Disability Management Practice Standard

Version #1

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RECOGNITION

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INTRODUCTION

Disability management is a risk management approach designed to:

- manage employee medical absenteeism and the related costs;
- identifying reasons for medical absences through data collection and trend analysis;
- preventing employee illness/injuries;
- ultimately improve employee health status and quality of life;
- contain/decrease disability-related and replacement costs;
- uphold legal requirements; and
- increase time at work, productivity, employee satisfaction, and perceived fairness.

Disability management is a management function. A Disability Management Program is a risk management tool that enables an organization to prevent and mitigate workplace illness or injury absences. This approach uses prevention, early intervention, claim management, case management, and graduated return-to-work interventions. Today, many organizations use an Integrated Disability Management Program approach¹ to respond to and reduce, the rising physical, psychological, social, and economic costs of disabilities, as well as to contribute to organizational success.

Occupational Health Nurses (OHNs) are competent practitioners capable of overseeing pro-active Disability Management Programs. This Disability Management Practice Standard is designed to serve as a practice standard. Unlike disability guidelines which advise on expected length of absences for various illnesses or injuries, this practice standard or code of practice outlines the disability management “nursing best practice” strategies that are evidenced based, and the steps that the COHNA expects OHNs to uphold.

Practice standards are stated approaches to care and practice based on recognized and accepted principles of clinical practice for planned processes, such as disability case management. They form the guidelines and rules for the practice, provide the boundaries for the practice activity, clarify stakeholder roles and responsibilities, and serve as a practice benchmark. Practice standards are beneficial because they:

- promote a consistent approach to case management;
- provide meaningful direction to the practice in question; and
- promote effectiveness and efficiency of practice through a reduction of errors, complications, and costs.

To remain current and credible, practice standards must be regularly reviewed and updated.

This document contains the:

1. Disability Case Management Standard of Practice;
2. Disability Management: Regional Differences;

¹ An Integrated Disability Management Program is a planned and coordinated approach to facilitate and manage employee health and productivity. It is a human resource risk management and risk communication approach designed to integrate all organizational/company programs and resources to minimize or reduce the losses and costs associated with employee medical absence regardless of the nature of those disabilities.

3. OHNs: Unique Role in Disability Management; and
4. Disability Management: Nursing Best Practices.

These materials are presented in this manner so that the reader gains a working understanding of the COHNA Disability Case Management Standard of Practice; how disability management practices differ throughout Canada as a result of the various pieces of legislation; why OHNs are competent at providing a unique role in disability management; and the related “nursing best practices” in disability management.

DISABILITY CASE MANAGEMENT STANDARD OF PRACTICE

Companies and the professionals involved in disability management should provide a planned approach to remove barriers so that employees can return to work in a timely manner without risk to their health or to the health of others. The purpose of this standard of practice is to provide guidelines for disability case management.

Disability Case Management

Definition

Disability case management is a collaborative process for assessing, planning, implementing, coordinating, monitoring, and evaluating the options and services available to meet an individual’s health needs through communication and accessible resources to promote quality, cost-effective outcomes. Case management promotes:

- safe and timely return-to-work efforts;
- early identification of disability claims for services and coordination of services, such as early intervention;
- maintaining contact with disabled employees;
- developing and monitoring modified/alternate work opportunities; and
- coordinating issues with the insurer and arranging for vocational rehabilitation when required.

Goal

Disability case management is intended to assist ill and injured employees in reaching the highest level of medical improvement possible and to facilitate a return to work in the most cost-effective manner. The Disability Case Manager is the navigator of the process.

Disability Case Managers

As Disability Case Managers, OHNs must ensure that appropriate rehabilitative care is underway with the employee, and that the goal from the onset of the injury/illness, is to return the employee to

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productive work in a safe and timely manner. “Successful (disability) case management requires skills in communication, diplomacy, and relationship-building, as well as in planning, coordinating, and evaluating the rehabilitation plan.”

Qualifications

The qualifications necessary to competently perform as a Disability Case Manager are, but not limited to:

- Maintenance of current professional licensure.
- Completion of occupational health nursing certificate.
- Completion of specific training and experience in the health needs of the population to be served.
- Demonstration of knowledge of disability management, occupational health, organizational behaviour, employee group benefits plans, the Canadian workers’ compensation system, public health services, and community health care services.
- Maintenance of continuing education appropriate to disability case management and professional licensure.
- Maintenance of case management certification. Certifications that are equivalent to case management certification (CCM) that is offered in the United States include the Canadian occupational health nurse certification (COHN). Other acceptable credentials are the Certified Disability Management Professional (CDMP) and university diplomas/degrees in Disability Management.

Role of Disability Case Manager

In the field of Disability Management, OHNs often assume a variety of roles – the Disability Management Program Manager, Disability Case Manager, Occupational Health Technical Specialist, etc. To accomplish this, the OHN uses good business management practices coupled with emergency, medical, nursing, occupational health, and disability management knowledge and skills.

The OHN, as a Disability Case Manager:

- initiates and maintains contact with injured/ill employees, health professionals, the insurance carrier, the employer, and other involved parties;
- reviews medical care of injured/ill employees and their response to treatment;
- facilitates and coordinates sharing of information among all involved parties;
- communicates and educates stakeholders regarding graduated return-to-work guidelines;
- facilitates graduated return-to-work strategies, including modified/alternate work opportunities;
- monitors modified/alternate work efforts;
- establishes vocational rehabilitation when required; and
- collects data to show cost-effectiveness of the Disability Management Program and any identified trends for illness/injury prevention.

Disability Case Management Process

The OHN as a Disability Case Manager, functions as the catalyst and liaison to facilitate the recovery of employees with non-occupational and work-related illness/injury in the most expedient
and cost-effective manner. Specifically, the OHN performs the following functions in an orderly manner:

1. **ASSESSMENT**

Disability management requires a comprehensive approach. The following are some of the factors that need to be assessed when determining the need for disability case management (Figure 1):

**Physical factors**, such as:

- the employee’s physical capabilities;
- the job demands of the employee’s own job;
- the potential for job modification of the employee’s own job; and
- the potential for use of adaptive devices; and
- the potential for worksite/environmental modifications.

**Personal factors**, such as:

- any changes in the employee’s family since the onset of the illness/injury;
- the presence of a personal crisis compounding the disability (*i.e.*, legal, domestic problems, job insecurity, *etc.*);
- the employee’s cultural orientation to illness/injury, recovery, and disability management;
- the health status of other family members; and
- how the employee’s family dynamics are impacting the current disability situation.

**Vocational factors**, such as:

- the level of job satisfaction;
- the occurrence of recent changes at work (*i.e.*, hours, assignment, performance, availability of work, labour unrest, *etc.*);
- any previous work activities and other marketable skills that the employee might possess;
- the employee’s vocational interests and aptitudes; and
- the supervisor, union, and human resources professional’s promotion of a graduated return-to-work opportunity.

**Medical factors**, such as:

- medical diagnosis;
- prognosis;
- treatment plan;
- expected return-to-work date;
- employee confidence and satisfaction with the medical treatment;
- potential residual limitations;
- presence of pain;
- presence of other health problems;
- quality of the employee’s coping skills; and
- existing independent practitioner, nutritional guidance, adaptive devices, aids to daily living, home help, and/or home care services, *etc.*
### Figure 1: Rehabilitation Assessment Form

**Rehabilitation Assessment Form**

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>(Check if appropriate)</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. PHYSICAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical capabilities</td>
<td></td>
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<tr>
<td>Job demands</td>
<td></td>
<td></td>
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<tr>
<td>Job modification potential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for adaptive devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worksite modification</td>
<td></td>
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</tr>
<tr>
<td><strong>B. PERSONAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in family dynamics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal crisis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health of family members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact of disability on family</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. VOCATIONAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of job satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General employment skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational interests/aptitudes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisory/union support for MW</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D. MEDICAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prognosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected RTW date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee’s confidence/satisfaction with treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential residual limitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain and coping skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other health problems</td>
<td></td>
<td></td>
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<tr>
<td>Other health care supports</td>
<td></td>
<td></td>
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<tr>
<td><strong>E. PSYCHOLOGICAL</strong></td>
<td></td>
<td></td>
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<tr>
<td>Employee’s reaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee ou tlook/self-esteem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee treatment goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of alcohol, drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress management needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willingness to work MW</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>F. PERFORMANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship with supervisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relations with co-workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past absenteeism rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>G. EDUCATIONAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized training</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>H. FINANCIAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available group benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial assets/liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>H. ORGANIZATIONAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Union/Management support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of case conferences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available rehabilitation resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>REHABILITATION GOAL:</strong> OWN JOB □ OTHER JOB □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Return to Work Date</td>
<td>______________________</td>
<td></td>
</tr>
</tbody>
</table>
Psychological factors, such as:

- the employee’s reaction to illness/injury;
- the employee’s thoughts and feelings, level of self-esteem, outlook, locus of control, and degree of personal power;
- cultural factors;
- the employee’s interests and attitude about work and the illness or injury;
- reliance on alcohol and/or drugs; stress management needs; and
- the employee’s willingness to try modified work/alternate work duties.

Performance issues, such as:

- quality of the relationship between the employee and his/her supervisor;
- quality of relationships with co-workers;
- level of social acceptance and credibility;
- employee’s past and recent work performance; and
- past history of absenteeism.

Educational factors, such as:

- technical training;
- formal education; and
- specialized training.

Financial factors, such as:

- available employee group insurance benefits;
- income;
- financial assets/liabilities; and
- treatment/rehabilitation expenses.

Organizational factors, such as:

- union/management willingness to support case management conferences to expedite a successful graduated return-to-work plan; and
- resources available to meet the employee’s rehabilitation needs.

An industry example of a Disability Case Management Initial Assessment Form is provided in Appendix 1.

Effective disability case management requires the appropriate assessment and evaluation of the employee’s situation and needs; of the availability and utilization of appropriate medical treatment; and of the factors that may impede/promote the employee’s successful recovery and reintegration into the workforce. By providing parallel assistance with work and medical issues, return-to-work barriers can be eliminated or reduced.

2. PROBLEM IDENTIFICATION

Background

An overwhelming majority of injured, ill, or disabled employees return to work without difficulty. For approximately 20% of employees on short-term and long-term disability and Workers’ Compensation, disability evokes a constellation of personal, emotional, and work-related issues that
delay return to work. The existence of person-job mismatch, workplace discord, and a performance problem usually indicates a prolonged absence from work.

Effective disability case management requires the appropriate assessment and evaluation of the employee’s situation and needs; of the availability and utilization of appropriate medical treatment; and of the factors that may impede/promote the employee’s successful recovery and reintegration into the workforce. By providing parallel assistance with work and medical issues, return-to-work barriers can be eliminated or reduced.⁸

Some factors associated with a delayed return to work, commonly called barriers, are:

- the absence of graduated return-to-work opportunities;
- time lags in obtaining medical care or other forms of therapy;
- lack of knowledge on the part of the community practitioner about the workplace and what accommodations can be made for the disabled employee;
- disability insurance plans that promote a “reward” for being disabled;
- unreliable methods for tracking the ill or injured worker;
- employee fear of losing disability income if he or she attempts an unsuccessful return to work;
- physical/psychological pain;
- employee fear of relapse or re-injury;
- employee anxiety concerning poor job performance due to disability;
- decreased self-confidence;
- a physical illness with strong psychological overtones;
- a work situation perceived as intolerable by the employee;
- a negative industrial relations climate;
- layoffs due to “downsizing”;
- cultural differences in illness/injury response;
- limited social acceptance and supports within the workplace;
- a breakdown in communication between the employee and employer; and
- lack of understanding by all stakeholders of the real costs associated with disability.

The factors associated with a timely and safe return to work, commonly called drivers, are:

- job satisfaction;
- respect for the worker;
- open communication between the employer and worker;
- existence of a modified/alternate work program; and
- use of a team approach (i.e., employee, supervisor, union, insurance company, human resources professionals, physician, Employee Assistance Program counsellors, occupational health & safety professionals, etc.) towards a graduated return to work outcome with the employee being the key player.

Recent changes in the workers’ compensation and human rights regulations in Canada demand workplace accommodation for the disabled worker. For larger companies, this can mean workplace and/or work duty modifications, or necessitate the development of alternate job positions.

The challenge for OHNs is to not only identify the barriers and drivers for a safe and timely return to work, but also to:

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• Increase the drivers for return to work by decreasing the barriers whether real or perceived in nature;
• Facilitate open communication between the employee and the workplace; and
• Promote a team approach to bringing employees back to work.

Lewin’s Force Field Analysis (Figure 2) is a tool that the OHN can use to determine the various ways to decrease the barriers for a timely return to work, while increasing the drivers for a graduated return to work.

Figure 2: Lewin’s Force Field Analysis

<table>
<thead>
<tr>
<th>Driving Forces</th>
<th>Restraining Forces (Barriers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor values the employee</td>
<td>— Unable to drive</td>
</tr>
<tr>
<td>Employee likes the work</td>
<td>— Labour position</td>
</tr>
<tr>
<td>Employees requesting to return to work from a disability</td>
<td>— No definitive diagnosis</td>
</tr>
<tr>
<td>Employee Assistance Program available</td>
<td>— Prognosis unknown</td>
</tr>
<tr>
<td>Some supportive policies available</td>
<td>— Perception of no graduated return-to-work opportunities</td>
</tr>
<tr>
<td>Claim management</td>
<td>— Limited rehabilitation resources</td>
</tr>
<tr>
<td>Case management</td>
<td>— Physician support is absent</td>
</tr>
<tr>
<td>Attendance Support &amp; Attendance Program in place</td>
<td>— Limited transferrable skills</td>
</tr>
</tbody>
</table>

This Force Field Analysis helps individuals select the targets for change. By focusing on the restraining forces (barriers to return to work), and looking for ways to reduce their effect, or ways to change them into driving forces, the OHN can identify the real underlying factors preventing the employee from returning to work and hence, broker a workable solution.9

3. Disability Case Manager Role
Disability Case Managers identify cases, non-occupational/occupational in origin that will benefit the most from case management intervention. Criteria for early identification include:

• the absence of a graduated return-to-work opportunities;
• time lags in obtaining medical care or other forms of therapy;
• lack of knowledge on the part of the community practitioner about the workplace and what accommodations can be made for the disabled employee;
• disability insurance plans that promote a “reward” for being disabled;
• unreliable methods for tracking the ill or injured worker;
• employee fear of losing disability income if he or she attempts an unsuccessful return to work;
• physical/psychological pain;
• employee fear of relapse or re-injury;
• employee anxiety concerning poor job performance due to disability;
• decreased self-confidence;

9 For more information on this approach, refer to the Institute for Work and Health publication, Red flags/Green lights: A guide to identifying and solving return-to-work problems. Available online at: http://www.iwh.on.ca/rtw-problems-guide
• a work situation perceived as intolerable by the employee;
• a negative industrial relations climate;
• layoffs due to “downsizing”;
• cultural differences in illness/injury response;
• few or limited social credits\textsuperscript{10} and supports;
• a breakdown in communication between the employee and employer; and
• lack of understanding by all stakeholders of the real costs associated with disability.

The Disability Case Manager should be aware that the longer the employee is absent from work, the less likely they will successfully return to work.\textsuperscript{11}

4. **Outcome Identification**

Disability case management is a goal-directed process. Information is gathered and evaluated to form an assessment of an injured or ill employee’s situation and needs. When these needs have been identified, the Disability Case Manager, in collaboration with the medical care provider, employee, employer, union, and other involved parties, identifies cost-effective and appropriate resources that can be utilized to facilitate the worker’s recovery. In order to appropriately evaluate the case management outcome, the Disability Case Manager must be able to report, in quantifiable terms, the impact of each identified resource, or intervention, on the quality of care or quality of life for the employee.

5. **Planning Process**

The Disability Case Manager facilitates the planning of care and the selection of resources. This facilitation is not conducted in a vacuum but rather in collaboration with the employee, management, union, physician, Employee Assistance Program counsellor, and often, family members. All of the factors identified in the assessment process (Figure 1) are considered in deciding on appropriate care, the delivery of that care, and necessary resources, such as equipment, supplemental assistance, available Employee Assistance Programs (own and spousal), and extended or supplemental health care plans.

A rehabilitation action plan (Figure 3) is developed for each employee who can benefit from proactive intervention. This is accomplished by gathering data using the following techniques:

- **Job Demands Analysis** — The job description and physical demand requirements of the employee’s job (Figure 4) are reviewed to identify capabilities, as well as any limitations.
- **Attending Physician Support** — The purpose of the case management process is to work as a team to benefit the employee. This includes involvement of the attending physician. The Disability

\textsuperscript{10} **Social Capital Theory** suggests that our willingness to help others is based on the quality of our social relationships. We are willing to help (exchange favors) only when we feel a sense of goodwill, trust, and empathy towards other members of our social group. We are also more likely to grant favors if we know that at some point in the future, the same courtesy will be returned, either directly by the recipient, or by someone else within our social group. So social capital actually belongs to “the social group as a whole” (it is one element of organizational culture), but access to it, depends on one’s degree of individual social credit. Social credits are built by following group norms, being trustworthy, meeting group expectations, and returning favors. Employees gain access to the goodwill of others when they have worked to establish personal credits. Disability can influence an employee’s ability to participate effectively in the activities that build and maintain access to social capital. Employees, who begin a return-to-work opportunity with few social capital credits, and those who deplete their social credits as a result of multiple health episodes, often face distinct social sanctions (William-Whitt, 2009 in Dyck, 2009).

\textsuperscript{11} According to the SAW-RTW Report, 2005, and to a number of Canadian Workers’ Compensation Board Reports, the ideal time for getting the employee back to work is within the first 30days of the absence. Workers who are away from work for 12 weeks, experience a 50% return to work rate; those away for 24 weeks, a 20% chance of returning to work; and if away for 48 weeks, only a 2% likelihood for getting back to work (SAW & RTW Committee. (2005). Preventing Needless Work Disability by Helping People Stay Employed: A Report from the Stay-at-Work & Return-to-Work Committee of the American College of Occupational & Environmental Medicine. Author.).
Case Manager needs to explain the benefits and corporate support available for the employee to the physician, if appropriate.

- **Job or Worksite Modification** — The opportunity for job changes, or the reassignment of parts of a job, are considered so that the employee can return to work in a safe and timely manner. Once the employee’s capabilities have been identified by an occupational health professional, the supervisor, union representative, Return-to-Work Coordinator, and human resources personnel are usually the leaders of a modified/alternate work opportunity.

- **Employee Assistance Program Support** — The Disability Case Manager should offer Employee Assistance Program support to the employee and family as appropriate. Many disabled employees need help to cope with a disability, work stress, personal issues, and any mental health component of the existent medical conditions. The management of employee personal problems is illustrated in Figure 5.

- **Coordination with a Specialist** — When warranted, a Disability Case Manager may arrange to obtain an earlier appointment with a specialist for the employee. Under certain circumstances, it may be advantageous for the organization to fund a medical assessment, especially if it facilitates getting the employee an earlier appointment. To move forward with a medical assessment that is not with the employee’s usual health care provider, consider the employee’s employment or collective agreement contract, and obtain the employee’s consent.

- **Third Party Functional Capacity Assessment/Evaluation (FCA/FCE)** — A third party FCA/FCE may be sought to determine the employee’s fitness to work.

- **Adaptive Devices** — Special clothing, devices, or equipment that allow adaptation of the work to the employee’s limitations are considered where possible. From the beginning, the disabled employee and supervisor are involved in selecting and learning how to use any device that assists in the workplace accommodation of the returning employee. The occupational therapy professionals can be an excellent team resource in this area.

- **Job Finding** — Human resources personnel should be advised as early as possible of the likelihood that the employee will not be able to return to his or her own job. In that way, an internal job search can be instituted.

- **Employee Education** — Company resources may be used to help the employee understand and cope with his/her disability. This is important when trying to encourage a positive attitude towards illness/injury management. The employee must feel a sense of control over life if he or she is to successfully cope with the situation.

- **Case Conferences** — It is critical to invite all the relevant stakeholders to attend any required case management meetings. Specific goals and time frames are developed and communicated to the team, of which the employee is the key player. In this way, all the stakeholders can review and address any identified rehabilitation or return-to-work barriers. This is particularly important if the employee will not be able to return to his/her own job.

- **Independent Medical Examinations** — IMEs function to provide clarity to discrepancies or provide missing information in a disability situation. They are third-party medical examinations aimed at determining the employee’s level of disability, length of disability, as well as to make recommendations regarding possible rehabilitation and modified work programs. They are to be used as a last resort measure, not the first mode of intervention.

Rehabilitation action plans should be regularly reviewed and updated to reflect the progress being made. The Disability Case Manager documents the effectiveness of each step of the plan, identifies any unforeseen obstacles, and prepares all participants in the plan for the subsequent steps. By involving the employee in case management decisions, the employee retains a sense of control over his/her life.
**Figure 3: Rehabilitation Action Plan**

**Rehabilitation Action Plan**

<table>
<thead>
<tr>
<th>Case Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee:</td>
<td>Employee #:</td>
</tr>
<tr>
<td>Work Location:</td>
<td>Tel #:</td>
</tr>
<tr>
<td>Occupational:</td>
<td>Supervisor:</td>
</tr>
<tr>
<td>Disability Type:</td>
<td>Physician:</td>
</tr>
<tr>
<td>Case Opened:</td>
<td>Case Closed:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Management Activity</th>
<th>Date</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Contact:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Assessment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Assessment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Assessment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional Capacities Evaluation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job Demands Analysis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job Redesign</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modified Work Available:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Barriers to RTW</th>
<th>Counter-Actions Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drivers for RTW</th>
<th>Support-Actions Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Interview:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Stakeholders:</td>
<td>Employee ☐</td>
<td>HR ☐</td>
</tr>
<tr>
<td></td>
<td>Supervisor ☐</td>
<td>Union ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Case Management Plan: Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RTW</th>
<th>Anticipated MW date:</th>
<th>Actual MW date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MW Progress:</td>
<td>Progress as expected ☐</td>
<td>Progress fair ☐</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Figure 4: Job Demands Analysis

<table>
<thead>
<tr>
<th>Job Demands</th>
<th>Category</th>
<th>Frequency</th>
<th>Essential Duty</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Lifting</td>
<td>Upper arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carrying</td>
<td>Upper arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handling</td>
<td>Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reaching</td>
<td>Above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gripping</td>
<td>Minimum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finger Movements</td>
<td>Right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sitting</td>
<td>Conversation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climbing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kneeling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twisting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Inside Work</td>
<td>(%) of time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outside Work</td>
<td>(%) of time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noise</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to Extreme Heat</td>
<td>(-20°C)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to Extreme Cold</td>
<td>(-7°C)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to Vibration Sources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to Chemicals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to Hazardous Materials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to Radiation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to Biological Hazards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to Electrical Hazards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to Dust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to Welding Fumes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Works With Moving Objects</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operates a Vehicle or Mobile equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operates Hazardous Machinry/Equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Works With Sharp Tools</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Works on Uneven/Slippery Terrain/Surfaces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposed to Confined Spaces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Respiratory Equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Works at Heights (&gt; 2.4 meters high)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repetitive Motion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Video Display Terminal Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air Travel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vehicle Travel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interaction With Public</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overtime</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Responsibilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Response Duties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Demands/Pressures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Pace</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisory/Managerial Duties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control of Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Span of Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irregular Hours/Fatigue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Job Specific Comments:
Figure 5: Management of Employee Personal Problems

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM
FLOWCHART

EMPLOYEE WITH PERSONAL PROBLEM

AFFECTS JOB PERFORMANCE

MANAGER FORMAL REFERRAL

OFFER ASSISTANCE

REJECTS ASSISTANCE

REFER TO EFAP

CONTINUE WITH FORMAL REFERRAL

EFAP ASSESSMENT

1

2

1) REJECTS EFAP RECOMMENDATIONS, CONTINUE WITH FORMAL REFERRAL STEPS
2) SUPERVISOR KEPT INFORMED OF APPROPRIATE INFORMATION (E.G., EMPLOYEE
FOLLOWING PROGRAM) BUT NOT GIVEN DIAGNOSTIC OR PERSONAL INFORMATION

DOES NOT AFFECT JOB PERFORMANCE

NO ACTION REQUIRED

VOLUNTARY/INFORMAL REFERRAL TO EFAP:
• SELF
• SUPERVISOR
• UNION/ASSOCIATION REPRESENTATIVE
• OTHER

MEDICAL ASSESSMENT

TREATMENT/COUNSELLING

NOT SUCCESSFUL

SUCCESSFUL

VOCA TIONAL/ CAREER ASSESSMENT

NO FURTHER ACTION
6. **MONITORING AND COORDINATION**

The Disability Case Manager:

- provides for the assessment and documentation of the quality of care, services and products delivered to the employee;
- determines if rehabilitation goals are being met;
- determines whether the case management goals and the expected outcomes are realistic and appropriate;
- continuously monitors the rehabilitation process through good oral and written communication practices;
- ensures effective coordination of care and services for the injured or ill employee;
- documents the rehabilitation process;
- ensures a timely response to rehabilitation issues; and
- ensures prompt reporting to the management of any relevant workplace issues.

A Disability Case Management Flow Chart like the one presented in Figure 6, can be used by Disability Case Managers to assess the employee’s progress and fitness-to-work status throughout the case management process. Research indicates that follow-through in terms of removing barriers to recovery and putting practices in place to help recovering employees need enhancement. This is an important role for OHNs to assume.

7. **EVALUATION**

Evaluation of the case’s progress and outcomes is necessary to determine the effectiveness of the case management plan and the quality of medical care, services, and products from providers. Evaluation is most effective if metrics, or medical case measurements, are used. Comparing the results of a particular case management scenario against the case-plan metrics can be a valuable exercise when it comes to appropriately evaluating outcomes. Figure 7 is a listing of some of the possible Disability Case Management Metrics.

---

### Figure 7: Disability Case Management Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis verified</td>
<td>Diagnosis verified by appropriate testing or observations. If the diagnosis is not verified, the Disability Case Manager will challenge diagnosis until it is verified.</td>
</tr>
<tr>
<td>Evidence-based practice protocols</td>
<td>The most common diagnoses will have practice protocols available.</td>
</tr>
<tr>
<td>Identification of barriers and drivers for return to work</td>
<td>The Disability Case Manager will assess the situation with a view to identifying and addressing barriers and drivers for a successful return to work.</td>
</tr>
<tr>
<td>Presence of “Red Flags”</td>
<td>“Red Flags” should alert the Disability Case Manager to institute or increase case management. The Disability Case Manager has established criteria or indicators for increased case acuity.</td>
</tr>
<tr>
<td>Specific diagnosis-based disability-duration guidelines</td>
<td>The Disability Case Manager will assess if there is alignment with the disability-duration guidelines.</td>
</tr>
<tr>
<td>Resources care, recovery and rehabilitation</td>
<td>The Disability Case Manager will assess if the most appropriate resources are identified and used.</td>
</tr>
<tr>
<td>Case notes/documentation</td>
<td>The Disability Case Manager will ensure that well-documented treatment plan, decision-making, and case management actions are taken.</td>
</tr>
<tr>
<td>Medical management</td>
<td>The Disability Case Manager will monitor treatment process changes based on the available case management information.</td>
</tr>
<tr>
<td>Average number of disability days per diagnosis</td>
<td>The Disability Case Manager will track the number of disability days.</td>
</tr>
<tr>
<td>Case cost with case management</td>
<td>The Disability Case Manager will monitor the case costs as a result of case management.</td>
</tr>
<tr>
<td>Individual (employee/manager) satisfaction</td>
<td>The Disability Case Manager will assess the level of employee satisfaction rates as related to case management (using a survey tool).</td>
</tr>
</tbody>
</table>

Individual case management process and results are reviewed continually and process improvements sought. The Disability Case Management Assessment and Evaluation Checklist (Figure 8) can be a useful evaluation tool for Disability Case Managers.
### Figure 8: Disability Case Management Assessment and Evaluation Checklist

<table>
<thead>
<tr>
<th>Information to be Obtained</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Age affects recovery time and rate of rehabilitation.</td>
</tr>
<tr>
<td>Gender</td>
<td>Gender plays a role in the recovery time.</td>
</tr>
<tr>
<td>Years of service with the company</td>
<td>Raises the issue of motivation to return to work, interest in medical retirement, etc.</td>
</tr>
<tr>
<td>Length of time in the current job position</td>
<td>In-depth knowledge of the job position aids in developing opportunities for modified work.</td>
</tr>
<tr>
<td>Previous disability claims</td>
<td>If yes, what is the employee’s perspective towards returning to modified work, litigation, etc.?</td>
</tr>
<tr>
<td>Current injury, diagnosis, treatment, and prognosis</td>
<td>In addition to gathering the particulars, it is important to note any areas in which the employee, the healthcare provider, or the insurer adjudicator lacks all the needed information.</td>
</tr>
<tr>
<td>Diagnostic testing</td>
<td>Determine what tests have been done and the results; but also review what tests, which might be expected for a particular diagnosis, have not been done.</td>
</tr>
<tr>
<td>Medications: (a) Appropriateness of use</td>
<td>Some personal medications may have an addictive or negative combination effect. Employees may not be taking medication in the appropriate time frame or manner, thus delaying recovery. Medications that seem ineffective, or have side effects, should be brought to the attention of the physician.</td>
</tr>
<tr>
<td>(b) Use of other personal medications</td>
<td></td>
</tr>
<tr>
<td>(c) Outcomes of (a) and/or (b)</td>
<td></td>
</tr>
<tr>
<td>Physical medicine modalities and results</td>
<td>Treatment modalities should be scientifically based, and if the employee is not showing progress after 4 to 6 weeks, a re-evaluation by the physician should be initiated.</td>
</tr>
<tr>
<td>Psychological counselling and results</td>
<td>As a result of the counselling, the employee should show progress after 4 to 6 weeks. If not, a psychological re-evaluation should be initiated.</td>
</tr>
<tr>
<td>Expectations of the disability duration</td>
<td>Expectations of disability duration by the physician, employee, and family may influence recovery and return to work.</td>
</tr>
<tr>
<td>Psychosocial variables</td>
<td>Family and social issues may be incentives or disincentives in the recovery process. This is an area in which Disability Case Managers may frequently uncover hidden agendas or issues that would have delayed recovery if not addressed.</td>
</tr>
<tr>
<td>Cultural variables</td>
<td>Each culture has a unique response to illness/injury and recovery. Cultural competency is a must for successful case management and a timely and safe return-to-work outcome for the employee.</td>
</tr>
<tr>
<td>Communication:</td>
<td>The Disability Case Manager fills a vital role as liaison with the employee, insurance providers, employer, and third-party administrator. Open communication is critical to successful case management and a timely and safe return-to-work outcome for the employee.</td>
</tr>
</tbody>
</table>

---

Program results, costs, system concerns, and recommendations are tabulated and reported annually to management and to the Disability Management Program Steering Committee\(^\text{14}\). Confidentiality of individual information is maintained as per the company’s Disability Management Standard of Practice for Confidentiality of Personal Health Information.

Annual auditing, peer review, and self-auditing of the Disability Case Management practices are recommended as appropriate evaluation techniques.

**Confidentiality\(^\text{15}\)**

Individuals who collect, maintain, handle, and use personal health information are required to protect the confidentiality of the information.

This standard is based on the *Model Code for the Protection of Personal Information*\(^\text{16}\) and the various pieces of provincial and federal privacy legislation. It details the procedures for collection, retention, storage, security access, disclosure, transmittal, reproduction, and destruction of identifiable personal health information held by the company or organization.

All staff must comply with the Disability Management Standard of Practice document on confidentiality of personal health information when interpreting personal health information to the employer-client without divulging any privileged information.

**General**

The company or organization recognizes the individual’s right to privacy in relation to personal health information collected.

The principles governing confidentiality are:

- personal health information is only used on a “need-to-know” basis;
- personal health information should be relevant to the purposes for which it is to be used;
- personal health information is restricted to the company or organization staff who sign a pledge of confidentiality and who are subject to a recognized professional code of ethics;
- upon request, an employee has the right to access all information regarding his or her health;
- personal health information is protected by reasonable security safeguards;
- documented personal and health information is the property of the company or organization entrusted to occupational health staff for safeguarding and protection; and
- compliance with this standard is the responsibility of the Disability Case Manager.

---

\(^\text{14}\) *A Disability Management Program Steering Committee* is a joint labour-management committee that promotes joint involvement in the program design, infrastructure development, implementation (i.e., marketing, communication, education and training, dispute resolution, etc.), evaluation, and continuous improvement of a Disability Management Program. It serves as a foundation for the Disability Management Program; and provides support for the Disability Management Coordinator and the program (Dyck, 2009).


Definitions

Collection — The act of gathering, acquiring, or obtaining personal information from any source, including third parties, by any means.

Confidentiality — The maintenance of trust and the avoidance of invasion of privacy through accurate reporting and authorized communication.

Consent — The voluntary agreement with what is being done or proposed. Consent can be either expressed or implied. Expressed consent is given explicitly, either orally, or in writing. It is unequivocal and does not require any inference on the part of the organization seeking consent. Implied consent arises where consent may reasonably be inferred from the action or inaction of the individual.

Designated Representative — Any individual or organization to whom an employee gives written authorization to exercise a right to access.

Disclosure — The act of making employee personal information available to others outside the organization.

Personal Health Information — An accumulation of data relevant to the past, present and future health status of an individual which includes all that the company or organization staff learn in the exercise of their responsibilities. It is the information about an identifiable individual that is recorded in any form.

Privacy — The claim of individuals, groups, or institutions to determine for themselves when, how and to what extent information about them is communicated to others.

Application

These guidelines apply to all occupational health and disability management staff, and include contract employees and all other support staff whether permanent, temporary, or volunteers.

Collection of Personal Health Information

The primary purpose for collecting and retaining personal health information is disability management. All information collected is subject to confidentiality and must be treated with respect.

Disability case management requires information on the employee’s physical and emotional capabilities and restrictions. Input from the employee’s attending physician is essential.

According to Canadian legislation, an employer must obtain the consent of the employee before approaching the employee’s physician for personal medical information. Thus the company, or its representative, the OHN, must make efforts to obtain the employee’s written consent before seeking such input from the employee’s physician.17

Knowledge and consent of the employee are required for the collection and disclosure of personal health data relevant to disability management. Figure 9 shows how personal information should be collected. In essence, personal health information is not to be collected indiscriminately. Only the personal health information relevant to disability management should be collected.

Figure 9: Collection of Information

- Request for information will be in writing and contain the following:
  - Name and address of recipient of information.
  - Purpose or need for information.
  - Full name, address, and date of birth of person whose information is being requested.
  - Specific definition of the type and extent of information required.
- All requests will be accompanied by the appropriate “Release for Medical Information” form signed by the employee whose personal health record is being requested.
- A record of all requests will be maintained on the employee’s personal health record.

Personal health information is collected using various methods, including interviewing, written documentation (i.e., insurance claims, Workers’ Compensation Board forms, etc.) and electronic data processing, all of which are subject to confidentiality.

The personal health information collected relates to medical assessments, Employee Assistance Program treatment reports, illness and injury reports, personal and family history, and consultant reports.

Personal health information is only collected by designated staff subject to a pledge of confidentiality (Figure 10).

Accessibility

Upon request, an employee is to be informed of the existence, use, and disclosure of personal health information and is given access to that information.

Employees, former employees and other properly designated representatives have the right to inspect and copy, all or in part, personal health records. All such written requests are to be honoured within a reasonable time that should not exceed 15 days.

Note: The actual health record is the property of the company; however, the information contained in the record belongs to the employee.

To the extent practicable, inspection of a personal health record is to be made in the presence of a representative of the company or organization, who endeavours to explain the meaning of the content of the record to the employee. Rebuttal of information contained in the personal health record by the employee will be included in the record, signed, and dated by the employee. The representative will add a note to the file concerning explanation and agreement, or disagreement.

The company or organization personnel may delete the identity of a family member, personal friend, or fellow employee who has provided confidential information concerning an employee’s health status from the requested health records.
It is recommended that employees:

- accept a summary of material facts and opinions in lieu of copies of the records requested; or
- accept a release of the requested information only to the family physician or other qualified health care professional.

**Figure 10: Disability Management Team’s Pledge of Confidentiality (Sample)**

- All personal health information related to an identified employee will be treated as confidential. This information may be in writing, oral, electronic or in any other format.
- Confidentiality extends to everything Company XYZ staff learns in the exercise of their responsibilities. It extends to both obviously important and apparently trivial information and includes the nature of the employee’s contact with the staff, all information an employee discloses and all information learned from external caregivers.
- Personal health information related to the disability claim can be shared with occupational health professionals employed by Company XYZ in privacy to enhance continuity of care and a coordinated disability management approach.
- The dissemination of personal health information will be considered a breach of confidentiality and will be reported to Director, Human Resources and the CEO, Company XYZ. Disciplinary action will be taken up to and include immediate termination of employment with cause.
- Senior Management is responsible for ensuring that the Company XYZ staff involved in the disability management function are aware of the Pledge of Confidentiality and that they sign the pledge acknowledging this awareness.
- To acknowledge and emphasize the serious responsibility in safeguarding employee health information, all Company XYZ staff (permanent or temporary), or contract staff involved with disability management will be required to sign a pledge of confidentiality on the first day of work and annually thereafter, which will be worded as follows:

**Pledge of Confidentiality**

I have read and reviewed Company XYZ’s Standard of Practice on Confidentiality of Personal Health Information. I understand that all employee personal health information, to which I may have access, is confidential and will not be communicated except as outlined in the Disability Management Standard of Practice.

_____________________________  __________________________  ______________________
Signed  Witness  Date

_____________________________  __________________________  ______________________
Signed  Witness  Date

_____________________________  __________________________  ______________________
Signed  Witness  Date

**Note:** This pledge is to be signed annually. The original form is to be sent to the staff member’s file, Company XYZ Human Resources Department. Copies are to be retained by the area Manager and the Company XYZ staff person.
Access to health information that may have an adverse impact upon the health of the employee will only be provided to a designated physician of the employee.

No other personnel, except designated staff, have the right to access health information unless disclosure obligations have been met.

**Disclosure Internal to the Employer-Client**

Personal health information released to management (managers and/or supervisors) is limited to the following:

- report of fitness to work following a mandated or statutory health assessment;
- determination that a medical condition exists and that the employee is under medical care. This could include the dates or follow-up appointments or referrals to specialists or treatment programs;
- time that the employee has been or is expected to be off work;
- medical limitations, if any, to carry out work in a safe and timely manner;
- medical restrictions, if any, regarding specific tasks; and/or
- estimated date for a realistic return to work, or a return to modified/alternate work.

However, if in the opinion of an OHN, disclosure is necessary because of a *clear danger* to the employee, other employees, the workplace or the public at large, and:

- the employee consistently refuses to give consent; and
- a second opinion is obtained from the employee’s personal physician when the concern is for the health of the employee or fellow employees-clients, or from the medical officer of health when the risk is to the public;

the appropriate staff member may make the disclosure to the appropriate manager after giving notice in writing to the employee, indicating that confidential information will be disclosed.

**External Disclosure**

Subject to the exceptions specified below, the company or organization should not disclose personal health information regarding employees, or former employees, to external sources unless the individual has authorized such release by providing a signed and dated consent form for release of medical information or its equivalent. Disclosure will follow the checklist provided in Figure 11, and the Requirement for Informed Consent in Figure 12.
## Figure 11: Disclosure of Information Checklist

- All requests for disclosure of information will be directed to the Company XYZ Disability Case Manager.

- Any authorization for release of information will be an original form and will specify the source, content, recipient, purpose, and time limitations. The form will identify the:
  
  - Name of the individual or institution who is to disclose the information.
  - Name of the individual or institution who is to receive the information.
  - Full name, address, and date of birth of the person whose information is being requested.
  - Purpose or need of information, unless included in accompanying request.
  - Extent or nature of information to be released, including date(s) of treatment or contact (blanket authorizations requesting “any” or “all” information will not be honoured).
  - Date that consent/authorization is signed which must be subsequent to the date of treatment or contact in question and within sixty (60) days of signature of person whose information is to be released, or that of his or her legally authorized representative.
  - Information released to legally authorized persons is not to be made available to any other party without further authorization. The recipient will be so informed by including a copy of the following letter with the information.

### Sample Letter

To Whom It May Concern:

The enclosed information is being forwarded to you from our records, which are the property of Company XYZ and managed by Company XYZ. Such copies are released only to persons authorized according to law and the policy of Company XYZ. In this way, we seek to uphold the trust vested in us by the individual and ensure that his or her wishes and best interests are served at all times. Accordingly, this information is released on the following conditions:

- that it not be further copied, transmitted, or disseminated without further specific authorization of the person concerned;
- that it be used only for the purpose as outlined in your request; and
- that it be destroyed by shredding or incineration when the original purpose has been served.

Your cooperation and compliance with the above is appreciated.
**Figure 12: Requirements for Informed Consent**

- There is an obligation to ensure that sufficient information is provided to employees about the nature and consequence of the intended action to allow the employee to come to a reasoned decision.
- The employee is mentally competent, and has the ability to understand and appreciate the nature and consequences of the procedure.
- Consent is freely given.
- Consent is not obtained through misrepresentation or fraud.
- Consent cannot be given to the performance of an illegal procedure.
- Consent is in relation to the specific act contemplated unless the employee’s life is immediately endangered and it is impractical to obtain consent.

*Routine Request for Release of Medical Information* — A written request by a physician, medical institution, another health agency, or insurance company, for abstracts or copies of part or all of the individual’s health record is honoured when the consent form or its equivalent is signed by the employee.

*Release of Pertinent Medical Data to Appropriate Public Health Authorities* — When it is determined that a public health issue or risk has been uncovered, as in the case of a reportable communicable disease, appropriate notification to provincial or district health authorities will be made in accordance with the statutory requirement.

*Disclosure to Government Agencies* — To preserve the confidentiality of employee health records, the company or organization usually requests government agencies for consent for release of medical information signed by the employee. However, government legislation may have the authority to require immediate access to employee and former employee medical information. Whenever access is necessary without the prior written consent of the employee, a government agency must present a written access order to the company or organization.

*Disclosure to Designated Representative* — The company or organization, upon presentation of a written consent by an employee or former employee, will release copies of the individual’s medical record to the designated representative. With respect to medical information that may be deemed to have a detrimental impact upon the health of the employee, medical information will be provided only to the employee’s family physician. Information received in confidence from external sources that is part of the health record will not be divulged to the employee’s designated representative.

*Disclosure of Subpoenaed Information* — A company or organization should respond to a subpoena as follows:
- with the server present, the employee’s name and the validity of the subpoena are verified;
- the Chief Executive Officer is notified;
- only the specific material requested in the subpoena is collected and photocopied;
• authorization to release information is given by the Chief Executive Officer and the Senior Counsel, Corporate; and
• without written authorization of the employee, subpoenaed records are not available for review by outside counsel prior to being established as evidence.

Misuse of Personal Health Information

Any individual who becomes aware of an abuse of confidentiality of health information must document the misuse and report the incident to the appropriate corporate authority for action.

Documentation

This documentation standard is intended to provide guidance and direction to OHNs as Disability Case Managers, in the initiation, maintenance, and disposal of employee health records. When completed properly, the personal health record can:

• provide a profile of the health status and the health care provided to each employee;
• provide a means of communication among members of the Disability Management Team contributing to the disability case management process;
• provide a basis for planning and for continuity of rehabilitation care for employees;
• provide a basis for review, study and evaluation of the case; and
• assist in the provision of protection for the medical and legal interests of both the employee and the company.

General

Disability Case Managers are required to discharge their legal responsibilities by providing accurate and timely records of events and information affecting the health of the employee.

Information recorded in the employee health record is confidential. The COHNA Disability Management Confidentiality Standard applies to all OHNs as Disability Case Managers documenting and handling employee personal health records.

Personal health records are to be cumulative and sequential. Filing in the chart is done in such a way that the most current information in each selection is on top when the file is opened.

Application

These practices apply to all staff who gather information for the purpose of disability case management, but is critical for OHNs to observe.

Personal Health Record Format

The employee’s health record is kept in an appropriately labelled data file folder in a secured manner. The employee’s name must appear on every page of the record.

Each record will contain the following information:

- reports of sickness and injury absences;
- reports of all medical examinations and consultations;
- record of all inquiries related to health problems, whether presented in person or by phone;
- copies of disability claim forms;
- correspondence with other health care professionals or agencies;
- copies of Workers’ Compensation Board claims;
- memos or notes regarding discussions relevant to the case (e.g., discussions between professionals, medical experts, Employee Assistance Program counsellors);
- record of communication with other health and safety related bodies (e.g., Workers’ Compensation Board, insurance companies and government agencies); and/or
- record of all communication with management, unions and employees. These signed notes should include time and date of call.

Recording

The general guidelines for recording are:

- all entries are to be recorded on the Disability Case Management Status Report (Figure 13);
- all entries should be dated and entered sequentially;
- every entry must be signed. The accepted format for a signature is the initial, surname and professional designation (if applicable);
- entries are to be made in ink or typed;
- entries should be made at the earliest opportunity following contact;
- writing in the record must be legible;
- entries should be continuous, do not skip lines between entries or leave space within an entry;
- entries in the record are permanent. Do not obliterate material on the record by scratching out, using correction fluid, felt tip pen or typewritten XXXs; and
- when content corrections are required, the following procedure is to be observed:

  - draw a single line through each line of inaccurate recording making certain it is still legible;
  - date and initial the line;
  - enter corrections in chronological order;
  - time the entry and sign;
  - make certain to indicate which entry the correction is replacing; and
  - in questionable situations, it is wise to have the corrected material witnessed by an occupational health colleague. Countersigning of the record is completed with the signature of the responsible party and the witness or counter-signatory (signature should be in the standard format).
Figure 13: Disability Case Management Status Record

COMPANY XYZ
LOGO/ADDRESS

Employee Name
Company/Organization
Employee Number/Identifier

<table>
<thead>
<tr>
<th>Date</th>
<th>Status</th>
<th>Signature</th>
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</tbody>
</table>

Retention, Storage and Security

All personal health information must be stored separately from other employee information. The storage location is checked regularly and safeguarded from fire, water, and other potential disasters. All computerized health information must be secured using passwords and access codes.

All activities of employees and visitors to the company or organization offices must be supervised in order to protect the confidentiality of personal health information.

During active use, records and other personal health information must be kept in private offices, always ensuring that identifiable information is protected from the observation and the hearing of other individuals.

All personal health information must be retained for a period of seven years from the last date of contact.

Personal health records of employees who have left the company are retained as outlined in Figure 14.
Figure 14: Retention, Storage, and Security

• Disability management data should be kept for a period of at least 7 years after the employee leaves the company; however, in actual practice, it may be more prudent to keep this data for 10 years. However, if the disability data includes occupational exposures, the retention period should be in accordance with the applicable provincial OH&S Act.

• The medical records of terminated employees are to be pulled from the active files, placed in a designated envelope marked “Confidential Personal Health Document: To Be Opened By Authorized Personnel Only”, labelled and placed in a storage box. The box is to be numbered.

• A list of the medical files in the storage box is to be created. Three sets of this list are to be made: one copy to go with the storage box, another is to be sent to the employee, and a third is to be retained by Company XYZ.

• A system of archiving that links the file with the storage box is required.

• Files are to be stored in a location that is safeguarded from water, fire and access by unauthorized persons.

Reproduction and Transmittal

Reproduction of any individualized health information is to be done by designated staff in privacy.

Transmittal of individualized health records can be faxed to a recipient with a confidentiality notice. Information can also be mailed or couriered in envelopes clearly marked “Confidential: To Be Opened by Addressee Only”.

Transmittal of individualized health records will be in sealed envelopes or boxes. The envelopes or boxes must be clearly marked “Confidential: To Be Opened by Addressee Only”.

Destruction

When it becomes appropriate to dispose of health information, including formal health records, notes and messages pertaining to an individual employee, they will be rendered completely and permanently unidentifiable through destruction by burning, shredding, or automated erasure.

When burning, shredding, or automated erasure is not feasible, health information will be transmitted to the closest office with the ability to destroy such information.

Company or organization staff will personally transmit the information to be destroyed and remain with the information until it is destroyed.
Review of Health Record

Regular and periodic review of personal health records is conducted to ensure that policies and practices are implemented, and that forms and records continue to capture appropriate information without duplication.

DISABILITY MANAGEMENT: REGIONAL DIFFERENCES

In Canada, employers must uphold three key pieces of legislation that directly impact the field of disability management:

- Canadian Human Rights Act (1977);
- Provincial Workers’ Compensation Acts; and
- Privacy legislation.

As such, regional differences exist. To identify all the regional differences is less expedient and meaningful than explaining why these differences exist.

Canadian Human Rights Act

The Canadian Human Rights Act is a statute originally passed by the Government of Canada in 1977 with the express goal of extending the law to ensure equal opportunity to individuals who may be victims of discriminatory practices based on a set prohibited grounds such as gender, disability, or religion. It applies throughout Canada, but only to federally regulated activities; each province and territory has its own anti-discrimination law that applies to activities that are not federally regulated. However, the provincial acts are relatively the same in their intent.

The Canadian Human Rights Legislation impacts the treatment of employees, in particular in the disability management processes. Under the Canadian Human Rights legislation, the following aspects are addressed:

- **Discrimination:**
  - Prohibits discrimination in hiring or retaining employees. It is based on the principle of individual assessment – that is, people should be evaluated on their ability;
  - Impacts pre-placement and return-to-work fitness requirements;
  - Means that employers should:
    - Concentrate on employee capabilities; not disabilities;
    - Assess employees as individuals, not as members of a group;
    - Avoid generalizations about disabilities;
    - Define specific employment needs according to business priorities;
    - Clearly state the essential components of the job; and
    - Establish reasonable standards for evaluating job performance.

- **Duty to Accommodate:**
  - Requires employers to make reasonable accommodation for injured/ill employees up to the point of undue hardship. However, this is a tripartite effort:
    - The employer is legally expected to:
      - Ask for relevant information about the employee’s medical condition and fitness to work;
Determine if a suitable work accommodations exists;
Get expert advice on the employee’s fitness to work when needed;
Respond to the employee’s request for accommodation within a reasonable timeframe;
Document the process and actions taken;
Protect the employee’s right to privacy;
Assume the related costs;
Monitor the work accommodation, making changes as required; and
Should an offer of work accommodation be deemed impossible, the employer is obligated to explain to the employee why, and be prepared to substantiate that decision.

- The employee is legally expected to:
  - Advise the employer that he/she is fit for some level of work;
  - Provide documented medical support for the modified work along with work limitations;
  - Accept offered modified work and endeavour to make it successful;
  - Advise the employer if the work accommodation is suitable; and
  - Update the employer on his/her ongoing fitness to work.

- The union is legally expected to:
  - Support the work accommodation efforts and facilitate the process up to the point of undue hardship. Duty to Accommodate legislation takes precedence over any collective agreement clause that would appear to be discriminatory.

**Undue Hardship:**
- A flexible concept that is highly dependent on the individual circumstances and factors.
- Interpretation and determination of “undue hardship" depends on the individual case. It includes consideration of:
  - Size of the employer’s operation.
  - Interchangeability of the workforce and facilities.
  - Whether the employee’s health would be harmed.
  - Disruption of the collective agreement.
  - Effect on the rights of other employees.
  - Effect on the morale of other employees.
  - Financial cost to employer.
  - Safety concerns.  

- The employer is legally expected:
  - Not to create a job or make major changes to the employee’s job.  
  - Not to displace an incumbent worker to accommodate the employee.  
  - To demonstrate an earnest attempt to accommodate the worker.

And, in the event that the trial of work accommodation fails, then the employer has satisfied the test of undue hardship. 

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• The employee is legally expected to:
  o Accept reasonable accommodation; if not, then employment can be terminated. 23
  o Advise the employer as to the existence of a disability and the need for work accommodation, as well as what they can do in terms of their job duties. 24

• Bona Fide Occupational Requirement (BFOR):
  ▪ Affects employee pre-placement and fitness to return-to-work from medical absence assessments, necessitating that that job tasks match the person’s capabilities;
  ▪ For a condition to be deemed a BFOR, the employer must show that a specific job element/task is “essential” to the job.

• Substance Abuse Policies:
  ▪ Alcohol and drug addictions are deemed disabilities, and as such employers have a duty to accommodate employees with substance abuse problems, by:
    o Offering assistance;
    o Allowing time off work for treatment;
    o Offering work accommodation upon their return; and
    o Bearing the cost of monitoring the employee’s compliance with treatment.

Provincial Workers’ Compensation Acts

Provincial and Federal jurisdictions demonstrate different approaches to the management of occupational illness/injuries. Although provincial Workers’ Compensation Acts (WCAs) are similar in their intent and wording, how they “play out” differs; for example:

a) Workers’ Compensation Boards (WCBs): Waiting Periods

In most provinces, the injured employee, whose claim is accepted, is entitled to receive compensation beginning the first regular work shift following the day of injury. However, New Brunswick (NB), Nova Scotia (NS), and Prince Edward Island (PEI) have waiting periods. Waiting periods do not affect the employee’s right to medical aid from the date of injury.

In terms of payment for the day of injury, employers are required to pay the employee for the day of injury in Alberta (AB), Manitoba (MB), Newfoundland (NL), Ontario (ON), Quebec (QC), and Yukon Territory (YT). In the rest of the provinces, the employer does not have to pay the employee for the day of injury. WCBs do not reimburse the employer for the day of injury in any province, but if the claim is accepted, WCBs do pay the employer for payments made in the days subsequent to the day of injury. 25

b) Workers’ Compensation Boards: Payment of Compensation Benefits

The payment of compensation benefits differ by province.\(^{26}\) As well, the frequency of payments and periodic and lump sum payment\(^{27}\) are province-specific. The WCB benefits information is provided in Figure 15.\(^{28}\)

Table 15: 2011 Key Benefits Information by Province\(^{29}\)

<table>
<thead>
<tr>
<th>Prov.</th>
<th>Max. Comp. Earnings</th>
<th>% of earnings benefits are based on</th>
<th>Period</th>
<th>Employer required to pay worker for Day of Injury</th>
<th>Employer required to pay worker for Period after Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB</td>
<td>$82,800</td>
<td>90% net</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>BC</td>
<td>$71,700</td>
<td>90% net</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>MB</td>
<td>No Maximum</td>
<td>90% net</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>NB</td>
<td>$56,700</td>
<td>85% loss of earnings</td>
<td>3/5ths of weekly benefits</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>NL</td>
<td>$51,595</td>
<td>80% net</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>NT/NU</td>
<td>$75,200</td>
<td>90% net</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>NS</td>
<td>$52,000</td>
<td>75% net 1st 26 weeks then 85% net</td>
<td>2/5ths of weekly benefits</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>ON</td>
<td>$79,600</td>
<td>85% net</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>PE</td>
<td>$47,800</td>
<td>80% net 1st 38 wks then 85% net</td>
<td>3/5ths of weekly benefits</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>QC</td>
<td>$64,000</td>
<td>90% net</td>
<td>No</td>
<td>Yes</td>
<td>14 days</td>
</tr>
<tr>
<td>SK</td>
<td>$55,000</td>
<td>90% net (for injuries on or after September 1985)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>YT</td>
<td>$77,920</td>
<td>75% gross</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>


c) Workers’ Compensation Boards: Duty to Accommodate Legislation

Legally, the face of work accommodation differs by province. Most provinces, except AB and NT/NU, have some stipulation regarding accommodating employees back into the workplace.  

30


d) Workers’ Compensation Boards: Rehiring Workers

Having a job to return to, is a strong predictor of a timely recovery and return to work by ill/injured employees. Canadian provinces, except for AB, BC, and, SK, oblige employers to re-employ ill/injured employees.  

31


e) Workers’ Compensation Boards: Rehabilitation Services by Jurisdiction

Provinces approach rehabilitation of ill/injured employees differently. The Association of Workers’ Compensation Boards provides a summary of the rehabilitation service by jurisdiction.  

COHNA recommends that OHNs be aware of the pieces of WCB legislation that are applicable to their locale.

Privacy Legislation

In Canada, there are a number of provincial and federal statutes that govern the collection, use, disclosure, and destruction of personal information:

- **Freedom of Information and Protection of Privacy (FOIP)** - increases government accountability by ensuring that individuals have the right of access to their information in the custody or under the control of government or public bodies.

- **Personal Information Protection and Electronic Documents Act (PIPEDA)** - private sector privacy legislation that balance the rights of individuals and employees of organizations to have their personal information protected while ensuring that the needs of private sector organizations to collect, use and disclose personal information for business purposes that are reasonable.

- **Personal Information Protection Acts (PIPA)** - Alberta and British Columbia enacted largely similar Personal Information Protection Acts (“PIPA”). These statutes provide that private sector organizations in those provinces may only collect, use and disclose the personal information of individuals and employees for purposes that are reasonable, and to the extent that is reasonable to carry out the purposes. An important exclusion contained in the PIPA statutes allows organizations to collect, use and disclose “personal employee information” without the consent of the individual in some cases: if the information is reasonably required by an organization and is collected, used or disclosed solely for the purpose of establishing, managing, or terminating the employment relationship. This exclusion can be important as an organization determines its conduct and strategy in respect to an injured worker.

The impact of privacy legislation on disability management practices include:

• Assurance of confidentiality of medical information is essential, especially in the area of case management;
• Personal information must be safeguarded with security that is appropriate for the relative sensitivity of the information; and
• Personal information must be protected against unauthorized access, collection, use, disclosure, copying, modification, disposal, or destruction.

As such, under PIPA and other similar pieces of privacy legislation, individual employees have the right to:

• Know why personal information is collected, used, or disclosed.
• Know who is accountable for the organization’s privacy laws and practice.
• Expect the organization to use appropriate security measures to protect the information.
• Expect information to be accurate and complete.
• Request corrections.
• Complain to the organization about how it collects, uses or discloses personal information.
• Appeal to the Privacy Commissioner if a dispute over personal health information cannot be resolved.
• Complain to the organization about how it collects, uses, or discloses personal information.
• Access their personal information that is in the custody or under the control of the organization, unless one or more of the exceptions under the applicable privacy legislation apply.33

In terms of the field of Disability Management, the various pieces of privacy legislation, in general:

• Require employers to advise employees about the nature of personal information collected, used and disclosed, along with why, how and when, unless one of the enumerated exceptions applies;
• Restrict the amount of personal information that may be collected;
• Require employee consent for the collection, use and disclosure of personal information, unless the personal information is reasonably required by the organization and is collected, used or disclosed solely for the purposes of establishing, managing or terminating the employment relationship;
• Limit the free flow of employee personal health information between health care providers and the employers;
• Reaffirm the need for “information firewalls” between occupational health personnel and the workplace;
• Obligate Disability Management Coordinators to ensure that the employee personal information is accurate and complete; and
• Require employers to ensure that employee personal information is collected, used, retained, disclosed, and destroyed in an appropriate manner. 34

The assurance of confidentiality of medical information is essential in performing effective disability management processes, especially in the area of case management. Health care professionals are bound by professional ethics to maintain confidentiality, but this can be a challenge in the workplace setting, and the health care professional must be extremely stringent in maintaining confidentiality. These obligations are also reiterated in the privacy laws: personal information must be safeguarded with security that is appropriate for the relative sensitivity of the information. It must be protected against such risks as unauthorized access, collection, use, disclosure, copying, modification, disposal, or destruction. All stakeholders in the disability management process should be aware of privacy legislation in their jurisdiction and the impact this has on the processes of their programs.

Conclusion

It is important to stress that disability management processes are impacted by a variety of pieces of legislation. This legislation tends to vary from province to province, and from provincial to federal jurisdiction. The most important thing to note is that stakeholders in disability management must be:

- aware of the current legislation in their locale; and
- aware that specific acts and regulations are constantly changing and that they should obtain legal counsel to ensure they have the most current and up to date case law information when setting up programs or when dealing with specific human rights cases.

COHNA advises OHNs to understand the law applicable to the jurisdiction in which they are providing disability management services.

**OHNS: UNIQUE ROLE IN DISABILITY MANAGEMENT**

OHNs have a unique role to play in the field of Disability Management. They are professionally prepared and qualified to understand and interpret medical reports that address employee fitness-to-work status. That coupled with their knowledge of the workplace and organizational systems, position OHNs to effect timely and successful return-to-work experiences.

**Occupational Health Nursing Skills**


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The additional skills that pertain to disability management nursing best practice are:

- **Clinical Assessment Skills** – the ability to conduct an objective assessment of an injured/ill worker’s situation by integrating and applying clinical, professional, communication, and practical skills for nursing practice.

- **Critical Thinking** – the examination of an issue or concept from a number of perspectives with a view to gaining greater understanding. It is the purposeful and reflective judgment about what to believe or what to do.

- **Cultural Competence** - the ability to provide quality Disability Management care and services to a diverse employee population. It encompasses the development of a receptive environment for disability management systemic responses (e.g., organizational policy, procedures, practices, etc.) as well as the delivery of individual Disability Management services. Hence, cultural competence implies a responsibility at both the organizational and individual level.

- **Disability Management Research** – the use of the “scientific method” to discover, understand, interpret, and develop disability management principles, models, practices, and processes.

- **Legal Knowledge** – a working knowledge of the various pieces of legislation relevant to the field of disability management.

- **Liaison** - the position, or responsibility, within an organization for maintaining communication links with external individuals, agencies, or organizations, as well as the internal stakeholders.

- **Coaching** - the process of assisting a supervisor, union leader, employee to effectively participate in a Disability Management Program. It is the act of enabling an individual to successfully undertake a new role/responsibility.

- **Disability Management Governance** – consistent disability management – that means cohesive policies, processes, and decision-making practices.

- **Disability Management Stewardship** – personal responsibility for overseeing and guiding an organization’s Disability Management Program and its functioning.

Additional to the above skills, the Occupational Health Nurse (OHN) has the nursing knowledge, process, and expertise to interact with the employee and family, the various players in the healthcare system, the workplace, the unions, the insurers, and community resources to affect a timely recovery and safe return to work by the employee. Importantly, this professional group is qualified to receive, comprehend, and, interpret medical reports and findings - a unique aspect in the world of disability management. Hence, they can play a pivotal role in assessing ill/injured workers and in coordinating effective return-to-work plans – a true cost saving for employers and employees.

**The Nursing Process**

By way of a reminder, the nursing process is a systematic, rationale method of planning and providing individualized nursing care. It is the process by which registered nurses deliver nursing care to patients, clients, companies, or workers. The process is supported by nursing philosophies and concepts. A deductive theory, the nursing process was originally an adapted form of the problem-solving process.
A patient-centered, goal-oriented method of “caring”, the nursing process provides a framework to nursing care. It involves five major steps:

- assessment (of company/worker's needs);
- diagnosis (of human response needs that nursing can assist with);
- planning (of company/worker's care);
- implementation/intervention (of care); and
- evaluation (of the success of the implemented care).

The characteristics of the nursing process are that it is:

- **Cyclic and dynamic** - The nursing process, which exists for every problem that the patient/client/company/worker has, is a cyclical and ongoing process that can end at any stage if the problem is solved (Figure 15).

- **Goal-directed and client-centered** – The nursing process focuses on the patient/client/company/worker and the individual’s specific needs.

- **Interpersonal and collaborative** – The nursing process is not only centered on ways to improve the patient/client/company/worker's physical needs, but also on the social and emotional needs. Working in consort with the patient/client/company/worker, the nurse is able to facilitate/deliver nursing care that addresses the identified bio-psychosocial needs.

- **Universally-applicable** – The nursing process applies to all peoples, regardless of race, religion, and geographic location.

- **Systematic** – The nursing process is a planned and coordinated approach to providing nursing care.

Additional to the above skills, the Occupational Health Nurse has the nursing knowledge, process, and expertise to interact with the employee and family, the various players in the healthcare system, the workplace, the unions, the insurers, and community resources to affect a timely recovery and safe return to work by the employee. Importantly, this professional group is qualified to receive, comprehend, and, interpret medical reports and findings - a unique aspect in the world of disability management. Hence, they can play a pivotal role in assessing ill/injured workers and in coordinating effective return-to-work plans – a true cost saving for employers and employees. Lastly, they are bound by a code of ethics – the **Canadian Nurses Association Code of Nursing Ethics**.
DISABILITY MANAGEMENT: NURSING BEST PRACTICES

Based on the Disability Management Best Practices described by Dyck (2009), the 18 Evidence-based Nursing Best Practices are:

1) **Joint Labour-Management Commitment to a Disability Management Program**

The most successful workplace models of an Integrated Disability Management Program involve joint labour-management support and participation.

**Nursing Best Practices**

1. Educate the labour and management on the value of a Disability Management Program for the organization.
2. Explain the potential benefits for the union and management of having an Integrated Disability Management Program in the workplace.
4. Invite and strongly encourage union/employee promotion and participation in the graduated return-to-work activities. The most successful Disability Management Programs garner labour commitment and involvement.
5. Facilitate the development of a Disability Management Program that has an effective and sustainable infrastructure - program structure, processes, and outcomes.
6. Seek ways to collaboratively address employee absenteeism and lower the organization’s absenteeism rate.

2) **Integrate Disability Management Efforts**

For effective disability management, a design or model for an Integrated Disability Management Program should exist. An Integrated Disability Management Program is a planned and coordinated approach to facilitate and manage employee health and productivity. It is a human resources risk management and risk communication approach designed to integrate all organizational/company programs and resources to minimize or reduce the losses and costs associated with employee medical absence regardless of the nature of those disabilities.

**Nursing Best Practices**

1. Promote the establishment of a joint labour-management steering committee to oversee the Integrated Disability Management Program.
2. Actively participate as the disability management subject matter expert.

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3. Assist in conducting a comprehensive needs-analysis to identify specific organizational needs, and to establish baseline data before implementing the Integrated Disability Management Program.

4. Participate in assessing the related disability policies and procedures in terms of their impact on the Integrated Disability Management Program, and recommend changes if warranted.

5. Assist with the development of the roles and responsibilities of all major stakeholders involved in the Integrated Disability Management Program.

6. Promote the development of an inventory of modified work/alternate work positions.

7. Assist with the development of the organization's return-to-work program and processes.

8. Develop suitable disability claim and case management forms. These forms should focus on the claimant's functional abilities versus disabilities (i.e., diagnosis).

9. Develop an absence and disability database for all types of absences — casual absence, Short Term Disability, occupational absence (Workers’ Compensation), and Long Term Disability. Link this system with the company or organization's/organization's Occupational Health, Employee Assistance Program, Occupational Health & Safety Program, employee group benefit plans, and Workplace Wellness Program outcomes.

10. Use the above outcome data along with other human resources and employee group benefit plan outcomes to assist in the interpretation of the disability management issues.

11. Seek ways to maximize the integration of all the organizational/company programs so as to maximize the individual program efforts and outcomes.41

3) Disability Program Policies and Procedures

Policies and procedures for maintaining contact with absent staff members, accessing treatment or rehabilitation, and ensuring an expedient return to work can be applied to the entire continuum of employee medical absence regardless of cause, including casual absence, Short Term Disability, Workers’ Compensation Board, and Long Term Disability illness/injuries. The intent of the Integrated Disability Management Program policies and procedures is to ensure that processes are in place and are applied fairly, equally, and consistently. They are also a means of communication about the Integrated Disability Management Program – its goals, structure, processes and outcomes, as well as labour-management’s support for the program. Research indicates that, “Organizational policies and practices play a role in whether or not injured workers will return to work and if they will perform well once back at work.”42

Nursing Best Practices

1. Serve as a subject matter expert in the development and implementation of policies and procedures that deal with:

   • disability leaves (i.e., casual absence, sick leave, Short Term Disability, Workers’ Compensation Board, Long Term Disability, etc.);
   • rehabilitation measures (i.e., case/claim management, vocational rehabilitation, etc.);
   • claim management standards of practice;
   • case management standards of practice;

• confidentiality standard of practice;
• documentation standard of practice;
• return-to-work practices;
• alcohol and drug policy; and
• harassment and respectful workplace policies.

2. Provide governance and stewardship regarding the content of these policies.
3. Identify deficits in these policies and advise management.

4) Graduated Return-to-Work Initiatives

Graduated return-to-work initiatives can be an effective method of systematically returning employees to health and work, and can contribute to cost-containment. 43, 44

Nursing Best Practices

1. Serve as a subject matter expert in the development and implementation of graduated return-to-work initiatives that involve labour and management support and participation.
2. Communicate the roles, responsibilities, and accountabilities of the key stakeholders.
3. Elicit employee, union, and line identification of modified/alternate work options.
4. Manage safe and timely return-to-work activities.
5. Endorse the development of flexible and creative return-to-work options.
6. Act as a neutral participant in the return-to-work process.
7. Promote a collaborative approach to the return-to-work process – employee, supervisor, union, human resources, health care provider(s), and insurer involvement.
8. Develop individualized return-to-work plans for employees that enable them to return to work in a safe and timely manner.
9. Promote respectful and healthy employment relationships.
10. Identify the need for conflict resolution and assist with this process.
11. Monitor the accommodation process, making adjustments as required.
12. Collect and manage modified/alternate work data, and the graduated return-to-work outcomes.
13. Evaluate the graduated return-to-work initiatives, plans, and outcomes regularly.
14. Communicate the benefits, challenges, and outcomes of the Integrated Disability Management Program to all the key stakeholders. 45

5) CENTRALIZE THE RESPONSIBILITY FOR AN INTEGRATED DISABILITY MANAGEMENT PROGRAM

To ensure effective functioning, one central figure should coordinate the daily operations of an Integrated Disability Management Program.⁴⁶

NURSING BEST PRACTICES

1. Assist the Integrated Disability Management Program steering committee to identify the duties of the Disability Management Coordinator, as well as the requisite skills for the position.

2. If deemed appropriate, manage the Integrated Disability Management Program – this includes the planning, organizing, directing, evaluating, and continuous improvement activities.

3. Coordinate the Disability Management Program with other organizational/company programs such as the Employee Assistance Program, Occupational Health & Safety Program, Workplace Wellness Program, and Human Resources Program/services.

4. Advise the company’s Occupational Health & Safety department of the cause and nature of all occupational claims. The intent is to seek workable illness and injury prevention strategies.

5. Advise Human Resources of the cause and nature of the non-occupational claims. The intent is to seek workable illness and injury prevention strategies.

6) DISABILITY MANAGEMENT COMMUNICATION STRATEGY

An essential component of any successful Integrated Disability Management Program is the widespread understanding and support of stakeholders both within the workplace and in the broader community.

NURSING BEST PRACTICES

1. Assist in the development of the Integrated Disability Management Program’s communication strategy and plan. The aim is to promote awareness and overcome organizational barriers to implementing an Integrated Disability Management Program.

2. Assist with the identification of the key stakeholders along with their respective needs and wants from the Integrated Disability Management Program.

3. Assist with the development of the key messages that are to be delivered to each stakeholder group as well as with the appropriate communication media and vehicles.

4. Play a major role in informing the key stakeholders about the Integrated Disability Management Program, and its successes and problems. That is, keep them in the decision-making loop.

5. Provide stakeholders with the relevant outcome data and benefits realized by the Integrated Disability Management Program. This approach garners continued support for the Integrated Disability Management Program.

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7) **Disability Management Education and Training**

The purpose of Disability Management Program education and training is to create awareness around the need for and value afforded by workplace-based attendance and disability management programs.\(^{47}\)

**Nursing Best Practices**

1. Assist with the development and delivery of generalized training for all supervisors and human resources staff in dealing with ill or injured employees and family members.

2. Provide specialized disability management education for supervisors, union, and other staff leaders involved in the implementation of the Integrated Disability Management Program.

3. Develop and deliver “train-the-trainer” sessions for employee/union peer counsellors if appropriate.


5. Develop and deliver quality educational sessions.

6. Avail oneself of specialized education and training in disability management. This should include continuing education in the field of disability management and other related fields (e.g., in Employee Assistance Programs, Human Resources principles, Occupational Health & Safety, risk management and risk communication, Workplace Wellness Programs, management human resource theories and practices, etc.).

8) **Link the Disability Management Program with the Employee Assistance Program**

External services can play an important role in effective employee attendance support and disability management. Companies that integrate the Employee Assistance Program services with attendance support and Disability Management Programs tend to encounter the need for a comprehensive Employee Assistance Program service when dealing with the psychological and physiological aspects of absence.\(^{48}\)

**Nursing Best Practices**

1. Partner with the organization’s Employee Assistance Program to develop an effective manner in which to link the Integrated Disability Management Program with the Employee Assistance Program. The focus is on the employee’s functional ability, the characteristics of workplace environment, and the job demands. Hence both parties can reach a common ground on which to jointly assist the ill/injured employee.

2. Ensure that all the service providers attain a mutual understanding of and respect for the individual program goals and objectives, as well as for the overall Integrated Disability Management Program goals and objectives.

3. Promote a partnership approach that allows for multi-disciplinary interventions.

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4. Develop the appropriate channels of information and consent forms through which information on the employee’s functional ability, the characteristics of workplace environment, and the job demands can be shared.

5. Evaluate the outcome measures on the cases served jointly by the Employee Assistance Program and Integrated Disability Management Program personnel. Knowledge of utilization rates, types of cases served, trend analyses and success or failure rates, and anticipatory guidance for illness and injury prevention can be attained using aggregate data.

9) **Medical Consents and Certificates**

The process of obtaining consent to collect personal health information creates a reasonable expectation of privacy by the employee. This requires the employer to take all reasonable steps to ensure the level of confidentiality promised in the consent form is not compromised. Some reasonable steps include:

- maintaining confidentiality;
- retaining information;
- secure storage of information;
- appropriate disclosure of information internally and externally;
- proper transmittal of information;
- appropriate methods of destruction; and
- identification of the consequences for staff violations, if any should occur.

**Nursing Best Practices**

1. Review the disability claim forms and medical certificates; revise any forms/certificates that fail to gather the necessary information in a manner that is in compliance with the applicable legislation.

2. Ensure the form/certificate is clear, concise and designed to gather only the information relevant to the current disability. Appendices 4 and 5 provide sample Reports of Absence. Appendix 7, Restricted Work Form; Appendix 8, Physician's Statement of Medical Status Form; and Appendix 9, Return-to-Work Report are additional forms for obtaining fitness to work information.

3. Develop and communicate the procedures for the submission and retention of consent forms and medical certificates.

4. Educate unions, management, and employees on the elements of informed consent. 49

5. Serve as the custodian of informed consent.

6. Ensure the existence of a consent form signed by the ill or injured worker before any contact with the physician is initiated. Appendix 10 provides sample consent forms.

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49 **Informed consent** - There is an obligation on the employer to ensure that sufficient information is provided to employees about the nature and consequence of the intended action to allow the employee to reach a reasoned decision. The employee must be mentally competent, and possess the ability to understand and appreciate the nature and consequences of the procedure. The consent must be freely given; not obtained through misrepresentation or fraud. The consent given must be in relation to the specific act contemplated unless the employee’s life is immediately endangered and it is impractical to obtain consent. Consent cannot be given to the performance of an illegal procedure.
10) **Policies and Procedures to Protect the Confidentiality of Medical Data**

Medical diagnoses and health-related data are obtained during the course of claim and case management. Policies and procedures are required to deal with confidentiality and access to medical files, as well as with the responsible retention, storage, transfer, or disposal of medical data.

**Nursing Best Practices**

1. Assist with the development of a confidentiality policy and code of practice. This should comply with the applicable legislation.
2. Develop a protocol for the retention, maintenance, release, and disposal of medical documentation.
3. Retain all medical data in a secure and confidential manner with access by authorized personnel, and only on a “need-to-know” basis.
4. Retain all medical documentation for a minimum period of seven years from the last point of activity.
5. Limit the dissemination of medical diagnoses to broad categories or neutral descriptors, such as occupational injury, occupational illness, non-occupational injury, or non-occupational illness. When diagnoses are used, limit them to disease classifications or aggregate the data so that individual diagnoses cannot be determined.
6. Provide governance and stewardship in terms of current case law and legislative changes that impact the disability management practices.

11) **Case Management Practices**

Effective case management promotes quality, cost-effective outcomes in terms of human and financial saving.  

**Nursing Best Practices**

1. Serve as a subject matter expert in the development of the organization's/company's case management practice standards.
2. Educate stakeholders on what case management is and what it is not, thereby managing the expectations of the key stakeholders.
3. Uphold the established case management standards.
4. Develop disability management nursing plans that are based on the nursing process, and which include the use of evidence-based data, as well as knowledge of the workplace and its culture.
5. Track the disability data, plus the hours of modified/alternate work, dollars saved with modified/alternate work, and types of cases that were the most successful with early return-to-work initiatives.
6. Evaluate the case management process employed through the use of peer or internal reviews, or external quality assurance measures (audits).

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7. Track occupational health and case management activities, such as the amount of time required to case manage each claim, administer the service, train supervisors, undertake process development, conduct follow-up activities, and pursue professional development.

8. Evaluate, on a case-by-case basis, the return on investment of the case management interventions.

9. Continue to review disability claim outcomes, paying special attention to claims that are closed. Use the closed claims as indicators of the case management outcomes.

12) Early Intervention

Research and industry experience strongly endorses the importance of early intervention in any absence.  

Nursing Best Practices

1. Educate the workplace on the value of early intervention and what early intervention looks like.

2. Promote the development of a work culture that actively supports early intervention.

3. Manage the case management expectations of the key stakeholders.

4. Promote early contact between the supervisor and the ill/injured employee ideally on the first day of absence; by the third day at the latest. Appendix 2 provides a sample Letter to the Absent Employee, in which the organization’s expectations of the absent employee are explained.

5. If required, implement early case management (within the first three to five days of the absence).

6. Function as an advocate, not an enabler, to the disabled employee and family.

7. Involve the Employee Assistance Program in situations as appropriate.

8. Encourage open communication and positive relationships within organization.

13) The Claim Adjudication Process

Employers require a documented process for claim adjudication. This helps to ensure the use of a standardized approach. The exact criteria used to determine claim eligibility depend on the terms of the benefit plan in place. Most of this task is undertaken by non-nursing personnel. They vary greatly from nursing skills in that they involve adherence to claim management criteria, as opposed being based on concepts, principles, and practices. However, the Occupational Health Nurse does have a significant role to play in the claim management processes.

Nursing Best Practices

1. Determine employee fitness-to-work.

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53 Advocate – the role of pleading or representing an employee’s cause to management, or to external individuals or agencies.

54 Enabler – the role of enabling another to persist in self-destructive behavior (as substance abuse) by providing excuses or by making it possible to avoid the consequences of such behavior.

2. Communicate that information to management/human resources services in a timely manner.

3. Assist with the ongoing monitoring of the employee’s fitness-to-work status.

4. Communicate the degree of employee compliance with the recommended treatment and rehabilitation.

5. Communicate the expected return-to-work date along with any identified work limitations.

6. Consider the use of flow charts and visual aids to depict the claim management process, and how and when the OHN can assist.

14) **Effective Management of Disabilities**

Disability management is highly dependent on workplace relationships. Employee willingness to help each other is based on the quality of their social relationships. The stronger the social relationships, the more tolerant the workplace culture is of employee disabilities; and the greater the likelihood that the workplace will support the recovering employee through the return-to-work process.\(^5^6\)

**Nursing Best Practices**

1. Educate the workplace about the impact of workplace disabilities and how to recognize an employee who is experiencing health problems. Add to that, an explanation of the concept of social capital and its influence on the return-to-work process.

2. Encourage the workplace to redesign work processes to decrease certain physical and psychological stressors, and hence, to decrease the likelihood of relapse and secondary health conditions when the employee does return to work.

3. When designing a rehabilitation and return-to-work plan, involve the employee, supervisor, and union. Working collaboratively enhances relationships and provides clarity as to the plans and processes.

4. Regularly communicate with employees who are on sick leave. Document those conversations to reinforce the agreed-upon decisions and action plans. Include line management and the union representative on this correspondence.

5. Reinforce that the OHN is qualified to receive and interpret medical information. In most workplaces, the occupational health nurse will be the only professional qualified to do so.

6. Promote a good person/job fit when offering work accommodation.

7. Seek to develop return-to-work plans that build the employee’s confidence, particularly when employee fear of relapse or pain is evident.

8. Manage the expectations of the returning employee as well as the expectations of co-workers, managers, and union representatives. Ensure they remain realistic as to what “a successful rehabilitation and return-to-work” looks like, and how long it might take to complete. Appendices 5 and 6 provide sample Modified/Alternate Work Plan Forms.

9. Seek to legitimize the work accommodation of the returning employee. Some of this can be done by tackling misinformation “head on” - debunking myths about workplace safety and authenticity. Teaching line management how to “assist” rather than to “blame”, when an employee experiences symptoms or a relapse at work.

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10. Encourage the resolution of conflict. Conflict decreases trust, liking, and therefore, social capital – all detrimental to a successful return to work.

11. Promote the development of a fair and transparent process for investigating discipline-worthy conduct. This will go a long way to prevent the escalation of workplace conflict and perceptions of favoritism.

12. Seek ways to recognize and reward managers for maintaining healthy work teams and for successfully accommodating employees from other business units. Likewise, employees should be positively recognized for following medically sanctioned work restrictions and for assisting in the accommodation of co-workers.

15) MANAGEMENT OF MENTAL HEALTH DISABILITIES

A. Mitigation
With a rising incidence rate of mental health claims, the recommended approach is the use of return-to-work plans specific to the management of mental illness in the workplace. This is consistent with the work undertaken by the Global Business and Economic Roundtable on Addictions and Mental Health, as well as the Canadian Mental Health Association.

BEST PRACTICES: MITIGATION
1. Promote early contact with the ill or injured employee by the supervisor.
2. Implement early case management (within the first three to five days).
3. Involve the Employee Assistance Program or some other form of counselling as part of the treatment plan.
4. Use a technique such as The Green Chart (Appendix 11) to open the lines of communication between the healthcare providers and the occupational health professionals, or Disability Management professionals/practitioners, who represent the workplace interests.
5. Work with a significant person in the individual’s life to ensure that workplace issues or concerns are properly addressed.
6. Ensure that support is available to the employee upon his/her return to work.
7. Maintain that support for a number of months post-return to work.

B. Prevention
Prevention of mental health problems in the workplace is a “best practice” – an approach that is cost-effective in terms of the human and financial aspects.

BEST PRACTICES: PREVENTION
1. Promote the development of effective strategies for protecting the psychological health and safety of employees.
2. Participate in the implementation of those strategies.
3. Assist with the monitoring and evaluation of the effectiveness of the implemented strategies.
4. Assist with the enhancement of the identified prevention approaches.
16) **Cultural Diversity and Disability Management**

By becoming culturally competent, employers can appreciate and maximize the strengths of each of the various cultures present in their workplaces. Recent survey data indicates that cultural differences in terms of disabling conditions. Hence, cultural diversity brings challenges to managing employee disabilities. Reaction to illness/injury and recovery is culturally based. Nurses recognize this fact many years ago. Hence, the early focus on cross-cultural nursing.

**Nursing Best Practices**

1. Assist with the identification of the cultural mix within the organization.
2. Promote cultural competence within the organization.
3. Seek to communicate effectively with the various cultures – use of translators or multilingual communication tools.
4. Identify areas of potential cultural conflict and seek ways to address them.
5. Provide clarity on the Integrated Disability Management Program while being culturally respectful.
6. Compromise by showing respect for different beliefs and by being willing to work with those beliefs to reach a “win-win” solution for the stakeholders.
7. Help workers understand their options so that they can make informed consents to treatment and return-to-work options.
8. Ensure that support is available to the employee upon a return to work.
10. Seek ways to continuously improve the organization’s approach to cultural diversity, especially in the area of disability management.

17) **Disability Data Management**

Data collection and analysis is the foundation on which the success of an Integrated Disability Management Program is based.

**Nursing Best Practices**

1. Use evidence-based research when designing the data management processes for the Disability Management Program.
2. Capture all absence and disability data in a format that can be compared with other Canadian disability databases.
3. Ensure that the claim and case management data collected includes casual sick time, Short Term Disability, Workers’ Compensation, and Long Term Disability absence rates and costs.

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4. Monitor the Workers’ Compensation Board data, investigate opportunities for cost avoidance and cost savings, and seek guidance regarding Workers’ Compensation Board claim management techniques.

5. Investigate the potential implementation of an integrated occupational health and safety data management system that can link Disability Management Program outcomes (i.e., Short Term Disability, Workers’ Compensation Board claims, Long Term Disability, etc.) with Occupational Health and Safety Programs, Employee Assistance Programs, employee benefits, and Workplace Wellness Programs.

6. Seek opportunities to link employee absence data with human resources information.

7. Use the company’s available communication systems (e.g., e-mail, internal mail, cheque inserts, newsletters, reports, etc.) to encourage the transmission of absence, disability, and modified/alternate work data.

8. Ensure that all stakeholders are aware of the reasons for, and costs of, medical absenteeism and disability.

9. Encourage industry disability management benchmarking such as the Institute for Work and Health’s Workplace Disability Benchmarking Project to determine what is working and not working in the organization’s Disability Management Program.

10. Monitor and evaluate the effectiveness of the data management processes, making improvements as required.

18) Measurement, Monitoring, and Continuous Improvement of the Disability Management Program

Integrated Disability Management Programs must demonstrate continuous evaluation and modifications to:

- justify the program;
- improve workplace health and safety practices;
- ensure that the program objectives are met; and
- ensure that employer and employee needs are met.

Nursing Best Practices

1. Develop Short Term Disability performance measures that include absentee rates, lost time hours, lost time costs, average absentee length, percentage of hours saved on modified/alternate work, dollars saved due to modified/alternate work activities, percentage of employees who returned to work, number and types of interventions used and number of Short Term Disability claims that were successfully resolved.

2. Review the Workers’ Compensation Board data, investigate opportunities for cost avoidance and cost savings, and seek guidance regarding Workers’ Compensation Board claim management techniques.

3. Institute program outcome measures in the Long Term Disability period which include the following: reduced disabled lives liability, reduced Long Term Disability claims and costs, increased cost avoidance due to early intervention and modified/alternate work initiatives, case-by-case return on investment due to intervention, and return on investment using a formula customized to suit the company or organization’s needs.

4. Establish the contributing factors for employee absenteeism and disability such as employee age, lifestyle, drug or alcohol use, work environment, employee-employer
relationships, seasonal issues, legal issues, financial issues and existence of pre-existing health conditions.

5. Measure the effectiveness of the Integrated Disability Management Program through interviews, surveys, data analyses, and return on investment for the services provided and associated benefit costs.

6. Set program management targets for each year and measure success/failures.

7. Use the disability management data to provide insight into opportunities for corporate occupational health and safety initiatives and prevention strategies.

8. Regularly disseminate disability management data to all the departments along with the related costs.

9. Justify the Integrated Disability Management Program in terms of the return on investment attained through lower disability costs, reduced use of employee group benefits, improved employee well-being and health, and increased employee productivity.

CONCLUSION

This Disability Management Practice Standard is designed to be a “living document”. Given that “best practices” are the basis of many practice standards, and that “evidence-based best practices” are constantly changing, this Disability Management Practice Standard must be reviewed and updated regularly.

ADMINISTRATION RESPONSIBILITY

The primary responsibility for the administration and regular update of this Disability Management Practice Standard rests with the elected COHNA Board. It is recommended that this standard be updated at least every 4 years.

APPENDICES

Disability Case Management Practice Standard: Appendices include.  

- Appendix 1 – The ECM Group: Initial Assessment Form
- Appendix 2 - Sample Letter to Absent Employee
- Appendix 3 - Report of Absence Form (a)
- Appendix 4 - Report of Absence Form (b)
- Appendix 5 - Modified/Alternate Work Plan Notification (a)
- Appendix 6 - Modified/Alternate Work Plan Notification (b)
- Appendix 7 - Restricted Work Form
- Appendix 8 - Physician’s Statement of Medical Status
- Appendix 9 - Return-to-Work Report
- Appendix 10 - Consent Forms
- Appendix 11 – Road to Recovery: The Green Chart

Appendix 1

The ECM Group: Initial Assessment Form

Initial Assessment Form

Case Number

Employee Number

Employee Name

Current Health Status

Current Treatment & Medications

Previous Treatment

Primary Practitioner

Name

Address

City

Postal

Phone

Fax

Signed Consent

On File

At Practitioner's Office

With Employee

TYPE

Additional Practitioner(s) Name

Phone

Fax

Type

PSYCHOSOCIAL INFORMATION

FAMILY & SOCIAL SUPPORT

PERCEIVED CONTROL

ACTIVITIES (Daily living, recreation, hobbies, capabilities with examples - sitting, standing, walking, kneeling, bending, lifting, reaching, climbing, twisting, stooping, reaching pushing, pulling, gripping, writing, typing, level of perceived function at 1 month, 6 months, 1 year)

BARRIERS TO REHABILITATION (Include barrier client sees as largest barrier to return to work)
Appendix 2

Letter to the Absent Employee - (sample)\(^{62}\)

COMPANY XYZ
LOGO/ADDRESS

Date _______________________

Dear _______________________

(Employee)

RE: Medical Absence

We have been advised by your supervisor that you are unable to work due to illness/injury. We sincerely hope that you will experience an early recovery and we wish to assist you wherever possible.

As part of our corporate Disability Management Program, we require the following:

- a completed attending physician’s report (as attached); and
- a signed consent form for release of medical information to our Disability Case Manager(s), and our insurers/adjudicators (______).

The attending physician report must be completed and returned to Company XYZ’s Occupational Health Department within three (3) working days. Your signed consent form must accompany this physician report.

Your supervisor will be in contact on a weekly basis to determine if there are any opportunities for modified/alternate work. We would encourage you to utilize the Employee Assistance Program should you require such services during your disability.

If there is any additional assistance the company can provide, please contact ______________.

We look forward to having you return to your job in the very near future.

Yours truly,

Supervisor

---

Appendix 3

Report of Absence Form

Sample (a): For Organizations with Occupational Health Services:

<table>
<thead>
<tr>
<th>EMPLOYEE AUTHORIZATION: (To be completed by the employee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Work Injury ☐</td>
</tr>
<tr>
<td>Non-work Injury ☐</td>
</tr>
<tr>
<td>Is your injury or illness related to your work? ☐ Yes ☐ No If yes, please explain below:</td>
</tr>
</tbody>
</table>

I hereby authorize my insurer and attending physician to release any information related to this injury/illness, or copies thereof acquired in the course of examination or my treatment, Company XYZ’s Occupational Health Service. I further authorize the Occupational Health Service to release to my insurer/employer any information required to determine my eligibility for short term disability benefits and any information related to the employment relationship. I understand that this information will be used to determine my eligibility for disability benefits, to assist with the management of my claim, and to remediate any work-related factors contributing to my illness or injury or my return to work. This consent is valid for 180 days.

Signature: ___________________________ Date: ________________

COMPANY PHILOSOPHY

Company XYZ has a Disability Management Program designed to assist the safe and timely return of employees who are recovering from injury/illness, or who have ongoing health problems. We would appreciate your assistance and co-operation. If you have any questions or suggestions about the Disability Management Program, and/or the placement of this employee, please contact us.

Submit form to: The Occupational Health Service at above address, or in the confidential envelope provided, or by confidential fax (XXX-XXXX). Thank you for the time and consideration you have provided to Company XYZ and this employee.

PHYSICAL WORK RESTRICTIONS: (To be completed by the attending physician)

<table>
<thead>
<tr>
<th>Please check and complete either Section A or Section B:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section A: The employee may return to Regular Work on:</td>
</tr>
<tr>
<td>Section B: The employee may return to Modified Work on:</td>
</tr>
<tr>
<td>And may return to Regular Work on:</td>
</tr>
</tbody>
</table>

If Modified Work is required, please complete the following Work Restrictions:

- Lifting - from waist (weight/frequency) (how long)
- Lifting - from shoulder (weight/frequency) (how long)
- Prolonged standing (how long/frequency) (how long)
- Working in the cold (how long/frequency) (how long)
- Working in the heat (how long/frequency) (how long)
- Working outdoors (how long/frequency) (how long)
- Repetition (hands/arms) (how long/frequency) (how long)
- Operating heavy machinery (frequency) (Frequency)
- Climbing ladders (frequency) (Frequency)
- Working at heights (frequency) (Frequency)
- Climbing stairs (frequency) (Frequency)
- Driving (frequency) (Frequency)
- Working shift work (frequency) (Frequency)
- Crawling (frequency) (Frequency)

Other Comments: ___________________________

Temporarily reduced or gradually increasing hours are available. Please indicate any restriction of this type:

DIAGNOSIS: (To be completed by the attending physician)

Diagnosis of the Present Health Condition:

1. Primary Diagnosis:

2. Pre-existing condition or complications that may affect the work absence:

3. Date of next follow-up visit: Day __ Month __ Year __

4. Is the present condition the result of, or complicated by, a pre-existing condition? Yes ☐ No ☐

If Yes, please explain:

- Date of Hospitalization (if applicable): ________________
- Date of Injury/Illness Onset: ________________
- Nature of treatment (e.g., surgery, physical therapy): ___________________________
- Name of Specialist (if applicable): ___________________________

Duration/Frequency of Treatment:

- Date of First Treatment: ________________
- Date of Last Treatment: ________________
- Name of Physician: ___________________________
- Physician Phone Number: ___________________________
- Address: ___________________________
- Physician Fax Number: ___________________________
- Physician’s Signature: ___________________________ Date: ________________

Thank you for your assistance in supporting this employee through this injury or illness, and a timely return to work.

---

### Return-to-Work Certificate

*This must be completed and signed by an employee returning to work after an absence of 3 (three) or more days*

<table>
<thead>
<tr>
<th>Non-Work Related:</th>
<th>Work Related:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ <em>i.e., the flu, sports injury</em></td>
<td>☐ <em>i.e., a possible Workers’ Compensation claim</em></td>
</tr>
</tbody>
</table>

1. (a) ☐ I have seen a physician and he advised me that I would be medically fit to work on this date: _________________________

   (b) ☐ To the best of my knowledge I am fit for work.

   (check one)

2. Specify any work restrictions recommended by your physician:

   _______________________________________________________________
   _______________________________________________________________
   _______________________________________________________________

Physician’s Name and Address:

_______________________________________________________________

_______________________________________________________________

Employee Name: (please print)

_______________________________________________________________

Employee Signature:

_______________________________________________________________

Employee Number:

_______________________________________________________________

Date:

_______________________________________________________________

Return-to-work date:

_______________________________________________________________

---

Appendix 5

Modified/Alternate Work Plan Form — Sample (a) ⁶⁵

COMPANY XYZ
LOGO/ADDRESS

Date: __________________________

To: ____________________________

Department: ______________________

The following employee is to be placed in a Modified/Alternate Work Plan due to a medical condition:

Name: __________________________

Employee Number: __________________

Title: ____________________________

Company: _______________ Department: ______________________

Work Restriction:
Length of restriction: _______ days: _______ weeks: _______ months:

MWP begins (date): _______________ (time): _______________

THE EMPLOYEE WILL BE RE-EVALUATED ON (DATE): _______________ (TIME): _______________

Please contact our office if you have any questions at (telephone): __________________________

Completed by: ______________________ MD/OHN

Title: ____________________________

Address (of contract provider): __________________________

___

Appendix 6

Modified/Alternate Work Plan Form — Sample (b) 66

COMPANY XYZ
LOGO/ADDRESS

Modified/Alternate Work Plan:
[To be completed by the Disability Case Manager]

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>Supervisor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Day Worked:</td>
<td>Regular Work Location:</td>
</tr>
</tbody>
</table>
| Regular Occupation: | Information Provided by Employee:
| | |

Modified/Alternate Work Requirements:

- Permanent: □ Starting Date: ______
- Temporary: □ Starting Date: ______ Expected Ending Date: ______

Modified/Alternate Work Plan Details:

<table>
<thead>
<tr>
<th>Location:</th>
<th>Supervisor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modified/Alternate Work Description:</td>
<td></td>
</tr>
<tr>
<td>Comments/Special Considerations:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Next Medical Reassessment: | Next Review:

Signed: ___________________________ Date: __________
(Supervisor)

Signed: ___________________________ Date: __________
(Modified/Alternate Work Supervisor, if applicable)

Signed: ___________________________ Date: __________
(Employee)

cc: For WCB — Manager, Occupational Health
    All others — Manager, Employee Benefits

Appendix 7

Restricted Work Form — Sample

COMPANY XYZ
LOGO/ADDRESS

Date: ___________________________
Employee Name: ___________________________
Employee Number: ___________________________
Department: ___________ Title: ______________
Work Location: ___________________________

Work Restrictions are: ☐ job-related (WC)  ☐ non-occupational

Explain physical limitations: (and reasons for them on the medical copy only)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Expected length of restriction/limitation: _______ days _______ weeks

Restriction is (check one): ☐ Temporary  ☐ Permanent

Employee will be re-evaluated on: (date) __________________________

Signature: ________________________________________________

Examiner: (print name) __________________________

Telephone No.: __________________________

Date: __________________________

Appendix 8

Physician’s Statement of Medical Status Form — Sample

COMPANY XYZ
LOGO/ADDRESS

Company XYZ
Representative: ___________________________ Department: ___________________________
Title: ___________________________ Telephone No.: ___________________________
Address: ___________________________

Instructions to the Attending Physician/Health Care Provider:
Please complete all information requested regarding your patient and return this form within 3 days to the Company
Representative (address provided above). Thank you.

Date:
Employee Name: ___________________________ Employee Number: ___________________________
Job Title: ___________________________ Department: ___________________________
Date of Injury/Illness: ___________________________ First Day out of Work: ___________________________

Is this absence an occupational, workers’ compensation claim? ☐ or non-occupational disability claim? ☐
(Please explain/list chief complaints, signs, symptoms):

Date of first treatment for this condition:
Date of most recent treatment/diagnostic examination:

What were the findings of the above treatment/examination:

What treatment/therapy and medication regimen are you prescribing? Please indicate frequency and expected
duration of treatment, etc.:

Date:

Physician’s signature: ___________________________
Physician’s name (please print): ___________________________
Telephone No.: ___________________________
Address: ___________________________
Fax No.: ___________________________

Thank you for this information. It is essential to our efforts of safely returning employees back to work.

Company XYZ Disability Case Manager

Appendix 9

Return-to-Work Report — Sample
(For use by Occupational Health Professional)

COMPANY XYZ
LOGO/ADDRESS

Employee Name: (print last, first, middle) _______________________________________
Employee Number: _______________________________________________________

I hereby authorize my attending physician to release any information or copies thereof acquired in the course of examination or treatment for the injury/illness identified below to my employer or their representative.
Employee Signature: ___________________________ Date: _______________________

To be completed by personal physician:
Employee diagnosis: _____________________________________________________

Date of first injury/illness: _____________________________
Date of latest visit/treatment: _____________________________
Date last worked: _______________________________________

Current medical status:
☐ Recovered (may return to work with no limitations on __________ date).
☐ May return to work with the following limitations:*

*These limitations are in effect until: ___________________________ reevaluated on: ________
       (date)                        (date)

☐ Employee remains totally incapacitated at the present time and will be reevaluated on: ________
       (date)

Physician’s comments:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

__________________________________________________________________________

Physician’s signature: ___________________________ Date: _______________________
Physician’s name: ___________________________ Telephone No.: _______________________
(please print) Address: ___________________________ Fax No.: _______________________

Note: Both employee and physician must complete form.

Appendix 10

Consent Form — Sample

COMPANY XYZ
LOGO/ADDRESS

I hereby authorize all physicians, practitioners, hospitals and other institutions by this form or photographic copy thereof to give Company XYZ’s representatives, The Occupational Health Services, for inclusion in medical files, any information they may have regarding the status of my health when I was under observation for my disability.

______________________________  ___________________________
Employee Signature              Date

Please note that all information received will be kept in STRICT CONFIDENCE and will be used for adjudication, rehabilitation, and return to work purposes.

This consent form can be added to other Disability Management forms, like the Absence Report, Fitness to Work Form, etc.

Authorization for Release of Privileged Information — *Sample*

| TO: | _______________________________________________ |
| ADDRESS: | _______________________________________________ |
| | _______________________________________________ |
| | _______________________________________________ |

I AUTHORIZE YOU TO RELEASE HEALTH INFORMATION IN STRICT CONFIDENCE

| TO: | _______________________________________________ |
| ADDRESS: | _______________________________________________ |
| | _______________________________________________ |
| | _______________________________________________ |

INFORMATION TO BE PROVIDED CONSISTS OF:

| | | | | |
| | | | | |
| | | | | |

FOR THE PERIOD (DATES):  _________________________________________________________________________________

EMPLOYEE NAME (PRINT)  _______________________________________________

EMPLOYEE NAME (SIGNATURE)  ______________________  DATE  ______________________

WITNESS NAME (PRINT)  _______________________________________________

WITNESS SIGNATURE  ______________________  DATE  ______________________
Appendix 11

Road to Recovery: The Green Chart

The Case Management Approach to Recovery to Good Mental Health

To promote a safe, timely, and supportive return to work, it is very important to maintain contact and open communication between the workplace and the employee throughout the absence and return-to-work period of time. As previously mentioned, isolation worsens the employee’s situation. Hence, organizations/companies are encouraged to adopt a system of clear communication among the major stakeholders, especially between the Occupational Health professionals and the healthcare providers. The aim is to ensure that employer and employee needs are identified and addressed. One option is the use of the Green Chart (Figure 16), and the associated communication tools:

1) **The Case Manager’s Roadmap to Recovery** (Figure 17); and
2) **The Physician’s Roadmap to Recovery** (Figure 18).

The Green Chart, which is designed specifically for use by Occupational Health professionals and treating physicians, promotes a dialogue on the relevant workplace concerns and employee performance issues. The intent is to identify the current state of affairs so that appropriate treatment and return-to-work plans can be developed and implemented. It also enables the workplace to put forth their concerns so that the healthcare providers can appreciate the magnitude of the challenges faced by the employee and employer.

---

Figure 16: The Green Chart

The Green Chart

Goal:

Facilitate a safe, timely, and supported return to work for the employee suffering from a mental health problem.

Approach:

Implement the use of charts like the ones provided in Figures 17 and 18 to house:

1. Information that the attending physician needs to clearly understand the implications of the mental health disorder on the individual's ability to function in the workplace. It would include:

   • The employee's job and functions including bona fide physical and psychological job demands (e.g. claustrophobia would not be beneficial for some on working in confined spaces);
   • The required skills such as technical skills, planning skills, attention to critical details, interpersonal skills, organizational skills, ability to concentrate, retention of information, time management, etc.; and
   • The work demands: pace, dynamics, need for interpersonal exchange and features of the work environment.

2. Information the employer needs to support the employee’s recovery and return to work, such as:

   • The nature of communication recommended between work to home and home to work; and
   • The information the employee needs to understand, participate, and “own” the return-to-work plan.

Within the disability period, it is paramount for the internal/external Occupational Health professional to:

• promote appropriate medical treatment for the employee;
• support the workgroup throughout the absence and return-to-work periods; and
• facilitate a successful resolution of the absence and return-to-work for the employee and workgroup.

The Green Chart: Case Manager’s and Physician’s Roadmap to Recovery

To successfully carry out their responsibilities, Occupational Health professionals are encouraged to use The Green Chart – Case Manager’s Roadmap to Recovery (Figure 17). This tool is designed to track the case management details of the employee’s illness in terms of their mental health capabilities, as well as the steps for their re-entry into the workplace. It includes the physician’s rating of the employee’s capabilities, the physician’s recommendations, a plan of action, and the desired outcomes.

The Green Chart – Physician’s Roadmap to Recovery (Figure 18) is an assessment tool, as well as a communication tool with the workplace. It enables the physician to rate the employee’s mental/emotional functioning in terms of work performance, e.g., the ability to understand and follow instructions, the ability to perform simple and repetitive tasks, etc. The collection of workplace information, historical employee performance information, and other details is also enabled.

Please note that the employee who is being assessed should have full knowledge of the contents of the Green Chart and be in agreement with the assessments made.
**Figure 17: The Green Chart: Case Manager’s Roadmap to Recovery**

```
<table>
<thead>
<tr>
<th>Employee:</th>
<th>Case Manager:</th>
<th>Date:</th>
<th>Date of Next Case Meeting:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
```

<table>
<thead>
<tr>
<th>Physician’s Rating (1 to 5)</th>
<th>Physician Recommendations</th>
<th>Plan of Action</th>
<th>Desired Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**General work skills**

- Understanding and following instructions
- Performing and repetitive tasks
- Maintaining a work pace appropriate to the work load
- Relating to other people beyond giving and receiving instructions
- Influencing others, accepting instructions, planning

**Specific job functions or requirements (not covered above as outlined by the case manager)**

<table>
<thead>
<tr>
<th>Additional tasks for Case Manager</th>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-entry interview scheduled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People invited to bring friend, family member, or physician to re-entry interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee assured his/her job is waiting for him/her</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee formally welcomed back by employer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-entry plan established and reviewed; a realistic timeline implemented</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

The Green Chart: Physician’s Roadmap to Recovery

(In the space provided explain and/or list specific accommodations that can be made by the employer to ease the Return to Work Process)

<table>
<thead>
<tr>
<th></th>
<th>1 At this time, this task is impossible for the employee to perform</th>
<th>2 The employee can perform some aspects of this task with accommodations</th>
<th>3 The employee can perform this task with accommodations</th>
<th>4 The employee performs this task well although some accommodations are still necessary</th>
<th>5 The employee can easily perform this task with little or no special assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General work skills</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding and following instructions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performing and repetitive tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining a work pace appropriate to the work load</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relating to other people beyond giving and receiving instructions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influencing others, accepting instructions, planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specific job functions or Requirements (not covered above as outlined by the case manager)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Information Required by the Physician</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Characteristics of the workplace – pace, dynamics and history</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patterns of absence or downtown in the last 30 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other relevant information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

RESOURCES

Association of Workers’ Compensation Boards of Canada. Accessible at www.awcbc.org


The Institute for Work and Health publications:


Editor. (2012). “Getting back on the horse: Return to work has beneficial effect on health”, At work, Issue 68, p. 5. Available online at: http://www.iwh.on.ca/at-work/68/getting-back-on-the-horse-return-to-work-has-beneficial-effect-on-health


## Government Legislature and OH&S Law

<table>
<thead>
<tr>
<th>Resource</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Human Rights Commission (CHRC)</td>
<td>CHRC administers the Canadian Human Rights Act and is responsible for ensuring compliance with the Employment Equity Act. Both laws ensure that the principles of equal opportunity and non-discrimination are followed in all areas of federal jurisdiction.</td>
</tr>
<tr>
<td>National Institute for Disability Management and Research (NIDMAR)</td>
<td>NIDMAR is committed to reducing the human, social, and economic costs of disability. As an education, training, and research organization, NIDMAR's primary focus is the implementation of workplace-based reintegration programs which international research has proven is the most effective way of restoring and maintaining workers' abilities, while reducing the costs of disability for workers, employers, government, and insurance carriers.</td>
</tr>
<tr>
<td>Canadian Society of Professionals in Disability Management (CSPDM)</td>
<td>CSPDM seeks to minimize the socio-economic impact of disabling injuries and illnesses on employees and employers by establishing and supporting the practice of consensus based disability management through professional standards of quality, innovation and leadership in the field.</td>
</tr>
<tr>
<td>Canadian Association of Disability Management Coordinators (CADMC)</td>
<td>CADMC aims to attract individuals and companies involved with Disability Management and to share industry best practices.</td>
</tr>
<tr>
<td>Canadian Centre for Occupational Health and Safety (CCOHS)</td>
<td>CCOHS serves Canadians - and the world - with credible and relevant tools and resources to improve and advance workplace health and safety programs.</td>
</tr>
<tr>
<td>Canadian Network for Human Health &amp; the Environment (CNHHE)</td>
<td>CNHHE is a Canadian network of non-governmental, research, health professional and policy organizations focusing on human health and the impacts of environmental exposures.</td>
</tr>
<tr>
<td>Health Canada (HC)</td>
<td>HC is the Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances.</td>
</tr>
<tr>
<td>Human Resources Skills and Development Canada (HRSDC)</td>
<td>HRSDC’s mission is to build a stronger and more competitive Canada, to support Canadians in making choices that help them live productive and rewarding lives, and to improve Canadians’ quality of life.</td>
</tr>
<tr>
<td>Canadian Workers’ Compensation System</td>
<td>Each province has a workers’ compensation act and board. Refer to the Association of Workers’ Compensation Boards of Canada for current links for these provincial boards. Federally, the HRSDC oversees the provincial WCB administration of Federal WCB claims.</td>
</tr>
</tbody>
</table>
REFERENCES


PIPEDA, Case Summary #226.


