

# Individual DM Interventions, Supports and Incentives

IFDM 2010

A Comprehensive Societal Disability  
Management Strategy

Tuesday 21<sup>st</sup> September

# Context

- DM Excellence Initiative
- VCH - IDMSC Consensus Based DM Audit
- LTD Disability Costs Rising
- DM externalized to a 3<sup>rd</sup> Party (3 parties involved)
- Relevant recommendations
  - Integrate the varied and sometimes ‘maze-like’ program approaches and policies into a clearly communicated and unified process to support employees with disabilities in returning to work,
  - Review and revamp current early intervention strategies,
  - Move from an externally based DM process with an insurer to an internal bipartite process managed by the employer and conduct a cost-benefit analysis to evaluate its effectiveness

# Early Intervention & Rehabilitation Program Values

- Employee centered: focus on maintaining connection with the employer
- Employer driven: employer to maintain employee contact and lead case management
- Union participation: partnership with the union to develop and manage the program

# Response

- Negotiated a letter of understanding with the union to re-design the Disability Management program
- Pilot Project - A problem solving approach
- Create a dialogue that makes sense to employees
- RTW processes that build trust

# Ingredients

- Agreements on data collection & sharing
- Voluntary participation by employees
- Measurement of employee satisfaction
- VCH to assume responsibility for rehabilitation and return to work
- VCH to work directly with its insurer
- Joint Union-Management Committee

# DM Action Research

- Aims: To document –
  - The issues, challenges and things that work when internalising DM into an organization,
  - The outcomes, impact and implications of an internalised DM system after 12 months.
- Internal Action Researchers
- External Action Researcher
- Project Team

# The Role of the Internal Action Researchers

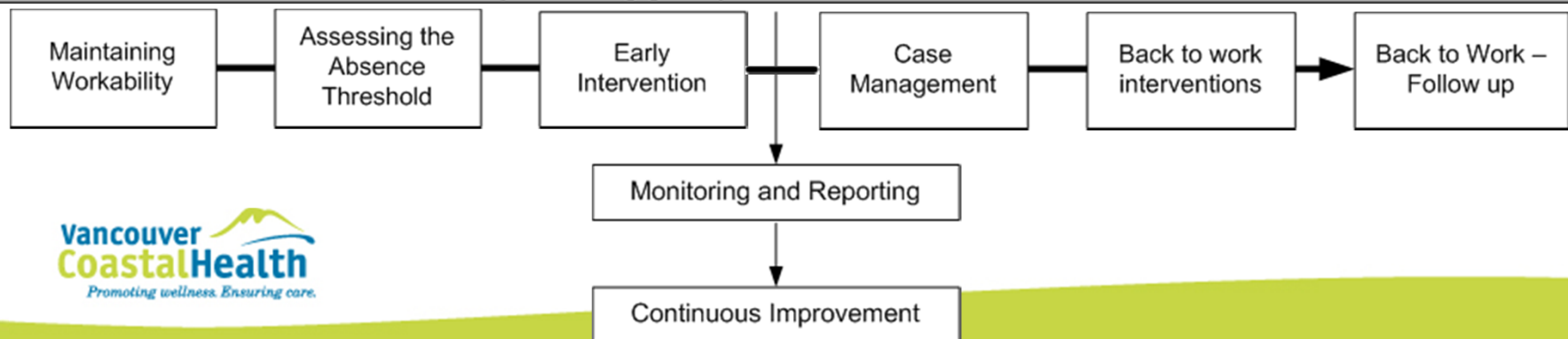
- The main responsibilities of the IARCs include:
  - Leading the organizational change project
  - Developing and documenting an initial action plan
  - Recording their views of the results, implications and impact of the implementation of the change plan using an Action Research Journal,
  - Reviewing and revising the action plan based on their experiences and the data they have collected,
  - Acting as members of the PCT,
  - Contributing to the production of the final report.

# The Primary Axes of an Organisational DM Strategy

## Implementing organisational change



## Implementing good practice at the individual level



# The Key Individual Level DM Processes

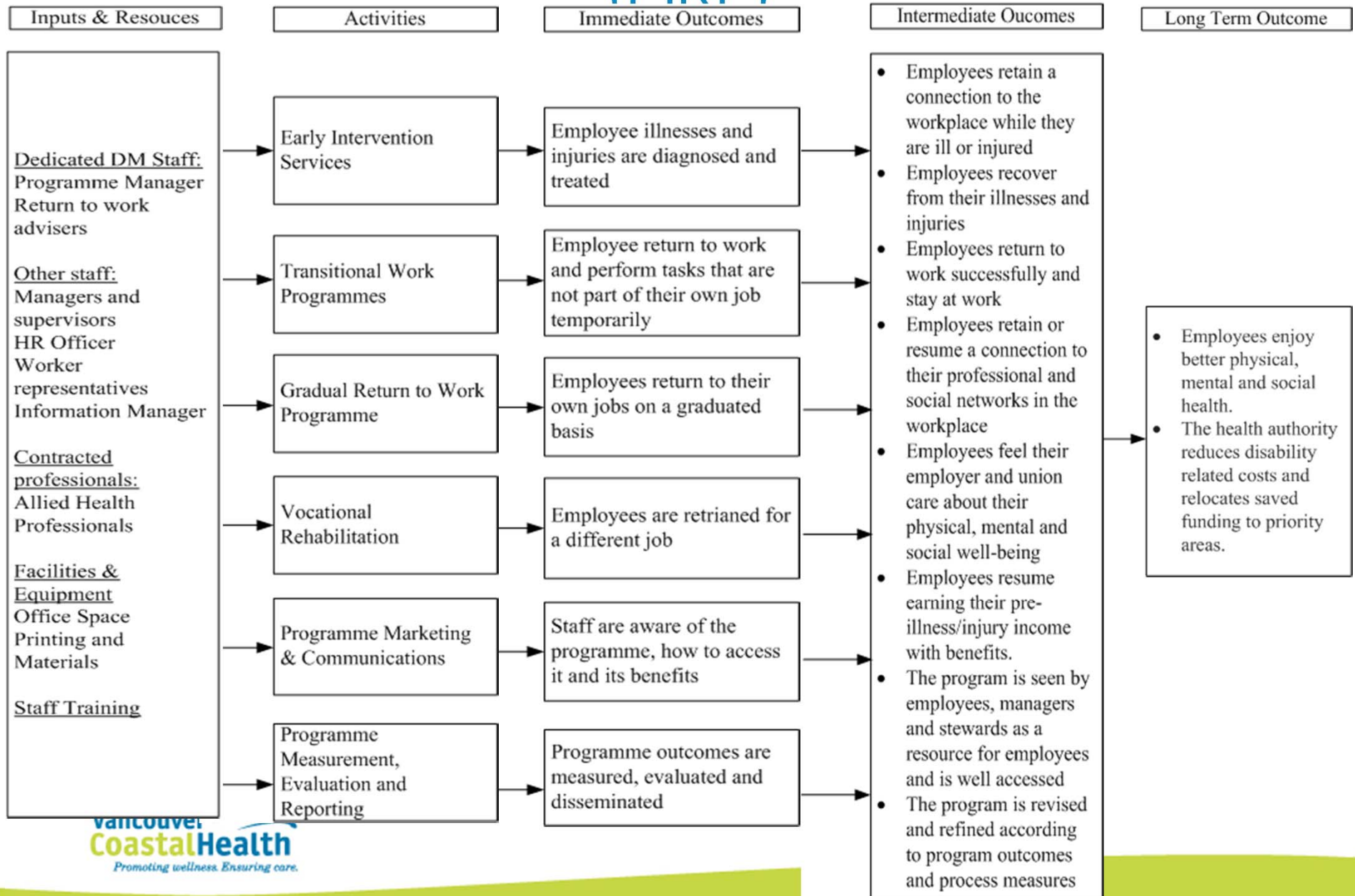
- Early intervention, assessment and referral to appropriate services
- Engagement with the treatment process
- The opportunity for mediation between the absent worker and the organisation
- Access to a person to advocate for the worker with medical professionals, the supervisor or family where required
- The right to a customised and flexible Individual Return to Work plan for the absent worker
- The provision of stable and appropriately individualized, supported accommodations and adjustments

# The Key Individual Level DM Processes

- Measures for a gradual resumption of work
- An active case management system for overseeing the reintegration process
- Opportunities for ill/injured workers to build their capacity through retraining
- Opportunities to obtain experience in an alternative, transitional work position
- Use of technical support and advice
- Role integration between internal actors including HR, Line Management, Occupational Health and external providers

# The Early Intervention and Rehabilitation Program

## (FIRP)



# Pilot Project Union Demographics

## Pilot Project Union Profile

Number of Members (Excluding Casuals) – 4,415

Average Age: 46

Clinical Areas: 70% Acute  
22 % Residential  
8% Community

%Male: 10

% by Age Category

20 - 30: 16%

31 – 40: 27%

41 – 50: 26%

51 – 60: 26%

>61: 5%

## EIRP Participant Profile

Number of Participants - 344

Average Age: 45

Clinical Areas: 70% Acute  
18 % Residential  
12% Community

% Male: 10

% Referrals by Age Category

20 - 30: 13%

31 – 40: 21%

41 – 50: 25%

51 – 60: 32%

>61: 9%

***75% of all Referrals non-work related illness/ injury***

# Case Studies

- Pre-EIRP
- EIRP

# Summary Differences in Case Studies

Pre vs. Post EIRP:

- **DM Advisor:**

- knew reasons for absence and was able to make informed determination of RTW date
- Advisor worked directly with employee, union and manager and was able to plan for change within the workplace

- **Employee:**

- Felt listened to, attached to the workplace, and an active participant in planning, and consistent messaging

- **Union:**

- Had a good raps of what was happening throughout medical absence
- Able to reassure member regarding departmental changes and how they would impact her

# Challenges to effective RTW

- Access to appropriate services and assessment
- Previous history of absence
- Inappropriate initial plan
- Pre-absence work record
- Reservations of manager
- Employee difficulty in progressing to full time return to work
- The presence of another health condition
- Employee not wishing to participate
- Intervening while the person was back at work

# Things that worked best

- Graduated RTW
- Accommodation of disabled employees into their own jobs
- Time - Extending the GRTW (several cycles)
- Communication with Employee
- Access to internal resources
- Early intervention
- Face to Face meetings with manager and employee