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Intended Uses of This Report

This report documents the preparation activities, attendees, proceedings, and detailed outcomes of the British Columbia Summit to Prevent Needless Work Disability. The Summit was planned and produced by the BC Summit Steering Committee in conjunction with The 60 Summits Project which is convening multi-stakeholder summits across North America, aiming for 60 events in 10 Canadian provinces and 50 U.S. states. The BC Summit was held November 25, 2008, in Vancouver and was the first of the 60 Summits to be held in Canada.

This document should be shared with everyone who attended the Summit as well as others who will be interested to learn what happened there. This document is also intended to serve as a resource for the people who intend to continue the work begun in the Summit.

The next steps are to:

1. Harness the good will and energy for positive change unleashed by the Summit;
2. Build on the understandings and relationships developed during the Summit;
3. Consolidate, categorize, and analyze the opportunities for action identified during the Summit, then choose which ones to address and in which order;
4. Get the new BC Collaborative for Health, Productivity and Disability Prevention off the ground and grow it into a vibrant and action-oriented community of purpose. (A start-up kit for the interim leadership of the Collaborative to use during its first several meetings is included as an appendix to this report.)

Key Definitions

Work disability. The term “disability” or “work disability” as used here means either time spent away from work or time spent working at less than full productive capacity that is attributed to a medical condition. Work disability does not mean "having an impairment", because many people with substantial impairments work full time and full duty. A key precept of the new work disability prevention model is that needless work disability (absence or withdrawal from work) is disruptive, potentially harmful, and costly both to the employee and the employer.

The Stay-At-Work and Return-To-Work (SAW / RTW) process occurs whenever an employed person becomes injured, ill, or has had a change in their ability to function. The SAW/RTW process consists of a sequence of questions, actions and decisions made
separately by several parties that, taken as a whole, determine whether, when and how an injured or ill person stays at or returns to work. It is often derailed because the focus is diverted to certifying, corroborating, justifying, evaluating, or determining the extent of the disability rather than preventing it.

The purpose of the 60 Summits Project

The 60 Summits Project is a grassroots initiative that is creating a multi-stakeholder community of like-minded people who intend to:

- Prevent needless work disability by helping people stay employed;
- Upgrade the performance of workers' compensation and disability benefits systems by employing a multi-stakeholder collaborative approach to:
  - mitigate the impact of illness, injury or impairment on each individual's ability to function at work, and
  - promote the economic vitality and productivity of workers, employers, and local economies;
- Inform people about the new work disability prevention paradigm and the American College of Occupational & Environmental Medicine's recommendations for improving the stay at work and return to work process;
- Inspire and convince people to take action to make those improvements and cooperate under the new paradigm;
- Lead by example and support each other in actually doing these things ourselves;
- Within our community, enable buyers and sellers of products and services that effectively prevent needless work disability to find each other so that they thrive and prosper;
- Grow our community until people across North America are employing this new multi-stakeholder, collaborative, and problem-solving approach, and it eventually becomes the norm everywhere.

Background and History of the BC Summit

The impetus for the BC Summit to Prevent Needless Work Disability was provided by Dr. Larry Myette, Director of Strategic Workplace Health at Health Care Benefit Trust. Dr. Myette had attended a presentation on the ACOEM report on preventing needless work disability given by Dr. Jennifer Christian, Chair of The 60 Summits Project. He shared the possibility of bringing The 60 Summits Project to BC with Dr. Marc White, Executive Director for the Canadian Institute for the Relief of Pain and Disability and Dr. Celina Dunn, Manager of Medical Services at WorkSafeBC who agreed to nominate prospective steering committee members.

They invited additional stakeholders to a feasibility meeting in January 2008 at which time they decided the time was right to bring together government and private sector leadership throughout various BC agencies, organizations and companies and hold a Summit on preventing needless work disability. The Committee of sixteen members representing twelve different organizations consisted of representatives from employers, occupational health, safety and wellness providers, insurance, disability management, rehabilitation, academia, research and consumer-based health organization. Dr. Myette and Dr. Celina Dunn became the Steering Committee Co-Chairs.
The Committee decided to affiliate its planning efforts with The 60 Summits Project and to produce a Summit in Vancouver in November 2008. The Canadian Institute for the Relief of Pain and Disability a registered charity committed to the reduction of needless disability provided administrative support to the Steering Committee responsible for registration, delegate communication, meeting logistics and web-programming services on a cost recovery basis.

The BC Summit and this report are the outgrowth of the BC planning team’s purpose and vision, as described below:

“The purpose of the Summit is to create an opportunity for key stakeholders to:

- participate in a needs assessment;
- discuss the ACOEM Report’s 16 recommendations on preventing needless work disability;
- identify priorities for change in British Columbia;
- develop concrete action plans to affect those changes;
- encourage collaborative approaches to put the plans into action.

It is hoped that the BC Summit will provide a venue for respectful dialogue among the many stakeholders involved in the disability system in the province and will generate support for a new BC Collaborative for Health, Productivity and Disability Prevention. That group will consolidate the gains made at the Summit and move forward to further improve the quality of disability prevention and management in British Columbia.”

Planning the event took about 10 months. A complete list of the BC Summit Planning Committee members and their roles are included in Appendix A.

The BC Summit represented several firsts for The 60 Summits Project. This was the first Summit in a Canadian province and the first one to include a formal research component. The research committee members are: Marc White, PhD (Research Committee Coordinator), Jaime Guzman, MD MSc FRCPC (Principal Investigator), Noushin Khushrushahi (Research Associate), Philip Mah, Celina Dunn, HBSc, MD, CCFP and Perry Strauss. The design of the research study is described in Appendix B.

The Canadian Institute for the Relief of Pain and Disability under the direction of the Steering Committee created a website: www.cirpd.org/BC60Summit The 60 Summits Project created a link to BC on its website www.60summits.org/grp-sums/group-BC.html.

The BC Steering Committee’s plan for a Summit included significant financial and in-kind support from a total of 13 organizations. (See list of sponsors in Appendix C.)

A successful Summit with 116 participants was held on November 25, 2008 at the Morris J. Wosk Centre for Dialogue at Simon Fraser University in Vancouver, BC. Simon Fraser University provided the facility and arranged for food and refreshments throughout the Summit.

Participation in the event was by invitation. The guest list was carefully composed to maximize balance among stakeholder groups and to assure participation by influential people of good will with a reputation for wanting to do the right thing and for being action-
oriented. There was good representation of healthcare providers, employers, labour, insurance companies, case management and rehabilitation companies, and government. (See list of attendees in Appendix D.)

**Proceedings During the Summit Meeting**

Dr. Larry Myette opened the day-long Summit meeting and recognized the members of the BC Steering and Planning Committee. Dr. Celina Dunn introduced Dave Anderson, CEO of WorkSafe BC who provided the BC perspective on work related injuries and illness. Dr. Myette followed with the BC perspective on non-occupational health issues and chronic diseases that are impacting the workplace in BC. Dr. Jennifer Christian established the framework for the rest of the day’s workshop through her keynote address, “Preventing Needless Work Disability by Helping People Stay Employed: ACOEM’s 16 Recommendations.” She then gave instructions to the attendees on how the day would be structured, and how to get the most out of their participation.

There were three rounds of deliberations:

1. First, participants broke into 13 multi-stakeholder workgroups. Each was assigned one or two of the 16 specific recommendations made in the ACOEM work disability prevention report. Their charge was to decide whether their assigned recommendations should be implemented, and if so, how to do so. After deliberation, the stakeholder workgroups reported their initial findings, and described their preliminary action plans, to all attendees and received feedback from Dr. Christian designed to make the plans concrete and actionable.

2. In the next round of deliberations, 10 groups consisting of stakeholders with similar backgrounds, professions or expertise were utilized. These similar stakeholder workgroups were asked to answer these questions:
   - What might make members of your stakeholder group reluctant to fully support implementing the work disability prevention model?
   - What needs to be true in order for your stakeholder group to thrive and prosper under the work disability prevention model in BC?
   - Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur?

   Each similar stakeholder group designated a spokesperson to form a panel to give their reports. A question and answer session with the audience followed.

3. Lastly, the multi-stakeholder workgroups reconvened to upgrade their action plans based on the feedback they had received plus the new information they had heard during the general sessions. They were strongly pushed to make the plans specific and actionable, rather than general ideas. Each of the multi-stakeholder workgroups then presented their revised plans to all attendees.

In addition, throughout the day participants used a form provided to record the promises or commitments they were making to themselves for what actions they were personally going to take in their own organization or in the community.
In a summary session, Dr. Christian summarized the themes that had appeared during the day and discussed next steps. She emphasized the fact that the workgroups’ plans should be viewed as drafts, more like the product of a brainstorming session than a finished product. Working together under time pressure had been good practice in working in a multi-stakeholder environment and in moving from good ideas to concrete action plans.

As the event drew to a close, Dr. Myette laid out the next steps. The Steering Committee would meet after the Summit to analyze the results and plan for the first action group meeting in mid-February. A key function of the Steering Committee and the BC Collaborative will be to provide a mechanism for consolidating, coordinating, analyzing, and prioritizing among all the ideas for activities and projects developed during the Summit, and then for supporting the people and organizations that intend to start carrying them out.

An informal reception with networking followed adjournment and completion of the Summit evaluations.

**Outcomes of the Summit**

Foremost among the results of the Summit was the formation of the BC Collaborative for Health, Productivity and Disability Prevention which will continue the process begun in the Summit.

However, for most of the attendees, the most important result may prove in retrospect to be the powerful experience of the day itself. For a day, multiple stakeholders were fused into a single community with a shared vision of how the stay-at-work and return-to-work process should go, and then sat side-by-side making plans for how to make that vision into a reality and create a better future together for people throughout BC. For many, this was their first experience sitting side by side with people in other disciplines and sectors of society working on an issue that touches all of them – the stay-at-work and return-to-work process that is common to workers’ compensation and all disability benefit programs. For virtually every attendee, this was the first time they had ever considered the question of what “first class” might look like in these systems. Precisely because focusing on obstacles, outliers and intractable problems is so common, people found it empowering and inspiring to sit side-by-side designing positive solutions. They focused on what needs to be put in place in order to make sure things go “the right way” most of the time – instead of focusing on what is wrong and how to “fix” that.

The event produced deeper understanding and insight among the attendees as well as new or deeper relationships with other participants, particularly those from different sectors of society. It also empowered the attendees by revealing opportunities for them to drive change themselves. In particular, the similar stakeholders groups produced in many a realization that “if I’m not part of the solution then I’m part of the problem.” The similar stakeholder reports appear in Appendix F.

The feelings evoked by this positive multi-stakeholder experience are the fuel that drives the formation of action groups after the Summit. Eighty three percent (97 out of 116 attendees) said they want to remain engaged on an on-going basis. Out of the 75 attendees who responded to the question whether they thought the workshop would bear fruit in the future 63 (84%) indicated either “Very Good” or “Good”, with 11 of the remaining indicating “Satisfactory”.

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The Summit produced a number of tangible outcomes:

- The creation of the BC Collaborative for Health, Productivity and Disability Prevention which will carry on the work begun during the Summit.
- Identification of a larger community of potential future collaborators. A list of all those who attended the Summit is included in this Report in Appendix D.
- A set of preliminary ideas and plans produced by the multi-stakeholder workgroups. All of the workgroups thought the ACOEM recommendation(s) they had been assigned were worthwhile and should become common practice. Therefore, all of the groups brainstormed about action plans to begin implementing them. See Appendix E which is derived from the groups’ written and oral reports.
- A set of personal commitments made by each participant – promises they made to themselves for the things they want to do. Social science research has shown that promises that are written down are more likely to be kept. See Appendix G.
- The feedback from evaluations completed by attendees. See Appendix H.
- This report, which provides a historical record of the event, which can be shared with others, and which can serve as the starting point for other kinds of documents, meetings and other events.

Commonalities among the many plans being made by the workgroups became apparent while they gave their oral reports during the Summit. Many of the plans involve the same topic areas. Successful implementation of many of the plans will require similar types of behaviors and tasks.

The major topic areas on which most of the action plans were focused were:

- Spread the word: communications and engagement.
- Teach concepts and skills: education and training
- Collaborate with other stakeholders – take a team approach
- Develop and deploy missing solutions
- Get the facts, establish benchmarks, and use data to guide improvements

Successfully accomplishing these plans will require the behaviors required to accomplish certain general tasks, such as:

- Develop and refine strategies, make and agree on project plans and schedules
- Find suitable people and assign them appropriate tasks
- Identify key parties and/or opportunities
- Schedule and coordinate events (meetings, presentations, etc.)
- Participate in and speak persuasively in casual conversations, meetings, speaking engagements
- Inventory, assess, and analyze existing resources / data
- Design, write, test, and issue new materials or tools (brochures, ads, educational courses, forms, etc.)
- Make changes to existing protocols; implement revisions to routine operations
- Create indicators of best practice
- Set up pilot programs; conduct research
- Collect data; track and measure outcome/performance
The same repertoire of behaviors / tasks will be essential for projects in each of the four main topic areas. In fact, most of the behaviors / tasks are common to most of the projects. Thus, these are the behaviors and tasks that an effective action group must possess – along with a thirst for accomplishment.

Given the technical training of many action group members, they may not currently be proficient with or comfortable with some of these behaviors. Some professional development, recruiting of additional members, or collaboration with other groups will probably be required. Key examples include such things as speaking persuasively in small groups, giving powerful presentations, developing effective educational strategies and materials, designing forms that perform as intended, obtaining and analyzing data, and so on.

During the Summit, the attendees also wrote down their personal plans to take action on their own for positive change in their own organizations and business relationships, and to participate in group or community-based initiatives. See an “anonymized” list of those commitments in Appendix G.

At the end of the Summit day, participants were asked to complete evaluations and indicate the extent of their desire for on-going involvement with the BC Collaborative for Health, Productivity and Disability Prevention. Overall, the attendees were highly satisfied with their experience at the BC Summit with more than 83% (97 of 116 participants) expressed a desire to remain engaged with the initiative in some way. See the detailed results of the evaluations and signup sheets in Appendix H.

The committee decided to affiliate its planning efforts with The 60 Summits Project and to produce a Summit in Vancouver in November 2008. The Canadian Institute for the Relief of Pain and Disability a registered charity committed to the reduction of needless disability provided administrative support to the Steering Committee responsible for registration, delegate communication, meeting logistics and web-programming services on a cost recovery basis.

Next Steps

The next challenge is to grow a dynamic and action-oriented multi-stakeholder action group. The first meeting of the BC Collaborative will take place on February 12th. 53 attendees have confirmed their participation at this meeting with 17 sending formal regrets due to time conflicts. Many people who made personal commitments for action will be more likely to succeed if they are supported in some fashion. The workgroups who planned to continue working together will benefit from a structure within which to collaborate.

This Report should serve as a starting point resource for the members of the Collaborative. They can use the Start-Up Kit to guide their first three meetings. They can use the lists of preliminary ideas and plans developed during the Summit as a source for part of their action agenda. It will be necessary to consolidate, analyze and categorize those preliminary ideas and plans, and then choose the ones to take on in sequence. In addition to their work inside the Collaborative, interested individuals can use the lists of people who participated in the Summit to find kindred spirits with whom to partner on projects, either independently or under other organizational umbrellas.

The BC Summit Planning Group’s website can be used to share information: www.cirpd.org/BC60Summit. In addition to BC-specific issues, the 60 Summits website
(www.60Summits.org) provides a central clearinghouse for all the other state groups participating in The 60 Summits Project. An Alliance of 60 Summits groups is now in its formative stages. While each jurisdiction, planning group, and follow-up action group has unique characteristics, they also have many issues and challenges in common. Since common themes and proposed solutions are emerging from many of the Summits, local groups are enthusiastically supporting the idea of working together. They see little need to "re-invent the wheel" and have already grasped the advantages of cross-fertilization of ideas and sharing of solutions.
FINAL REPORT

British Columbia Summit
to
Prevent Needless Work Disability

November 25, 2008
Vancouver, BC

Introduction

This report was developed to document the preparation activities, event proceedings, and detailed outcomes of the BC Summit to Prevent Needless Work Disability held in conjunction with The 60 Summits Project on November 25, 2008 in Vancouver, BC. Consistent with the purpose and vision of the BC Summit Steering Committee which planned and produced the Summit, this document should be shared with everyone who attended the event as well as others who will be interested to learn what happened there.

This document is also intended to serve as a resource for those who intend to continue the multi-stakeholder grassroots initiative whose first step was the BC Summit. They can use the lists of people who participated to find kindred spirits with whom to collaborate. They can begin with the lists of preliminary ideas and plans developed during the Summit, and then consolidate, analyze, prioritize them, and turn them into action in the real world.

Acknowledgements

Members of the BC Summit Steering Committee  The membership of this all volunteer committee is itself an example of the multi-stakeholder approach. The Committee consisted of sixteen members representing twelve different organizations. Representatives from employers, occupational health, safety and wellness providers, insurance, disability management, rehabilitation, government, academia, research and consumer health organization worked together to plan and produce this event. There would have been no Summit without the leadership, dedication and firm resolve of this Steering Committee. A list of committee members appears in Appendix A.

Sponsors  Without the generous support of our sponsors, the BC Summit would not have been possible. A list of sponsors appears in Appendix C.

The Facilitators  Some of the planning team members served as work group facilitators, and others were recruited from various agencies. In all, 13 facilitators provided leadership for the
workgroups and helped them to focus and remain on task while deliberating on their assigned ACOEM recommendations and questions for similar stakeholder workgroups. The facilitators were responsible for making sure that all viewpoints were shared in the group, that the workgroup action plans were representative of the group and that the workgroup report was created and delivered.

60 Summits Project staff We appreciate the support of Diana Cline, David Siktberg, Anita Nyyssonen, and Jennifer Christian MD of the 60 Summits Project who assisted us throughout the planning process as well during as our Summit event, and then prepared the draft of this report.

**Key Definitions**

**Work disability:** It is important to note that the term “disability” or “work disability” as used here means time either away from work or working at less than full productive capacity that is attributed to a medical condition. Work disability does not mean "having an impairment", because many people with substantial impairments work full time and full duty. A key precept of the new work disability prevention model is that needless work disability (absence or withdrawal from work) is disruptive, potentially harmful, and costly both to the employee and the employer.

**The Stay-At-Work and Return-To-Work (SAW / RTW) process** occurs whenever an employed person becomes injured, ill, or has had a change in their ability to function. The SAW/RTW process consists of a sequence of questions, actions and decisions made separately by several parties that, taken as a whole, determine whether, when and how an injured or ill person stays at or returns to work. Thus, the SAW/RTW process is an outcome-generating process. However, it often becomes derailed because the focus is diverted to certifying, corroborating, justifying, evaluating, or determining the extent of the disability rather than preventing it.

**ACOEM Guidelines:** The American College of Environmental Medicine has issued a variety of guidelines, guidance documents, policies, and position statements over time.

- The most well-known of its guidelines are the *Occupational Medicine Practice Guidelines* for diagnosis and treatment of occupational conditions, adopted in 2002. This several hundred page document is available for purchase from ACOEM. The evidence-based Practice Guidelines were adopted as the presumptively correct standard of care by the California workers' compensation system. The ACOEM treatment guidelines – which make specific recommendations for medical care in individual cases of injured or ill individuals – WERE NOT the focus of the BC SAW/RTW Summit.

- The work disability prevention paper which WAS the focus of the BC SAW/RTW Summit is a completely different document covering a very different set of topics. Entitled “Preventing Needless Work Disability by Helping People Stay Employed”, it was adopted in May 2006. It is 27 pages long, and is free on ACOEM’s website (www.acoem.org) under Policies and Position Statements, or at www.60summits.org. Although initially classified as a guideline, it has been reclassified as a guidance document. The report makes general and systemic recommendations to all the participants in the stay-at-work and return-to-work process for how to improve
the way it functions – in order to improve service to workers and their supervisors, and to improve outcomes of injury-, illness- or aging-related employment predicaments.

Background and History

The American College of Occupational & Environmental Medicine (ACOEM) adopted a report entitled “Preventing Needless Work Disability by Helping People Stay Employed” in May 2006. Dr. Jennifer Christian led the committee of 21 Canadian and U.S. physicians who developed it. She founded The 60 Summits Project shortly thereafter which is convening multi-stakeholder summits across North America, aiming for 60 events in 10 Canadian provinces and 50 U.S. states.

The purpose of the 60 Summits Project:
The 60 Summits Project is a grassroots initiative that is creating a multi-stakeholder community of like-minded people who intend to:

- Prevent needless work disability by helping people stay employed;
- Upgrade the performance of workers’ compensation and disability benefits systems by employing a multi-stakeholder collaborative approach to:
  - mitigate the impact of illness, injury or impairment on each individual’s ability to function at work, and
  - promote the economic vitality and productivity of workers, employers, and local economies;
- Inform people about the new work disability prevention paradigm and the American College of Occupational & Environmental Medicine’s recommendations for improving the stay at work and return to work process;
- Inspire and convince people to take action to make those improvements and cooperate under the new paradigm;
- Lead by example and support each other in actually doing these things ourselves;
- Within our community, enable buyers and sellers of products and services that effectively prevent needless work disability to find each other so that they thrive and prosper;
- Grow our community until people across North America are employing this new multi-stakeholder, collaborative, and problem-solving approach, and it eventually becomes the norm everywhere.

The momentum for the BC Summit to Prevent Needless Work Disability was provided by Dr. Larry Myette, Director and Occupational Medicine Consultant, Strategic Workplace Health, Healthcare Benefit Trust. Dr. Myette had listened to an earlier presentation on preventing needless work disability and The 60 Summits Project given by Dr. Jennifer Christian, Founder and Chair of The 60 Summits Project. Dr. Myette believed that the timing was right to bring together government and private sector leadership throughout various BC agencies, organizations and companies who have an impact on health and productivity of the BC workforce to prevent needless work disability.
Shortly afterwards, Dr. Christian came to BC to speak about preventing needless work disability at WorkSafe BC’s annual medical meeting at the request of Dr. Celina Dunn, Manager of Medical Services at WorkSafeBC. While in BC, she met with Dr. Myette and Dr. Marc White from CIRPD to discuss the possibility of bringing the 60 Summits idea to BC.

Afterwards, Dr. Christian held a teleconference to talk about The 60 Summits Project with several individuals from WorkSafe BC including Dr. Celina Dunn. A meeting between WorkSafeBC and Dr. Myette resulted later that month. A partnership among the thought leaders was begun. At a feasibility meeting hosted by Dr. Myette in January 2008, the BC Summit Steering Committee was formed and Dr. Myette and Dr. Dunn became Co-Chairs of the Steering Committee. Planning committee members were recruited from stakeholders throughout BC. The Committee of sixteen members representing twelve different organizations consisted of representatives from employers, occupational health, safety and wellness providers, insurance, disability management, rehabilitation, academia, research and consumer health organization. The Committee decided to affiliate its planning efforts with The 60 Summits Project and to produce a Summit in Vancouver in November 2008. A complete list of the BC Steering Committee is included in Appendix A. The planning process spanned 11 months in all.

The BC Summit represented several firsts for The 60 Summits Project. This was the first Summit in a Canadian province and the first one to include a formal research component. The research committee members are: Marc White, PhD (Research Committee Coordinator), Jaime Guzman, MD MSc FRCP  (Principal Investigator), Noushin Khushrushahi (Research Associate), Philip Mah, Celina Dunn, HBSc, MD, CCFP and Perry Strauss. The design of the research study is described in Appendix B.

The Canadian Institute for the Relief of Pain and Disability under the direction of the Steering Committee created a website: www.cirpd.org/BC60Summit The 60 Summits Project created a link to BC on its website www.60summits.org/grp-sums/group-BC.html.

The Summit planning cycle took about a year.

The BC Steering Committee’s plan for a Summit included significant financial and in-kind support from a total of 13 organizations. (See list of sponsors in Appendix C.)

A successful Summit of 116 participants was held on November 25, 2008 at The Morris J. Wosk Centre for Dialogue at Simon Fraser University in Vancouver, BC. Simon Fraser University provided the facility and arranged for food and refreshments throughout the Summit. Participation in the event was by invitation. The guest list was carefully composed to maximize balance among stakeholders and to assure participation by influential people of good will with a reputation for wanting to do the right thing and with an action orientation. There was good participation by healthcare providers, employers, insurance companies, case management and rehabilitation companies, and government. (See list of participants in Appendix D)
The Summit Planning Process

A group of committed volunteer professionals planned and produced the BC Summit in 11 months. They all work full time in some part of the absence management, workers' compensation, or disability management and benefits systems.

The co-chairs of the BC planning group represented both the occupational and personal (non-work-related) disability sectors. Unique among the 60 Summits Project groups to date, the two are both physicians.

Dr. Larry Myette has been with Healthcare Benefit Trust since 1999 and is currently Director, Strategic Workplace Health and Occupational Medicine Consultant. Dr. Myette holds degrees in Pharmacy, Medicine and Public Health, is certified as a specialist in Occupational Medicine and is a Clinical Assistant Professor in the Faculty of Medicine at UBC. He was Co-Chair of the Depression in the Workplace Collaborative and co-author of a comprehensive report, Depression & Work Function: Bridging the Gap Between Mental Health Care & the Workplace (which can be down-loaded at www.carmha.ca).

Dr. Celina Dunn, a physician with over 20 years of experience, has a background in family practice and as a Medical Advisor for WorkSafeBC where she is currently the Manager of Medical Services. She is also a clinical instructor with the Department of Family Practice at the University of British Columbia.

As a whole, the planning group’s composition reflected diversity of perspectives and professions. Representatives from employers, practicing clinicians, occupational health, safety and wellness providers, insurance, disability management, rehabilitation, government, academia and research worked together to plan and produce this event. (See list of planners in Appendix A.)

The BC Steering Committee was committed to becoming an ongoing force for positive change in BC. Since the ACOEM recommendations are applicable to both workers’ compensation and personal disability benefits systems, the Steering Committee decided to focus their planning efforts and the Summit on keeping people working whatever the cause of their medical condition. The planning team's purpose and vision are described below:

“`The purpose of the Summit is to create an opportunity for key stakeholders to:
- participate in a needs assessment;
- discuss the ACOEM Report’s 16 recommendations on preventing needless work disability;
- identify priorities for change in British Columbia;
- develop concrete action plans to affect those changes;
- encourage collaborative approaches to put the plans into action.

It is hoped that the Summit will provide a venue for respectful dialogue among the many stakeholders involved in the disability system in B.C. and will generate support for a new B.C. Collaborative for Health, Productivity and Disability Prevention. That group will consolidate the gains made at the Summit and move forward to further improve the quality of disability prevention and management in British Columbia.”
The BC Summit planning group worked together to plan the Summit by phone, email and face-to-face meetings. After a few independent meetings, they decided to affiliate with The 60 Summits Project so they could get assistance with planning and delivery of their all day Summit workshop and develop the draft of this report. The planning process involved clarifying the goals, purposes, design and agenda of the workshop, identifying invitees within each of the stakeholder groups, designing the invitations, conducting the invitation and registration process, arranging facility logistics and developing the associated materials to be used during the workshop. It also involved developing a budget, developing informational materials for potential sponsors, and raising money from local organizations.

**Summit Participants**

The 116 people who participated in the BC Summit represented a cross section of stakeholder groups. The planning committee carefully created an invitation list to assure a balance of perspectives from employers (large and small, public and private), clinicians, insurers, claims payers, government, policy makers and others involved as intermediaries in the SAW/RTW process. The committee invited individuals in all of these groups who they believed would make a positive difference if they attended the Summit. Email invitations were sent to specific individuals. Many received personal communications from Committee members in addition to the emails. Appendix D contains a list of all Summit participants.

The invitation informed prospective participants that the Summit would use the ACOEM work disability prevention report as the framework for discussion, and that the different stakeholders would sit side by side to create a better stay-at-work and return-to-work process to benefit both employees and employers in BC. They were also informed that the expected outcomes of the Summit were new relationships, an action agenda, and a consortium or coalition that would plan to transform that action agenda into improved human and financial outcomes for both employees and employers.

In the opening session, Dr. Christian reiterated the objectives for the Summit, and declared the intention that this event would become a historic milestone for British Columbia, signal a beginning, and cause the creation of a group of inspired and energized people who will gradually transform BC into a province that really does prevent needless work disability by actively helping people stay employed.

**Summit Facilitators**

Some of the planning team members served as facilitators for workgroups during the Summit. Additional facilitators were recruited. In all, 13 facilitators provided leadership for the workgroups and helped them to focus and remain on task in deliberating on their assigned ACOEM recommendations and similar stakeholder workgroup assignments. A few weeks before the Summit, Dr. Christian and Diana Cline provided several hours of training for all facilitators via teleconference to cover the specifics needed for the Summit day. The facilitators were responsible for managing logistics, keeping the discussion in their groups focused on the issues, making sure that all participants’ viewpoints were heard and that the groups produced their reports on time.
Description of the Opening Session and Summit Workshop

The BC Summit consisted of an all day workshop which included keynote addresses, workgroup sessions and presentations. A reception followed the workday. The agenda for the event appears in the box to the right. The Summit was held at the Morris J. Wosk Centre for Dialogue at Simon Fraser University in Vancouver which has a large conference facility with an almost round meeting room where all participants convened and additional conference room space for smaller workgroup sessions. The Summit workgroups were spread throughout the large meeting room and the smaller conference rooms which accommodated rectangular tables for the 13 workgroups’ deliberations.

The Summit Workshop

The Summit began with welcoming remarks by co-chair’s Dr. Larry Myette and Dr. Celina Dunn along with acknowledgement of the Summit planning team. The BC perspective on the workers’ compensation and the personal (non-work related) disability benefits systems in the province and Canada were provided by Dave Anderson, CEO, WorkSafe BC and Dr. Larry Myette respectively. Dr. Myette stressed that preventing needless work disability of employees with non-occupational illnesses or injuries is a growing issue as the population of BC and Canada ages and more chronic conditions become apparent, threatening the health and livelihood of workers. These conditions, both physical and mental, present a compelling case for this Summit today and the need to seriously consider the 16 ACOEM recommendations.

During her general session keynote address, Dr. Christian provided an overview of The 60 Summits Project. She described the workshop format, described the relationship between the BC planning group and The 60 Summits Project, and laid out the intended outcomes of the event as a whole as well as for each attendee. She stressed the importance of preventing needless work disability, outlined key concepts in the ACOEM work disability prevention report, and briefly reviewed each of the 16 recommendations it makes.

Following the keynote, Dr. Christian provided a short orientation to the day’s work and how to conduct the multi-stakeholder workgroup sessions. All Summit participants had been provided with the ACOEM report on Preventing Needless Work Disability prior to the Summit with a request to read it in order to come prepared to work and discuss it. A show of hands indicated that a large majority of the participants had read or at least scanned the ACOEM report.
One of the major instructions given to attendees during a Summit is to listen in a way that they have never listened before to what other attendees are reporting is “true” for them. Since most of the attendees already had extensive familiarity with the subject, Dr. Christian reminded them to “listen for the new part” and not listen simply to confirm that they already knew it. Dr. Christian also reminded attendees that making recommendations about what “somebody oughta do” will not produce the desired results. In order for change to happen, individuals need to take responsibility for what they can do themselves, and begin collaborating and communicating across sectors, and start by taking small steps.

The BC Steering Committee decided to include two different types and compositions of workgroup sessions in their Summit Day agenda, one in which multi-stakeholder workgroups deliberate on and devise strategies to implement their assigned ACOEM recommendation(s); and one in which similar stakeholder workgroups address reluctance and barriers to implementing the recommendations and also ways that their stakeholder group can remove the barriers.

The first break-out session of the day consisted of 13 multi-stakeholder workgroups. The planning team assigned attendees to a multi-stakeholder workgroup based on a pre Summit survey response which ranked recommendations in order of participant preference. During the first round of workgroup sessions, 90 minutes in duration, all of the workgroups decided that they agreed with the ACOEM recommendations that they had been assigned and that they should be implemented in BC. They then started formulating preliminary implementation strategies and plans. Each workgroup, comprised of 5-10 people from a variety of stakeholder groups, had been assigned different recommendations from the ACOEM paper. If they agreed with ACOEM’s recommendations, they were asked to come up with strategies for making them into realities, as well as concrete first steps and commitments for the action to take “tomorrow or next week.”

Each workgroup throughout the day had a facilitator, scribe and a presenter. The presenter had on average 2 minutes to present their plan to all participants followed by feedback on how to be even more concrete and specific in their action steps from Dr. Christian. The multi-stakeholder groups re-convened in the afternoon to incorporate feedback and other key information gleaned from listening to other workgroup reports.

The second round of deliberations consisted of discussions within similar stakeholder groups that were created based on 10 groups with similar professional backgrounds or worldviews:

- Groups 1 and 2: Occupational Health & Safety (two groups, one of which was healthcare specific)
- Groups 3 and 4: Human Resources and Insurer (two groups)
- Group 5: Mixed Health Professions – Related
- Group 6: Physician-Non Physician Consultants and Rehab

<table>
<thead>
<tr>
<th>TASKS ASSIGNED TO EACH MULTI-STAKEHOLDER WORK GROUP:</th>
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<tbody>
<tr>
<td>1. Decide if you agree with your assigned recommendation. If not, solve that problem another way.</td>
</tr>
<tr>
<td>2. If so, devise a strategy to make it become standard practice (what usually happens) in your own organization or community.</td>
</tr>
<tr>
<td>3. Identify the key steps involved in making that happen.</td>
</tr>
<tr>
<td>4. Identify concrete first action steps to get started making this a reality.</td>
</tr>
<tr>
<td>5. Describe what you are going to do starting tomorrow.</td>
</tr>
</tbody>
</table>
• Group 7: Physicians
• Group 8: Public Sector Policy – Health Care Leaders, Union & Government
• Group 9: Public Sector – Government

These workgroups convened for 45 minutes and were asked to address what might make members of their stakeholder group reluctant to embrace the work disability prevention model, what obstacles would have to be addressed in order for their group to thrive and prosper in the new paradigm and whether their stakeholder group sees an obstacle that they can remove without waiting for “decisions from the top or regulatory changes”. Upon completing their assignment, these similar stakeholder groups appointed a spokesperson who presented their comments to all participants. A question and answer session with the audience followed.

In the third round of deliberations, the multi-stakeholder workgroups reconvened to upgrade their action plans based on the feedback they had received from Dr. Christian and the new information they had heard during the general sessions. They were strongly pushed to develop specific and actionable plans that specified who was going to do what and by when, rather than general ones. A spokesperson for each of the multi-stakeholder workgroups then presented their revised plans to all attendees.

In aggregate, the final reports demonstrate a strong commitment to improving the SAW-RTW process across BC, and to do that from many angles of attack. Their still-preliminary yet practical “to do list” appears in Appendices E and F. It is a compendium of all of the action plans developed by the multi-stakeholder and similar stakeholder workgroups. Note that these plans were put together under extreme time pressure, and are most accurately considered the product of a day-long brainstorming session, rather than as a final work product.

In addition to the group reports developed by the workgroups, each individual participant used a form provided to record the promises or commitments they were making to themselves for what actions they were personally going to take in their own organization or in the community. The statements they were asked to respond to appear in the text box to the right. (Social science research has shown that people are more likely to actually do things if they have made a formal written or oral

<table>
<thead>
<tr>
<th>STATEMENTS COMPLETED BY EACH PARTICIPANT ON THEIR PERSONAL COMMITMENT FORM</th>
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<tbody>
<tr>
<td>1. The main things I see that I can actually do to improve MY OWN practice or organization are: __________.</td>
</tr>
<tr>
<td>2. The main opportunity where I can actually do something to improve how things work in MY WHOLE community or province is: __________.</td>
</tr>
<tr>
<td>3. Here’s what I personally intend to do about this tomorrow or next week.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TASKS ASSIGNED TO EACH SIMILAR-STAKEHOLDER WORK GROUP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What might make many of the people in our stakeholder group RELUCTANT TO FULLY SUPPORT adoption of this work disability prevention model? What might make it difficult for people to buy-in?</td>
</tr>
<tr>
<td>2. What needs to be true in order for the members of our stakeholder group (who do want to do the right thing) to THRIVE and PROSPER under the work disability prevention model in BC?</td>
</tr>
<tr>
<td>3. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that our stakeholder group might be able to help eliminate or reduce -- even if policy or regulatory change does not occur at the top? How can you push the ball down the field? Can your group contribute something that another group might not be able to?</td>
</tr>
</tbody>
</table>
commitment to do so.) The Personal Commitment forms were handed in and copied towards the end of the event so that the ideas that were arising during the Summit could be consolidated for inclusion in this report. The original forms were returned to the participants so they could take them home and use them as a reminder of the promises they had made to themselves and in some cases, to each other. Appendix G is a list of “anonymized” personal commitments made by participants.

Dr. Christian summarized the themes that had appeared during the day and discussed next steps. She said that the workgroups had taken a good swing at moving from good ideas to concrete action plans. She cautioned the participants that their “to do lists” should be regarded as preliminary, since they were the result of a brainstorming session under time pressure. That said, Dr. Christian encouraged attendees to begin carrying out the action plans that involved their own organizations and business relationships. She cautioned attendees about prematurely starting work on plans that might be redundant or in conflict with other groups’ projects.

Dr. Christian emphasized that if you want to see the Recommendations broadly adopted, sharing the ACOEM document with as many people as you can is an incredibly valuable first step. That’s something that each and every person in the BC Summit can start doing immediately with other colleagues, in their own organizations, at meetings or upcoming conferences, in their community and province wide. She cautioned those that will put together the list of projects on which to work to avoid the temptation to rank projects that “are a call to duty” over those that “light up” the individuals who will be responsible for making them come alive. The projects that people are passionate about are the projects that will get done.

Then, Dr. Myette laid out the next steps. The Steering Committee had already decided to implement one of the action plans developed during the Summit, namely forming a new BC Collaborative for Health, Productivity and Disability Prevention. The Steering Committee also planned to analyze the workgroup reports in the two months following the Summit and prior to the first action group meeting. A key function of the Steering Committee and the BC Collaborative will be to provide a mechanism for consolidating, coordinating, analyzing, and prioritizing among all the ideas for activities and projects developed during the Summit, and then for supporting the people and organizations that intend to start carrying them out.

An informal reception with networking followed adjournment and completion of the Summit evaluations.

Before leaving, the attendees were asked to complete evaluations of the event which also included some research questions. They were also given sign-up sheets where they could indicate their desire for continuing engagement by becoming part of The 60 Summits Project’s email list, being invited to future events, or becoming part of the BC follow-on action group. Unfortunately, the traffic flow as attendees exited the Wosk Centre made it difficult for conference staff to collect the evaluation forms and sign-up sheets, so forms were obtained from only sixty-eight percent of BC Summit attendees. A small number of additional evaluation forms were obtained via the BC Summit planning group’s website. Subsequently, attempts were made to contact every participant by telephone to inquire whether they wanted to be on any one of the mailing lists.
Participant Reactions

During the Summit event, there was a very high level of visible engagement. In general sessions, all eyes were on the front; no side conversations or drowsy participants were noted. In the small group sessions, the discussions were very active.

As a group, the attendees reported on their evaluations that they were very satisfied with their experience at the BC Summit and want to remain engaged with one another and with the overall initiative.

Of attendees who returned evaluations 80 - 95%: reported that the information presented was interesting

- stated that having met the other attendees will help them in the future.
- reported that the workshop was a good use of their time and effort.
- stated that this new angle or approach has made them think differently about some important issues.
- reported that the meeting impacted their prior beliefs, knowledge, and attitudes.
- stated they have a list of practical steps they can take to improve their participation in the SAW/RTW process

More than 83% of the 116 attendees expressed a desire to remain engaged with the initiative in some way – either electronically or through future meetings. Summit Results: Personal Commitments & Action Plans

A key outcome of the BC Summit was the creation of the BC Collaborative for Health, Productivity and Disability Prevention which will carry on the work begun in the Summit.

Overall, however, the most important – and least visible – outcome of the BC Summit was the experience itself that has created a group of 116 people from multiple stakeholder groups with:

- a shared vision of how the stay-at-work and return-to-work process should go;
- a shared experience of sitting side-by-side making plans for how to make that vision into a reality; and
- the conviction that they can create a better future for BC’s workers’ compensation and disability benefits systems by sharing this new perspective.

In addition to the experience itself, many people made new relationships or deepened existing ones during the Summit. In particular, the deeper understanding and insights produced by interactions with other attendees in different sectors of society are of value.

The positive feelings evoked by this positive multi-stakeholder experience are the fuel that will drive the formation and success of the action group afterwards.

For most of the attendees, this was their first experience sitting side by side with people in other disciplines and sectors of society working on an issue that touches all of them – the stay-at-work and return-to-work process that is common to workers’ compensation and all disability benefit programs. For virtually every attendee, this was the first time they had ever considered the question of what “first class” might look like in these systems. It may also
have been their first experience with focusing on what needs to be put in place in order to make sure things go “the right way” most of the time – instead of focusing on what is wrong and how to “fix” it.

**Workgroups’ Action Plans**

Every one of the workgroups thought the individual ACOEM recommendations that they had been assigned were worthwhile and should become common practice. Therefore, all of the groups developed action plans to begin implementing them. The details of their plans, derived from their paper forms and the recorded transcript of their oral reports, appear in Appendices E and F.

Commonalities among the many plans became apparent while the workgroups gave their oral reports during the Summit. Many of the plans are designed to solve similar problems or tackle **similar topics**. Successful implementation of many of the plans will also require **similar types of behaviors**.

The bulleted examples listed under each of the major topic areas below have been taken straight from the workgroup reports.

**MAJOR TOPIC AREAS**

1. **Communications and engagement**

   Spread the word across the province of BC to all stakeholders through outreach to multiple audiences using a variety of methods.

   Many of the workgroups spoke about how important it is to share the work disability prevention model with all stakeholders in the province. BC is a large province geographically with both large and small employers and providers spread throughout.

   Spreading the word about the work disability prevention paradigm to employers, their employees, and the clinicians who care for them is critically important.

   Many of the groups addressed this need with their plans, including:

   - Increase awareness of the opportunity / need to prevent needless work disability throughout BC and Canada.
   - Create and communicate a consistent message – social marketing - emphasize that work is good for you. Change the language from “disability” to “ability”. Look at NHS joint statement that “work is good” and see if that can be replicated in BC. Start with buy-in from the BC Business Council, and BC Labour Union representatives. Reduce the stigma regarding mental health issues. Get the message out across the province and Canada.
   - Create customized communications to all stakeholder groups
   - Get a consistent message; emphasize that work is good for you. Look at NHS joint statement that “work is good” and see if we can replicate that in BC. Start with buy-in from the BC Business Council, and BC Labour Union representatives, BC Federation of Labour.
Roundtables/coalitions provincially with key stakeholders (unions, employers, etc.) to work through issues and generate common purpose.

- Identify champions or “go to” people, identify who needs the services.
- Identify mechanisms for first line for employee contact.
- Provide urgent communication with the employee via a mentor – high trust.
- Get agreement through all levels of the organization.
- Identify appropriate personnel to be communicating with the employee on key issues in workplace – who is responsible to take issue forward – identify sponsor in the workplace.
- Find champions within each of the stakeholder groups.
- Get messaging delivered by the medical community to increase credence.
- Establish commitment from Labour & Management.
- Information transfer (communication campaign) – public policy statement (refer to endorsement by gov’t doctors, unions, employer associations).

2. **Education and training**

Individuals who work with employees who are off work for illness or injury need to have a good foundation in preventing needless work disability; they need to understand the facts rather than operate from myth; and they need to have the skills to work with all parties, the employee, employer, provider and insurer.

The Summit attendees overwhelmingly pointed to the need to help the people of BC understand that keeping people working during recovery is critical and that not knowing this is a major impediment to optimal SAW/RTW process performance. Most of the people who must deal with workplace injuries – especially workers, employers, and healthcare providers – lack basic information, key concepts, and skills.

Almost all the workgroups recommended ways to give people what they need in order to manage health-related employment situations better, which means some form of education or training.

Examples included educating all stakeholders about a variety of topics including:
- on the importance of remaining at work while recovering
- the limited numbers of medical conditions that require time away from work
- the importance of transitional work regardless of the cause of a medical condition or impairment, and regardless of whether the employee is still at work, about to go off work or is already off work
- roles and responsibilities; the importance of accountabilities, facts about insurance programs
- on the importance of treating employees well and in a caring manner
- on the need to have support systems in place that encourage recovery and wellness
- Training for employer supervisors, physicians and all health care providers, labour unions, insurance carriers, government etc. on topics that vary from how to care/communicate with employees to how to communicate with healthcare providers
- Develop standard education for all stakeholders (as appropriate by role)
- Mental health training offered to new employees during orientation
- Improve supervisors skills on an individual basis – coaching of supervisors
- Physician education – there are a group of influential MDs at our table who will approach Dean of Medical School at BC to improve residency education
- WORKSAFEBC/MH work on a campaign – similar to injured worker campaign that WorkSafe BC did
- Health promotion at employer and with physician
- Encourage/develop CME programs for family doctor to identify red flags for hidden agendas. Have WORKSAFEBC/ICBC/insurers integrate their programs.
- Research through resources at BCMA key players for policy and education of physician

3. **Collaborative approaches to system improvement**

Groups commented about the benefits of dovetailing with other groups’ or organizations’ initiatives.

- Collaboration was mentioned repeatedly among the work groups, across agencies, public and private sector and across Canada. Collaborating with key or influential groups to articulate the importance of this initiative, for example, the BC Business Council, BC Federation of Labour.
- Create coalition to coordinate research to establish evidence base. Marc-UBC Family Practice and Canadian Institute for the Relief of Pain & Disability with Pete Rothfels WorkSafeBC; Catherine – Society of General Practitioners.
- Pitch training of disability prevention as a way to reduce the stress link. Continuing Prof. Development & Knowledge Translation need to be involved. Need investment from WorkSafeBC, Ministry of Health, Business Council of BC, MLCS.

4. **Collaborative approaches in dealing with individual situations**

Groups also commented about the need to communicate with others and employ a team approach in individual SAW/RTW situations.

- Establish & communicate a protocol that is fair & consistent that involves all stakeholders (union, employer, employees)
  - Include specific timelines and steps to be taken
  - Expectations and issues of all stakeholders addressed up front
o Training provided for all people managers and “alternates”

o Maybe even a tool to facilitate conversation between employer of record, doctor and employee

- Develop communication tools/toolkits and standardized form(s) to share key RTW/SAW information on abilities, job availability categorized by function, and as to what should happen before/during and after illness or injury.

- Give employee package to take info on duties to doctor – improve info flow.

5. **Develop and deploy missing solutions**

- Develop screening tools to assist employers and providers in identifying mental health issues in the work place and in identifying barriers to SAW-RTW.

- Create support systems for employees in the work place and for navigating what can be a complicated RTW system – champions of the SAW-RTW process

- Work on MD education module, involving BCMA, WorkSafe, MINISTRY OF HEALTH & Ministry of Labour within 6-8 months to educate docs

6. **Get the facts, establish benchmarks/standards, and use data to guide improvement efforts**

- Gather data - Replicate U.S. occupational return to work data with BC/Canadian data (this refers to the physician survey that Dr. Christian did on the percentage of needless work absence, but it may also pertain to the Reveille graph with data from 5 U.S. states showing that workers with work-related injuries who qualify for permanent impairment awards experience a dip in total income that persists for a period of at least 5 years).

  o Get BC/Canada data on absenteeism, including work and non work related OSAH, WorkSafe, employers, insurance industry

  o Gather data on disability as a whole for BC

- Use the ACOEM Recommendations to create best practice guidelines in BC.

- Develop standards of practice for all stakeholders (as appropriate by role).

- Conduct research studies – where data doesn’t exist in BC, for example, the impact of needless work absence on employers, employees and the province/Canada or to determine a gap analysis between current practices and what the ACOEM report recommends.

- Coordinate & translate research on disability prevention. Beta testing site w/in 15 months to accomplish web portal so that information can be shared across disciplines (already in progress). Faculties of Business and Health Sciences across Canada need to be involved.

- Measure performance – create indicators of best practices brought forth in the Recommendations, set criteria and measure whether they are being met. Performance measurement was mentioned at many different levels, from
measuring employer supervisors and physician performance to system wide performance outcomes.

**SHARED REPERTOIRE OF TASKS AND BEHAVIORS**

Since the focus in The 60 Summits Project is on implementation, the types of behaviors or tasks required to implement the action plans are critically important. Recruiting volunteers with an intellectual interest in the topics is less likely to produce concrete outcomes than finding people who are interested in and good at doing the things that will "make things happen." If the follow-up action group is clear about the nature of the work to be done, that will assist them in attracting appropriate volunteers.

In other words, in order to successfully disseminate the new work disability prevention paradigm throughout BC, and specifically to implement ACOEM’s recommendations for SAW/RTW process improvement, the follow-up action group will need to:

- Possess (or be willing to develop or strengthen) the desire, persistence, skills, and ability to do the things (behaviors) that are required, or
- Add others to their group who do have those skills or abilities.

The behaviors involved in carrying out these action plans consist of the ability to do tasks like the following:

- Develop and refine strategies, make and agree on project plans and schedules
- Find suitable people and assign them tasks
- Identify key parties and/or opportunities
- Schedule and coordinate events (meetings, presentations, etc.)
- Participate in and speak persuasively in casual conversations, meetings, speaking engagements
- Inventory, assess, and analyze existing resources / data
- Design, write, test, and issue new materials or tools (brochures, ads, educational courses, forms, etc.)
- Make changes to existing protocols; implement revisions to routine operations
- Set up pilot programs; conduct research
- Collect data; track outcome

The point of the table below is to show that the same repertoire of behaviors / tasks will be essential for projects in each of the four main topic areas. The table’s pattern of check marks also shows that most of the behaviors / tasks are common to most of the projects. Thus, the action group must be skilled at and good at doing these particular tasks.

Given the technical training of many action group members, they may not currently be proficient with or comfortable with some of these behaviors. Some professional development, recruiting of additional members, or collaboration with other groups will probably be required. Key examples include such things as speaking persuasively in small groups, giving powerful presentations, developing effective educational strategies and materials, designing forms that perform as intended, obtaining and analyzing data, and so on.
<table>
<thead>
<tr>
<th>BEHAVIORS INVOLVED</th>
<th>MAJOR TOPIC AREAS</th>
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<tbody>
<tr>
<td>1. Spread the word: communications &amp; engagement:</td>
<td>2. Educate &amp; train all stakeholders</td>
</tr>
<tr>
<td>3. &amp; 4. Collaborate with other stakeholders; employ a team approach</td>
<td>5. Develop and deploy missing solutions</td>
</tr>
<tr>
<td>6. Get facts, set benchmarks, and use data to guide improvements</td>
<td></td>
</tr>
<tr>
<td>Refine strategy, make and agree on detailed plans and project schedule</td>
<td>✓</td>
</tr>
<tr>
<td>Find suitable people and assign them tasks</td>
<td>✓</td>
</tr>
<tr>
<td>Identify key parties and/or opportunities; schedule events (meetings, presentations, etc.)</td>
<td>✓</td>
</tr>
<tr>
<td>Participate in or speak at events: meetings, conferences</td>
<td>✓</td>
</tr>
<tr>
<td>Inventory / assess / analyze existing resources / data</td>
<td>✓</td>
</tr>
<tr>
<td>Develop / write / design new materials or tools</td>
<td>✓</td>
</tr>
<tr>
<td>Make changes to existing protocols / Conduct revised routine operations; Set up pilot programs; Do new research.</td>
<td>✓</td>
</tr>
<tr>
<td>Collect new data; Track outcomes</td>
<td>✓</td>
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Personal Commitments:

Most of the participants made personal commitments to take some sort of action to improve the SAW/RTW process in their own organizations and to participate in group or community projects. The edited details of those commitments appear in Appendix G. All individually identifying information has been removed. Portions of many forms were illegible since they were handwritten, and appear as an underlined blank.

Many of the personal commitments reflected solid engagement in the process and an intention to carry through with actions. As an example, here are some samples of the personal commitments made by Summit attendees.

<table>
<thead>
<tr>
<th>“The main things I see that I can actually do to improve MY OWN organization and MY OWN day-to-day working relationships are:………”</th>
<th>“The main opportunity where I can actually do something to improve how things work in MY WHOLE community or province/province is: ……”</th>
<th>“Here’s what I personally intend to do about this tomorrow or this week: ……………”</th>
</tr>
</thead>
</table>
| • More face-to-face contact with workers and employees  
• More employee outreach to direct/advise/review disability management packages. | • Sharing with those I come into contact with that SAW/early Return-to-Work is good medicine.  
• Be an advocate for change through discussions with staff/managers/executive as well as other employees and insurance carriers. | • Call one employer and plan job site visit to review my role in early intervention RTW.  
• Educate RTW coordinators.  
• Commence to redraft RTW and absenteeism guidelines.  
• Meet with Directors in Employee Relations to discuss sharing with bargaining agent. |
| • Establish meeting with Exec representatives to educate on approach to SAW included with RTW – outline findings of the Summit and key actions to move forward to make cultural changes.  
• Focus on Corporate Measures on facilitating SAW/RTW rather than absenteeism.  
• Peer review for BC Business Council. | • Share knowledge with my staff and clients.  
• Participate in committees and “walk the talk”. | • Meet with one nurse to discuss importance of looking at whether a worker needs to leave work or can they stay at work and start transitional duties.  
• Meet with physician groups to discuss importance of RTW.  
• Meet with employer groups – teach on transitional duties, graduated return to work planning, identifying transitional duties in workplace. |
Next Steps

The next steps are to:

1. Harness the good will and energy for positive change unleashed by the Summit;
2. Build on the understandings and relationships developed during the Summit;
3. Consolidate, categorize, and analyze the opportunities for action identified during the Summit, then choose which ones to address and in which order;
4. Get the new BC Collaborative for Health, Productivity and Disability Prevention off the ground and grow it into a vibrant and action-oriented community of purpose. (A start-up kit for the interim leadership of the Collaborative to use during its first several meetings is included as an appendix to this report.)

The experience of the BC Summit – the mutually-respectful relationships among people of good will in different professions and sectors of society, and the commitments they made to themselves, and the plans for action that the workgroups made during the Summit – must now be transferred to the real world. In order for this event to create the future outcomes that were originally envisioned by its planners, it is now time to start making things actually happen beyond the walls of the Wosk Center for Dialogue.

The BC Summit planning team intended their November 25 event to be a milestone for BC, a beginning of the process of disseminating the work disability prevention paradigm throughout the province. The paradigm shift begins at the Summit, by getting as many of the right people as possible in the room to do more than talk about ACOEM’s recommendations, but to speak for actually implementing them and to make specific plans for how to do that, by when, and with whom. The Summit starts the process by asking attendees to identify what is possible through communication and collaboration across sectors, and to make plans for spreading the word and actually making changes to how they conduct their everyday practices and businesses.

An on-going structure for fulfillment of this vision is required to support follow-on action. Something must preserve the momentum built during the Summit so that the attendees’ planned activities actually take place and bear fruit. Something must keep new relationships alive. Most people are more likely to succeed if they are supported in some fashion. Small groups who want work together will benefit from a framework within which to collaborate. The key functions of the structure for fulfillment established by the follow-up action group will be to:

- Continue to propagate the work disability prevention’s new way of thinking about workers’ compensation and disability benefits programs across the province.
- Support one another in fulfilling their Personal Commitments made during the Summit.
- Carry out a selected few of the ideas for group activities and projects developed during the Summit.

So, the next challenge for BC is to grow a dynamic and action-oriented follow-up group. Since more than two-thirds of the attendees expressed interest in follow-up activities, it is hoped that many of them will actually become active in the BC Collaborative for Health, Productivity and Disability Prevention. The first follow-up meeting was scheduled for
February 12, 2009. In the interim, the Summit Planning group’s webpage and their link to the 60 Summits website can be used to continue to share information.

The first step is for the group to get organized, to develop a strong sense of shared purpose and a game plan, and to take on their first projects. This Report and in particular the Start-Up Kit that appears as Appendix I should serve as a starting point resource for the leadership and members of the Collaborative.

The best project to begin with is finding opportunities to continue to propagate the paradigm among people in BC. The group can create the “next ripple in the pond” by spreading the word about the new work disability paradigm and the problem-solving team approach to the stay-at-work and return-to-work process among key individuals and groups within BC and within their own professional societies and trade associations. This entails a lot of meetings and presentations.

A few months later, when the group has developed a team spirit and sense of accomplishment based on those early successes, this Report can serve as a starting point resource. The group can use the lists of preliminary ideas and plans developed during the Summit as a source of raw material for their next projects. Remembering that the list was developed under extreme time pressure, the process should be to consolidate, analyze, categorize the ideas, and then choose the ones to take on first, second, and so on in sequence. It is best to select projects that appeal to people and inspire them, rather than ones that are “high priority” but do not generate enthusiasm. Also, it is better to pick projects for which the group has the required skills.

In addition to their work inside the Collaborative, interested individuals can use the Report’s list of people who participated in the Summit to find kindred spirits with whom to collaborate on projects, either independently or under other organizational umbrellas.

The BC Summit Planning Group’s website can be used to share information: www.cirpd.org/BC60Summit. In addition to BC-specific issues, the 60 Summits website (www.60Summits.org) provides a central clearinghouse for all the other state groups participating in The 60 Summits Project. In addition, the first national gathering of the whole 60 Summits Project Alliance (or community of interest) was held in November 2008. The goal of the gathering was to provide a venue in which all local groups could meet, share their experiences, successes and challenges, and collaborate on joint projects. While each jurisdiction, planning group, and follow-up action group has unique characteristics, they also have many issues and challenges in common. Since common themes and proposed solutions are emerging from many of the Summits, local groups are enthusiastically supporting the idea of working together. They see little need to “re-invent the wheel” and have already grasped the advantages of cross-fertilization of ideas and sharing of solutions.
Appendix A - Planning Committee Members

Planning Committee Co-Chairs

Larry Myette, MD, MPH, DABPM
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  Healthcare Benefit Trust

Celina Dunn MD, CCFP
  Manager Medical Services
  WorkSafeBC

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Marc White PhD  
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Appendix B - Research Design / Evaluation Framework

The BC Summit to Prevent Needless Work Disability is one of an anticipated series of strategic focal events to:

(a) increase awareness of ACOEM’s recommendations on disability prevention
(b) consider their relevance for British Columbia
(c) support individual and organization uptake and utilization of the guidelines
(d) support ongoing change within and across sectors

Proposed Committee Planning Schedule and Approval Process

<table>
<thead>
<tr>
<th>Proposed Steps</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evaluation goals to be drafted by working group based on Summit and BC</td>
<td>Tues, Aug 26th</td>
</tr>
<tr>
<td>Goals of the meeting, the ACOEM guidelines, and the facilitators’ work</td>
<td></td>
</tr>
<tr>
<td>sheet.</td>
<td></td>
</tr>
<tr>
<td>2. Drafted goals revised and approved by Steering Committee</td>
<td>Tues, Sept 10th</td>
</tr>
<tr>
<td>3. Methods and tools drafted by working group on the basis of the approved</td>
<td>Early October</td>
</tr>
<tr>
<td>goals; global budget plan and implications drafted</td>
<td></td>
</tr>
<tr>
<td>4. Methods and tools revised and approved by Steering Committee</td>
<td>Mid October</td>
</tr>
<tr>
<td>5. Commitment of resources for evaluation and ethics review (if needed);</td>
<td>End October</td>
</tr>
<tr>
<td>final budget established</td>
<td></td>
</tr>
<tr>
<td>6. Pre-meeting evaluation activities (i.e. pre-survey) circulated to</td>
<td>Mon, Nov 17th</td>
</tr>
<tr>
<td>participants (if needed) prior to the November 25th Summit.</td>
<td></td>
</tr>
</tbody>
</table>

Members of the Evaluation / Research Committee are proposing an evaluation framework considering three distinct time periods – Each time period represents opportunities to contribute to the measurement of program’s successes and weaknesses in accomplishing anticipated goals and objectives of the Summit.

- Pre-Summit
- During/ Immediate Post the Summit
- Post the Summit

A primary purpose of the Summit is to generate action/change in correspondence to the ACOEM recommendations, the main evaluation should assess whether such change takes place or actions taken to support future change. Based on the stated goals of the meeting (derived from BC Summit website and 60 Summit website, the Facilitator Worksheets, and the ACOEM recommendations), the following evaluation objectives are proposed
Evaluation Objectives:

1. Ensure necessary stakeholders are aware of the guidelines.
   - Identify appropriate stakeholders (attending or not attending)
   - Identify awareness of the guidelines before the Summit
   - Assess knowledge/ awareness of the guidelines after the Summit

Steering Committee members invested time into selecting a broad-base of stakeholders across sectors. An important outcome to measure is whether the Summit was successful in attracting and engaging key stakeholders across sectors.

Figure 1. Purposeful Selection of Stakeholders Representing Public and Private Market Sectors and Intervention Targets (Myette & White 2006)

2. Identify whether the guidelines were considered relevant within and across stakeholders / would be endorsed by the necessary stakeholders.
   - Which of the 16 recommendations were/ were not supported at the end of the meeting? By which stakeholder groups? (assess level of consensus, differences within and across groups, prioritize recommendations)
   - Collect from feedback from reports? Or gather via post survey?

3. Identify barriers for implementation
   - What factors would make stakeholders reluctant to fully support implementation of the recommendation?
   - How to overcome identified obstacles?

4. Identify facilitators for implementation
   - What existing processes need to be strengthened OR what new things need to happen in order to implement a specific recommendation?

5. Identify concrete actions of individuals and organizations/ stakeholder groups
   - What will the organization or individual do starting tomorrow?
   - Collect action items from reports? Determine methods of follow up (i.e. telephone interview, follow-up survey, etc)

6. Assess Presentation Quality and Summit Logistics, Satisfaction
   - Use measures to assess perceived quality of presentations (content, presenters)
   - Assess satisfaction measures
   - Identify perceived strengths and weaknesses to inform future planning
7. Identify impact final report and reflection of Summit Experience

- Use measures to assess perceived quality of presentations (content, presenters)
- Assess satisfaction measures
- Identify perceived strengths and weaknesses to inform future planning

**Timeframe & Duration:**

**BEFORE (Prior to Summit Pre-Readings, Surveys, Quizzes)**

<table>
<thead>
<tr>
<th>Objective</th>
<th>How</th>
<th>Comments/ References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1: Ensure necessary stakeholders are aware of guidelines</td>
<td>Assess Pre-Knowledge for Baseline Encourage stakeholder pre-reading</td>
<td>Use of web-portal and/or survey monkey /* Seek Jennifer/ Diana participation in creating knowledge test items per recommendation for review, pilot testing and item analysis Review survey questions Jennifer used for other Summits</td>
</tr>
<tr>
<td>Objective 2: Identify whether the guidelines are relevant/ would be endorsed by the necessary stakeholders</td>
<td>Seek stakeholders feedback on their priorities within their own context Prioritizing exercise</td>
<td>Use of web-portal and/or survey monkey Consider using some stepped approach to have stakeholders reflect on recommendations and consider talking points</td>
</tr>
<tr>
<td>Objective 2: Identify whether the guidelines are relevant/ would be endorsed by the necessary stakeholders</td>
<td>Use best practices in educational programming – use of pre-exercises to enhance learning Use prioritizing as a reflective exercise to enhance linking content to participant context</td>
<td>Capture pre-summit data to assess whether initial priorities change as a result of meeting activities</td>
</tr>
</tbody>
</table>
### DURING

<table>
<thead>
<tr>
<th>Objective</th>
<th>How</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1: Ensure necessary stakeholders are aware of the guidelines</td>
<td>Keynote Presentation</td>
<td>Use of web-portal and/or survey monkey</td>
</tr>
<tr>
<td>Objective 2: Identify whether the guidelines are considered relevant/ would be endorsed by the necessary stakeholders</td>
<td>Small group discussion</td>
<td>Use nominal group process principles and individual worksheets to capture all participant ideas for final report. Possibly collect data pre-survey and then provide participants with copies of their talking points</td>
</tr>
<tr>
<td>Objectives 3 and 4: Identify barriers and facilitators for implementation</td>
<td>Individual Change: Use of formal Memo's to Myself Group discussions and recording of group actions</td>
<td>Collect memo’s and assess congruence with recommendations and objectives Group recorder</td>
</tr>
<tr>
<td>Objective 5 – Assess Presentation Quality and Summit Logistics, Satisfaction</td>
<td>Use valid metrics to assess satisfaction, identify program strengths and weaknesses Identify if meeting/ content as planned was delivered and well received and identify strengths and weakness to inform future programs</td>
<td>Possible use of external evaluator to provide an alternate / naïve evaluation and to consider whether the event as planned was delivered Summarize and demonstrate that feedback has been considered in future programming.</td>
</tr>
</tbody>
</table>

### POST (3 Months Post Meeting)

<table>
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<tr>
<th>Objective</th>
<th>How</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Objective 6: Identify concrete actions of individuals and organizations/ stakeholder groups</td>
<td>Send reminders Send summary of their peers suggested change one month post the event</td>
<td>Initial first send reminder of what they said they were going to change – (use reminders to promote change) Increase awareness of what their peers considered important, assess whether peer summary stimulated new ideas for change</td>
</tr>
<tr>
<td>Objective 7. Identify impact final report and reflection of Summit Experience</td>
<td>Follow up evaluation assessing whether intended changes actualized, self report and documentation— Debriefing Steering Committee</td>
<td>Self report on whether they did what they said they intended to change. Identify whether they changed / revised their goals/ priorities Lesson learned and next steps</td>
</tr>
</tbody>
</table>

* Did not create a knowledge test.
Appendix C - List of Sponsors

The BC Summit was made possible in part by the generous financial support of a number of sponsors, all of whom are committed to improved stay-at-work / return-to-work outcomes for BC's employees and employers. Their contribution was key to the Summit’s success.

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Manulife Financial
Mercer (Canada) Limited
Organizational Health Incorporated

Affiliated with
The 60 Summits Project
Appendix D - List of Attendees

See attached
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<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Address</th>
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<th>Email</th>
</tr>
</thead>
<tbody>
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BC Summit to Prevent Needless Work Disability

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Appendix E - Multi-Stakeholder Workgroup Reports

The information contained in this appendix is a consolidated list of the reports delivered by the multi-stakeholder workgroups during the British Columbia Summit on November 25, 2008. The text is derived from a combination of the written sheets submitted and the audio recordings of the two-minute oral presentations made by the spokesperson for each group. In some places the written sheets were illegible. Words that could not be deciphered are represented by an underscore, like this: ____.

Each of the workgroups had been assigned one or two of the recommendations made in the ACOEM work disability prevention guideline.

The rest of this report summarizes in sequence the findings of each of the 12 groups. Each group’s report begins with a box displaying the text of the recommendation the group was assigned, followed by their answers to the items they were asked to address.

The full text of the items that appeared on each group’s worksheet was as follows:

1. Overall, we believe that the Recommendation(s) [should be / should not be] implemented in British Columbia.

2. We focused on [all / part] of the Recommendation. (If only part) We focused on: ....

[If they thought the recommendation should be implemented]

3. Here are some strategies for how to make this recommendation become standard practice (what usually happens) in our own organizations or community:

4. The key steps involved in making that happen are:

5. Some concrete FIRST ACTION STEPS that will get us started on making this a reality in our own organizations, community, and province wide are:

6. Here’s what some of us intend to do starting tomorrow: (Provide at least two examples from your group’s Personal Commitment Sheets)
Group A – Recommendations 1 and 13a

Text of Assigned Recommendation(s) from ACOEM Guideline:

I. ADOPT A DISABILITY PREVENTION MODEL
   1. Increase Awareness of How Rarely Disability is Medically Required
      Sub-recommendations
      a. Stop assuming that absence from work is medically required and that only correct medical diagnosis and treatment can reduce disability.
      b. Pay attention to the non-medical causes that underlie discretionary and unnecessary disability.
      c. Reduce discretionary disability by increasing the likelihood that employers will provide on-the-job recovery.
      d. Reduce unnecessary disability by removing administrative delays and bureaucratic obstacles, strengthening flabby management, and by following other recommendations in this report.
      e. Instruct all participants about the nature and extent of preventable disability.
      f. Educate employers about their powerful role in determining SAW/RTW results.

IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS
   13a. Disseminate Medical Evidence Regarding Recovery Benefits of Staying at Work and Being Active
      Sub-recommendations
      Undertake large-scale educational efforts so that activity recommendations become a routine part of medical treatment plans and treating clinicians prescribe inactivity only when medically required.

Work Group A Members:
- Ian Connell, Occ Physician, FHA, UCH, Terajan, Etc.
- Anne Harvey, VP Employee Engagement, VCH
- Adrienne Hook, Regional Manager, VCH
- Vernita Hsu, RTW Coordinator/Case Manager, Construction Safety Network
- Doug Kube, Director, Occ Health Services, Air Canada
- Lisa McGuire, Executive Director, BC Food Processors Health & Safety Council
- Mylee Powell, Pension & Benefits Manager, Weyerhaeuser
- Lisa Redmond, Mgr, Pension, Benefits, OHS & Wellness, ICBC
- Barb Severyn, ED, People & OD, VIHA
- Walter Stasiak, RAPG-Safety, BC Ferries

Group A stated that Recommendations 1 and 13a should be implemented in British Columbia.
We focused on all parts of the Recommendations.

Some strategies for how to make this recommendation become standard practice (what usually happens) in our own organizations or community are:

**General Strategies:**
1. + Getting Canadian data
2. + Creating practice guidelines
3. + Looking at “stay at work” – changing the language from RTW
4. (monetary incentives)
5. Identifying key stakeholder and customize communication to them – in particular unions, employers, employees
6. Find champions within each of the stakeholder groups
7. Get messaging delivered by the medical community to a credence
8. Recognizing different requirements with different occupations
9. + Have WORK SAFE BC reassess their requirements

**Strategies for Specific Sub-Points of the Recommendation:**

a. Stop assuming that absence from work is medically required and that only correct medical diagnosis and treatment can reduce disability.
   1. + Change the focus from disability to ability – What can I do? How can I stay at work?
   2. Standardized functional abilities form (simplified) – there is already a standard in ON/QC
   3. Contact BCMA-would there be interest in preferred payment for the standardized form?
   4. The form should be the last option – Go through all other steps first
   5. Create tools to go with forms – including training focusing on non medical issues
   6. Communicate stepped process between employee and employer

b. Pay attention to the non-medical causes that underlie discretionary and unnecessary disability.
   1. Identify what the issues are
   2. Educate managers and supervisors by showing that stay at work is the right thing to do

c. Reduce discretionary disability by increasing the likelihood that employers will provide on-the-job recovery.
   1. Look at the impact on the other employees when 1 employee comes back at less than 100%
   2. Ensure the effect is understood at the upper levels – this includes education and cost benefit

d. Reduce unnecessary disability by removing administrative delays and bureaucratic obstacles, strengthening flabby management, and by following other recommendations in this report.
1. Reduce administrative delay by starting small; get champions within stakeholder groups
2. Don’t contribute to the problem; do not build in delays where they are not required
3. Look for funding
4. Try to eliminate rationalization around budgeting
5. Eliminate passing of responsibility (i.e. it’s not mine). Build in an accountability framework

e. Instruct all participants about the nature and extent of preventable disability.
   1. Define who the participants are
   2. Ensure everyone is operating with an equal level of understanding – what really qualifies as a reason to be off work
   3. Educate the lay community on the very limited number of conditions should really cause an employee to be away from work (tie that into Jennifer’s slide Disability Required When…)

f. Educate employers about their powerful role in determining SAW/RTW results.
   1. WorkSafeBC and the medical community are considered credible sources and should provide education
   2. Build skills within employers
   3. Give supervisors the tools and resources, not just hold them accountable

The key steps involved in making that happen are to:
1. Get BC/Canada data on absenteeism, including work and non work related OSAH, WorkSafe, employers, insurance industry
2. Get a Canadian replication of Jennifer’s occupational return to work data (Anne Harvey)
3. Determine if there is already a tool in place to work with the data
4. Build a business case, tailored to specific stakeholder groups
5. Build some educational pieces tailored to stakeholder groups
6. Get support from a broader group on a practice guideline (Dr. Connell)

Some concrete first steps we can take to get started on making this a reality in our own organizations, community and province wide are:
1. Get a Canadian replication of Jennifer’s occupational return to work data (Anne Harvey)
2. Gather data on cost of disability as a whole for BC
3. Get a consistent message; emphasize that work is good for you. Look at NHS joint statement that “work is good” and see if we can replicate that in BC. Start with buy-in from the BC Business Council, and BC Labour Union representatives, BC Federation of Labour.

Here’s what we intend to do starting tomorrow (Give at least two examples from your group’s Personal Commitment Sheets):

Appendix E - Multi-Stakeholder Workgroup Reports
Example #1:
**What are you going to do, specifically?**
Get a BC replication of Jennifer’s occupational return to work data (initial inquiry)

**Who else needs to be involved?**
Dr. Christian, Anne Harvey, Dr. Connell

**By when?**
End of January 2009

**To accomplish what?**
To examine the data from a Canadian perspective or to get buy-in

Example #2:
**What are you going to do, specifically?**
Contact the BC Business Council and BC Federation of Labour present the data (or similar) from this session to attempt to get support/buy-in

**Who else needs to be involved?**
Walter Stasiuk, Lisa Richmond, BC Business Council V.P.

**By when?**
January 21, 2009

**To accomplish what?**
To engage BC Business Council and BC Labour to make a joint statement that “staying at work” is the right thing to do
Group B – Recommendation 2

Text of Assigned Recommendation(s) from ACOEM Guideline:

I. ADOPT A DISABILITY PREVENTION MODEL

2. Urgency is Required Because Prolonged Time Away from Work is Harmful
   Sub-recommendations:
   a. Shift the focus from “managing” disability to “preventing” it and shorten the response time.
   b. Revamp disability benefits systems to reflect the reality that resolving disability episodes is an urgent matter, given the short window of opportunity to re-normalize life.
   c. Emphasize prevention or immediately ending unnecessary time away from work, thus preventing development of the disabled mindset, and disseminate an educational campaign supporting this position.
   d. Whenever possible, incorporate mechanisms into the SAW/RTW process that prevent or minimize withdrawal from work.
   e. On the individual level, the health care team should keep patients’ lives as normal as possible during illness and recovery while establishing treatments that allow for the fastest possible return to function and resumption of the fullest possible participation in life.

Work Group B Members:

- Harry Gray, Director, Consulting Services, Health Employees’ Association, Work Group Facilitator
- Sinden Malinowski, Program Mgr., Health and Wellness, Pacific Blue Cross, Work Group Recorder
- Linsay Buss, Staff Representative, Benefits, BC Government & Services
- Cathy Cook, Safety and Training Manager, Corporation of Delta, HR
- Bill Dyer, Principal, Dyer and Associates
- Olivia Li, Occupational Health Nurse, OHSAH
- Marty Lovick, Senior Labour Relations Officer, HSABC
- Abha McDonell, Nurse Advisor, WorkSafeBC (North Vancouver)
- Rochelle Morandini, Hewit Associates, National Lead, Organisation
- Glen Rose, Manager, Rehab and Ability, Vancouver Island Health
- Ron Young

Group B said that Recommendation #2 should be implemented in British Columbia.

Group B focused on how to instill a sense of urgency among stakeholders.

Some strategies for how to make this recommendation become standard practice in our own organizations or community are:

1. Develop no fault insurance at the outset to focus on recovery rather than claims
2. Change culture to anticipate issues and act quickly
3. Build trust between employees and the employer
4. Communication in the workplace providing awareness to employees and tools to the people leaders and labour groups
5. Clearly outline accountabilities & motivate stakeholders (reward/support employee for SAW/RTW and supervisors for handling effectively)

The key steps involved in making this happen are:
1. Create clear expectations-communication plans, clear process for the employer
2. Face-to-face communication
3. Early intervention programs, early communications, support and resources & personalization of plans
4. Create a sense of urgency in the employee to recover as separate from RTW. Assignee to work with employee to support them through the process
5. Empower the employee to be more involved in case management

Some concrete first action steps that will get us started on making this a reality in our own organizations, community, and province wide are:
1. Separate adjudication and RTW; identify ability first and recovery plan using an action planning tool (tool to identify risks and barriers and how to overcome them)
2. Roundtables/coalitions provincially with key stakeholders (unions, employers, etc.) to work through issues and generate common purpose
3. Identify champions or “go to” people, identify who needs the services
4. Identify mechanisms for first line for employee contact
5. Provide urgent communication with the employee via a mentor – high trust
6. Work on action plans and direct resources to get the employee back to work
7. Get agreement through all levels of the organization
8. Give employee package to take info on duties to doctor – improve info flow
Group C – Recommendations 3 and 4

Text of Assigned Recommendation(s) from ACOEM Guideline

II. ADDRESS BEHAVIORAL AND CIRCUMSTANTIAL REALITIES THAT CREATE OR PROLONG WORK DISABILITY

3. Acknowledge and Deal with Normal Human Reactions
   Sub-recommendations:
   a. Encourage all participants to expand their SAW/RTW model to include appropriate handling of the normal human emotional reactions that accompany temporary disability to prevent it becoming permanent.
   b. Encourage payers to devise methods to provide these services or pay for them.

4. Investigate and Address Social and Workplace Realities
   Sub-recommendations:
   a. The SAW/RTW process should routinely involve inquiry into and articulation of workplace and social realities;
   b. Establish better communication between SAW/RTW parties;
   c. Develop and disseminate screening instruments that flag workplace and social issues for investigation; and
   d. Conduct pilot programs to discover the effectiveness of various interventions

Work Group C Members:

- Lucette Wesley, Director, BC Life Claims Service, Pacific Blue Cross, Work Group Facilitator
- Heather Biddell, Manager, Disability Claims, Pacific Blue Cross, Work Group Recorder
- Catherine Arber, Manager, Healthy Workplace, BCPSA, Ministry of Health
- Ada Arthur, Medical Officer, Health Canada
- Bobbi Frank, Team Leader, Disability Mgr., Healthcare Benefit Trust
- Mark Kane, Tam Manager, Great West Life
- Lois Macdonald, EIP Representative, Hospital Employees’ Union
- Laurel Mansfield, Org. Health Consultant, Great West Life
- Carole Taylor, Corp. Dir., Workplace Health, Interior Health Authority

Group C said that Recommendations #3 and #4 should be implemented in British Columbia.

We focused on all of Recommendation #3 and part A of Recommendation #4, most importantly communication between the employer and the employee.

Some strategies for how to make this recommendation become standard practice (what usually happens) in our own organizations or community are:

1. Develop standard education & standards of practice for all stakeholders (as appropriate by role)
2. Individuals to take accountability for their own wellness & recovery
3. Establish mechanism for communication between employer and employee
4. Ensure HR policies align with values

The key steps involved in making that happen are:
1. Identify appropriate personnel to be communicating with the employee on key issues in workplace – who is responsible to take issue forward – identify sponsor in the workplace
2. Business case for solutions
3. Establish standards of practice
4. Establish & communicate a protocol that is fair & consistent that involves all stakeholders (union, employer, employees)
   - Include specific timelines & steps to be taken
   - Expectations & issues of all stakeholders addressed up front
   - Training provided for all people managers & “alternates”
   - Maybe even a tool to facilitate conversation between employer of record, doctor and employee
5. Establish a “buddy” or peer referral program – EAP
   - Insurer/EAP collaboration
   - Make people managers accountable
   - Identify appropriate person/people to address workplace issues
   - Collective Agreements need to allow for collaboration

Some concrete first action steps that will get us started on making this a reality in our own organizations, community, and province wide are:
1. Establish a committee of like minded people – a SAW/RTW committee of workplace champions that will establish the specific steps that need to be taken
2. A forum for sharing findings, e.g. Set sample guidelines, policies & expectations
3. Need to obtain senior management support
4. Need to obtain HR support

Here’s what some of us intend to do starting tomorrow: (Give at least two examples from your group’s Personal Commitment Sheets).

Example #1:
*What are you going to do specifically?*
- GWL to draft letter to take to physician indicating workplace accommodation

*Who else needs to be involved?*
- Employee and physician

*To accomplish what?*
- Educate doctors
Example #2:

What are you going to do specifically?
- HBT to share information with all co-workers-disability management group – change their mindset

Who else needs to be involved?
- Co-workers

By when?
- In next 2 weeks

To accomplish what?
- Change mindset
Group D: Recommendations 3 & 5

Text of Assigned Recommendation(s) from ACOEM Guideline

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<tr>
<th>II. ADDRESS BEHAVIORAL AND CIRCUMSTANTIAL REALITIES THAT CREATE OR PROLONG WORK DISABILITY</th>
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<tr>
<td>3. Acknowledge and Deal with Normal Human Reactions</td>
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<tr>
<td>Sub-recommendations:</td>
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<td>a. Encourage all participants to expand their SAW/RTW model to include appropriate handling of the normal human emotional reactions that accompany temporary disability to prevent it becoming permanent.</td>
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<tr>
<td>b. Encourage payers to devise methods to provide these services or pay for them</td>
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| 5. Find a Way to Effectively Address Psychiatric Conditions |
| Sub-recommendations: |
| a. Adopt effective means to acknowledge and treat psychiatric co-morbidities |
| b. Teach SAW/RTW participants about the interaction of psychiatric and physical problems and better prepare them to deal with these problems |
| c. Perform psychiatric assessments of people with slower-than-expected recoveries routine |
| d. Make payment for psychiatric treatment dependent on evidence-based, cost-effective treatments of demonstrated effectiveness |

Work Group D Members:

- Celina Dunn, Manager, Medical Services, WorkSafeBC, Work Group Facilitator
- Joe Divitz, Union Liaison, OHSAH
- Jason Parker, DM Consultant, Centrix Disability Management Services
- Gianpiero Mameli, Business Development, EAP/RTW Provider, Shepelljgi
- Deb Connell, Occ Health Nurse, PSA
- Alan Buchanan, Psychiatrist, Collaborative Workplace Services
- Heather Middleton, Industry Specialist, WorkSafeBC
- Tracey Hawthorn, Regional Manager, BC Gov’t
- Paul Farnam, Occ. Health Consultant, Health Quest
- Margaret Tebbutt, Manager Workplace Mental Health, Canada Mental Health Assn.

Group D said that Recommendations 3 and 5 should be implemented in British Columbia.

We focused on finding a way to effectively address psychiatric conditions, Recommendation #5.

Some strategies to make this recommendation become standard practice in our own organizations and community are to:

1. Educate physicians, employees, unions etc.
2. Change stigma for employees with mental illness so access services ___
3. HCP screening for psychiatric illness based on risk factors/prolonged disability
4. Mental health training offered to new employees during orientation
5. Improve supervisors skills on an individual basis – coaching of supervisors
6. Provide awards to change experience employers have through skill building exercises, needs assessment, treating employees in compassionate manner

The key steps involved in making that happen are:
1. Educate physicians during residency
2. Improve bipartite education & negotiations among employees, union and employer
3. Campaign to change stigma of mental health issues
4. Increase HCPs’ awareness of the need to screen for mental health issues
5. Increase consumers awareness of the need to be screened

Some concrete first action steps and specific commitments are to:
1. Physician education – there are a group of influential MDs at our table who will approach Dean of Medical School at BC to improve residency education
2. Bipartite – other trainers at table (EAP/MH) who ___ single groups who will expand group
3. WSBC/MH work on a campaign – similar to injured worker campaign that WorkSafe BC did
4. Health promotion at employer and with physician
5. Develop CDM toolkit for physicians that has checkmark looking at prolonged disability and mental health issues (already in place – MOH initiated- is paid for
6. MHA/Sheppell/WSPC ?

Here’s what some of us intend to do starting tomorrow:
1. Alan, Paul and Celina to meet with Gavin Stuart, Dean of Medical School.
2. Sandra Lee and Celina Dunn to meet to propose CDM Toolkit on disability prevention (contact L. Agnew)
Appendix E - Multi-Stakeholder Workgroup Reports

Group E – Recommendations 6 and 8

Text of Assigned Recommendation(s) from ACOEM Guideline:

| II. ADDRESS BEHAVIORAL AND CIRCUMSTANTIAL REALITIES THAT CREATE OR PROLONG WORK DISABILITY |
| 6. Reduce Distortion of the Medical Treatment Process by Hidden Financial Agendas |
| Sub-recommendations: |
| a. Develop effective ways and best practices for dealing with these situations. |
| b. Instruct clinicians on how to respond when they sense hidden agendas. |
| c. Educate providers about financial aspects that could distort the process. |
| d. Procedures meant to ensure independence of medical caregivers should not keep the physician “above it all” and in the dark about the actual factors at work. |
| e. Limited, non-adversarial participation by impartial physicians may be helpful. For example, ask an occupational medicine physician to brief the treating clinician. |

| III. ACKNOWLEDGE THE POWERFUL CONTRIBUTION THAT MOTIVATION MAKES TO OUTCOMES, AND MAKE CHANGES TO IMPROVE INCENTIVE ALIGNMENT |
| Sub-recommendations: |
| The SAW/RTW process should: |
| a. recognize the treating physician’s allegiance; |
| b. reinforce the primary commitment to the patient/employee’s health and safety and avoid putting the treating physician in a conflict-of-interest situation; |
| c. focus on reducing split loyalties and avoid breaches of confidentiality; |
| d. use simpler, less adversarial means to obtain corroborative information; |
| e. and develop creative ways for treating physicians to participate in SAW/RTW without compromising their loyalty to their patients. |

Work Group E Members:
- Jaime Guzman, Chief Scientific and Medical Officer, OHSAH
- Lois Jones, Benefits Manager, University of Victoria
- Sami Youakim, Consultant, WorkSafeBC

Group E said that both recommendations should be implemented in British Columbia.

Here are some strategies for how to make this recommendation become standard practice in our own organizations or community:

1. Encourage/develop CME programs for family doctor to identify red flags for hidden agendas. Have WSBC/ICBC/insurers integrate their ___programs
2. When identified-separate from objective evidence. If identify non-medical- state not respond as not medical. Discuss w/BCMA re – policy statement – also College of Physician & Surgeons
3. Develop universal standardized forms for all insurers. Avoid questions F.P. not able to answer – i.e. how much can lift. Identify specific needs for form – is it adjudication or GRTW?
4. Have fees for completing forms paid by a neutral party
5. Do not ask a physician when a person should return to work
6. Ask instead to report on current functional abilities and limitations
7. Do not ask questions that cannot be answered within the sources available in a general medical office
8. Support the concept that gti? is the worker who completes the form, then just ask the physician if there is any medical contraindication to the above. Is it medically reasonable?

The key steps toward making this happen are:
1. Develop CME programs – discuss with all agencies
2. Change medical work absence certification – i.e. how much time off work before need medical note

Some concrete first steps toward making this recommendation reality are:
1. Research through resources at BCMA key players for policy and education of physician
2. Convey a meeting to discuss how to approach CME deliverers; WSBC, ICBC and insurers to set up training to help doctors identify red flags for hidden agendas and how to deal with them. Do not ask for employment or benefits determination.
3. Participate with other groups from this meeting to develop standardized form (build on current initiative by WSBC and HBT); next engage the BCMA and the College.
4. Have explanatory meeting to identify how to reach employers and/or unions to standardize when medical notes or certification are actually needed for time off work
5. Have fees for this paid by a neutral party (rather than patient or employer)
6. Set up time and place to have these three working groups – we need to set up a meeting time for these groups
III. ACKNOWLEDGE THE POWERFUL CONTRIBUTION THAT MOTIVATION MAKES TO OUTCOMES, AND MAKE CHANGES TO IMPROVE INCENTIVE ALIGNMENT

7. Pay Physicians for Disability Prevention Work to Increase Their Professional Commitment

Sub-recommendations:

a. Develop ways to compensate physicians for the cognitive work and time spent evaluating patients and providing needed information to employer and insurers as well as on resolving SAW/RTW issues. ACOEM developed a proposal for new multilevel CPT codes for disability management that reveals the variety and extent of the intellectual work physicians must do in performing this task. Adopting a new CPT code (and payment schema) for functionally assessing and triaging patients could achieve similar goals. Payers may be understandably reluctant to pay all physicians new fees for disability management because of reasonable concerns about billing abuses – extra costs without improvement in outcomes.

b. Make billing for these services a privilege, not a right, for providers and make that privilege contingent on completion of training and an ongoing pattern of evidence-based care and good-faith effort to achieve optimal functional outcomes.

IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS

12. Educate Physicians on “Why” and “How” to Play a Role in Preventing Disability

Sub-recommendations:

a. Educate all treating physicians in basic disability prevention/management and their role in the SAW/RTW process; provide advanced training using the most effective methods;

b. Make appropriate privileges and reimbursements available to trained physicians;

c. Focus attention on treatment guidelines where adequate supporting medical evidence exists;

d. Make the knowledge and skills to be taught consistent with current recommendations that medicine shift to a proactive health-oriented paradigm from a reactive, disease-oriented paradigm.

Work Group F Members:

- Marc White, Executive Director, CIRPD, Work Group Facilitator
- Catherine Clelland, Executive Director, Society of General Practitioners
- Maria Da Silva, Occ Health and Safety Manager, Good Samaritan Society
- Kim Fournier, Director, Corp & Strategic Initiatives, Ministry of Labour and Citizens’ Services
- Sylvie Gelinas, Manager, Benefits, Terasen Gas
- Allon Reddoch, Chief Medical Consultant, Yukon Worker Comp/Safety
Group F states that Recommendations #7 and #12 should be implemented in British Columbia.

Group F focused on Recommendation #12. Here are some strategies for how to make this recommendation become standard practice in our own organizations or community:

1. To get buy-in from physicians, there needs to be an evidence base first. From there, a push for curriculum development & ultimately a way to disseminate the right information to all.
2. Use PDSA cycle – Plan, do, study, act – evidence base
3. Translate to MD/MOA practice
4. Engage other care stakeholders
5. Social marketing
6. Create evidence-base (by GPs for GPs with other players) by opinion leaders with clear transparent evidence-based tables-towards the creation of a disability prevention Cochrane Group
7. Link with Primary Care Centre for Research Excellence/ Dept of Family Practice) and Health and Work Productivity Web-Portal
8. Create working group with academic leadership to address Curriculum Renewal (move away episodic training) working with Department of Family Practice – link to

The key steps involved in making that happen are:

1. Collect the evidence
2. Get stakeholders together to develop curriculum
3. Increase awareness about disability prevention and urgent need for action due to dire consequences with knowledge about +ve aspects and impact on outcomes
4. Creating partnerships funding to support EB acceptable for GPs

Some concrete action steps that will get us started on making this a reality in our own organizations, community and province wide are:

1. Create, partnership & funding – identify key “champions” already involved in undertaking disability prevention work (GP Services, ____, BCMA)
3. Build partnership to create credible Cochrane Group on Disability Prevention with BC scientists.
4. Consolidate efforts in conjunction w/establishing Cochrane Group
5. Use existing pathways
6. CIRPD, UBC, WorkSafeBC to follow up on introducing training into the medical curriculum
7. GP Services Committee PSP integrated with Medical Office Assistants (MOA) has a payment process for paying session time for training both physicians and MOA.
8. Primary Care Centre of Research Excellence in partnerships with other collaborators with a goal of establishing a Cochrane Scientific workgroup on disability prevention (Dept. of Family Practice linked to the continuum of medical education and other primary care providers and business/labour)

9. All stakeholders must work from common evidence base

10. Action: Create Effective Persuasive Key Message with transparent information on levels of evidence translated to all stakeholders

11. MDs need to know what is available in the workplace to make informed decisions once they understand the importance of disability prevention – possible use of employer-employee form

12. Create funding for curriculum renewal and support infrastructure support for research

13. Curriculum renewal: Avoid episodic teaching; change medical curriculum fundamentally integrated with physician – patient communication, patient adherence-engagement, risks for non-compliance, special component on impact on health communication on outcomes.

14. Create OSCE for curriculum to make it real and testable for undergraduate

Here’s what some of us intend to do starting tomorrow:

1. Create coalition to coordinate research to establish evidence base. Marc-UBC Family Practice and ___ Institute for Pain & Disability with Pete Rothfels USBC; Catherine – Society of G.P.

2. Coordinate & translate research on disability prevention. Beta testing site w/in 15 months to accomplish web portal so that information can be shared across disciplines (already in progress). Faculties of Business and Health Sciences across Canada need to be involved.

3. Pitch training of disability prevention as a way to reduce the stress link. Continuing Prof. Development & Knowledge Translation need to be involved. Need investment from WSBC, MOH, Business Council of BC, MLCS.

4. Work on MD education module, involving BCMA, WorkSafeBC, and MOH & Ministry of Labor within 6-8 months to educate docs
Group G – Recommendations 10 and 11

Text of Assigned Recommendation(s) from ACOEM Guideline

III. ACKNOWLEDGE THE POWERFUL CONTRIBUTION THAT MOTIVATION MAKES TO OUTCOMES, AND MAKE CHANGES TO IMPROVE INCENTIVE ALIGNMENT

10. Be Rigorous, Yet Fair in Order to Reduce Minor Abuses and Cynicism

Sub-recommendations:

a. Encourage programs that allow employees take time off without requiring a medical excuse;

b. Learn more about the negative effect of ignoring inappropriate use of disability benefit programs;

c. Discourage petty corruption by consistent, rigorous program administration;

d. Develop and use methods to reduce management and worker cynicism for disability benefit programs;

11. Devise Better Strategies to Deal with Bad-Faith Behavior

Sub-recommendations:

a. Devote more effort to identifying and dealing with employers or insurers that use SAW/RTW efforts unfairly and show no respect for the legitimate needs of employees with a medical condition;

b. Make a complaint investigation and resolution service – an ombudsman, for example – available to employees who feel they received poor service or unfair treatment.

Work Group G Members:

- Shelagh Locke, Industry Specialist, WorkSafeBC, Work Group Facilitator
- Lara Acheson, Coordinator, OH & S, BC Nurses Union
- Chris Arcari, S.I.P. Plan Administrator, B.C.T.F.
- Eileen Beadle, Benefit Consultant, Mercer (Canada) Limited
- Bill Blackler, Manager, Claims Services, B.C. Maritime Employers Association
- Gerry Smith, Staff Rep. Research, United Steelworkers

Group G stated that Recommendations #10 and #11 should be implemented in British Columbia.

We focused on Recommendation #10 – Be Rigorous, Yet Fair in Order to Reduce Minor Abuses and Cynicism

Some strategies for how to make this recommendation become standard practice in our own organizations or community:

1. Make sure everyone know their roles, responsibilities and what they are accountable for
The key steps involved in making that happen are to:

1. Educate all stakeholders on roles, responsibilities and accountabilities; facts about insurance programs
2. Monitor program
3. Run pilot programs to try out new and different processes
4. Regularly review EFAA/Wellness programs to see if they meet needs of workers & if not, adjust

Some concrete action steps that will get us started on making this a reality in our own organizations, community and statewide are to:

1. Establish commitment from Labour & Management
2. Define disability management initiatives to both parties
3. Agree on goals and objectives
4. Develop joint training as required
5. Keep in touch with people in our group so we can continue to work

Here are some specific things we intend to do starting tomorrow:

**Example #1:**

*What are you going to do specifically?*
- Work with organization to enable commitment for labor and management

*Who else needs to be involved?*
- A designated employer and union

*By when?*
- Can assist by end of Quarter 1-2009

*To accomplish what?*
- Educate on the need for disability management
Groups H – Recommendation 13b

Text of Assigned Recommendation(s) from ACOEM Guideline

<table>
<thead>
<tr>
<th>IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>13b. Disseminate Medical Evidence Regarding Recovery Benefits of Staying at Work and Being Active</td>
</tr>
<tr>
<td>Sub-recommendations:</td>
</tr>
<tr>
<td>a. Or preferably, adopt an evidence-based guideline as the standard of care.</td>
</tr>
</tbody>
</table>

Work Group H Members:
- David Barle, Director Emp-Adv, Ministry of Labor
- Tamy Gould, Executive Director, IWA Forest Industry
- Dave Keen, Regional Director, Fraser Health
- Joan Perry, Citizen’s Services, Ministry of Labor
- Ramona Sgares, Director, Ministry of Labor

Group H agreed that Recommendations #13b should be implemented in British Columbia.

We focused on all of the Recommendation but primarily on medical care.

Some strategies for how to make this recommendation become standard practice in our own organizations and communities is:

1. Information transfer (communication campaign) – public policy statement (refer to endorsement by gov’t doctors, unions, employer associations)
2. Payer influence, including contingencies like benefits contingent on compliance

The key step(s) involved in making that happen are:

1. Identify & disseminate financial impact of guidelines (payer in best position to provide)
2. GAP analysis of missing guidelines
3. Develop best practices if not in existence
4. Develop contingencies & incentives associated with guidelines
5. Measurement/evaluation by credible party

Some concrete action steps that will get us started on making this a reality in our own organizations, community and statewide are:

1. Collect guidelines in existence (NHS-UK)
2. GAP analysis & develop/research new guidelines
3. Create central repository of peer-reviewed guidelines (negotiated)
4. Payers will adopt contingencies with employer input
Here’s what some of us intend to do starting tomorrow:

Example #1:
*What are you going to do specifically?*
- EAO-Disseminate financial impact to worker on workplace injury

*Who else needs to be involved?*
- Dave

*By when?*
- Dec. 31/08

*To accomplish what?*
- Increase awareness among employers to influence their commitment to early RTW/SAW processes

Example #2:
*What are you going to do specifically?*
- Fraser Health to identify work’s contribution to health

*Who else needs to be involved?*
- Physicians in the Fraser Health authority

*By when?*
- Upon hire of VP of Medicine (person of influence)

*To accomplish what?*
- Physicians consider work as part of treatment – leads to productive workers & internal workplace systems work better

Example #3:
*What are you going to do specifically?*
- WAO – disseminate info to injured workers – info kit

*Who else needs to be involved?*
- Ramona

*By when?*
- Jan. 31/09

*To accomplish what?*
- Awareness of personal impact of injury
Example #4:
What are you going to do specifically?
- Joan will be following up - speak to Marc White/Allan Reddoch

Who else needs to be involved?
- Marc

By when?
- Dec. 31/08

To establish what?
- Identify resources to the Best Guideline Repository (60 Summits link?)

Example #5:
What are you going to do specifically?
- Research other relevant initiatives

Who else needs to be involved?
- Faculty @ UBC-Health Initiatives

By when?
- Jan. 31/08

To establish what?
- Understand what is available instead of “recreating the wheel”
Group I – Recommendation 14

Text of Assigned Recommendation(s) from ACOEM Guideline

<table>
<thead>
<tr>
<th>IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS</th>
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</thead>
<tbody>
<tr>
<td>14. Simplify/Standardize Information Exchange Methods between Employers/Payers and Medical Offices</td>
</tr>
<tr>
<td>Sub-recommendations:</td>
</tr>
<tr>
<td>a. Encourage employers, insurers, and benefits administrators to use communication methods that respect physicians’ time;</td>
</tr>
<tr>
<td>b. Spend time digesting, excerpting and highlighting key information so physicians can quickly spot the most important issues and meet the need for prompt, pertinent information;</td>
</tr>
<tr>
<td>c. Encourage all parties to learn to (a) discuss the issues – verbally and in writing – in functional terms and to (b) mutually seek ways to eliminate obstacles.</td>
</tr>
</tbody>
</table>

Work Group I Members:
- Werner Schulz, Director, Healthcare Benefit Trust, Work Group Facilitator
- Douglas Carra, Disability Team Leader, Telus Corp Health Services
- Rebecca Chow, Work-Life Consultant, HR, University of Victoria
- Peter Duncan, Senior Health, Safety, HR Advisor, District of West Vancouver
- Todd Gill, Manager, Occ Abilities Mgmt, Canada Post
- Kelli McMartin, Disability Coordinator, London Drugs
- Lucy Samuel, Nurse Advisor, WorkSafeBC (North Vancouver)
- Dorothy Steele, Manager, Compensation/Benefits, London Drugs

Group I states that Recommendation #14 should be implemented in British Columbia.

Group I focused on all of Recommendation #14.

Some strategies for how to make this recommendation become standard practice in our own organizations or community:

1. Standard form for the Province
2. Redesign form with employee, doctor, employer and union input
3. Empower employee with reminder “tell doctor what you can do” – get employee to decide
4. In order to get doctors to complete, develop trust with employees, then doctor validates
5. Form must be available to line supervisor
The key steps involved in making that happen are:
1. ____working group broad based
2. Get broad based input
3. Pilot form
4. Redesign form that has section for employee to complete ahead
5. Form needs to be employee driven
6. Educate all parties – unions, doctors, employees, supervisors and management
7. Ask what you can do now, what you do in two weeks, four weeks

Some concrete first action steps that will get us started on making this a reality in our own organizations, community, and province wide are:
1. Reconvene group to develop framework for developing form – all at our table agreed to participate
2. Invite key stakeholder with idea to find organization to pilot in organization pre and post measurement
3. Educate via newsletter, lobby to get this in educational curriculum
4. Volunteer to participate in a work group to design
5. Contest to design form from anyone in Province

Here’s what some of us intend to do starting tomorrow:

**Example #1:**

*What are you going to do specifically?*
- Volunteer to participate in a form design work group

*Who else needs to be involved?*
- Personnel at this table and others that are interested from this conference and networking thereafter; contact professional researchers in the field (CLHIA has just redesigned a new STD claim form for insurance that will be introduced January 1, 2009 for all insurers across Canada)

*By when?*
- Jan 30/09

*To establish what?*
- At first meeting we will determine Terms of Reference, Mission, Guidelines

**Example #2:**

*What are you going to do specifically?*
- Run design contest for form design

*Who else needs to be involved?*
- Anyone (sponsor)

*By when?*
- After form design workgroup has been struck & to be determined by the group

*To establish what?*
- To get more ideas, like a survey
Example #3:

*What are you going to do specifically?*
- Identify areas to pilot forms

*Who else needs to be involved?*
- Work group, industry associations, employer groups, medical groups
Group J – Recommendation 15

Text of Assigned Recommendation(s) from ACOEM Guideline

<table>
<thead>
<tr>
<th>IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS</th>
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</thead>
<tbody>
<tr>
<td>15. Improve/Standardize Methods and Tools that Provide Data for SAW-RTW Decision-Making</td>
</tr>
<tr>
<td><strong>Sub-recommendations:</strong></td>
</tr>
<tr>
<td>a. Help physicians participate more effectively in the SAW/RTW process by standardizing key information and processes;</td>
</tr>
<tr>
<td>b. Persuade employers to prepare accurate, up-to-date functional job descriptions (focused on the job’s maximum demands) in advance and keep them at the benefits administrator’s facility; and send them to physicians at the onset of disability;</td>
</tr>
<tr>
<td>c. Teach physicians practical methods to determine and document functional capacity;</td>
</tr>
<tr>
<td>d. Require purveyors of functional capacity evaluation methods and machines to provide published evidence in high-quality, peer-reviewed trials comparing their adequacy to other methods.</td>
</tr>
</tbody>
</table>

Work Group J Members:
- Catherine Kidd, Regional Director, Vancouver Coastal Health
- Michael Carr, V.P. Disability Mgt Services, Ultima Medical Services
- Karlene Dawson, Program Leader, Fraser Health
- Scott Fraser, Health & Safety & Kinesiology, Farm and Ranch Safety and Health Assn. (FARSHA)
- Bruce Johnson, Executive Director, Farm and Ranch Safety and Health Assn. (FARSHA)
- Catherine Kidd, Regional Director, Vancouver Coastal Health
- Inderneet Mann, Occupational Therapist, Back In Motion
- Sean O’Neill, Director-Vancouver, Manulife Financial Disability Claims
- Stephen Torrence, CEO, Construction Safety Network

Group J said that Recommendation #15 should be implemented in British Columbia. Group J focused on Part a.

Here are some strategies for how to make this recommendation become standard practice in our own organizations or community:

1. Convene a conference of specialists to develop a common framework (focus on wellness) with definition of terms and a format for templates &/or tools for communication on SAW/RTW in BC between the employer, employee & physicians
2. Include in conference specialists that include unions
3. Develop: 3 separate tools each with a communication package for each decision maker role (employer, employee and MD)
The key steps involved in making this happen are:
1. Getting, finding the support to develop the framework
2. Focus on occupational disability at the beginning & then the framework can be applied to non-occupational injury and illness

Some concrete first action steps that will get us started on making this a reality in our own organizations, community, and statewide are:

1. Stephen Terrence to contact WSBC to convene groups from employer community, safety and leadership groups so all employers, workers, and physicians can speak the same language
2. The purpose is to build shared understanding of issue of requirement for common language & definition
3. Ask the employer groups to fund the conference of experts – we will start with workplace injuries

Here’s what some of us intend to do starting tomorrow:
1. Work with own staff to write definitions regarding common terms
Group K – Recommendation 16

Text of Assigned Recommendation(s) from ACOEM Guideline

<table>
<thead>
<tr>
<th>IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS</th>
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<tbody>
<tr>
<td>16. Increase the Study and Knowledge about SAW/RTW</td>
</tr>
<tr>
<td>Sub-recommendations:</td>
</tr>
<tr>
<td>a. Complete and distribute a description of the SAW/RTW process with recommendations on how best to achieve desired results in disability outcomes;</td>
</tr>
<tr>
<td>b. Establish and fund industry-specific, broad-based research programs, perhaps in the form of independent institutes or as enhanced university programs;</td>
</tr>
<tr>
<td>c. Collect, analyze, and publish existing research;</td>
</tr>
</tbody>
</table>

Work Group K Members:

- Philip Mah, Program Manager, Disability Prevention, OHSAH
- Brent Mulhall, Director, Back in Motion
- Renee-Louise Franche, Director, Disability Prevention, OHSAH

[The report below is taken solely from the audio recording of the oral report: No written report was available.]

Here are some strategies for how to make this recommendation become standard practice in our own organizations or community:

1. We are committed to developing a research project to identify practices or absence of practices in the SAW and RTW continuum in the healthcare sector

Some concrete first action steps that will get us started on making this a reality in our own organizations, community, and statewide are:

1. Types of methodology – interviews w/workers and supervisors, possibly videotaping the interactions that involve SAW-RTW
2. Ultimate goal is to increase awareness around SAW
3. Identify gaps between practices and ACOEM guidelines
4. Deliverable – to deliver a SAW process that could be further evaluated afterwards

The key and concrete steps involved in making this happen are:

1. Get the right players around the table, such as, employers, unions, HBT, WSBC, researchers and members of our work group
2. We all have specific individuals to contact in the next few weeks
3. We will set up a meeting by the end of January or February to meet again
4. We also think it’s important to link with the steering committee in the healthcare sector
5. We hope to secure funding by having the right players at the table
6. This week we will send the first volley of emails and f/u with the appropriate people
“Further explanation of concrete steps – much is being done now – it’s been mentioned by today’s work groups that a lot of people are doing certain things but they are all different. We need to identify current practice to see how it differs from the guidelines. We want to use the approach of intervention mapping, developing an intervention based on data, based on data that could be gathered involving the stakeholders’ perspectives who are participating in the intervention mapping and simple theory. Through that process we end up with a consensus based intervention model that you can then later on test in terms of whether it’s effective or not.”
Group L – Recommendation 9

Text of Assigned Recommendation(s) from ACOEM Guideline

III. ACKNOWLEDGE THE POWERFUL CONTRIBUTION THAT MOTIVATION MAKES TO OUTCOMES, AND MAKE CHANGES TO IMPROVE INCENTIVE ALIGNMENT


Sub-recommendations:

a. Encourage or require employers to use transitional work programs;

b. Adopt clearly written policies and procedures that instruct and direct people in carrying out their responsibilities;

c. Hold supervisors accountable for the cost of benefits if temporary/transitional work is not available to their injured/ill employees;

d. Consult with unions to design on-the-job recovery programs;

e. Require worker participation with ombudsman services available to guard against abuse;

f. Make ongoing expert resources available to employers to help them implement and manage these programs.

Work Group L Members:

- Chris Back, Director, Injury Prevention, OHSAH
- Leslie Allan-Reed, Managing Consultant, Disability, Fraser Health Authority
- Shelley Baldry, Senior Certification Officer, WorkSafeBC
- Jan Beesley, Manager, Nursing Services, WorkSafeBC
- Catherine Fast, Director, Employee Wellness, PHSA
- Douglas Hanson, Consultant (Private Practice)
- Larry Morgan, QA Mgr., OHS Coordinator, Pattison Sign Group
- Carmel Murphy, Consultant, IHDMS, Healthcare Benefit Trust
- Nancy Paris, Director, PART, BCIT
- Sheldon Staszko, Director, Occ Health Programs,
- Kenneth Strobl, Director, Disability Mgmnt Programs, BC Public Service Agency
Group L agreed that Recommendation #9 should be implemented in British Columbia.

Here are some strategies for how to make this recommendation become standard practice in our own organizations or community:

1. Education – all stakeholders, all levels, start in educational institutions-management programs – “work is good for your health"
2. Accountability – performance reviews of mgmt/supervisors – financial (link costs to savings)
3. Incentive – bonus or reinvestment of savings to specific department
4. Measurement – “proof” that transitional work is of benefit to organization, customers/individuals >industry specific
5. Involve all stakeholders, involve them early (joint labor-management) to develop process>participation model (remember that most important person is injured/ill individual

The key steps involved in making that happen are:
1. Bring together the stakeholders w/in our organizations
2. Assemble evidence for best practice >translate/transfer
3. Increase public awareness (social marketing) that work is good for you and you can get better at work

Some concrete first action steps that will get us started on making this a reality in our own organizations, community, and statewide are:

1. Orientation programs (new/young) to include promotion of SAW/RTW when employee joins organization
2. BC Gov.-defined communication plan – better info dissemination – improved marketing
3. WSBC – increased awareness with employers – you don’t have to be off work to benefit from transitional duties
4. FHA – increased preparedness-have JDAs break down into light/med/heavy
5. HBT – policy related to SAW/RTW complete with definitions
6. WSBC – Injured worker/Cared For at Work Pilot; make available to all WorkSafeBC Education Partners

Here’s what some of us intend to do starting tomorrow:
1. Develop research proposal for the role of tech & equipment to benefit SAW/RTW – adaptive equipment by first quarter 2009
2. Hold Summit where those workers and employers who have been beneficiaries of SAW/RTW can share success stories
Group P – Policy Multi-Stakeholder Work Group Report

Work Group P Members *:

- Kim Thorau, Management Consultant, Perrin Thorau & Assoc. Ltd.
- Jonathan Agnew, Asst. Director of Policy, BC Medical Association
- Margaret Smithson, Regional Mgr. WorkSafeBC
- Nan Bennett, CEO, Healthcare Benefit Trust
- Bob Bluman, Assistant Dean, UBC Division of CPD
- Mike Clarke, Vice President, BC Gov’t Employees’ Union
- Janusz Kaczorowski, Prof and Research Director, UBC Dept. Family Practice
- William Lakey, Med Director, Occ Health Program, BC Public Service Agency
- Mike Werbowecki, AVP Group Disability Operation, Manulife Financial
- Andrew Wharton, Assistant Deputy Minister, Ministry of Housing
- Barry Wilton, Assistant Deputy Minister, BC Public Service Agency
- Larry Myette, Director Strategic Workplace Health, Healthcare Benefit Trust
- Terry Bogyo for Dave Anderson

* Work Group P members were chosen given their ability to influence the framework being adopted in BC.

Work Group P members focused on the following Recommendations to provide a broader strategic policy perspective:

- #1 – Increase Awareness of How Rarely Disability is Medically Required
- #2 – [Instill a Sense of Urgency] Urgency is Required Because Prolonged Time Away from Work is Harmful
- #13-a – Disseminate Medical Evidence Re: Recovery Benefits of Staying at Work & Being Active
- #16 – Increase the Study of an Knowledge about SAW/RTW

Broad Strategies:

A. Adopt/support the ACOEM document – based on this as a “Best Practices” document
   - Needs to be adapted/modified/adjusted to BC environment & community
   - Need to standardize terminology
   - Need to emphasize “first contact” step – the first contact is critical

B. Establish a “collaborative” – a form of governance, guideline making body for moving this initiative forward
   - The “collaborative” will be multi-stakeholder and at Provincial level
   - Need to ensure broad & representative membership of all sectors including business organizations (BC Business Council; Board of Trade; small business organizations, unions etc.)
• Need to identify other champions (those who can be spokespersons for the initiative and movement)
• Need to engage corporate leaders

C. Establish an integrated Provincial performance measurement system (for all aspects of disability and health benefits) to make the business case and demonstrate cost/benefits for employers and employees
   • Needs to highlight broad financial impacts/economic impacts
   • Needs to address the bottom line social/human elements
   • Needs to address the chronic disease impact on disability

D. Identify and prioritize actions from BC Summit

E. Build awareness at all levels through development of data/information to drive the initiative forward by outlining the business case – the cost/benefits of both financial/economic & social/human
   • For employers: impact on operations overall; including human capital management (impact on people and staffing; health & wellness supports bottom line)
   • For employees: outline risks of chronic disability; health benefits from work; negative impact on employability
   • For MDs: impact of decisions (need for support for physicians – i.e. development of a Work Disability Prevention Program for MDs (developed in concert with MDs and Medical Association) that provide policy, program & practice for MDs in preventing needless work disability (similar to BCMA Chronic Disease Program)
### Specific Actions to Take:

<table>
<thead>
<tr>
<th>Broad Strategies</th>
<th>Specific Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Adopt ACOEM document with adaptations</td>
<td>- Did not discuss in 3:30 to 4:00 p.m. session; except to confirm that this should be a priority action item for “collaborative” to act on</td>
</tr>
</tbody>
</table>
| B) Establish a “collaborative” (leadership/governing body to move initiative forward @ broad policy & strategic level) | - B1. Nov.08 – at next BC Summit Steering Committee Mtg. determine future of Steering Committee (pull into collaborative)  
- B2. Nov.08-Jan.09 – canvass members of ___Group and other Summit participants for key names for collaborative  
- B3. Feb.08 – host initial mtg of collaborative  
- B4. June 09 – consider & design/develop an ongoing communication forum for disseminating communications  
- B5. June 09 – plan for Nov. 09 Summit |
| C) Establish integrated Provincial Performance Measurement System                 | - Only a very brief discussion @ end of 3:30-4:00 session  
- C1. June 09 - establish a research/performance measurement component & research/performance measurement plan |
| D) Identify and prioritize actions from BC Summit                                 | - D1. Feb.09 – Review Report from BC Summit  
- D2. Feb.-June 09 – Identify & prioritize actions & establish timelines  
- D3. Sept.09-establish working/task groups for priorities (identifying champions/leaders to lead these tasks)  
- D4. Jan.09-collaborative to survey all Summit participants about areas of expertise & interest |
| E) Build awareness @ all levels – employees, employers and MDs                    | - Did not have time to discuss                                                                                                                     |
Appendix F – Similar Stakeholder Workgroups Reports

The information contained in this appendix is a consolidated list of the reports delivered by the similar stakeholder workgroups during the British Columbia Summit on November 25, 2008. It combines information from the written reports and oral presentations. In some places the written reports were illegible; words that could not be deciphered are represented by an underscore, like this: ____.

In addition to 12 multi-stakeholder work groups, the BC Summit Steering Committee decided to also divide participants into similar stakeholder groups to gain their insight on implementing the Work Disability Prevention model in BC. Ten similar stakeholder work groups were set up:

- Occupational Health & Safety (2 groups, one that was healthcare specific)
- Human Resources and Insurer (2 groups)
- Mixed Health Professions – Related
- Physician-Non Physician Consultants and Rehab
- Physicians
- Public Sector Policy- Health Care Leaders, Union & Government
- Public Sector –Government
- Health, Safety and Benefits – End User

This Appendix summarizes the findings of each of the 10 similar stakeholder workgroups. Workgroup members were asked to discuss and respond to the following 3 questions:

a. What might make many of the people in your stakeholder group RELUCANT to fully support adoption of the Work Disability Prevention model here in BC?

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”? 
Occupational Health & Safety (OHS)

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?

Barriers:
- Old beliefs
- Lack of education
- Disconnection between OHS & worksite
- Change in accountability
- Incorrect understanding of process
- Fear & apprehension
- Possible change in liability
- Are the worker & co-worker safe if accommodation not correct?

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?

- Senior management support
- Develop communication process between medical community & all stakeholders
- Employer organizations/association take leadership role
- Align disability plans with disability management model
- Educate employers/worker on insurance benefits
- Hold insurers accountable
- Need cultural shift

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?

- Develop metrics to show true – including direct and indirect costs of work disability
- This can be done by partnering with Sauder School of Business
Occupational Health & Safety (OHS) Public Practice - Healthcare

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?

- Costs
- Role changes
- Power shifts
- Lack of education
- Lack of trust
- Entitlement
- Unknown (fear of?)

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?

- Common vision/goals between union & management
- Communication of benefits for all stakeholders (results)
- Commitment/investment in programs to support DM guidelines
- Part of organization’s strategic plan-core value

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?

- Create healthcare provider SAW/RTW Screening Committee
- Provincial initiative vs. authority specific; build momentum and increase trust and partnership with stakeholder groups that cross boundaries
- Steering committee inclusive of unions, management to create a framework including vision & values related to disability guidelines; followed by knowledge transfer
- Common strategy testing the message; surfacing the unknowns
Human Resources (HR) and Insurer (INS)

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?

- Labour side – human side
- Low priority from those controlling funds
- Time required (most companies want results in a short amount of time)
- May not get needed training-but need to make it work
- No market yet

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?

- Employer look at occupational health @ holistic approach
- Straw dog model for integrated approach
- Consistent approach to employee absence with consistent forms and education, preventive approach
- Capture data
- Workplace welcoming/orientation educating in support and RTW/SAW programs
- Change in attitude w/employees

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?

- Obstacle getting to know the CEOs
- Prepare a presentation for the BC Business Council including specific data around ______?
- Go to BC Labour Council with presentation & work with the employers/employees providing education

d. Here are a few examples of what some of us intend to do starting tomorrow:

*If there is a willingness to proceed we will develop a presentation of facts.

What are you going to do specifically?
- Make contact w/BC Business Council/BC Federation of Labour to offer presentation contacts and action steps (Lisa to contact)
- Develop presentation and vet it through UP and ICBC

Who else needs to be involved?
- UP and ICBC
- Union Leaders (Eileen Beadle)
By when?
- For both #1 and #2 - end of Q1 2009

To accomplish what?
- Bring the presentation to the BC Business Council
- Develop presentation and vet it through UP and ICBC
Human Resources (HR) and Insurer (INS)

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?
   - Resources – time and money
   - Collective agreements may need renegotiation
   - Cost-benefit hard to quantify to senior management
   - Cost-benefit not realized right away
   - Changes related to cost-benefit analysis
   - Lack of expertise, common language & goal
   - No understanding of duty to accommodate frame of mind; is unknown to small to medium size employers

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?
   - Common language for communication between stakeholders, i.e. when does disability start?
   - Relationship building – comfortable environment
   - Education for supervisors
   - Tools, autonomy & accountability for supervisors
   - Promote benefits & culture of SAW
   - Need buy-in from employees – need to create the right culture for SAW

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?
   - HR coaching supervisor
   - Set expectations with employees – culture shift
   - Banks of modified duties
   - Share our knowledge with co-workers and clients
   - Communication between employer & employee stakeholders
   - Deal with situation effectively. Supervisor may not want employee back until “fully fit”
   - Small companies don’t have resources or programs – can’t afford alternate work options

d. Here are a few examples of what some of us intend to do starting tomorrow:

   **What are you going to do specifically?**
   - Share information with co-workers (HR/supervisors)
   - Provide documentation to unions

   **Who else needs to be involved?**
   - Frontline supervisors and employers
By when?
• Now

To accomplish what?
• Improve communication lines for better understanding of processes & improve durations & outcomes
Mixed Health Professions - Related

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?

- Legal implications bring ___ back
- MD: lack of time, incentive knowledge, supports limited resources for non-occupational injuries
- MD in conflict of interest, loyalties
- Lack of objective measurement tools to assess realities
- No standard tools & measures, lack of evidence
- Boundaries
- Px compliance, self-management

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?

- More robust research base
- Creation of tools, develop the message
- Communicate to docs
- Build on what’s working to engage docs
- Mine existing data
- Employer-employee RTW form completed, web??>pilot
- Consensus conferencing
- CMA RTW policy ___ guide MDs
- Doc understands seriousness of consequences
- CDM – but episodic, multiple payers/stakeholders – how to integrate?

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?

- Demonstrate success
- Create knowledge base, develop measures, tools & incentives – fill gaps
- Advanced access model; build off practice support program; do pilot
- Funding via USBC, _HR partnership
Physician-Non Physician

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?

- MD lack of time
- Lack of knowledge
- Lack/limited enabling resources
- Lack of information
  - about workplace options/environment/job
  - unclear roles/responsibilities
  - patient advocacy
  - long term financial consequences
  - difficulties dealing with patients with soft tissue complaints
  - problems with occupational consequences of non-work related injuries
  - lack of acceptable evidence (by physicians for physicians)
  - need for empirical evidence

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?

- Mine evidence
- Systematically create evidence done by and for respected physicians
- Utilize or create validated tools and metrics to make appropriate decisions and address liability issues
- Work with WorkSafeBC to have more responsive call backs when requested
- Determine low lying fruit – studies that can make a difference and address a gap
- Prospective studies
- Further develop idea about using employer-employee RTW to provide physicians with better work related information
- Make sure that as evidence is available for knowledge to be translated for patient education resources so patients/public understand the need to adopt disability prevention.
- Join with Dept. of Family Practice with Primary Care Centre of Research Excellence
- Systematically determine what is known
- Build relationships wit partners
- Work with BCMA with Advance Access Program and explore whether chronic disease model funding program could facilitate system changes necessary

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?

- See above
Physician-Non Physician B – Consultants and Rehab

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?
   
   • Attitude change, culture
   • Cynicism
   • Not having the authority
   • No effective model
   • Insurance system
   • Difference between education and training

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?
   
   • Differentiate mental health and physical – education for employees
   • Remove stigma with mental health issues – more transparent system
   • Developing expertise for MH issues
   • Re-brand RTW as being productive
   • Look beyond just work place injury – also non-workplace
   • More stakeholders participating – rehab, nursing, OT, PT, people experienced with disability
   • More stakeholders collaborating

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?
   
   • Assist in developing policies and procedures
   • Grassroots level – use herd mentality
   • Champion employees in particular industry – their share
   • Education & training
   • Share successes and challenges within industries & between industries – create transparency
   • Newsletter and meeting forum
Physicians

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?
   - Loyalty bind
   - What is advocacy – health vs. ___
   - Not on radar for existing MDs
   - Paperwork burden (57% NPS)
   - Lack of interest/knowledge
   - __________ - adequacy/pays

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?
   - Standardize forms
   - Appropriate use of forms for medical purposes vs. attendance management
   - Improve GPAC guidelines to include disability prevention
   - Enhance attendance for conferences thru incentives
   - Appropriate payment (e.g. phone calls/side notes ____

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?
   - MDs at this table will lobby BCMS & UPSBC to place this on the agenda
   - Identify disability prevention as CDM & develop tool
   - Develop standard form
   - Get into Dept. of Psychiatry to train occupational
   - MD awareness of disability as health indicator & urgent __
Public Sector Policy #11 – Health Care Government – Red Group

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?

- Confidentiality
- Lack of integration/programs siloed
- Bad experiences
- Slippery slope – need control
- Lack of skills
- Societal belief of entitlement
- Who has ownership/leadership
- Lack of clear roles/accountabilities
- Lack of trust
- Not a holistic approach
- Stakeholders have competing interests
- Healthcare employers, unions and insurers

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?

- Redefine confidentiality so access is ethical, timely & with appropriate consents
- Process needs to shift to keep employee at work rather than bureaucracy
- Need to stop medicalizing all issues in workplace – deal with root causes & change processes; provide instant intervention for workplace issues
- Decrease/remove fractionalization of programs – more integration of how all programs support each other; clear 1st contact information; streamlined processes
- Establish SAW programs with guidelines & protocols, privileges?

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?

- Shifting the culture
  - Zero in on some small things
  - Define what we want to change
  - Spread the benefits of work – Work is good for you
  - Focus on those employees – You can get back to work successes
  - Engage workers in coming up with solutions – focus groups
  - Systemic approach – multi-level from top to bottom & bottom to top
d. Here are a few examples of what some of us intend to do starting tomorrow:

- Put protocols in place to address SAW & RTW
- Employees need to feel safe to say they are OK
- Start talking about de-medicalizing processes
- Ask employees, “What do you need to be at work?”
- Simplify the system
Public Sector /Government

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?

- Medical model
- Collective agreements
- Budget – loss of control and power
- Off work is good – entitlement
- Demographics
- Lack of trust
- Poor communication
- Proxy data

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?

- There is impetus
- State of urgency
- Need for change
- Improved accountability
Public Sector – Room 13

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?

- It is a medical model
- Lack of trust
- Sense of entitlement of worker
- Loss of power & control
- Lack of awareness = understanding of model & its benefits (see flip chart sheets)

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?

- Development & education/information on business case outlining cost/benefits of SAW/RTW for both employer & employee (See flip chart sheets)

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?

- Public sector must lead as a model employer in order to have credible impact on creating change
- No ONE ministry/agency in government
- Public sector that has lead responsibility for this issue
- Establish a collaborative/coalition of all government ministries/agencies/NGOs to forward this important initiative by heading up guideline adoption & SAW/RTW model

d. Here are a few examples of what some of us intend to do starting tomorrow:

**What are you going to do specifically?**
- Identify ministries/agencies

**Who else needs to be involved?**
- Other key stakeholders and key agencies from Summit

**By when?**
- ASAP

**To accomplish what?**
- The foundation/core of a coalition or collaborative for Public Service
Health, Safety and Benefits – End User

a. What might make many of the people in your stakeholder group RELUCTANT to fully support adoption of the Work Disability Prevention model here in BC?

- Credibility of programs-
  - To employees the barrier is lack of trust in management
  - To employers there are challenges in measuring presenteeism & productivity
  - Will perception of cost bring relative value (ROI)?
- Administrative challenges/resources & lack of flexibility in the organization
- Culture, lack of skill in employee management and other stakeholders (physicians)

b. What needs to be true in order for the members of your stakeholder group who want to do the right thing to THRIVE and PROSPER under the work disability prevention model in BC?

- Breakdown culture of entitlement and build culture of trust
- Sell the credibility
- Management needs to build morale and help employees to want to come to work through
  - Wellness programs
  - Supervisory training
  - Job satisfaction
  - Orientation
  - Joint committees of management & employees
  - Sharing the success stories
- Find measurement models and publish them
- Communicate the RTW program to all employees
- Build trust & understanding of the workplace with physicians

c. Is there an obstacle to improving outcomes of the SAW/RTW process in BC that your stakeholder group might be able to help eliminate or reduce – even if policy or regulatory change does not occur “at the top”?

- Culture – build on your success stories
- Develop skill sets in employees and managers
- Orientation for employees
- Build trust and integrity
- Communicate value to employees and employers
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<th>Name</th>
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<tr>
<td>CATHY RAMBARRAN</td>
<td>Disability Mgmt Consultant</td>
<td>Manulife Financial</td>
<td>Facilitator 1-A</td>
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<td>LEAH WOSK</td>
<td>Account Associate</td>
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<td>JOHN ALLEN</td>
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<td>Vernita Hsu</td>
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<td>Bruce Johnson</td>
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<td>Doug Kube</td>
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<td>Associate Dean, Research, Faculty of Health Science</td>
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<tr>
<td>Janusz Kaczorowski</td>
<td>Prof and Research Director, UBC Dept Family Practi</td>
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<td>Nancy Paris</td>
<td>Director, PART, BCIT</td>
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<td>Peter Rothfels</td>
<td>Medical Director, WorkSafeBC</td>
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<tr>
<td>Isabel Schultze</td>
<td>Professor, UBC Dept of Ed, Couns</td>
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<tr>
<td>Chris Back</td>
<td>Director, Injury Prevention, OHSAH</td>
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<tr>
<td>Philip Mah</td>
<td>Program Manager, Disability, OHSAH</td>
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<tr>
<td>Michael Carr</td>
<td>VP, Disability Mgmt Service, Ultima Medical Services</td>
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<tr>
<td>Douglas Hanson</td>
<td>Consultant, Private Practice</td>
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<tr>
<td>Inderneet Mann</td>
<td>Occupational Therapist, Back in Motion</td>
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<tr>
<td>Abha Mcdonnell</td>
<td>Nurse Advisor, WorkSafeBC (North Van)</td>
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<tr>
<td>Brent Mulhall</td>
<td>Director, Back in Motion</td>
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<tr>
<td>Jason Parker</td>
<td>Principal, Centrix Disability Mgmt</td>
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<tr>
<td>Lucy Samuel</td>
<td>Nurse Advisor, WorkSafeBC (North Van)</td>
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<tr>
<td>Margaret Tebbutt</td>
<td>Workplace Mental Health, Canadian Metal Health A</td>
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Participant List - MASTER 25/11/2008 Page 1
Appendix G – Personal Commitments Made

During the Summit, participants were asked to fill in a form recording the commitments they personally were willing to make to accomplish things following the Summit. This Appendix documents, anonymously, the commitments that were made during that day.

Note that not all completed commitment forms were turned in, and not all participants completed a form.

<table>
<thead>
<tr>
<th>Person</th>
<th>Internal Opportunity</th>
<th>External Opportunity</th>
<th>Immediate Action</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>• Be conscious of the needs of the various stakeholders to ensure delivery of messaging is attuned to their needs (i.e. demonstrates benefit/value)</td>
<td>• Work with employers within my industry to educate and reinforce SAW/RTW benefits.</td>
<td>• Create summary of key benefits for various stakeholders in “selling” SAW/RTW.</td>
</tr>
<tr>
<td>2</td>
<td>• Initiate conversations with leaders about changing our policies, programs and culture (expectations) • Include SAW/RW metrics in our HR dashboard.</td>
<td>• Tell someone else about this model</td>
<td>• Find a place/organization/network I can plug into to keep the momentum.</td>
</tr>
<tr>
<td>3</td>
<td>• Lead by example to shift the culture. • Provoke thought/discussion around the way we presently deal with disability. • Champion development of SAW Program.</td>
<td>• Participate on initiatives. • Support other employer’s programs and promote within my own organizations. • Share success stories.</td>
<td>• Talk it up!! • Share with my boss on Thursday at our status meeting.</td>
</tr>
<tr>
<td>4</td>
<td>• Establish meeting with Exec representatives to educate on approach to SAW included with RTW – outline findings of the Summit and key actions to move forward to make cultural changes. • Focus on Corporate Measures on facilitating SAW/RTW rather than absenteeism. • Peer review for BC Business Council.</td>
<td>• Be an advocate for change through discussions with staff/managers/executive as well as other employees and insurance carriers.</td>
<td>• Educate RTW coordinators. • Commence to redraft RTW and absenteeism guidelines. • Meet with Directors in Employee Relations to discuss sharing with bargaining agent.</td>
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<td>5</td>
<td>• Develop effective communication between the organizations that are involved with our Industry to work together on the RTW strategy.</td>
<td>• Develop resources, tools and training programs to educate employers in our industry on how to develop RTW programs.</td>
<td>• Incorporate the RTW program strategy in our 2009 business plan.</td>
</tr>
<tr>
<td>6</td>
<td>• I have committed to again approaching Practice Guideline Committee for a guideline re “Disability Management” (the first step is to change the title – perhaps “Disability Prevention”).</td>
<td>• See above.</td>
<td>• Need support from this group as my first request was rejected as not a priority by the committee.</td>
</tr>
<tr>
<td>7</td>
<td>• Provide leadership around scientific processes involving work disability prevention.</td>
<td>• Participate in a research project on identifying common practices (or absence of) in SAW.</td>
<td>• Follow up on emails to set up a working group on SAW.</td>
</tr>
<tr>
<td>8</td>
<td>• Work in close conjunction with the Employee Wellness manager to support and not block these stay at work initiatives.</td>
<td>• Encourage everyone in my life about this topic.</td>
<td>• Meet with Employee Wellness manager upon taking on my new job.</td>
</tr>
<tr>
<td>9</td>
<td>• Utilize information provided today for staff and customer development.</td>
<td>• Better understanding of the impact of disability.</td>
<td>• Change educational seminar (??).</td>
</tr>
<tr>
<td>10</td>
<td>• Support the unions on this issue.</td>
<td>• Work (??) on SAW on this issue.</td>
<td>•</td>
</tr>
<tr>
<td>11</td>
<td>• Bipartite educational programs rather than programs directed only at managers. • Go forward in next month to firm up supervisor program on mental health issues.</td>
<td>• NA</td>
<td>• Talk to group about finishing up this.</td>
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Appendix G - Personal Commitments Made
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<th>Person</th>
<th>Internal Opportunity</th>
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</table>
| 12     | •                    | • Continue work on one-page form – include person A, person B, other ER insurer, union.  
|        |                      | • BPAC Guideline with person C (triplicate: BCMA, WSBC, MOH)  
|        |                      | • Increase influential group of physicians wishing to place this on agenda – f/u curve with Summit.  
|        |                      | • Psychiatry initiative with person D/ person E/ see if person F and university will also engage on Dec 3 and 4 when have: both meetings for 1) and 4)  
|        |                      | • Met/ discuss with person E agenda re: language . |
| 13     | • Share information from today – encourage Summit participation in Ontario and other provinces – build national strategy.  
|        |                      | • To bring our company’s successes in SAW/ RTW to Public Sector/ Private Sector – help build model based on best practices and proven success.  
|        |                      | • Share Summit material/ findings with colleagues.  
|        |                      | • Share Summit material/ findings with customers and prospects looking to be involved in shifting the paradigm. |
| 14     | • Identify staff that may have a psychiatric condition.  
|        |                      | • Educate stakeholders – other health care professionals, peers, staff, executive in my ministry.  
|        |                      | • Disseminate info to peer managers and staff that I work with. |
| 15     | • Network with others from Summit.  
|        |                      | • Expand reach of "Mental Health Works" training.  
|        |                      | • Think |
| 16     | • Acknowledge the benefit of cooperating and collaborating with other stakeholders.  
|        |                      | • Continue self-education in this realm.  
|        |                      | • Stay in contact with some of the individuals I met today. |
| 17     | • Share info with HR Directors and Disability Management staff.  
|        |                      | • Identify an issue and make action plan, i.e. performance issue.  
|        |                      | • Be part of establishing a coalition to move this initiative forward at the policy/ sponsorship level.  
|        |                      | • Ensure my senior management (CEO) is aware and sponsors the concepts for my organizations. |
| 18     | • Share knowledge with my staff and clients.  
|        |                      | • Participate in committees and "walk the talk".  
<p>|        |                      | • Discuss with my staff at team meeting on Friday. |</p>
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<tr>
<th>Person</th>
<th>Internal Opportunity</th>
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<th>Immediate Action</th>
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<tr>
<td>19</td>
<td>• Share the information learned today with HR and our union executive and plan for a learning session with all people leaders in my organization in conjunction with our EAP provider who was here today as well.</td>
<td>• Sharing this information -&gt; recommendations with our clients who have STD benefit with my org. I can set up a more robust partnership with the EAP provider we offer to our clients and help employers focus on early RTW and SAW.</td>
<td>• NA</td>
</tr>
<tr>
<td>20</td>
<td>• Discuss with the disability patients I see, the financial and the social and personal costs of extended time lost from work.</td>
<td>• Encourage and facilitate early intervention following injury or diagnosis of chronic illness to keep or return the employee at work.</td>
<td>• Promote the development of a Stay at Work program in my organization.</td>
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<td>21</td>
<td>• Educate the appropriate staff responsible for dealing with employees either struggling in workplace or who have just gone off sick re: best practices (staying connected) • In my own team as a leader, practice being flexible, encouraging, supportive to help create a culture of connectedness (keep people at work)</td>
<td>• NA</td>
<td>• Discuss with my Director what we can identify as a priority to go forward in implementing and some of the recommendations (e.g., our approach when an employee is struggling in the workplace.)</td>
</tr>
<tr>
<td>22</td>
<td>• Introduce concept of a letter to physician identifying all the accommodations and resources an employer can provide to their patient for SAW/ RTW.</td>
<td>• Carry the gospel forward. • In my team build trusted communication.</td>
<td>• Build trust and communication with my team for discussion of normal human reactions and social or workplace realities that could prove a barrier. • Identify decision makers and focus on them for SAW/ RTW paradigm.</td>
</tr>
<tr>
<td>23</td>
<td>• Raise the profile of RTW/SAW through discussion within related program areas.</td>
<td>• Integrate SAW/ RTF concepts into communications wellness material.</td>
<td>• Brief leader of related programs. • Translate ideas into work plan. • Connect with contacts met at Summit.</td>
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<td>24</td>
<td>• Continuously engage the union/stakeholders – walk the walk.</td>
<td>• Work with the other Health Authority managers to ensure that we are not duplicating research/projects – share success/learnings.</td>
<td>• Share all of the information gathered with the rest of our safety &amp; wellness team.</td>
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<tr>
<td>25</td>
<td>• Form industry-wide Disability Management group – invite union representation.</td>
<td>• Educate everyone about benefits of SAW/RTW.</td>
<td>• Speak to my boss. • Invite member company reps to join in Disability Management Program for Industry.</td>
</tr>
<tr>
<td>26</td>
<td>• NA</td>
<td>• Assist with education of CEO’s and union leaders about the cost of disability and the ongoing cost if something isn’t done.</td>
<td>• In Q1 2009, work with members of Group 1 to develop a presentation of facts.</td>
</tr>
<tr>
<td>27</td>
<td>• Work closely with the Rehab program to impress upon the employer the need to address increase use of sick leave/short term and long term disability. • Set up meetings with Union #1 and Union #2. • *Find an approachable business unit (check with Rehab program)</td>
<td>• Do a better job of outreaching the union through district/regional workshops/conferences/activities.</td>
<td>• Debrief this day with others on staff at the union and Team manager &amp; case managers at company A.</td>
</tr>
<tr>
<td>28</td>
<td>• Ensure all speaking the same language and identifying barriers to implementing SAW/RW, trying to make it “real” and easier to understand from actual users.</td>
<td>• Being part of a steering committee and sharing learnings among organizations particularly with respect to mental health issues; • Possibly help organize a workshop on this topic.</td>
<td>• Follow up with some of participants so can see what is being done and how it is working and then seeing how it applies to my clients/customers.</td>
</tr>
<tr>
<td>29</td>
<td>• Continue developing and promoting our established D.M. Programs. • Work toward the development and implementation of wellness initiatives within our operations.</td>
<td>• To share my collective experiences with others to develop a program for both small and large employers.</td>
<td>• Back to work!</td>
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<tr>
<td>30</td>
<td>• Continue providing my SAW/ RTW workshop.</td>
<td>• Continue providing training in non-medical factors that can impact duration.</td>
<td>• Market the next Workshop to the Human Resources Association.</td>
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<td></td>
<td>• Increase transparency.</td>
<td></td>
<td>• Work with person A to plan a strategy to provide training to Physicians on RTW Motivation.</td>
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<tr>
<td>31</td>
<td>• Providing better outcomes to my clients’ process of building consensus-based ability management programs in engaging employee health.</td>
<td>• As a consultant to embrace the SAW/ RTW Guide and apply its process to clients I work with.</td>
<td>• Apply the knowledge to my business practice.</td>
</tr>
<tr>
<td>32</td>
<td>• To share with my co-workers and unions the importance of Stay-at-Work. (Concept that was not applied for non-occupational illness.)</td>
<td>• Be involved in the follow-up activities, i.e., part of the BC Action Group.</td>
<td>• Diffuse the knowledge about preventing needless disability.</td>
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<td></td>
<td>• We are doing RTW.</td>
<td>• Join the 60 Summits national mailing list and BC mailing list.</td>
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<tr>
<td>33</td>
<td>• Meet with Case/ Care Managers to obtain their observations and recommendations – re: urgency of less time in disability duration and especially the relationships with Medical providers.</td>
<td>• Meet with CEO and management team to discuss opportunities and a timetable to implement certain objectives.</td>
<td>• Have discussions and also with Management Team at [organization].</td>
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<tr>
<td>34</td>
<td>• More face-to-face contact with workers and employees</td>
<td>• Sharing with those I come into contact with that SAW/ early Return-to-Work is good medicine.</td>
<td>• Call one employer and plan job site visit to review my role in early intervention RTW.</td>
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<td>• More employee outreach to direct/ advise / review disability management packages.</td>
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<td>35</td>
<td>• Communication with HR on how we can be better at early intervention and anticipating disability, training for supervisors and employees alike.</td>
<td>• NA</td>
<td>• Set up a meeting with the key people- VP HR and Director of Disability Management.</td>
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| 36     | • Link up with HR to review current Promoting Recovery program status and next steps for continuous improvement.  
• With clients – refocus back to basics at workplace – not just “[??]” to other?  
• Prepare presentation with person A for [-] council & illness council.  
• Health Evidence/ Engagement/ Paradigm change – what to do coming out of it.  
• Next steps for these leaders  
• To peer review | • Stay in touch/ involved for SAW/ RTW.  
• Introduce other business sector participants.  
• Help develop SAW/ RTW systems structures for [??] BC, working group.  
• Lobby BCMA to make a priority  
• Advance support for measurement framework and business case. | • Already spoke to unions reps re: their thoughts/ buy-in to presentation.  
• Reach out to Dr. A regarding what areas were not discussed that are still key.  
• Talk to my employees/ fellow directors about SAW/ RTW.  
• Remain involved/ plan to attend next meeting re: SAW/ RTW. |
| 37     | • Increase routine identified of employer [??] that impact disability – accommodation.  
• Ensure first call [??] support and hope for our staff to focus on optimistic outcomes – focus on ability.  
• Lobby BCMA to make a priority  
• Advance support for measurement framework and business case. | • Develop RTW working group with BCMHAS.  
• Partner with OSH directors to develop Provider HA SAW. RTW steering committee. | • Summarize our agency priorities with our employer stakeholder. |
| 38     | • Communications to stakeholders -> better dissemination of info on SAW/ RTW concepts. | • NA | • Go to OSH directors next week and put it on the agenda.  
• Discover “Success Stories” -> use for communication material.  
• Meet with communication staff re: developing plan & materials. |
| 39     | • Meet with the nurse advisors in smaller groups to discuss importance of “stay-at-work” rather than grtw plans – not all workers need to be off work especially with soft tissue injuries – transitional duties.  
• Meet with physician groups to discuss importance of RTW.  
• Meet with employer groups – teach on transitional duties, graduated return to work planning, identifying transitional duties in workplace. | • Meet with one nurse to discuss importance of looking at whether a worker needs to leave work or can they stay at work and start transitional duties. |
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<tr>
<td>42</td>
<td>• 3 Research Project Ideas: 1. how can adaptive technology be used to support transitional work? And reduce physical workload so people can stay-at-work/ RTW. 2. Develop a proposal to WorkSafeBC to bring together people that have benefitted from SAW/ RTW programs to develop a support group pilot website and evaluating the pilot. Talk to Person A at [-] Centre about partnering on this and/ or OHS AH. 3. Develop a research project related to a small business assistive equipment grant similar to California and evaluate the program.</td>
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<td>43</td>
<td>• New employee orientation • Policy development • Local network</td>
<td>• Train employees.</td>
<td>• Revise and train</td>
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<td>44</td>
<td>• Continue to work with manager group to create opportunities in our workplace for SAW. • Reach out to union groups to discuss this philosophy - &gt; greater buy-in, trust, belief that this is good service for their member.</td>
<td>• Provincial healthcare Steering Committee for SAW/ RTW.</td>
<td>• Connect with OSH Director to commit to provincial committee. • Relay message from this session to my staff who have opportunity to take this message to our manager/ supervisor group (ask them what their barriers are to get this done)</td>
</tr>
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<td>45</td>
<td>• Health care seat for [?] BC. • Establish the ‘doer’ stakeholders together to develop and implement a SAW/ RTW initiative to roll-out to the workplace. • Enable access to medical case management support to keep employees at work.</td>
<td>•</td>
<td>• Contact the ‘doer’ stakeholder contacts who participated in the 60 Summit forum. (Include unions, ERs, WVB and OHS AH HBY) • Intent – to simplify and integrate total disability prevention process.</td>
</tr>
<tr>
<td>46</td>
<td>• Reinforce the understanding of the impact to the person during an event.</td>
<td>• PABC best practice with WorkSafe.</td>
<td>• NA</td>
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</table>
| 47     | • Be a champion in advocating a SAW model.  
  • Add [?] barriers that prevent SAW.  
  • Engage employees relations in SAW [illeg - be add? legal conce?] | • Demonstrate [??] in SAW success [illeg - adju?] with other stakeholders. | • Get some next for the [illeg h? wo?] ahead. |
| 48     | • NA | • Make disability prevention high priority for curriculum renewal across the continuum of medical education  
  • Be involved in follow up activities. | • Work on Health and Work Productivity web-portal project. |
| 49     | • Help case managers understand importance of the type of questions they ask family doctors/ care providers.  
  • Keep the focus on capacity  
  • Help the understanding of medical | • Be available for presentations/participation in primary care education programs. | • Debrief with the various teams I work with regarding new info that arose out of this seminar.  
  • Commit to participate in follow up with our Summit workgroup re: action points. |
| 50     | • Be more receptive to other organizations in initiatives to integrate processes.  
  • At my own workplace look into our SAW/ RTW process to make sure it is compatible with the principles discussed today.  
  • Email document to my HR. | • Working with Healthcare employers and unions to:  
  - Design and pilot test SAW programs  
  - Simplify process to have a single first contact for assisting worker with injury/illness. | • Convene a meeting with my staff at to lay out strategy to accomplish the two points to the left. |
| 51     | • As noted below take steps to ensure the program our agency has for RTW is part of every new employee’s orientation. | • Canvass policy/legislation personnel for ideas on how to create policy initiatives to put prevention of Disability in focus. | • Ensure reference to RTW plan is added to new orientation website currently being developed for [one organization’s] employees.  
  • Contact rep from Committee Against Preventable Injuries to see if preventable disability initiative can be added. |
| 52     | • Maintain contact and act as conduit for 60 Summits/ BC project. | • Train MD’s in Yukon Territory. | • Help to lobby BCMA re: need for disability management guidelines  
  • Invite person A to speak on functional limitations in psychiatry conditions. |
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<td>53</td>
<td>• Incorporate the</td>
<td>• Share our practices/</td>
<td>• Get curious about</td>
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<td>recommendations from the</td>
<td>guidelines/ learnings –</td>
<td>the guidelines and</td>
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<td>knowledge transfer</td>
<td>how they can impact</td>
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<td>into our daily practices</td>
<td>amongst peers, other</td>
<td>my organization and</td>
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<td>– from a program leader’s</td>
<td>health authorities.</td>
<td>what I do and how I</td>
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<td>daily practice.</td>
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<td>54</td>
<td>• Improve relationships</td>
<td>• Communication mediums</td>
<td>• Speak with my own</td>
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<td>with employers for the</td>
<td>and data can be enhanced</td>
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<td>purpose of better</td>
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<td>educational practices.</td>
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<td>develop with clients</td>
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<td>• Provide a different</td>
<td>important to them.</td>
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<td>level of support to</td>
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<td>communicate with Dr’s.</td>
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<td>employers.</td>
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<tr>
<td>55</td>
<td>• NA</td>
<td>• Provide education,</td>
<td>• Meet our Sr Medical</td>
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<td>training, policy &amp;</td>
<td>Director to strategize</td>
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<td>and implementation.</td>
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<td>• Occupational Medicine</td>
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<td>docs to conduct training</td>
<td>training material.</td>
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<td></td>
<td></td>
<td>to GP</td>
<td>• Hold discussions</td>
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<td></td>
<td></td>
<td>• Meet our Sr Medical</td>
<td>and research to</td>
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<td></td>
<td></td>
<td>Director to strategize</td>
<td>determine what</td>
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<tr>
<td></td>
<td></td>
<td>on how to approach –</td>
<td>GP’s need/ want.</td>
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<tr>
<td></td>
<td></td>
<td>college</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>• Foster better</td>
<td>• Through my professional</td>
<td>• Contact COTBC and/</td>
</tr>
<tr>
<td></td>
<td>communications with</td>
<td>college (COTBC)</td>
<td>or CAOT for</td>
</tr>
<tr>
<td></td>
<td>physicians and employers</td>
<td>• Through Canadian</td>
<td>evidence-based</td>
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<tr>
<td></td>
<td>; Encourage my manager to</td>
<td>Association of BC, i.e.</td>
<td>practice research to</td>
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<tr>
<td></td>
<td>include RTW policies in</td>
<td>CAOT</td>
<td>propose [? illeg-</td>
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<td></td>
<td>the [new] employee</td>
<td></td>
<td>education] on</td>
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<tr>
<td></td>
<td>training/orientation</td>
<td></td>
<td>standardized methods</td>
</tr>
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<td></td>
<td>programs</td>
<td></td>
<td>for SAW/RTW decision-</td>
</tr>
<tr>
<td></td>
<td>• Educating employers,</td>
<td></td>
<td>making</td>
</tr>
<tr>
<td></td>
<td>employees and physicians</td>
<td></td>
<td>• Browse websites and</td>
</tr>
<tr>
<td></td>
<td>re: benefits of SAW/RTW</td>
<td></td>
<td>explore professional</td>
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<tr>
<td></td>
<td>(early RTW)</td>
<td></td>
<td>support groups locally</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>to explore SAW</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>methods.</td>
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<tr>
<td>57</td>
<td>• Develop communication</td>
<td>• Develop/create a</td>
<td>• Begin developing a</td>
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<td>database of information</td>
<td>form or template and</td>
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<tr>
<td></td>
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<td>to draw upon for RTW</td>
<td>take it to a physician,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>purposes, i.e.,</td>
<td>create interest and</td>
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<td></td>
<td></td>
<td>Construction Safety</td>
<td>begin a quorum to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Council Pilot Project</td>
<td>draw from or at least</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>develop interest</td>
</tr>
<tr>
<td>58</td>
<td>• Improve the processes</td>
<td>• Support the utilization</td>
<td>• Start assessing my</td>
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<td></td>
<td>in place</td>
<td>of one common medical</td>
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<td></td>
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Appendix H – Evaluation and Sign-Up Sheet Results

At the Summit's conclusion, participants were asked to complete an evaluation of the conference, and were given an opportunity to sign-up for future Summit-related activities. This appendix presents an overall picture of the responses received.

Summary of Major Results

Overall, the attendees were very satisfied with their experience at the BC Summit.

As a group, the attendees reported on their evaluations that they were very satisfied with their experience at the BC Summit and want to remain engaged with one another and with the overall initiative.

Almost 70% (68.9%) of the attendees returned or responded to the print or electronic version of the course evaluation form and reported:

- having met the other attendees will help them in the future.
- the workshop was a good use of their time and effort.
- that this new angle or approach has made them think differently about some important issues.
- that the meeting impacted their prior beliefs, knowledge, and attitudes.
- they have a list of practical steps they can take to improve their participation in the SAW/ RTW process

More than 83% of the 116 attendees expressed a desire to remain engaged with the initiative in some way – either electronically or through future meetings.

Summit attendees were provided with a sign-up sheet that they could return at the end of the day signaling their interest to remain involved with the BC Summit initiative follow-up action group, the BC Collaborative.
Course Evaluation

Meeting Preparation:
The email invitation and/or conference brochure
The phone call or personal invitation you received
The reading materials emailed prior to the meeting

Design & Flow of the Meeting:
Overall plan for the meeting; what was on the agenda
Flow of the meeting; facilitation of general sessions
Value of work group/facilitators

Meeting Events:
Welcoming remarks, orientation and instruction
BC Speaker
Keynote address: Dr. Jennifer Christian
Multi-stakeholder work group sessions
Same stakeholder work group session
Work group reports to large group
Same stakeholder panel and Q&A
Going forward planning session

Value of the meeting:
The information presented was very interesting to me
The meeting impacted my prior beliefs, knowledge, and attitudes
Having met the people here will help me in the future
This new angle or approach has made me think differently about some important issues
I have a list of practical steps I can take to improve my participation in the SAW/RTW process
This workshop was a good use of my time and effort today
I think this workshop will really bear fruit in the future
Invitation Process

- Email-Brochure n=74
- Phone Call-Personal n=61

<table>
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<th>Very Good (5)</th>
<th>Good (4)</th>
<th>Satisfactory (3)</th>
<th>Poor (2)</th>
<th>Very Poor (1)</th>
</tr>
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<tbody>
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<td>38</td>
<td>15</td>
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<tr>
<td>Phone Call-Personal</td>
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<td>30</td>
<td>10</td>
<td>2</td>
<td>0</td>
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</table>

Pre – Summit Reading Materials

Reading Materials n=70

<table>
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<tr>
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<th>Very Good (5)</th>
<th>Good (4)</th>
<th>Satisfactory (3)</th>
<th>Poor (2)</th>
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</thead>
<tbody>
<tr>
<td>Reading Materials</td>
<td>18</td>
<td>28</td>
<td>21</td>
<td>3</td>
<td>0</td>
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</table>
Keynote Speaker and Content

- Keynote Speaker n=79
- Info Presented Very Interesting n=79

- Very Good (5): 43, 39
- Good (4): 29, 34
- Satisfactory (3): 5, 6
- Poor (2): 1, 0
- Very Poor (1): 1, 0

Stakeholder Break-Out Groups

- MultiStakeholder Grps n=78
- SameStakeholder Grp n=77

- Very Good (5): 16, 17
- Good (4): 41, 40
- Satisfactory (3): 18, 18
- Poor (2): 2, 2
- Very Poor (1): 1, 0
Group Reports and Panel

- Work Group Reports n=77
- Same Stakeholder Panel-QA n=74

Moving Forward & Impact - Part 1

- Going Forward n=58
- Impact Prior Beliefs, Knowledge & Attitudes n=77
Overall, however, the most important – and least visible – outcome of the BC Summit was the experience itself that has created a group of 116 people from multiple stakeholder groups with:

- a shared vision of how the stay-at-work and return-to-work process should go;
- a shared experience of sitting side-by-side making plans for how to make that vision into a reality; and
- the conviction that they can create a better future for BC’s workers’ compensation and disability benefits systems by sharing this new perspective.

In addition to the experience itself, many people made new relationships or deepened existing ones during the Summit. In particular, the deeper understanding and insights produced by interactions with other attendees in different sectors of society are of value. The positive feelings evoked by this positive multi-stakeholder experience are the fuel that will drive the formation and success of the action group afterwards.

For most of the attendees, this was their first experience sitting side by side with people in other disciplines and sectors of society working on an issue that touches all of them – the stay-at-work and return-to-work process that is common to workers’ compensation and all disability benefit programs. For virtually every attendee, this was the first time they had ever considered the question of what “first class” might look like in these systems. It may also have been their first experience with focusing on what needs to be put in place in order to make sure things go “the right way” most of the time – instead of focusing on what is wrong and how to “fix” it.

**Workgroups’ Action Plans**

Every one of the workgroups thought the individual ACOEM recommendations that they had been assigned were worthwhile and should become common practice. Therefore, all of the groups developed action plans to begin implementing them. The details of their plans, derived from their paper forms and the recorded transcript of their oral reports, appear in Appendices E and F.

Commonalities among the many plans became apparent while the workgroups gave their oral reports during the Summit. Many of the plans are designed to solve similar problems or tackle similar topics. Successful implementation of many of the plans will also require similar types of behaviors.

The bulleted examples listed under each of the major topic areas below have been taken straight from the workgroup reports.
MAJOR TOPIC AREAS

1. **Communications and engagement**

   Spread the word across the province of BC to all stakeholders through outreach to multiple audiences using a variety of methods.

   Many of the workgroups spoke about how important it is to share the work disability prevention model with all stakeholders in the province. BC is a large province geographically with both large and small employers and providers spread throughout. Spreading the word about the work disability prevention paradigm to employers, their employees, and the clinicians who care for them is critically important.

   Many of the groups addressed this need with their plans, including:
   - Increase awareness of the opportunity / need to prevent needless work disability throughout BC and Canada.
   - Create and communicate a consistent message – social marketing - emphasize that work is good for you. Change the language from “disability” to “ability”. Look at NHS joint statement that “work is good” and see if that can be replicated in BC. Start with buy-in from the BC Business Council, and BC Labour Union representatives. Reduce the stigma regarding mental health issues. Get the message out across the province and Canada.
   - Create customized communications to all stakeholder groups
   - Get a consistent message; emphasize that work is good for you. Look at NHS joint statement that “work is good” and see if we can replicate that in BC. Start with buy-in from the BC Business Council, and BC Labour Union representatives, BC Federation of Labour.
   - Roundtables/coalitions provincially with key stakeholders (unions, employers, etc.) to work through issues and generate common purpose.
   - Identify champions or “go to” people, identify who needs the services.
   - Identify mechanisms for first line for employee contact.
   - Provide urgent communication with the employee via a mentor – high trust.
   - Get agreement through all levels of the organization.
   - Identify appropriate personnel to be communicating with the employee on key issues in workplace – who is responsible to take issue forward – identify sponsor in the workplace.
   - Find champions within each of the stakeholder groups.
   - Get messaging delivered by the medical community to increase credence.
   - Establish commitment from Labour & Management.
   - Information transfer (communication campaign) – public policy statement (refer to endorsement by gov’t doctors, unions, employer associations).

2. **Education and training**
Individuals who work with employees who are off work for illness or injury need to have a good foundation in preventing needless work disability; they need to understand the facts rather than operate from myth; and they need to have the skills to work with all parties, the employee, employer, provider and insurer.

The Summit attendees overwhelmingly pointed to the need to help the people of BC understand that keeping people working during recovery is critical and that not knowing this is a major impediment to optimal SAW/RTW process performance. Most of the people who must deal with workplace injuries – especially workers, employers, and healthcare providers – lack basic information, key concepts, and skills.

Almost all the workgroups recommended ways to give people what they need in order to manage health-related employment situations better, which means some form of education or training.

Examples included educating all stakeholders about a variety of topics including:

- on the importance of remaining at work while recovering
- the limited numbers of medical conditions that require time away from work
- the importance of transitional work regardless of the cause of a medical condition or impairment, and regardless of whether the employee is still at work, about to go off work or is already off work
- roles and responsibilities; the importance of accountabilities, facts about insurance programs
- on the importance of treating employees well and in a caring manner
- on the need to have support systems in place that encourage recovery and wellness
- Training for employer supervisors, physicians and all health care providers, labour unions, insurance carriers, government etc. on topics that vary from how to care/communicate with employees to how to communicate with healthcare providers
- Develop standard education for all stakeholders (as appropriate by role)
- Mental health training offered to new employees during orientation
- Improve supervisors skills on an individual basis – coaching of supervisors
- Physician education – there are a group of influential MDs at our table who will approach Dean of Medical School at BC to improve residency education
- WORKSAFEBC/MH work on a campaign – similar to injured worker campaign that WorkSafe BC did
- Health promotion at employer and with physician
- Encourage/develop CME programs for family doctor to identify red flags for hidden agendas. Have WORKSAFEBC/ICBC/insurers integrate their programs.
- Research through resources at BCMA key players for policy and education of physician

3. **Collaborative approaches to system improvement**
Groups commented about the benefits of dovetailing with other groups’ or organizations’ initiatives.

- Collaboration was mentioned repeatedly among the work groups, across agencies, public and private sector and across Canada. Collaborating with key or influential groups to articulate the importance of this initiative, for example, the BC Business Council, BC Federation of Labour.
- Create coalition to coordinate research to establish evidence base. Marc-UBC Family Practice and Canadian Institute for the Relief of Pain & Disability with Pete Rothfels WorkSafeBC; Catherine – Society of General Practitioners.
- Pitch training of disability prevention as a way to reduce the stress link. Continuing Prof. Development & Knowledge Translation need to be involved. Need investment from WorkSafeBC, Ministry of Health, Business Council of BC, MLCS.

4. **Collaborative approaches in dealing with individual situations**

Groups also commented about the need to communicate with others and employ a team approach in individual SAW/RTW situations.

- Establish & communicate a protocol that is fair & consistent that involves all stakeholders (union, employer, employees)
  - Include specific timelines and steps to be taken
  - Expectations and issues of all stakeholders addressed up front
  - Training provided for all people managers and “alternates”
  - Maybe even a tool to facilitate conversation between employer of record, doctor and employee
- Develop communication tools/toolkits and standardized form(s) to share key RTW/SAW information on abilities, job availability categorized by function, and as to what should happen before/during and after illness or injury.
- Give employee package to take info on duties to doctor – improve info flow.

5. **Develop and deploy missing solutions**

- Develop screening tools to assist employers and providers in identifying mental health issues in the work place and in identifying barriers to SAW-RTW.
- Create support systems for employees in the work place and for navigating what can be a complicated RTW system – champions of the SAW-RTW process
- Work on MD education module, involving BCMA, WorkSafe, MINISTRY OF HEALTH & Ministry of Labour within 6-8 months to educate docs

6. **Get the facts, establish benchmarks/standards, and use data to guide improvement efforts**
- Gather data - Replicate U.S. occupational return to work data with BC/Canadian data (this refers to the physician survey that Dr. Christian did on the percentage of needless work absence, but it may also pertain to the Reveille graph with data from 5 U.S. states showing that workers with work-related injuries who qualify for permanent impairment awards experience a dip in total income that persists for a period of at least 5 years).
  - Get BC/Canada data on absenteeism, including work and non work related OSAH, WorkSafe, employers, insurance industry
  - Gather data on disability as a whole for BC
- Use the ACOEM Recommendations to create best practice guidelines in BC.
- Develop standards of practice for all stakeholders (as appropriate by role).
- Conduct research studies – where data doesn’t exist in BC, for example, the impact of needless work absence on employers, employees and the province/Canada or to determine a gap analysis between current practices and what the ACOEM report recommends.
- Coordinate & translate research on disability prevention. Beta testing site w/in 15 months to accomplish web portal so that information can be shared across disciplines (already in progress). Faculties of Business and Health Sciences across Canada need to be involved.
- Measure performance – create indicators of best practices brought forth in the Recommendations, set criteria and measure whether they are being met. Performance measurement was mentioned at many different levels, from measuring employer supervisors and physician performance to system wide performance outcomes.

**SHARED REPERTOIRE OF TASKS AND BEHAVIORS**

Since the focus in The 60 Summits Project is on implementation, the types of behaviors or tasks required to implement the action plans are critically important. Recruiting volunteers with an intellectual interest in the topics is less likely to produce concrete outcomes than finding people who are interested in and good at doing the things that will “make things happen.” If the follow-up action group is clear about the nature of the work to be done, that will assist them in attracting appropriate volunteers.

In other words, in order to successfully disseminate the new work disability prevention paradigm throughout BC, and specifically to implement ACOEM’s recommendations for SAW/RTW process improvement, the follow-up action group will need to:

- Possess (or be willing to develop or strengthen) the desire, persistence, skills, and ability to do the things (behaviors) that are required, or
- Add others to their group who do have those skills or abilities.

The behaviors involved in carrying out these action plans consist of the ability to do tasks like the following:

- Develop and refine strategies, make and agree on project plans and schedules
- Find suitable people and assign them tasks
- Identify key parties and/or opportunities
- Schedule and coordinate events (meetings, presentations, etc.)
- Participate in and speak persuasively in casual conversations, meetings, speaking engagements
- Inventory, assess, and analyze existing resources / data
- Design, write, test, and issue new materials or tools (brochures, ads, educational courses, forms, etc.)
- Make changes to existing protocols; implement revisions to routine operations
- Set up pilot programs; conduct research
- Collect data; track outcome

The point of the table below is to show that the same repertoire of behaviors / tasks will be essential for projects in each of the four main topic areas. The table’s pattern of check marks also shows that most of the behaviors / tasks are common to most of the projects. Thus, the action group must be skilled at and good at doing these particular tasks.

Given the technical training of many action group members, they may not currently be proficient with or comfortable with some of these behaviors. Some professional development, recruiting of additional members, or collaboration with other groups will probably be required. Key examples include such things as speaking persuasively in small groups, giving powerful presentations, developing effective educational strategies and materials, designing forms that perform as intended, obtaining and analyzing data, and so on.
### BC SAW/RTW WORKGROUP ACTION PLANS – MAJOR TOPIC AREAS AND TYPES OF BEHAVIORS INVOLVED

<table>
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<th>BEHAVIORS INVOLVED</th>
<th>MAJOR TOPIC AREAS</th>
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<tbody>
<tr>
<td>Refine strategy, make and agree on detailed plans and project schedule</td>
<td>✓</td>
</tr>
<tr>
<td>Find suitable people and assign them tasks</td>
<td>✓</td>
</tr>
<tr>
<td>Identify key parties and/or opportunities; schedule events (meetings, presentations, etc.)</td>
<td>✓</td>
</tr>
<tr>
<td>Participate in or speak at events: meetings, conferences</td>
<td>✓</td>
</tr>
<tr>
<td>Inventory / assess / analyze existing resources / data</td>
<td>✓</td>
</tr>
<tr>
<td>Develop / write / design new materials or tools</td>
<td>✓</td>
</tr>
<tr>
<td>Make changes to existing protocols / Conduct revised routine operations; Set up pilot programs; Do new research</td>
<td>✓</td>
</tr>
<tr>
<td>Collect new data; Track outcomes</td>
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</table>
**Personal Commitments:**
Most of the participants made personal commitments to take some sort of action to improve the SAW/RTW process in their own organizations and to participate in group or community projects. The edited details of those commitments appear in Appendix G. All individually identifying information has been removed. Portions of many forms were illegible since they were handwritten, and appear as an underlined blank.
Many of the personal commitments reflected solid engagement in the process and an intention to carry through with actions. As an example, here are some samples of the personal commitments made by Summit attendees.

| THE TABLE BELOW DISPLAYS SAMPLES OF WHAT ATTENDEES WROTE IN ORDER TO COMPLETE THESE 3 PROVINCEMENTS: |
| "The main things I see that I can actually do to improve MY OWN organization and MY OWN day-to-day working relationships are:……….." | "The main opportunity where I can actually do something to improve how things work in MY WHOLE community or province/province is: ……" | "Here’s what I personally intend to do about this tomorrow or this week: …………………" |
| • More face-to-face contact with workers and employees • More employee outreach to direct/ advise / review disability management packages. | • Sharing with those I come into contact with that SAW/ early Return-to-Work is good medicine. | • Call one employer and plan job site visit to review my role in early intervention RTW. |
| • Establish meeting with Exec representatives to educate on approach to SAW included with RTW – outline findings of the Summit and key actions to move forward to make cultural changes. • Focus on Corporate Measures on facilitating SAW/ RTW rather than absenteeism. • Peer review for BC Business Council. | • Be an advocate for change through discussions with staff/ managers/ executive as well as other employees and insurance carriers. | • Educate RTW coordinators. • Commence to redraft RTW and absenteeism guidelines. • Meet with Directors in Employee Relations to discuss sharing with bargaining agent. |
| • Share knowledge with my staff and clients. | • Participate in committees and "walk the talk". | • Discuss with my staff at team meeting on Friday. |
| • Meet with the nurse advisors in smaller groups to discuss importance of "stay-at-work" rather than grtw plans – not all workers need to be off work especially with soft tissue injuries – transitional duties. | • Meet with physician groups to discuss importance of RTW. • Meet with employer groups – teach on transitional duties, graduated return to work planning, identifying transitional duties in workplace. | • Meet with one nurse to discuss importance of looking at whether a worker needs to leave work or can they stay at work and start transitional duties. |
Next Steps

The next steps are to:

1. Harness the good will and energy for positive change unleashed by the Summit;
2. Build on the understandings and relationships developed during the Summit;
3. Consolidate, categorize, and analyze the opportunities for action identified during the Summit, then choose which ones to address and in which order;
4. Get the new BC Collaborative for Health, Productivity and Disability Prevention off the ground and grow it into a vibrant and action-oriented community of purpose. (A start-up kit for the interim leadership of the Collaborative to use during its first several meetings is included as an appendix to this report.)

The experience of the BC Summit – the mutually-respectful relationships among people of good will in different professions and sectors of society, and the commitments they made to themselves, and the plans for action that the workgroups made during the Summit – must now be transferred to the real world. In order for this event to create the future outcomes that were originally envisioned by its planners, it is now time to start making things actually happen beyond the walls of the Wosk Center for Dialogue.

The BC Summit planning team intended their November 25 event to be a milestone for BC, a beginning of the process of disseminating the work disability prevention paradigm throughout the province. The paradigm shift begins at the Summit, by getting as many of the right people as possible in the room to do more than talk about ACOEM’s recommendations, but to speak for actually implementing them and to make specific plans for how to do that, by when, and with whom. The Summit starts the process by asking attendees to identify what is possible through communication and collaboration across sectors, and to make plans for spreading the word and actually making changes to how they conduct their everyday practices and businesses.

An on-going structure for fulfillment of this vision is required to support follow-on action. Something must preserve the momentum built during the Summit so that the attendees’ planned activities actually take place and bear fruit. Something must keep new relationships alive. Most people are more likely to succeed if they are supported in some fashion. Small groups who want work together will benefit from a framework within which to collaborate.

The key functions of the structure for fulfillment established by the follow-up action group will be to:

- Continue to propagate the work disability prevention’s new way of thinking about workers’ compensation and disability benefits programs across the province.
- Support one another in fulfilling their Personal Commitments made during the Summit.
- Carry out a selected few of the ideas for group activities and projects developed during the Summit.

So, the next challenge for BC is to grow a dynamic and action-oriented follow-up group. Since more than two-thirds of the attendees expressed interest in follow-up activities, it is hoped that many of them will actually become active in the BC Collaborative for Health, Productivity and Disability Prevention. The first follow-up meeting was scheduled for
February 12, 2009. In the interim, the Summit Planning group’s webpage and their link to the 60 Summits website can be used to continue to share information. The first step is for the group to get organized, to develop a strong sense of shared purpose and a game plan, and to take on their first projects. This Report and in particular the Start-Up Kit that appears as Appendix I should serve as a starting point resource for the leadership and members of the Collaborative. The best project to begin with is finding opportunities to continue to propagate the paradigm among people in BC. The group can create the “next ripple in the pond” by spreading the word about the new work disability paradigm and the problem-solving team approach to the stay-at-work and return-to-work process among key individuals and groups within BC and within their own professional societies and trade associations. This entails a lot of meetings and presentations. A few months later, when the group has a developed a team spirit and sense of accomplishment based on those early successes, this Report can serve as a starting point resource. The group can use the lists of preliminary ideas and plans developed during the Summit as a source of raw material for their next projects. Remembering that the list was developed under extreme time pressure, the process should be to consolidate, analyze, categorize the ideas, and then choose the ones to take on first, second, and so on in sequence. It is best to select projects that appeal to people and inspire them, rather than ones that are “high priority” but do not generate enthusiasm. Also, it is better to pick projects for which the group has the required skills. In addition to their work inside the Collaborative, interested individuals can use the Report’s list of people who participated in the Summit to find kindred spirits with whom to collaborate on projects, either independently or under other organizational umbrellas.

The BC Summit Planning Group’s website can be used to share information: www.cirpd.org/BC60Summit. In addition to BC-specific issues, the 60 Summits website (www.60Summits.org) provides a central clearinghouse for all the other state groups participating in The 60 Summits Project. In addition, the first national gathering of the whole 60 Summits Project Alliance (or community of interest) was held in November 2008. The goal of the gathering was to provide a venue in which all local groups could meet, share their experiences, successes and challenges, and collaborate on joint projects. While each jurisdiction, planning group, and follow-up action group has unique characteristics, they also have many issues and challenges in common. Since common themes and proposed solutions are emerging from many of the Summits, local groups are enthusiastically supporting the idea of working together. They see little need to “re-invent the wheel” and have already grasped the advantages of cross-fertilization of ideas and sharing of solutions.
<table>
<thead>
<tr>
<th>Person</th>
<th>Internal Opportunity</th>
<th>External Opportunity</th>
<th>Immediate Action</th>
</tr>
</thead>
</table>
| 59     | • Being more prompt – human cost  
         • Speak SAW (rather than always RTW or DTA) | • Establish a transitional work program | • Provide guidelines to unions & offer a follow-up meeting  
         • Write article in our publication  
         • Write article for HR newsletter  
         • Add personal adjustment to brochure and also to doctors  
         • Research transitional work program and job bank |
| 60     | • Develop a FAQ on our employee portal to educate employees on our SAW/RTW policies to assist them in their approach with their doctor  
         • On-going development of our DM program | • Work with the Summit to lobby BCMA, BC Business Council and other major groups to get provincial buy-in and consistent applications | • Talk to my COO to get assistance and buy-in. Investment is low but ROI is high.  
         • Improve overall communication with employees and supervisors – Ask pertinent questions – help employees buy-in to RTW/SAW process |
| 61     | • Share info with HR team  
         • Discuss creating a FAW for employees to educate on SAW/RTW concepts  
         • Health& Safety committee discussion | • Make more A.P. contact to educate on benefits of early RTW | • Take more time to ask workers about personal status  
         • Follow-up with APs earlier on in disability  
         • To take care with “how” I say & not “what” I say. |
| 62     | • Explore / address the non-occupational issues that may be impacting RTW  
         • Better communication with employers  
         • Sharing of resources between co-workers | | • Volunteer for the group that is being formed to redesign physician/employer/ [? illeg – insurer] forms  
         • Speak to my first line staff on the concepts of SAW/RTW |
| 63     | • Make a presentation to my staff on the concepts of RTW/SAW | • Volunteer for the group that is being formed to redesign physician/employer/ [? illeg – insurer] forms | • Speak to my first line staff on the concepts of SAW/RTW |
| 64     | • Look at incorporating CME related to reducing needless workforce disability  
         • Encourage my patients directly and via other worker supports to SAW/RTW quickly if appropriate | • Through my university office of [? illeg] | • Discuss with others in my university division and other stakeholders |
<table>
<thead>
<tr>
<th>Person</th>
<th>Internal Opportunity</th>
<th>External Opportunity</th>
<th>Immediate Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>• The language we use around disability</td>
<td>• Use the concepts in the ACOEM guidelines in my interactions with stakeholders</td>
<td>• Incorporate ACOEM concepts into my communications / presentations</td>
</tr>
<tr>
<td>66</td>
<td>• Transfer the new framework / concepts from what I learned today into an action plan for implementation within the nursing services department at [organization]</td>
<td>• Accomplish the above and that will allow 1:1 and group transfer of knowledge e.g., nurse advisor educating primary caregiver about work disability or me speaking to an employer +/- union group</td>
<td>• Collaborate with my manager and director to discuss the above.</td>
</tr>
<tr>
<td>67</td>
<td>• Develop effective RTW programme tools for the three decision maker groups at various levels of comprehension</td>
<td>• Development of framework</td>
<td>• Develop a RTW orientation for workers for our current program</td>
</tr>
</tbody>
</table>