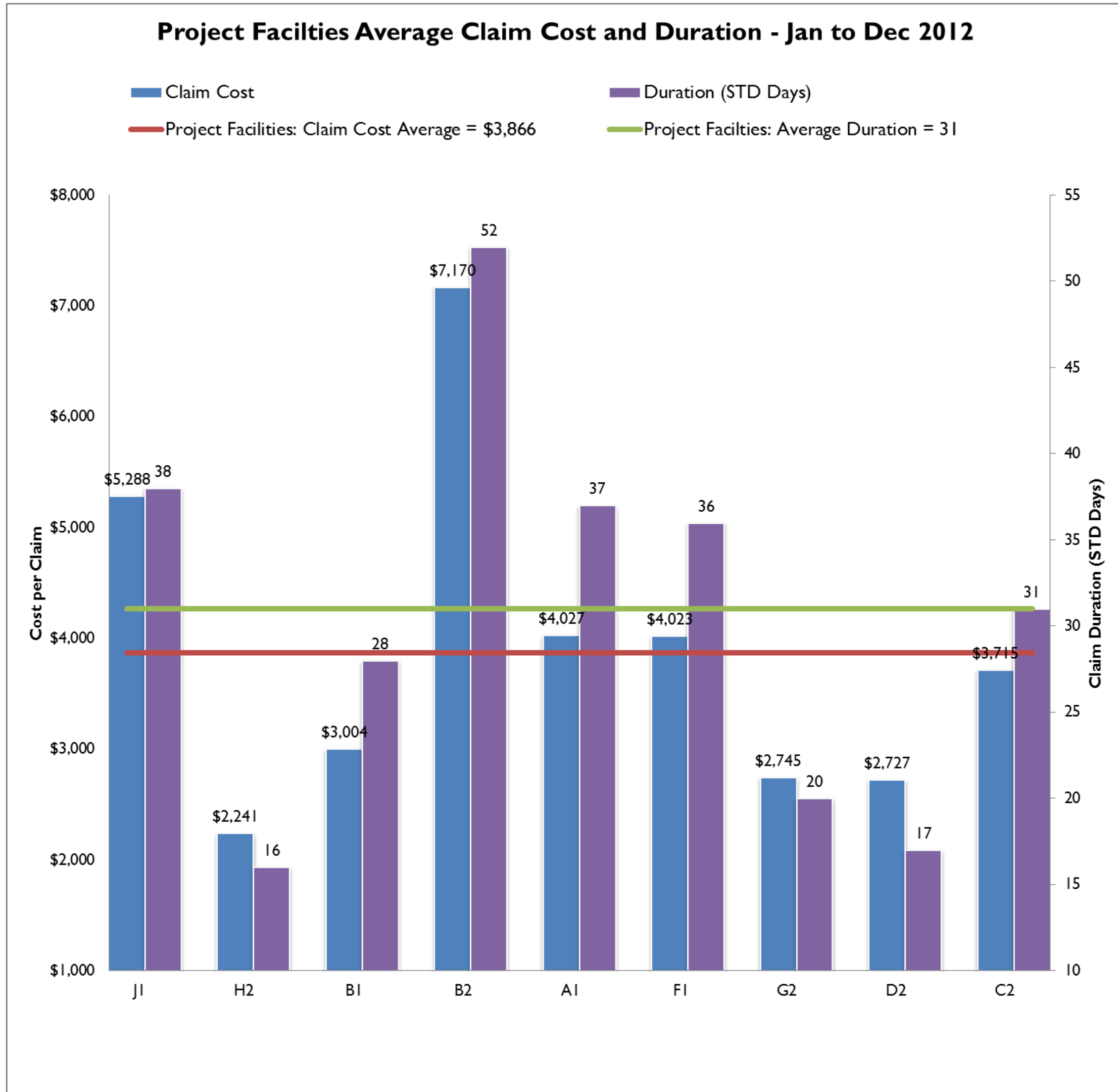

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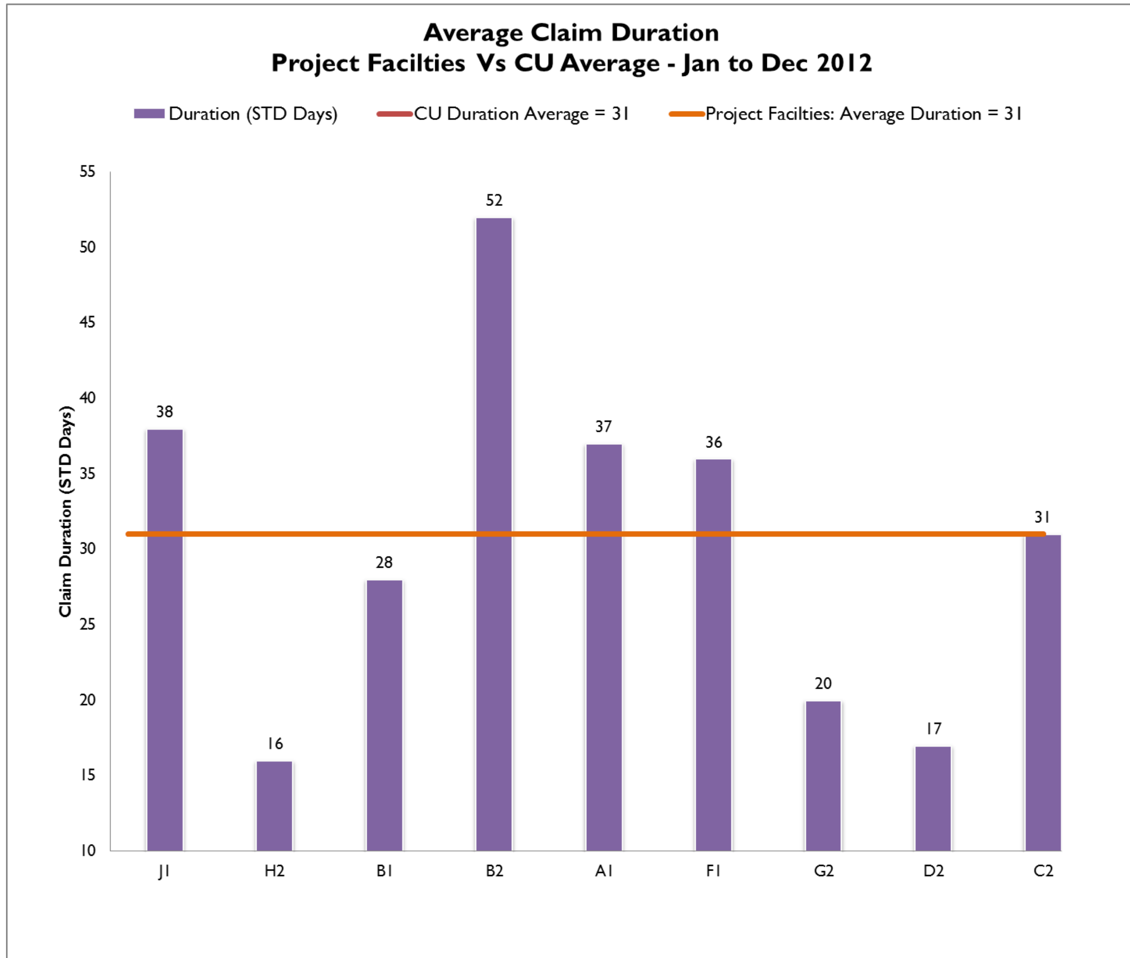

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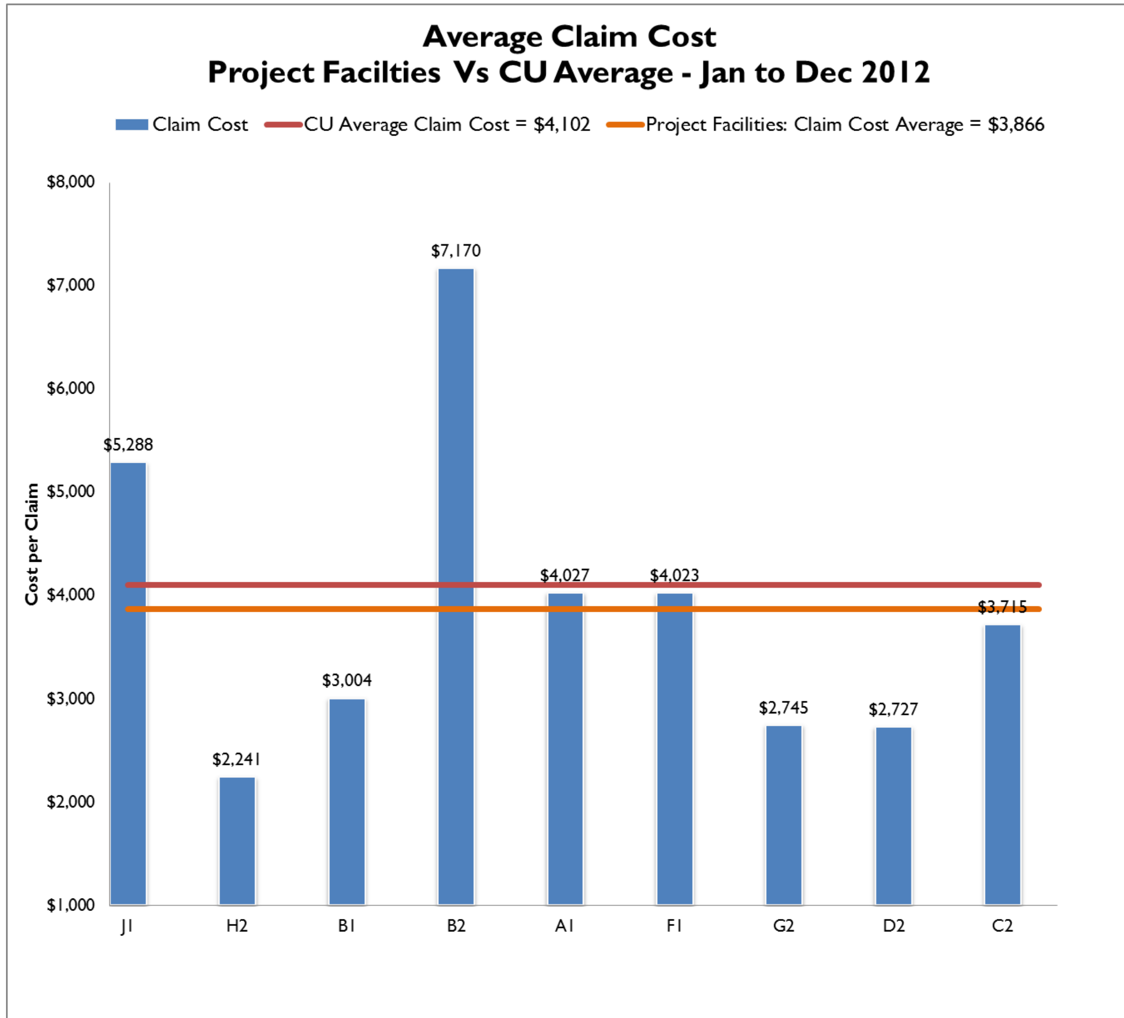

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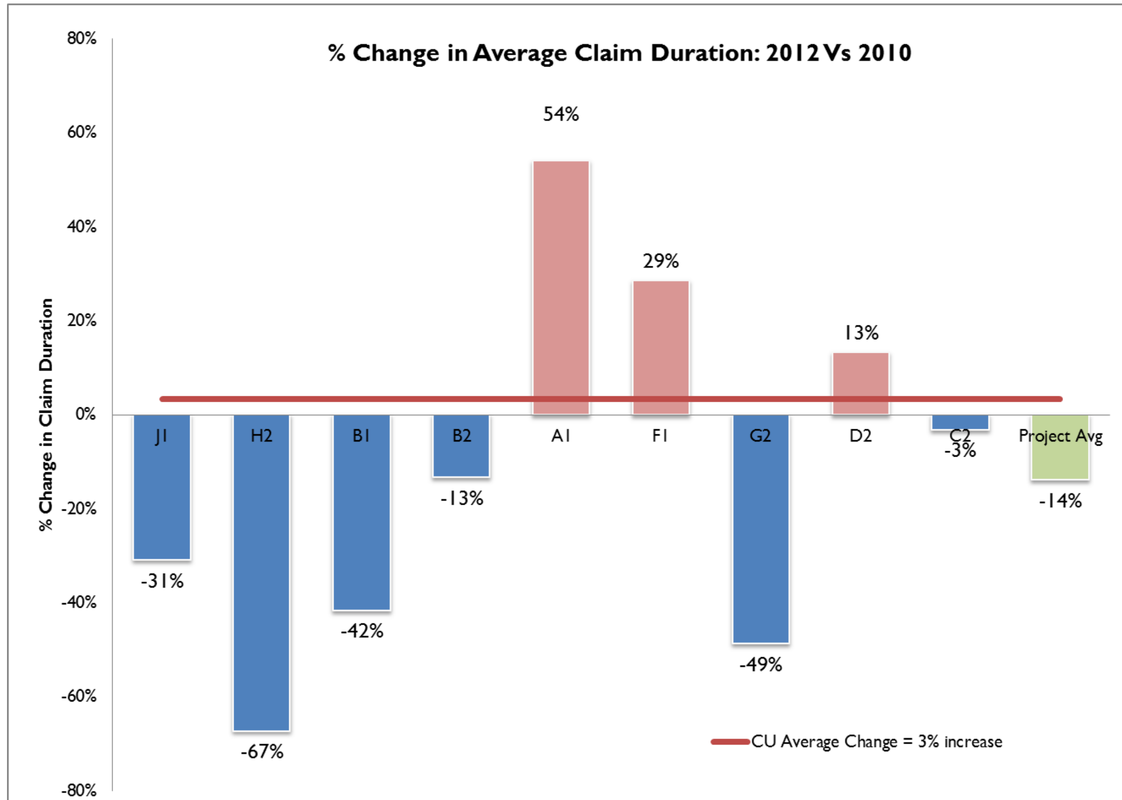

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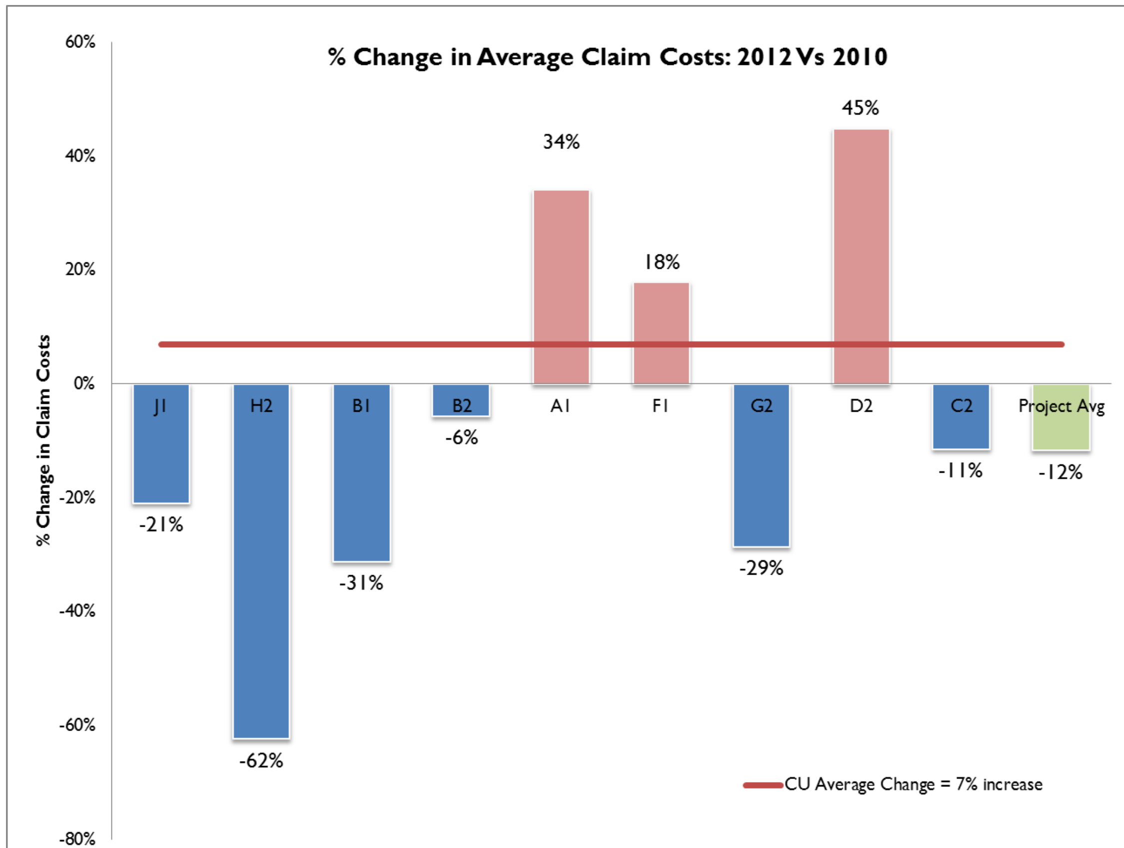

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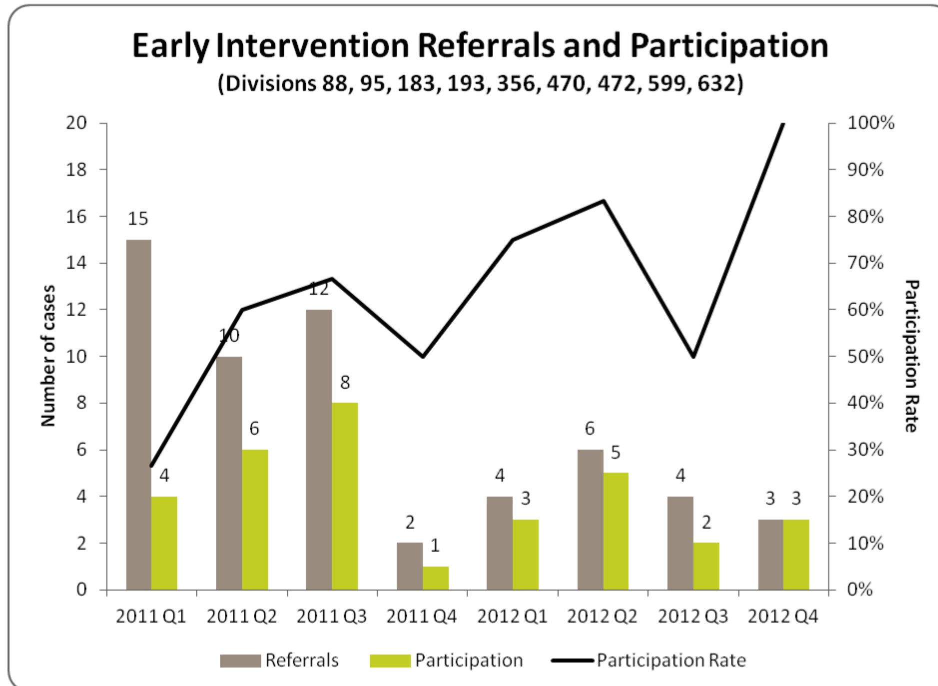
HBT, Early Intervention Services referral Participation rates



4. Reference, Proposals, and Other Related Project Documents

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HEABC
HEALTH EMPLOYERS ASSOCIATION OF BC

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Appendix A

WorkSafeBC

Health and SafetyFunding Application

Disability Management Project

June 22, 2010

HEABC
HEALTH EMPLOYERS
ASSOCIATION OF BC

1. Health and Safety Funding Application

Disability management services for long term care ("LTC") employers.

2. Applicant

Health Employers Association of British Columbia ("HEABC")
#200 – 1333 West Broadway
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V6H 4C6

The Health Employers Association of BC coordinates the human resource and labour relations interests of more than 275 publicly funded health care employers in BC. HEABC represents denominational, proprietary and affiliate health employers, as well as the province's health authorities. These members range in size from organizations with less than 25 employees to large health authorities with thousands of employees.

3. Purpose of Proposal

There are approximately 270 HEABC member employers currently providing health care services in affiliation with the BC Health Authorities. Very few of these "affiliates" have a dedicated human resource function and none have a dedicated disability management resource. Typically, the human resource and OH&S function is the responsibility of someone with another primary role such as payroll, nursing or administration.

From time to time affiliated employers have inquired with HEABC regarding the utility of implementing a comprehensive disability management program to enhance return to work and reduce costs. Disability management programs require an investment in time and resources; however, there is little data available (none in BC health care) to justify the expense of introducing an effective program. Consequently, affiliate employers are not well equipped to rationalize the diversion of funds currently being used for other purposes into disability management.

The purpose of this proposal is to implement a best practice "hands on" disability management program for a group of approximately ten long term care facilities in the Lower Mainland and use the results to demonstrate the potential "return on investment" associated with effective disability management.

The results will be communicated to all HEABC affiliate organizations and used as a tool to encourage improved disability management and cost savings.

4. Background

HEABC has over 100 long term care affiliate members with a total of 3,855 full-time, 4,133 part-time and 7,148 casual employees. These affiliates have limited or non-existent human resources with the expertise to manage their WSBC, LTD, sick leave and duty to accommodate processes. These challenges also hamper their ability to implement injury and illness prevention, as well as claims management processes and programs. The result is that the financial and human capital cost of injury and illness are increasing for these affiliate employers who are also facing potentially reduced funding. Without proper management, illness, injury and disability will increase both in financial and human resources costs. There is increasing pressure on the public healthcare to deliver services to a growing and aging population and this can only be achieved through a healthy and working employee population.

Currently, over 2,600 workers in long term care facilities sustain injuries requiring WorkSafeBC time-loss compensation each year. Long term care/Nurses Aides account for the majority of injuries - estimated around 70%. In addition to the rising occupational injuries, long term care affiliates are also experiencing increased LTD premiums and increased sick leave costs.

Despite various interventions, pilot projects and support from HEABC, HBT, OHSAH and WSBC, affiliate employers are not able to implement comprehensive or sustained injury/illness, disability prevention and claims management systems.

On or around 2002, HEABC was involved in setting up WSBC claims management services for affiliate members with an external company - Reach. This company provided hands on claims management for a fee for service. Some affiliate employers are still using Reach; however, they require a full spectrum of Disability Management services, not just WSBC claims management.

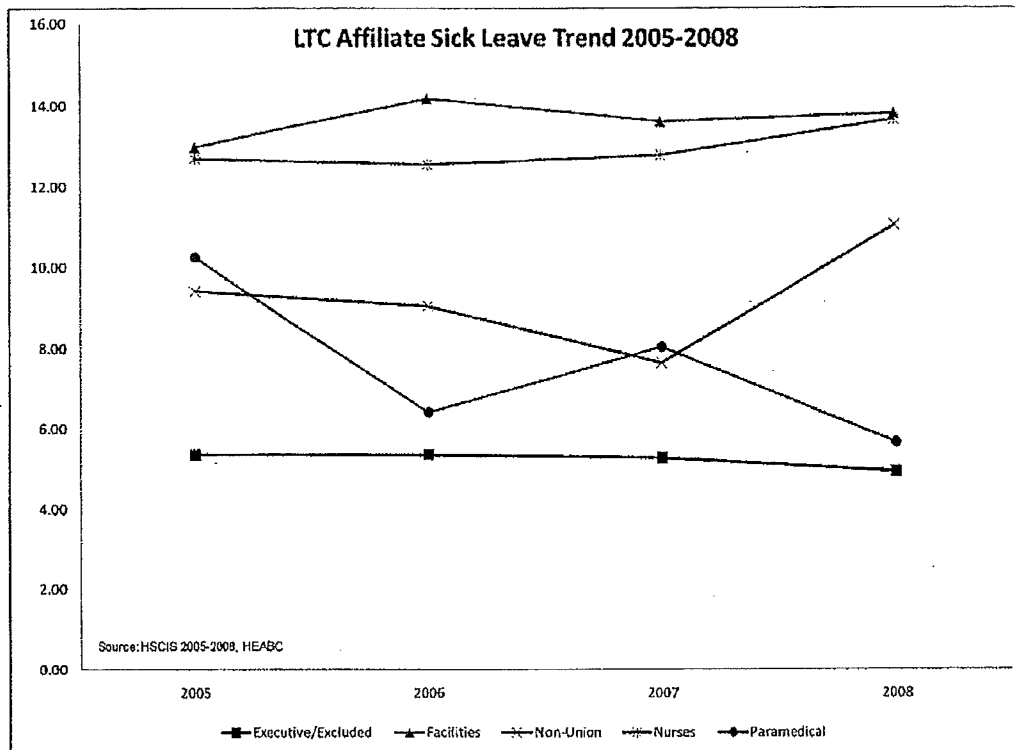
Another initiative was launched in the 2002/3 with WSBC partnering with HEABC to assist Health Care Employers with difficult claims. WSBC provided a dedicated FTE on site at HEABC to take assist all HEABC members with WSBC claims issues. This provided some resources for employers dealing with difficult claims, however, it was not sustainable.

In January 2008 by OHSAH launched the COSHARE project designed to assist 10 affiliate organizations to look at effective ways to build their internal Occupational Health & Safety (OHS) capacity in order to identify and address their own OHS concerns through their Joint Occupational Health & Safety Committees (JOHSCs). In the first year, these JOHSCs worked through eight strategies intended to increase their capacity to respond to occupational health and safety concerns at their workplaces.

Unfortunately, this project was also not sustainable. In the final report, "COSHARE findings demonstrated a need for a distinct resource with OHS expertise capable of implementing and managing health and wellness initiatives in affiliate organizations. COSHARE evaluation results suggest that:

- The COSHARE strategies were somewhat effective in building JOHSC capacity (knowledge) to recognize OHS needs and find a resource for assistance (typically COSHARE staff).
- In most cases, the strategies were not effective in building JOHSC capacity to effectively share or apply information in a meaningful way due to limited resources at the local level capable of continuously managing the program(s).
- Availability of information is not the primary barrier to answering OHS questions the organizations encounter.
- Provision of education and information alone does not necessarily facilitate implementation.
- Further exploration is required to identify and address the barriers to bridging the gap between having OHS knowledge and applying it effectively.

In HEABC's view one of the most critical factors for successful disability management is to identify someone within the workplace, with the necessary skills, to be responsible for disability management and return-to-work. A shared claims and disability management program with fully-integrated claims management systems, staffed with skilled disability and return-to-work expertise, could provide these affiliate employers with sustainable disability management programs that would reduce some of the human and financial costs.



5. The Program

This disability management program is designed to improve disability claims processes within each of the participating employers with a goal to reduce number of claims and duration of claims. The disability advisor will be available to each of the participating employers on site and will take on the role of monitoring all claims. This will include regular contact with insurance carriers to ensure every opportunity for early safe return to work is assessed during recovery. It will also include continuous follow up until the employee returns to work or claim is finalized. The disability advisor will ensure that the insurance carriers are provided with the employer's early safe return to work programs. As part of the process injured employees will be required to take a functional abilities form to their physician who can authorize participation in a modified work plan.

Claims Process:

- Injured employee completes employee incident report form
- Injured employee goes off work and takes functional abilities form to their physician
- Employer completes form 7 and faxes employee incident report and Form 7 to disability advisor
- Employer completes an accident investigation with injured employee

- Employer faxes outcome to disability advisor
- Disability advisor initiates file, enter data and manages claim until RTW or claim finalized

The disability advisor will complete referrals to the Enhanced Disability Management Program and be the contact on behalf of the participating employers. He/she will also assist the participating employers with the LTD application process and manage the LTD claims ensuring that opportunities for early safe return to work are carried out. The disability advisor will also be responsible for managing all duty to accommodate requests by following all necessary steps up to and including undue hardship.

The disability advisor will meet monthly with each of the participating employer's managers group to review all employees attendance. Attendance records are reviewed to identify those employees whose absenteeism may be a concern. A plan may be developed for the department manager to address the absenteeism.

This Disability Management Program will provide the following services:

1. Coordination and delivery of return to work programs
2. WSBC/LTD claims management
3. Cooperating with external providers (OHSAH, WSBC, HBT, etc.) to provide employers with a comprehensive menu of services related to disability management
4. Assistance with duty to accommodate requests
5. Attendance promotion education; and program evaluation

The target audience is small to medium sized long term care facilities in the Lower Mainland area employing 30 to 100 employees. Most employees are involved in physical work either as Care Aides or in food service, housekeeping or maintenance. Most injuries are MSI's.

Our intention is to include approximately ten LTC employers in the trial. Thus far, without the benefit of a funding subsidy, six LTC employers have expressed some interest. With a subsidy reducing the per employer cost, we expect more employers will be interested in participating.

6. Proposed Workplan

Key Activities/Deliverables	Time Frame
1. Draft business plan	Completed
2. Review business plan with employers and identify	In progress

	employers willing to be part of pilot group	
3.	Develop a plan for data tracking	In progress
4.	Develop a plan for employers to complete the preliminary steps in implementing the one year pilot disability management program to ensure there is commitment and support for the program. This would include the development of policies and procedures	TBD
5.	Hire consultant to deliver agreed upon services	TBD
6.	Develop an evaluation tool to track progress / cost savings / improvements	TBD

7. Consultation with Stakeholders

HEABC has been working closely with two Lower Mainland LTC facilities since January 2010 to discuss the concept and develop a business plan. The concept has also been presented to the Vancouver Association of Long Term Care Administrators. Many LTC facilities expressed interest, however, most had concerns re the potential cost. Six indicated they are sufficiently interested to pursue further discussion. Others indicated they may be interested if the cost was less than the proposed approximate cost of $10,000 per facility per year.

8. Funding

HEABC is not seeking full funding for this project. We believe it is important for employers to make a financial investment in disability management to ensure

buy-in and follow-through. We are proposing that WorkSafeBC subsidize the project for a two year period to reduce the cost per employer and encourage participation.

Initial discussions with employers were based on each of ten employers contributing approximately $10,000 for a one year project to cover the cost of the disability management advisor. Six employers expressed interest and are "on board" although some have indicated a concern regarding the cost. Others expressed interest in the project but found the cost to be prohibitive.

We have concluded that a one year period is not sufficient for the project to be properly implemented and produce meaningful data. Two years is more appropriate.

HEABC
HEALTH EMPLOYERS ASSOCIATION OF BC

Consequently, we are proposing a 24 month project with an annual employer contribution of approximately $5,000 -$6,000 per year and with this funding matched by WorkSafeBC; i.e. a total annual contribution of $50,000 - $60,000 by employers and the same amount contributed for each of the two years by WorkSafeBC. We expect that by lowering the annual employer contribution amount ten employers will agree to participate.

9. Project/Program Evaluation Plan

A comprehensive data base will be developed to track injury statistics to assess the status of the program.

10. Deliverables

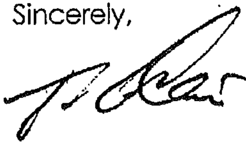
a) Introduction of a "best practice" disability management program at each of the participating employers.
b) Provision of a shared "hands on" disability management specialist available to work with employers and employees individually to carry out the function described in Part 5 above.
c) Comprehensive metrics and evaluation tool to track progress.
d) Regular status reports in accordance with WorkSafeBC requirements.
e) Comprehensive evaluation report after 12 months and 24 months of program implementation in accordance with WorkSafeBC requirements.
f) Development of a plan to communicate the project results to HEABC affiliate member organizations.

11. Intent to Sign WorkSafeBC Contract

HEABC is willing to sign an appropriate contract with WorkSafeBC for this project.

Respectfully submitted on behalf of HEABC.

Sincerely,



Tony Collins
Vice President, Affiliate Services