

INNOVATIVE DISABILITY
MANAGEMENT
MANAGING RESOURCE DEPLETION
THROUGH TEAM DIVERSITY AND
COLLABORATION

Ann-Marie Kehoe, MA, BSc (Kin), Dip DM

Developing/Improving DM Program

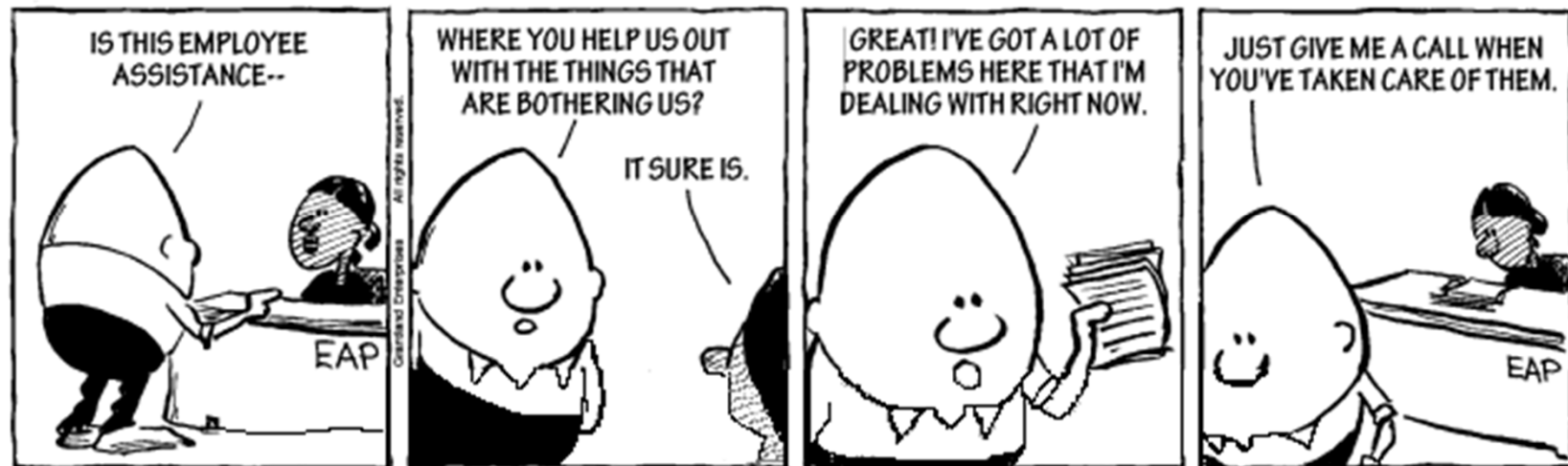
- Set guiding principles
- Set boundaries
- Leverage diversity
 - ▣ within DM team
 - ▣ Human resource colleagues, rehabilitation providers, insurer
- Sustainability plan
- Use experts for high level tasks



Change Management

□ Culture shift

- “Do on own” vs. “Do for”
- “When return to work” vs. “If return to work”
- Increase manager independence and manager/employee communication

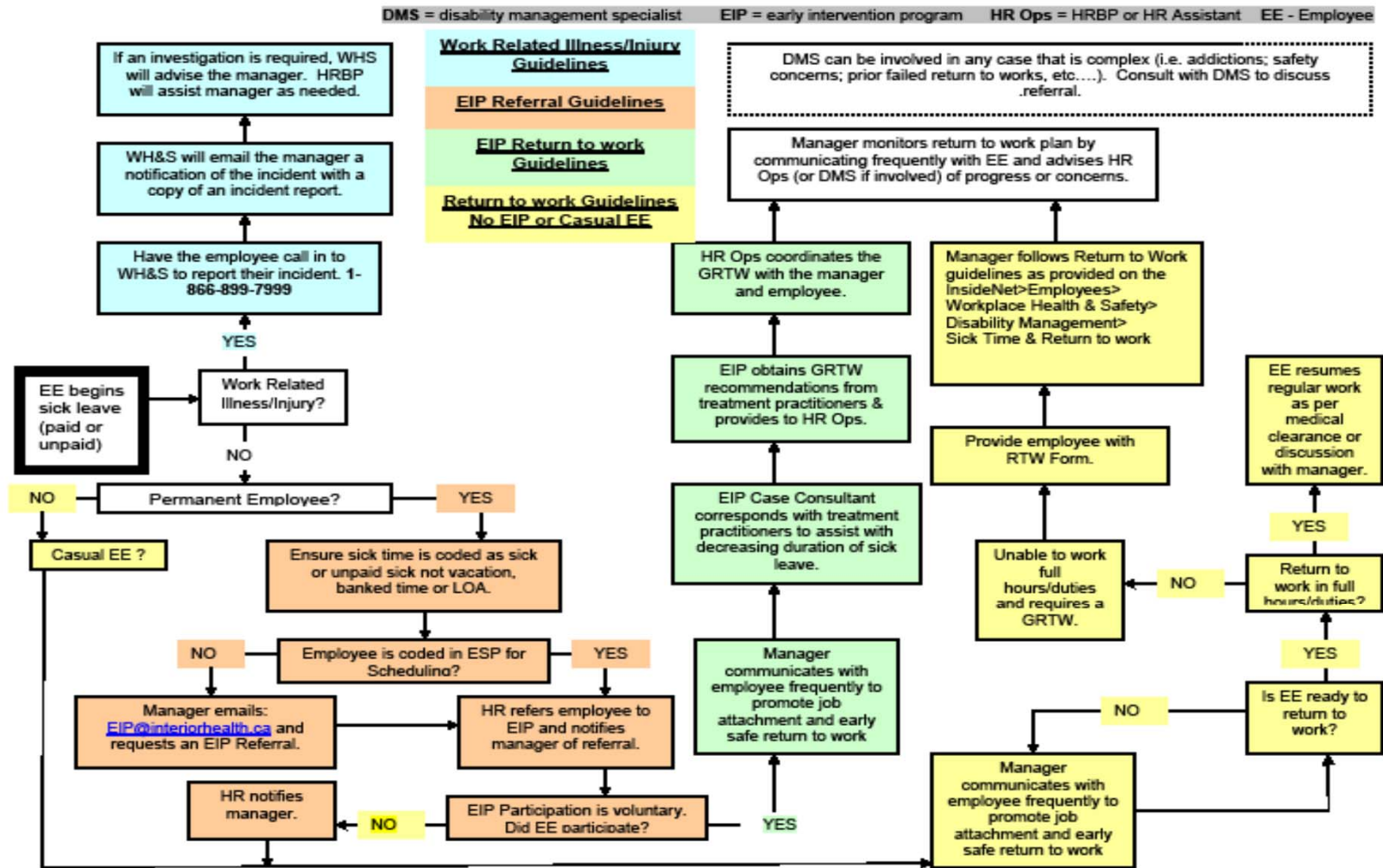


Solutions/Tools



- Dynamic Knowledge of DM Program
 - ▣ Manager education sessions (virtual)
 - ▣ Forms, process maps, tip of the month, FAQ
 - ▣ Website (24/7 access, one-stop shop)
 - ▣ Availability for support (one point of contact)
- Offer of DM support letters
- RTW (sick leave) form
- Tapping into outside expertise & sharing between employers

Frontline Guidance/Standardize



RTW and Function Focused

1. The patient requires temporary duty/hours modification from: _____ / _____ / _____ to _____ / _____ / _____
Year Month Day Year Month Day

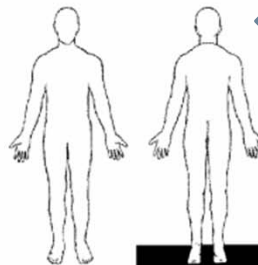
2. Circle appropriate category and location to provide the general nature of the patient's illness or injury? (Diagnosis not required).

Musculoskeletal

Systemic Disorder

Cognitive Impairment

Other: _____



Front

Back

Nature of Illness

3. Is the prescribed treatment/therapy likely to impair performance or safety? Yes No

4. Are there any other complicating factors that may interfere with this return-to-work? Yes No
 If yes, please provide details.

Return to Work

5. Please indicate/circle all functional restrictions the employer should be aware of during a return to work plan.

Example of Functional Restrictions

Lifting (kg)	No more than:	5	10	20	Walking	No more than _____
Carrying (kg)	No more than:	5	10	20	Bending	No more than _____
Pushing (kg)	No more than:	5	10	20	Kneeling/Squatting	No more than _____
Pulling (kg)	No more than:	5	10	20	Climbing Stairs/Ladder	2-3 steps at a time

**Restrictions
Limitations**

Example Return to Work Plan			
Week/Set 1	4 hour shifts, 3 shifts per week/set with day off in between	No	Over 5kg
		No	Shoulder reach
Week/Set 2	6 hour shifts, 5 shifts per week/set	No	Over 10kg
		Abd	Shoulder Reach as tolerated only
Week/Set 3	Resume Regular Work	No	

The below details will be reviewed by the manager/supervisor to determine if a temporary individual/modified return to work plan can be supported.

Week/Set	Max. Hours per Shift/Day; Max. Shifts per Week; Minimal time off interval bit shifts	Functional Restrictions/Comments

** It is anticipated the patient/employee will be able to resume regular hours/duties by the last week of the above plan.*

6. The patient/employee is cleared to start the above plan on _____ / _____ / _____
Year Month Day

Comments:

Using Resources for Development

TO BE COMPLETED BY THE TREATING PRACTITIONER

The following information will assist Interior Health determine this employee's request for medical accommodation as it pertains to their stated disease that impacts their ability to work the full duties of their position with Interior Health.

History of respiratory disease Asthma Eczema Rhinitis Sinusitis COPD
 Co-morbidity acid-reflux Other: _____

If asthma diagnosis, please describe typical symptoms? (please check any/all that apply)	
<input type="checkbox"/>	shortness of breath with exertion
<input type="checkbox"/>	wheezing
<input type="checkbox"/>	coughing
<input type="checkbox"/>	chest tightness
<input type="checkbox"/>	exercise limitations

Method of asthma diagnosis (please check all/any that apply)	
<input type="checkbox"/>	spirometry testing
<input type="checkbox"/>	methacholine challenge testing
<input type="checkbox"/>	challenge with inhaled corticosteroid or oral prednisone
<input type="checkbox"/>	consult with respirologist or allergist
<input type="checkbox"/>	referral for asthma assessment date

Has Allergy skin testing been done? YES Date: _____ NO
 If testing was positive, list allergens/food allergies: _____

Triggers/Triggers (check all/any that apply)

Allergens		Other Triggers	
<input type="checkbox"/>	animals and dander	<input type="checkbox"/>	air pollution
<input type="checkbox"/>	pollens	<input type="checkbox"/>	wood stove smoke
<input type="checkbox"/>	moulds	<input type="checkbox"/>	exercise
<input type="checkbox"/>	smoke	<input type="checkbox"/>	temperature change
<input type="checkbox"/>	dust/mites	<input type="checkbox"/>	medications such as ASA and beta blockers
<input type="checkbox"/>	others _____	<input type="checkbox"/>	emotional stress
Work		<input type="checkbox"/>	reflux
<input type="checkbox"/>	paints/solvents	<input type="checkbox"/>	others _____
<input type="checkbox"/>	odors examples _____	Respiratory infections	
<input type="checkbox"/>	chemical irritant	<input type="checkbox"/>	cold infections

Has your patient required emergency treatment for asthma in the past year?
 YES, please outline frequency and nature of same _____
 NO UNKNOWN

Does your patient currently smoke tobacco or marijuana? YES NO UNKNOWN

Is your patient exposed to 2nd hand smoke at home? YES NO UNKNOWN

Does your patient have a wood burning stove or fireplace in his/her home environment? YES NO UNKNOWN

In your opinion, is the disease controlled? YES NO

If YES, what is the treatment plan and action plan (e.g. medications, daily maintenance or exposure control)

Would your patient's condition be managed with the use of the following in her work environment? Please check all that apply:

<input type="checkbox"/>	Hepa Filter (or other personal space air filter)	<input type="checkbox"/>	Wearing gloves at all times
<input type="checkbox"/>	Personal Protective Equipment (face mask, filtered respirator, etc...)	<input type="checkbox"/>	Regular use of hand sanitizer
<input type="checkbox"/>	Other: _____		

Is your patient compliant with the prescribed treatment in order to reduce their reactions to stated triggers in their personal and work life?

YES NO Please comment _____

If no, would referral to an asthma specialist be helpful? YES NO

Please advise if there are referrals or supports that the employer could consider assisting your patient to access (e.g. expedited referral to a specialist):

Please comment on your patient's prognosis for improvement and provide a time frame if possible.

Please describe any functional limitations your patient has as it relates to their work and their activities of daily living and how these are impacted by their diagnosis and resulting symptoms. Please include a discussion about the direct correlation between their diagnosis, symptoms and functional limitations.

Benefits/Outcomes

- Standardization
- Collaboration
- Efficient use of resources
- Management participation
- Clearer roles/boundaries

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"I'm forming a committee to create a task force to choose a team leader to assemble a board to hire the best people to determine the fastest way to deal with the problem."

Benefits/Outcomes

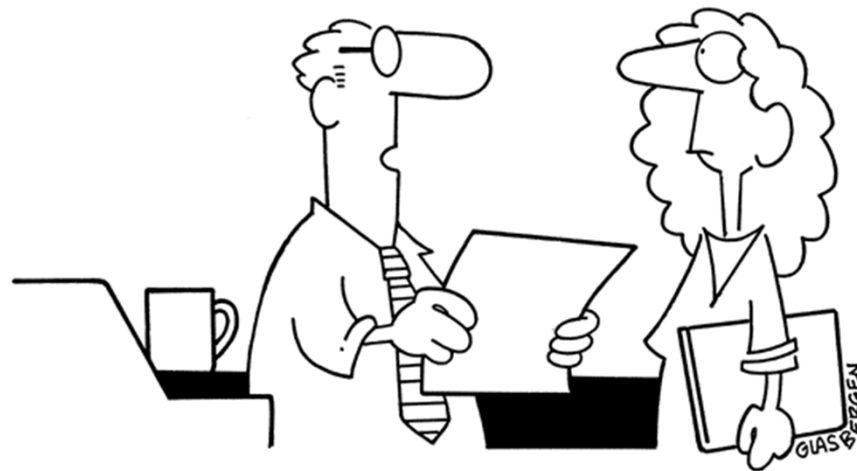


- ❑ Elimination of duplication
- ❑ Reduced sick time
- ❑ Timely return to work
- ❑ Encourage early job attachment
- ❑ Financial advantage of fewer DM staff

Questions

- Also available by email at annmarie.kehoe@gmail.com
- www.disabilitymanagement.wordpress.com

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“New safety regulations won’t allow us to think outside of the box anymore because boxes have sharp corners.”