# DRAFT Report - Appendices

## Ontario Summit to Prevent Work Disability

**May 12 and 13, 2010**

***Hart House - University of Toronto***
***Toronto, Ontario***

**www.60summits.org/ON**

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# Summit Report

## Appendices

# Appendix A

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## Steering Committee Bios

**Nancy Gowan** is president of Gowan Health Consultants and of Gowan Consulting. She is Co-chair of the *Ontario Summit to Prevent Work Disability*. Nancy is a registered Occupational Therapist and Certified Disability Management Professional with experience in industrial rehabilitation, accommodation, and access planning. She holds a Bachelor of Health Sciences, Occupational Therapy from McMaster University and a Diploma in Occupational Therapy from Mohawk College. Since graduating in 1988, Nancy has assisted local and national employers with the development of health and disability management strategies. She has presented at national and international forums on accommodation and disability. Nancy has chaired various committees that address planning, facilitation, and education dealing with many work-health related issues. Since 1998, she has been involved, as a lead faculty, with the National Institute of Disability Management and Research at the Mohawk College Disability Management Certificate program in Ontario and as an online facilitator. Among her many publications, dating back to 1990, Nancy coauthored a chapter on "Ergonomics in Disability Management" in *Ergonomics for Therapists*, 3rd edition, 2007.
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**Ann Morgan** is Mental Health Practice Leader for Great-West Life Group Disability and is Co-chair of the *Ontario Summit to Prevent Work Disability*. Ann holds a Bachelor of Arts in Psychology with certification as a Rehabilitation Services Provider. She also has conflict management certification, and CEBS training. She has an extensive background in vocational rehabilitation and disability management. Ann has worked in several insurance company environments and provided cognitive behavioural therapy for clients with chronic pain and other complex disabilities. In her current role as practice leader, Ann is dedicated to delivering knowledge, training, and tools related to best practice in the area of mental health in the workplace. Ann's passion for people and expertise in facilitating creative collaborations generates positive change wherever she goes.
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**Colin Argyle** is the Service and Promotions Coordinator for the Occupational Disability Response Team (ODRT) and is the Chair of Logistics for the *Ontario Summit to Prevent Work Disability*. Colin began his career in the field of Workers' Compensation and Return to Work/Disability prevention. In 1989, he was elected as Insurance Benefit Representative for CAW Local 303 at the General Motors Scarborough Van Assembly Plant.

Colin honed his skills while continuing his education in this rewarding field through the Ontario Federation of Labour's ODRT training program. In 1994, Colin became an instructor for the ODRT, and in 1999, the OFL hired him to coordinate the training program. Colin continues to educate and advocate on behalf of injured workers and people with disabilities. His passion and commitment to this important area of human rights keeps him grounded and relentless in the struggle for a barrier-free society.
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**John Bryden** is Director of Employer Services with Banyan Work Health Solutions and is responsible for the signage for the *Ontario Summit to Prevent Work Disability*. John has been involved in the occupational health and safety field for almost twenty years. Formally trained in Human Kinetics and Ergonomics John worked for a number of years as an Ergonomist and

Rehabilitation Manager with Canada's leading aerospace manufacturer. He later worked as an Ergonomist with the WSIB. He spent a number of years working as the Director, Client Services for a division of the Ontario Ministry of Labour where he oversaw injury prevention programming for the service sector. John then moved on to be the Senior Director of Health, Safety, and Wellness with Canada's largest retailer where he was responsible for retail operations national health and safety program, overseeing 650 stores and 100,000 employees. He developed a 5-year strategy aligning health and safety with the company's corporate objectives and developed a centralized health and safety program. He also managed the company's national disability claims management and return to work program. John joined Banyan Work Health Solutions in 2009 and currently heads up their new Employer Services unit, developing and overseeing all national operational activities.
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**Maribeth Clemens** is the National Trainer for Medical Coordination Services and Best Practice Consultant for Great-West Life Disability Management Services, and is responsible for the notebooks for the *Ontario Summit to Prevent Work Disability*. Maribeth has worked with the Disability Intervention Service department of Great-West Life for nine years, initially in the role of a Medical Coordinator. Maribeth is responsible for the development and implementation of curricula, and best practice strategies that focus on functional restoration to assist employees to return to the work environment.

Maribeth holds a bachelor of science in nursing from the University of Victoria and is a graduate of Fanshawe College where she earned her registered nursing diploma and is a member in good standing with the College of Nurses of Ontario.

Maribeth's clinical experience is extensive and includes work in general medicine, surgery, emergency, and community nursing. She spent several years working in Africa, where she taught health care and worked as the clinic nurse at the Canadian High Commission Health Unit. While in Africa Maribeth was involved with many volunteer activities including children's clubs, orphanages and women's groups.
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**Alice Dong** is a Canadian and American Board certified Occupational Health Physician, is a fellow of the American College of Occupational and Environmental Medicine. She is Co-Chair of the Agenda Task force for the *Ontario Summit to Prevent Work Disability*.

Dr. Dong has training and practical experience in disability management and is committed to rehabilitation and return to work programs. She feels strongly that work provides meaning and purpose to injured/ill workers whether the disability is work related or not. She has worked in both the public and private sectors including Northern Telecom, Bell Canada, WSIB, the City of Toronto, and is an occupational medical consultant at St. Michael's Hospital and RBC Insurance.

Dr. Dong is past Chair of the OMA Committee on Work and Health and the former Chair of the Canadian Board of Occupational and Environmental Medicine and continues to be an active member in her professional associations. She is Vice Chair of the Governing Council of the University of Toronto and a member of the Board of Directors of the New Women's College Hospital.
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**Kirsty Forrest Marton** is a senior Disability and Accommodation Consultant in Health and Well-being Programs and Services at the University of Toronto. She is Co-chair of the Communications Task Force for the *Ontario Summit to Prevent Work Disability*. During her career, Kirsty worked with numerous large insurers in the GTA as an Insurance Broker, Business Development Consultant, and Claims Adjudicator. She worked as a Vocational Rehabilitation Consultant and with the (former) Ontario Disability Support Program as an Adjudicator.

Kirsty earned a Bachelor Administrative Studies (B.A.S.) specializing in Marketing, and a Bachelor of Arts (Psychology) from York University. She earned her Certified Disability Management Professional designation in May 2008.
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**Donna Hardaker** is a Workplace Mental Health Specialist at the York Region branch of the Canadian Mental Health Association. She is Co-chair Communications Task Force for the *Ontario Summit to Prevent Work Disability*. Donna co-developed the award-winning Mental Health Works training and education program, where she is master trainer and consultant. The program provides strategies and approaches for organizations to improve their awareness and effectiveness in dealing with workplace mental health issues. Donna speaks at education and training events across Canada for return to work and accommodation, health and safety, disability management, human rights in the workplace, applied public health, and employee wellness.

Donna's background is in mental health policy, adult education, human resources management, and psychology. She sits on the York Region Accessibility Advisory Committee and is an advisory member of the Canadian Institute of Health Research. She is the Applied Public Health Chair for Developing Effective Interventions for Mental Illness and Mental Health in the Working Population. Her writing about mental health in the workplace is published in the *Canadian Journal of Community Mental Health*, *Canadian Healthcare Manager*, *Moods Magazine*, *Network Magazine,* and *Crosscurrents: the Journal of Addiction and Mental Health.*
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**Janet Marlin** is Vice President, Customer Relations, and Chief Operations Officer for Odyssey Health Services. She is Co-chair of the Guest List Task Force for the *Ontario Summit to Prevent Work Disability*. Odyssey Health Services combines medical and behavioural sciences to assess and treat chronic pain syndromes, chronic fatigue syndrome, fibromyalgia, chronic mood disorders, chronic anxiety disorders, and other complex or difficult-to-manage circumstances. Janet has an extensive background working with employers, insurers, and individuals addressing issues of work-related absenteeism and disability.

Janet holds a BA in psychology from McMaster University and a teaching certification. She began her health services career in related disability at the Behavioural Medicine Unit, St. Joseph's Hospital/McMaster University in 1981. Janet has held clinical and senior management positions at Off-Site Resources, an EAP provider, and was the Executive Director at Alternatives for Youth, a provider of addictions services for youth.
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**Terry O'Hearn** is the President and CEO of Caldwell O'Hearn, a disability management consulting company. He is the Budget Chair for the *Ontario Summit to Prevent Work Disability*. Terry has 32 years of experience in the disability management and worker's compensation field. His consulting experience includes the development of various new models for claims and for disability management service delivery. These were applied in complicated or difficult legislative, political, or budgetary environments. Terry continues to provide innovative disability management services in an ever-changing environment.

Before co-founding Caldwell O'Hearn Terry spent 20 years inside the Ontario Workplace Safety and Insurance Board. During his WSIB career, he advanced from the front lines of claims services through progressive levels of management. Terry's management skills focus on the design, administration, and delivery of claims and return to work services.
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**Nancy Shaw** is Assistant Vice President of Manulife Financial Group Disability National Services which includes Rehabilitation, Group Disability Best Practices, Litigation and Business Services, and is Co-chair Guest List Task Force for the *Ontario Summit to Prevent Work Disability*. Nancy has oversight of many aspects of disability management from case management to reporting. Nancy was previously responsible for the delivery of both short and long-term disability services in Toronto for many large corporate clients. Nancy also played a key leadership role in the development and implementation of customized Absence Management Solutions program, which has grown to a successful national short-term disability product at Manulife. She has 20 years of disability management experience and 16 years of specific Group Disability Management and Rehabilitation experience.

Nancy received her Masters of Business Administration from McMaster University and her Honours B.Sc. in Kinesiology from the University of Waterloo. Her work experience prior to entering the insurance industry included two years with Ontario's Workplace Safety and Insurance Board as a Kinesiologist working in the field with injured workers. She also spent five years as an Ergonomist/Occupational Health and Safety Specialist for Dofasco.
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The Ontario Summit to Prevent Work Disability

60 Summits

# Appendix B

## OFFICIAL PURPOSE STATEMENT (Approved February 10, 2009)

We, the members of the Ontario Summit to Prevent Needless Disability, are working together to effect positive change to prevent work disability and lessen its impact by:

- Promoting the principles of a new workplace disability prevention paradigm reflected in the American College of Occupational & Environmental Medicine (ACOEM) white paper entitled "Preventing Needless Work Disability by Helping People Stay Employed" and consistent with the various Ontario evidence based best practices.

- Establishing an effective mechanism for getting the common-sense and evidence-based framework made by ACOEM and Ontario based research off the paper and into everyday use.

- Propagating this new way of thinking throughout Ontario.

- Creating an event in Ontario that will in turn create fresh thinking, action for change, and system improvements through a Summit-type workshop for people of good will who are key stakeholders in Ontario– employers, physicians, healthcare professionals, claims/benefit administrators, workers, union, government and regulators.

- Ensuring that the Summit conference that we produce:

    o Introduces the new paradigm and ACOEM's 16 specific recommendations.

    o Challenges participants to decide how to utilize the recommendations to improve their own practice, organization, community and jurisdiction.

    o Creates a respectful, independent, and high quality environment in which the participants can communicate and collaborate with one another to identify concretely how to implement them.

    o Encourages the stakeholders in Ontario to join with us and form an on-going group that will work together over time to actually carry out the strategies and action plans identified in the Summit.

# Appendix C

## Sponsors

The Ontario 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 Ontario's employees and employers. Their contribution was key to the summit's success.

*Platinum*

**The Great-West Life Assurance Company** - www.greatwestlife.com

**Great-West Life Centre for Mental Health in the Workplace** - www.gwlcentreformentalhealth.com

*Gold*

**Banyan Work Health Solutions** - www.banyanconsultants.com

**Sun Life Financial** - www.sunlife.ca

*Silver*

**Air Canada** – www.aircanada.ca

**LifeMark Health** – www.lifemark.ca

**Manulife Financial** – www.manulife.ca

**Odyssey Health Services** - www.odysseyhealthservices.com

**Rogers** – www.rogers.com

**Shepell-fgi** - www.shepellfgi.com

*Bronze*

**AssessMed** - www.assessmed.com

**CIBC** - www.cibc.ca

**Gowan Consulting** - www.gowanhealth.com

**OPC-Optimal Performance Consultants** - www.optimalperformance.ca

**Northern Lights Canada** - www.northernlightscanada.ca

## Appendix D

## Stakeholder Representation

Below is a table showing the number of participants by stakeholder category. Some individuals could have been be counted in more than one group. For them we used the category that seemed most appropriate to the nature of their employer's role in the system.

There was a fairly good balance between differing stakeholder groups. No group was conspicuously absent or underrepresented.

| | | |
|---|---|---|
| Physicians | 15 | 11% |
| Mental Health | 15 | 11% |
| OT/PT/Ergo/Safety/Occ Health | 17 | 12% |
| RTW/DisabilityMgt/VocRehab | 14 | 11% |
| Intermediary | 13 | 9% |
| Insurers | 11 | 8% |
| Claims/TPA | 4 | 3% |
| Employers | 27 | 19% |
| Worker-Labour/InjuredWorker/ATT | 11 | 8% |
| Research | 6 | 4% |
| Government/Policy | 4 | 3% |
| Other | 3 | 2% |
| TOTAL | 140 | (101%) |

# Appendix E

## Participants

Below is a list of all 142 Summit participants. Notations appear for those who were on the steering committee, who served as facilitators, who were speakers, and whose organizations were sponsors.

**Susan Abbey** MD, FRCP(C)
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**Ken Suddaby** MD, FRCPC
Ottawa, Ontario

**Kim Sunderland**

**Dr. Neil Sutton**
Senior Medical Consultant
Air Canada VISTA Cargo Centre Toronto
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*Sponsor*

**John Taylor** MA, CEB, CHRP, P of C
Benefits Manager
PTI Group Inc.
Edmonton, Alberta

**Craig Thompson**
Senior VP
Human Solutions Canada Inc.
BC

**Cindy Trower** LLB
Office of the Worker Adviser

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**Curtis VanderGriendt** BSc, AE
Ergonomist
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**Sandra von Lippa**
Director, National Disability Services
Sunlife
Waterloo, Ontario
*Sponsor, Facilitator*

**Kathleen Walsh** BSc, CCPE
Ergonomist
Cornerstone Ergonomics
Whitby, Ontario

**Melanie Weller** BHScOT
Consultant
Gowan Health
Mississauga, Ontario
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**Diane Westcott**
Principal
Working 4 Wellness
Oakville, Ontario

**Laurie Whitton** B.A.
Director, Absence Management Operations
Manulife Financial
Toronto, Ontario
*Sponsor, Facilitator*

**Bill Wilkerson**
Co-Founder
Global Business and Economic Roundtable on Addiction and Mental Health
*Speaker*

**Jonathan Winston**
Director
Shepell.fgi
Toronto, Ontario
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**Laurene Wittich** R.N., GBA (CEBS)
Supervisor, Health and Disability
Cowan Insurance Group
Cambridge, Ontario

**Lila You** MSc, BSc PT, Hons. B.Sc
Staff Physiotherapy and Education, OHWD
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**Frances Ziesmann** RPT BScPT BSc DOHS
Consultant and Program Specialist
Public Services Health and Safety Association
Toronto, Ontario

# Appendix F

## Summit Agenda

**Wednesday, May 12, 2010**

| | |
|---|---|
| 4:30 pm – 5:30 pm | Registration and reception for delegates |
| 5:30 pm – 7:30 pm | Opening Remarks |

*Welcome from Summit Planning Committee*
Co-Chairs Nancy Gowan and Ann Morgan

*Helping Ill, Injured & Aging People Stay Employed in Ontario*
Peter Page, Ontario Network of Injured Workers Groups

*The Role of the Workforce Advisory Committee*
Dr. Ian Arnold, Mental Health Commission of Canada

*Will the Work Disability Prevention Model Fit in Ontario?*
Dr. David Brown, Canadian Imperial Bank of Commerce

*Setting the Stage for the Summit*
Dr. Jennifer Christian, Founder & Chair, The 60 Summits Project

| | |
|---|---|
| 7:30 pm | Adjourn - hors d'oeuvres until 9:00pm with cash bar |
| 9:00 pm | Dinner on your own |

## Thursday, May 13, 2010

| | |
|---|---|
| 7:00 am – 8:00 am | Registration and continental breakfast |
| 8:00 am – 8:30 am | Welcoming remarks<br>Summit Co-Chairs Ann Morgan and Nancy Gowan<br>Peter Fonseca, Minister of Labour<br>*An Opportunity to Make Good Things Happen for Ontario*<br>Bill Wilkerson, Co-Founder, Global Business and Economic Roundtable on Addiction and Mental Health; and Special Mental Health Adviser to the RCMP |
| 8:30 am – 10:00 am | Establish the framework for deliberation<br>*Preventing Needless Work Disability by Helping People Stay Employed: ACOEM's Report and Its 16 Recommendations*<br>Dr. Jennifer Christian |
| 10:00 am – 10:30 am | Coffee Break |
| 10:30 am – 10:45 am | Instructions to work groups |
| 10:45 am – 12:00 pm | Breakout – Multi-stakeholder work groups deliberate |
| 12:00 pm – 12:45 pm | Reports on preliminary action plans from work groups |
| 12:45 pm – 1:30 pm | Luncheon<br>Remarks: Steve Mahoney, WSIB Chair |
| 1:30 pm – 2:45 pm | Breakout – Multi-stakeholder work groups resume deliberations; refine action plans |
| 2:45 pm – 3:00 pm | Break |
| 3:00 pm – 4:15 pm | Report of final action plans from all work groups and response from panel of Ontario stakeholders:<br>• Deborah Hellyer, OMA Physicians<br>• Rick Marlin, RTW Providers<br>• Myra Lefkowitz, Employer<br>• Al Bieksa, Labour<br>• Irene Klatt, Insurance |
| 4:15 pm – 5:00 pm | Going forward: Next steps for this group – and for Ontario |
| 5:00 pm | Adjourn |

The Ontario Summit to Prevent Work Disability

60 Summits

# Appendix G

## Workgroup Reports:
## Action Plans Developed by Multi-stakeholder Workgroups

The information contained in this appendix is a consolidated list of the reports from the multi-stakeholder workgroups during the Ontario Summit on May 13, 2010. The data is taken directly from the groups' written reports and augmented by verbatim snippets from an audio recording of the 2 minute oral presentations made by a spokesperson for each group. In some places the written reports 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 Appendix summarizes in sequence the findings of each of the 14 workgroups. Since duplicate assignments were given to two groups, there are two reports for Groups C (C1 and C2) and D (D1 and D2). 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 their worksheet was as follows:

a. Overall, we believe that the Recommendation(s) [should be / should not be] implemented in Ontario.

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

c. *[If they thought the recommendation should be implemented]* Here are some strategies for how to make this recommendation become standard practice (what usually happens) in our own organizations or community: …

d. The key steps involved in making that happen are: …

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

f. Here's what some of us intend to do starting tomorrow: *(Provide at least two examples from your group's Personal Commitment Sheets)*. …

## Groups A – Recommendations 1 and 13a

**Text of Assigned Recommendation(s) from ACOEM Report:**

> ***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*
>
> *a. 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.*

**Workgroup A Members:**

- **Facilitator:** Nancy Gowan, Gowan Health
- John Brennan, B.A.Sc., M.D., Occupational Medicine Consultant and Medical Director Honda, Purolator
- David Brunarski, DC, MSc, FCCS(C), President Ontario Chiropractic Association
- Ron Colie, Workplace Safety and Insurance Board, Service Employees International Union (WSIB-SEIU)
- Louise Fish, Director, Risk Management, Trenton University
- Rick Marlin, Ph.D., Director, Odyssey Health Services Odyssey Health Services
- Joy McGuire, MHSC, ROH - Director Health & Safety Sick Kids Hospital
- Karen McKenzie, BscHK C.K. Occupational Health Specialist, Research In Motion Limited Research in Motion (RIM)
- John Taylor, MA, CEB, CHRP, P of C, Benefits Manager, PTI Group Inc PTI Group Inc.

- Dave Uez, CHRP, Director, Employment Practices, Sun Life Financial Sun Life Financial

**Group A stated that Recommendations #1 and #13a should be implemented in Ontario with rephrasing.**

- **"**Increase Awareness of How Rarely **WORK** Disability is Medically Required"
- Need to convey the true meaning of "Awareness"

Workgroup A focused on both recommendations.

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

1. Produce a template for educating stakeholders (leadership team, management, employees, union, medical focused on the WIlFM
2. Finding a credible source to deliver it (or establish our credibility)
3. Partnering with other organizations with this shared interest
4. Develop core message

The key steps involved in making that happen are:

1. Define groups that need and can distribute message
2. Address copyright issue of slides – Jennifer's slides

Some concrete first steps we can take to get started on making this a reality are:

1. Use manager groups and communication in our own organizations – we are going to start to use this information in our next employee conversations.
2. We are going to adjust policies and educate our own organizations
3. Define other organizations with own resources – check the philosophical alignment
4. Educate those organizations on the concepts and ideas
5. See if they can prepare template/participate in the process – we are going to prepare a checklist of what can/can't be asked

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

Example #1:

- Rick and Karen will prepare over the next 4 weeks the message that work is healthy and that the ability to work is part of overall health, then group will review through the eyes of the employee

Example #2:

- Nancy volunteered to view the message through the eyes of the employee; Joy though the eyes of the employer; John through the eyes of the medical world

Example #3:

- We are going to get together on June 28 to determine who the core audience is and which stakeholders we want to get the message to. We are going to prepare a checklist of what can/can't ask
- We are going to determine which associations can help us with it and request endorsement of the message.
- We are going to get together on June 28 to determine who the core audience is and what stakeholders we want to get the message. We are going to prepare a checklist of what can/can't ask

Example #4:

- John will speak with the Minister of Labour about funding to help us get the message out.

## Group B – Recommendation 2

**Text of Assigned Recommendation(s) from ACOEM Report:**

> ***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.*

**Workgroup B Members:**

- **Facilitator**: Sandra von Lippa, Director, National Disability Services, Sun Life
- Christine Ader, COHN(C); RN, Return to Work Co-coordinator Sunnybrook Health Sciences Centre
- Joanne Barkley, MSc, BSc, RRP - Director, Coaching & Training Banyan Consultants
- Lise Belanger, Sun Life
- Kate Berry B.Sc. (Kin), M.Sc. (O.T.), Occupational Therapist, TMOT-Life Mark
- Diane Bezdikian, VP Group Life & Disability Operations, Great-West Life Great Western Life
- Gail Enever, Director Member Services OTIP RAEO
- Jim Harding, Manager, Health Services & Rehabilitation, Hydro One
- Amanda Leeming, BA Psych/Soc, Regional Manager, Cascade Disability Management Inc. Cascade Disability
- Kacey Poulin, B.A., Director of Workplace Safety & Health Canada Post Corporation
- Lila You, MSc, BSc PT, Hons. B.Sc, Staff Physiotherapy and Education Providence Healthcare

**Group B said that Recommendation #2 should be implemented in Ontario.**

In Section I, Recommendation #2, Group B focused on sense of urgency and addressed all of Recommendation #2. We agree that the recommendation should be implemented in Ontario.

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

1. Need to change the mindset and the culture by getting many minds to stress the importance of urgency – more evolutionary than revolutionary
2. We believe there's a knowledge gap in this area with insufficient awareness of the impact of time
3. Key strategy is education- cultural change starting with education taking into consideration various stakeholders needs
4. Communication opportunity – needs to provide rationale, be logical and hit emotional points
5. Evolve into a research phase-fact finding about best practices

The key steps involved in making this happen are:

1. The burning platform – build the business case as to why time is of the essence
2. Develop fact sheets targeted for each of the stakeholders

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

1. Create the business case document
2. Include and target each stakeholder
3. Communicate and share the business case by creating compelling messages
4. Go to the specific links in the ACOEM document that link with our topic
5. Allow ideas some time for ideas to percolate so that we can take more meaningful action steps

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

1. Two of the employers on our team, Jim and Christine, have agreed to share best practices from their workplace and then we will determine what is relevant to develop a sense of urgency
2. Sandra will organize a conference call on May 31 to flush this out a bit more, to discuss fact sheets for stakeholders, review ACOEM links in relation to best practices
3. Meeting with senior leadership next week to stress the need to get the message of urgency to front line managers to accomplish getting education and support tools for front line managers
4. Raise the issue of employee isolation with staff and colleagues at a staff meeting in a couple of weeks to advocate for the role to educate employers about client needs

# Groups C1 and C2 – Recommendations 3 and 4

### Text of Assigned Recommendation(s) from ACOEM Report

> ***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*

**Workgroup C1 Members:**

- **Facilitators:** Sophie Soklaridis, PhD, Scientific Associate/KTE Specialist, Centre of Research Expertise in Improved Disability Outcomes and Ann Morgan, Mental Health Practice Leader, Great Western Life
- Mary Ann Baynton, MSW, RSW, Program Director, Great Western Life-Centre for Mental Health in the Workplace
- Ruth Berman, Executive Director, Ontario Psychological Association
- Nick De Carlo, National Representative, CAW-Canada
- Wally Devoe, Staff Representative, CUPE
- Annette Gibbs, Vice President, Group Life & Disability Claims, Sun Life
- Stephane Grenier, MSC, CD, Operational Stress Injury Special Advisor, Mental Health Commission of Canada
- Nancy Lyons, BA, Director, Work Safety Insurance Board Ontario

**Workgroup C2 Members:**

- **Facilitator:** Julie Holden, VP, Sales & Bus.Dev., Banyan Work Health Solutions
- Erna Bujna, Labour Relations Specialist, Ontario Nurses Association
- David Corey, PhD, President, Health Recovery Group
- Kathy Jurgens, B.A., W.W.H.P, National manager, Mental Health Works, Mental Health Works
- Leesa Levinson, Founder & Executive Director, Lights, Camera, Access!
- Wendy Nailer, M.Ed, Manager, Community Support and Research Unit, Centre for Addiction and Mental Health

- Peter Page, President, Ontario Network of Injured Workers Group
- Judy Plotkin, MSW, VP Business Development, Human Solutions
- Jill Ramseyer, Manager, Organizational Wellness, Tim Hortons, Inc.

**Workgroups C1 and C2 said that Recommendations #3 and #4 should be implemented in Ontario.**

**Group C1 focused on the social environment of the workplace.**
Some strategies for how to make this recommendation become standard practice in our own organizations and community are:

1. Promote a healthy workplace, not that you have done something wrong if you are injured or ill
2. Build competency for managers to create a psychologically safe workplace, for example, performance evaluations should include how managers manage around the care of the worker

The key steps involved in making that happen are:

1. Convince corporate leaders that there are monetary savings if you care about your workers
2. Get a champion at the level of government
3. Bring together major ____ insurers employer rep groups and say we have models and tools that support a paradigm shift and decide how to implement
4. Follow up action sp and build case 1st action sp
5. MOL to host/champion in government

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. Mary Ann will contact WSIB to set up a meeting next week to discuss how to use some of the free tools such as (GM@W and MHCC)that have already been identified (found on Guardian Lines and Great Western Life websites) to help them succeed toward the goal of better handling social context of mental health claims with their own employees
2. WSIB is just one example of organizations we will be contacting. The goal is to identify other employers and who want to address mental health claims better. We will approach them and help them to use these tools, then share their success stories
3. Stephane, through his connections at the Mental Health Commission of Canada, will get Senator Kirby's advice on whom to approach in Ontario government to promote a social campaign about the importance of civility and respect in the work place. Hopefully Senator Kirby can advise us on who we can turn to in Ontario to champion our efforts to either effect change or to initiate legislation
4. OR start a social campaign so that civility and respect in the workplace is something that we can talk about community wide, with our children and at the bus stop
5. Committee to prepare proposal to present to member of parliament on how to promote the objective
6. Other ways we can get the word out on the importance of civility in the workplace is through town hall meetings and requesting to speak at various industry meetings and conferences about the summit and the white paper

**Group C2 focused on Recommendations #3 and #4**

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

1. When someone goes off work, have the early conversation.
2. Keep the issue in the workplace and start the conversation even before you get the paperwork, BUT help managers and supervisors to have to the tools and skills to know how to start the conversation
3. Distinguish between “Big A” and “little a” accommodations – of course there’s the “Big A” legal duty to accommodate BUT there are little accommodations that can be done each day
4. Emphasize EARLY contact

The key steps involved in making that happen are:

1. Develop a business case for employers And/Or
2. If it’s available, we will find the documented support for expanding the model of RTW-SAW to include early outreach

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. Create a tool for outreach that is multilayered in multiple forms – emails, brochure, phone and website
2. Build compendium of resources and post it
3. We will create a group, put out a call for participants and set a date for 1st meeting to build on the 60 summits process we have started
4. We will ask 60 summits to form a lobbying group to address 4a – we thought some of the other workgroups might require lobbying so we could form together

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

1. Jill from Tim Horton’s is going to look at their corporate RTW process from an appropriate level, based on the Recommendation; will look at franchises too

# Groups D1 and D2 – Recommendations 3 & 5

**Text of Assigned Recommendation(s) from ACOEM Report**

> ***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*
>
> ***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*

**Workgroup D1 Members:**

- **Facilitator:** Donna Hardaker, Canadian Mental Health Association, York Region
- Donna Carbell, VP Group Life and Disability Benefits, Manulife Financial
- Andrea Carter, M.Ed (Counseling psych), Employment Equity AODA Officer University of Toronto
- Susan Domanski, OT Reg (Ont), Occupational Therapist, Occupational Health Center, Work Wise Occupational Therapy
- Adrian Ebrahimi- Manager, Canadian Benefits, TD Bank Financial Group TD Bank Financial Group
- Peter Farvolden, Ph.D., C.Psych., Clinical Director, Cognitive Behavioural Therapy Associates of Toronto Cognitive Behavioral Therapy Associates of Toronto
- Karen Liberman, Executive Director, Mood Disorders Association of Ontario Mood Disorders Association of Ontario
- Paul Luca, Pmp, Associate Director HR, Employee Services, Team Bell
- Gayle Roos, RN, BA,Vice President, Group Life and Disability Claims, Ontario Teachers Insurance Plan
- Ken Suddaby, MD, FRCPC

**Workgroup D2 Members:**

- **Facilitator:** Kirsty Forrest Martin BAS, BA, CDMP- Disability and Accommodation Consultant-University of Toronto
- Kelvin Brown, RRP, Director, VRAC Ontario

- Erika Pond Clements, OT Reg (Ont), CDMP-Occupational Therapist-Work Matters
- Katy Kamkar Ph.D. - Psychology Treatment Head - Centre for Addiction and Mental Health
- Charlotte Logan CDMP - Director, Disability Services - Homewood
- Joe Ricciuti - Client Solutions Leader, Group and Health Care - Towers Watson
- Craig Thompson, Senior VP, Human Solutions Canada, Inc.
- Kathleen Walsh, BSc, CCPE - Ergonomist - Cornerstone Ergonomics

**Group D1 said that Recommendation #5 should be implemented in Ontario with some changes to the wording of the sub-recommendations 5 a-d**

a) Include not just co-morbidities but also when psychiatric issue is primary diagnosis
b) Psychiatric illness or co morbidity
c) Routinely perform psychiatric assessments and screening for mental health issues when appropriate
d) Make payment for treatment of psychiatric conditions dependent on evidenced based practices

**D1 especially focused on sub-recommendation "5c" (see above)**

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

1. Early identification of individuals at risk
2. Identify opportunities to help workers have more meaningful and robust discussions with their physicians, along with self advocacy skills

The key steps involved in making that happen are:

1. Develop a screening tool to identify at risk employees, could be delivered through the employer or the case manager
2. Develop or identify a toolkit to help the employee facilitate discussion with his or her treating physician which will assist in better planning and help the physician better address the employee's needs
3. Place these two tools on the 60 Summits website to make it accessible to everyone in attendance
4. Provide resources to all stakeholders around screening tools including informing them on how to use the tools, when to use them, what to do with the information when it's gathered

Some concrete first action steps and specific commitments are to:

1. We committed to approaching our own employers and educating them about the need for these tools

Here's what we intend to do specifically:

1. Some of our group members have also agreed by signing the Personal Commitment Form and the Follow-Up Action Group Sign Up Form, indicating our interest to continue working on this initiative

2. We also want to look at developing a potential pilot project to determine whether and how the early identification of at risk employees with whom we have used a communication tool makes a difference
3. We still need to work on who is doing what

**D2 said Recommendation #5 should be implemented in Ontario.**

**D2 focused totally on Recommendation #5 but not all of the sub-recommendations**

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

1. Encourage leadership on how important it is to address psychiatric conditions from risk management to actually helping the person
2. The need to address stigma, not just in terms of how we treat each other but how stigma drives systems
3. Came up with 3 immediate steps

The key steps involved in making that happen are:

1. As a group we would develop an information sheet that would be mailed to all stakeholders at the commencement of disability covering the available and immediate resources that were there to help and support a person to early recovery
2. We will have to bring stakeholders together to get an inventory of what's out there/available already
3. We want to provide continuity of services at the right time

Some concrete first action steps and specific commitments are to:

1. "Check-Ups from the Neck Up" – in our own organizations.
2. The objective is to normalize mental health and psychological issues as it relates to preventing disability
3. We are committed to sharing with you the resources we know and find, for example, Mental Health Works, like this little booklet here which covers when something is wrong. It's from the psychiatric association and one of our group members is a co-author

## Group E – Recommendations 6 and 8

**Text of Assigned Recommendation(s) from ACOEM Report:**

> ***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***
>
> ***8. Support Appropriate Patient Advocacy by Getting Treating Physicians Out of a Loyalties Bind***
>
> *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.*

**Workgroup E Members:**

- **Facilitator:** Alice Dong, Occupational Medical Consultant, St. Michael's Hospital
- Barry Fowlie, Staff Representative, Workers United
- Leonardo Grbac, MD,CCFP, (EM), DOHS, FCFP, Acting Associate Medical Director, WSIB
- Dennis Robbins Ph.D.,M.P.H., President IDEAS and Professor of Health Policy, I.D.E.A.S, RS Medical, Pepperdine University
- Eric Rumack MD, Occupational Health Physician / Disability Management Consultant, self employed occupational medical consultant
- Doug Smeall, AVP Health Management Services, Sun Life Financial
- Jonathan Winston, Director, Shepell.fgi

**Group E said that both recommendations should be implemented in Ontario.**

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

1. Provide all relevant parts to the health care provider/physician
2. Review questions asked of the MD to ensure they represent functionality
3. Create an opportunity for dialogue between involved parties

The key steps involved in making that happen are:

1. Develop an employee specific objective document to provide relevant information to the healthcare practice – essential duties, alternative options and the hierarchy of RTW
2. Form owners to review questions to make sure they are evidenced based
3. In the document provide contact information to create dialog among all the involved parties

Some concrete first action steps and specific commitments are to:

1. How do you get there? Review of existing forms and re-development
2. Work independently then come together to build in a standard
3. Provide for ongoing data collection
4. How can we get it started? Each member to bring existing forms back to the table with data then use this form for expert opinion re: case studies/form review
5. Who will do that?
6. What is going to happen and when? Best practices from each company and then develop standard form
7. How will we know it's done? Reaching a consensus among the industry as to what is appropriate and engages the physician- will they use the information?

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

1. Work independently first – build on a standard, ongoing data collection of forms
2. For example, when I get the forms back are they completed with relevant information
3. Each of us needs to re-look at the forms to ensure quality evidenced based form
4. Each member of our group will take a look at our forms, collect them and see what works and doesn't work

## Group F – Recommendations 7 and 12

### Text of Assigned Recommendation(s) from ACOEM Report

***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.*

### Workgroup F Members:

- **Facilitators**: Laurie Whitton, B.A., Director, Absence Management Operations, Manulife Financial and Michel Lacerte MDCM, FRCPC, CCR, University of Western Ontario
- Susan Abbey MD, FRCP(C) - Director, Program in Medical Psychiatry - University Health Network - susan.abbey@uhn.on.ca
- Garry Derenoski CIP, RRP, President, Vocational Rehabilitation Association of Canada

- Navdeep Pooni H.B.Sc, EA, WSIB
- David Satok BSc,MD,CCFP,FCFP,CTI, Corporate Medical Director, Rogers
- Sol Sax MD Consultant, Dr. Sol E Sax Med Prof Corp
- Debbie Seagram, Senior Consultant Corporate Employee Relations, Bank of Montreal
- William Shapiro, P.Eng, MBA, President, Workplace Medical Corp.
- Laurene Wittich R.N., GBA (CEBS), Supervisor, Health and Disability - Cowan Insurance Group

**Group F states that Recommendation #7 should be implemented in Ontario.**

Group F focused on part of Recommendation #7, specifically 7a and b.

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

1. Define what disability prevention work is and break it down into practical categories and develop billing codes and compensation amounts that are appropriate for the types of services rendered for the activities needed in disability prevention and management by health care professionals (not just for physicians but all practitioners)
2. Have a 2 tiered compensation level based on completion of prevention certification
3. We extended the word “physician” in this recommendation to include other health care professionals, for example, OTs, PTs, chiropractors etc.

The key steps toward making this happen are:

1. Create working groups consisting of:
    a. Michel Lacerte – can tap into Ontario’s Rehabilitation Coalition
    b. Sol Sax – OMA conduit
    c. Laurene Wittich
    d. Need volunteer representatives from other healthcare fields

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

1. Laurene will schedule first meeting of working group. Meeting to occur in 6-8 weeks
2. Working group to define the disability prevention management activities: develop compensation recommendations
3. Create a sign in sheet with our contact information for us and anyone else in the room who wants to get involved in our initiative

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

1. Michel Lacerte will contact Coalition to bring vocational rehabilitation up to the table within 2 weeks
2. Dr. Sax will collect OMA guidelines and disseminate to working group within 2 weeks
3. Summit workgroup members will act as s from working group recommendations
4. Dennis Robbins has offered to provide us with US based resources and the US perspective

## Group G – Recommendations 10 and 11

**Text of Assigned Recommendation(s) from ACOEM Report**

> ***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.*

**Workgroup G Members:**

- **Facilitator:** Maribeth Clemens RN, BSN, Medical Coordinator, Great-West Life Assurance Company
- Colin Argyle, Project Coordinator, Ontario Federation of Labour-ODRT
- Al Bieksa, Trainer, Ontario Federation of Labour
- Orlando Buonastella, Community legal worker - Injured Workers of Canada
- Deborah Hellyer MD, OHCOW
- Irene Klatt, Canadian Life and Health Insurance Association
- Sheri Quinn, Nurse Disability Specialist, Air Canada
- Cindy Trower LLB, General Counsel, Office of the Worker Adviser
- N _____

**Group G stated that both Recommendations should be implemented in Ontario.**

Group G focused on Recommendation #11

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

1. Make a complaint investigations service, ombudsman service for employees who have received poor service or have been impacted by other work place issues such as bullying, safety issues, harassment
2. Develop strategy toward consensus based solution and promote fair, consistent and accessible to all; promote disability prevention and not disability 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. Individual group members will investigate present systems in place regarding information available to employees if they have work place concerns
2. Buddy system at work, pairing employees up to help them for example, dealing with multicultural situations
3. Involve facilitator/mediator – Ombudsman Service for Life and Health
4. Talk to our EAP providers to make sure they know and understand the employees' workplace so they can provide appropriate information to the employees

# Group H – Recommendation 13b

### Text of Assigned Recommendation(s) from ACOEM Report

> ***IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS***
>
> ***13b.Disseminate Medical Evidence Regarding Recovery Benefits of Staying at Work and Being Active***
>
> *Sub-recommendations:*
>
> *a. Specify that medical care should be consistent with current medical best practices, or preferably, adopt an evidence-based guideline as the standard of care.*

### Workgroup H Members:

- **Facilitator**, Janet Marlin BA, Chief Operations Officer, VP Client Relations - Odyssey Health Services
- Mike Affleck, Director Employer Services, CBI Health Group
- Sharon Bailey MEd., B.A. (Psych), CRS, RRP, CCRC, Case Manager and Rehabilitation Counsellor, ATF Canada Corp.
- Lori Braga, WSIB Claims Team Leader, Toronto Transit Commission
- Tom Keogh MD, FCBOM, Occupational Medical Consultants
- Leasa McLeod BHSc(OT), Disability Management Coordinator, St. Joseph's Healthcare Hamilton
- Leslie McMillan, Senior Consultant, Aon Consulting
- Drew Sousa RN COHN(C), Manager of Employee Health Services - City of Mississauga
- Frances Ziesmann RPT BScPT BSc DOHS, Consultant and Program Specialist, Public Services Health and Safety Association

**Group H agrees that Recommendation #13b should be implemented in Ontario.**

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

1. There needs to be an enforcement practice in order for doctors to change their practice of care, for example, a financial incentive for adhering to evidenced based practice
2. Non-compliance with evidence based care practices could be reported to the professional college for remediation or for disciplinary action

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

1. The WSIB, private carriers, payers, insurance companies, OHIP will provide incentive payment to the medical community for adherence to evidence based care practices

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. To lobby the larger 60 Summit members present for key contacts with WSIB, OMA, OHIP and private insurers

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

1. Leslie will follow up with contacts at AON re: contact at OMA by the end of the week to provide contact names with which to follow up
2. Jan will contact private insurers by the end of May and once the contact names are received a subcommittee will be developed to discuss recommendations for a conceptual meeting

# Group I – Recommendation 14

**Text of Assigned Recommendation(s) from ACOEM Report**

> ***IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS***
>
> ***14. Simplify/Standardize Information Exchange Methods between Employers/Payers and Medical Offices***
>
> *Sub-recommendations:*
>
> *a. Encourage employers, insurers, and benefits administrators to use communication methods that respect physicians' time;*
>
> *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;*
>
> *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.*

**Workgroup I Members:**

- **Facilitator:** Terry O'Hearn, President/CEO - Caldwell O'Hearn Inc.
- Tim Davison, Shepell FGI
- David Edwards, Director, National Occupational Health & Safety, Sobeys Inc.
- Terry O'Hearn, President/CEO, Caldwell O'Hearn Inc.
- Kerri O'Neil, Manager of Health, Safety and Disability, Staples
- Nancy Shaw, MBA - AVP, Group Disability, Manulife Financial

**Group I states that Recommendations #14 should be implemented in Ontario.**

Group I focused on all of Recommendation #14, specifically standardization. We worked on simplifying and standardizing information exchange methods among stakeholders

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

1. Standardized forms for STD are in progress with insurers. OMA & CLHIA next steps are to reach out to the other stakeholders (employers and WSIB) to create standard forms, for example, a standard functional demands form for employers
2. Approach E Health, understand their road map to standardize and share employee medical information electronically

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

1. Contact CLHIA, Irene Klatt; Can we use CHLIA approach to piggyback on the process and expand it to other stakeholders in the community? One of our group members is speaking with Irene today
2. Approach E Health & create workgroup with disability prevention stakeholders. What is E health doing in terms of standardization? Can we bring some type of E Health standardization to work disability? Members of our group are going to track down members of E Health who are working on standardization

3. Lobby Retail Council Association to work on forms
4. Research what all standardization work that has already been done by other organizations. Are there other organizations besides E Health?

## Group J – Recommendation 15

**Text of Assigned Recommendation(s) from ACOEM Report**

> ***IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS***
>
> ***15. Improve/Standardize Methods and Tools that Provide Data for SAW-RTW Decision-Making***
>
> *Sub-recommendations:*
>
> a. *Help physicians participate more effectively in the SAW/RTW process by standardizing key information and processes*
>
> *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;*
>
> *c. Teach physicians practical methods to determine and document functional capacity;*
>
> *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.*

**Workgroup J Members:**

- **Facilitators**: John Bryden, Director, Employer Services - Banyan Work Health Solutions and Jane Sleeth, Optimal Performance Consultants Inc.
- Kerry Bock MSc. Kin - Health Management Specialist, Research in Motion
- Angela Borges, Regional Manager, Disability Risk Management, Health & Wellness - Standard Life
- George Georgiou M.A., Vice President, Client Services, AssessMed Inc.
- Karen Hoodless M.Eng., B.Sc.(Hon.Kin), CCPE, CPE, Operations Manager, Ergonomist, Taylor'd Ergonomics Incorporated
- Ellen Jackson RN, COHN(C),Canadian Operations Manager, Crawford Healthcare Management
- Vern Ladouceur, Acting Director, Work Safety Insurance Board, (WSIB)
- John Sheard DiplC., Dipl.PA, WRI Group Inc.
- Curtis VanderGriendt BSc, AE - Ergonomist - Occupational Health Clinics for Ontario Workers

**Group J said that Recommendation #15 should be implemented in Ontario, but we felt that c and d may not be appropriate for Ontario. We didn't get to e.**

This recommendation addresses the quality of the information being provided and available from the physician to the employer and the employer to the physician.

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

1. Improve the quality of the information being provided between the physician and the employer by providing information at just the right time so the physician can make sound decisions on SAW-RTW

The key steps involved in making this happen are:

1. Physician paper (Lakeshore study and OMA paper) already exists that outlines the process that physicians should be using and we thought we should review it and encourage doctors to follow its recommendations.
2. Emphasize having the PDDs shared between the employer, insurance carrier and the physician; a shared database between employer, insurance, provider and WSIB
3. Insurers/WSIB would drive clinics to provide research based evidence on methodologies and best practices

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. We want to approach the insurance companies and providers and have them drive the process of having employers provide PDDs
2. Insurance companies will make the PDDs available to WSIB
3. Lobby the CHLIA to mandate providing PDDs; change the language between the individual employers and their contract with their insurance providers to reflect this mandate
4. RE: Insurers/WSIB would drive clinics to provide research based evidence on methodologies and best practices – our group would be asking providers for this information
5. Our group is committing to collaborating on developing a checklist that we would provide so there is something that docs or employers can use (an absence or paired workers process? Worker project? How does that fit here?)
6. Worker project – insurance providers require employers to provide PDDs or higher premiums for the employer if they fail to provide

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

1. We will be instructing, encouraging our own companies and clients to utilize an absent worker checklist upon any work place absence so that they have PDDs that go with RTW. Example of items on the checklist are PDD, job description, FAF, RTW plan, modified work letter etc.
2. We are going to share our email addresses and collect our own forms and actually put the checklist together so that we can give it to employers
3. Set next date to meet as a group
4. From #4 above, ask our FAE clinics for research backing up their methods of evaluation

# Group K – Recommendation 16 and Special Topic

**Text of Assigned Recommendation(s) from ACOEM Report**

> ***IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS***
>
> ***16. Increase the Study and Knowledge about SAW/RTW***
>
> *Sub-recommendations:*
>
> *a. Complete and distribute a description of the SAW/RTW process with recommendations on how best to achieve desired results in disability outcomes;*
>
> *b. Establish and fund industry-specific, broad-based research programs, perhaps in the form of independent institutes or as enhanced university programs;*
>
> *c. Collect, analyze, and publish existing research;*
>
> ***Special Topic:*** *What uses can be made of the ACOEM Work Disability Prevention document?*

**Workgroup K Members:**

- **Facilitator**: David Cassidy PhD, DrMedSc, Professor and Senior Scientist - University Health Network
- Ginette Baker, Manager, Disability Insurance Plans, Treasury Board of Canada Secretariat
- John Barry, President, Pursuit Health Management
- Carolyn Dewa, Program Head, Work & Well-being Research - Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health (CAMH)
- Monique, A. M. Gignac Ph.D, Senior Scientist, Toronto Western Research Institute Associate Professor - University Health Network & DLSPH, U of Toronto
- Susan Jakobson RN, Manager, Partner Relations – WSIB
- Myra Lefkowitz MSW RSW, Manager, Health and Well-being - University of Toronto
- Fergal O'Hagan Ph.D., Assistant Professor, Trent University/Wellness Works Professionals
- Susan Oliver, Case Management Specialist, Durham District School Board

**Group K agreed that Recommendation #16 should be implemented in Ontario.**

Group K focused on all of Recommendation #16 and the Special Topic.

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

1. Focus new research on the gaps in the guidelines. Use participatory action method that brings all stakeholders (including users) into the research process at all phases (for example, research question, design and dissemination)
2. Deal with difficulties in accessing research and in communicating the findings – needs to be in lay language and translatable into concrete strategies
3. Pay attention to the process. To translate the guidelines into practice, we need to focus on concrete tools and actions. To do this we need broad stakeholder involvement.

4. Need to find funding for new research and dissemination of knowledge. Go to new sources (for example, insurers, labour bodies, provincial bodies) and ask existing sources to review their priorities in light of the guidelines (eg., WSIB) and Canadian Institutes for Health Research (CIHR)

The key steps involved in making that happen are:

1. See above – 4 strategies have examples

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

1. Guideline accessibility; Link stakeholders to Guideline via website
2. Take Guideline to senior management-60 Summit's participant workplace
3. Set meeting within the next 3 weeks

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

1. Link WSIB employee representative to researcher in mental health area to review ways to reduce long term disability claims related to mental health in 2 weeks. Dr. Carolyn Dewa and Susan Jakobson from WSIB need to be involved.
2. Engage the Peterborough Public Health/Community Health Department in areas of work stress next week and disseminate the ACOEM report for discussion.
3. Translate research related to disclosing a chronic health problem to employers and co-workers in 2 weeks. Grassroots organizations for example, Episodic Disabilities Network, Canadian alliance of Patients with Arthritis (CAPA) need to be involved. Exchange research findings and the guidelines

## Group L – Recommendation 9

### Text of Assigned Recommendation(s) from ACOEM Report

> ***III. ACKNOWLEDGE THE POWERFUL CONTRIBUTION THAT MOTIVATION MAKES TO OUTCOMES, AND MAKE CHANGES TO IMPROVE INCENTIVE ALIGNMENT***
>
> ***9. Increase "Real-Time" Availability of On-the-job Recovery, Transitional Work Programs, and Permanent Job Modifications***
>
> *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 temporarytransitional 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.*

**Workgroup L Members:**

- **Facilitators:** Genevieve Sadak BSc. PT, Director, LifeMark and Melanie Weller BHScOT, Consultant, Gowan Health
- Lucy Beltempo Paralegal, Manager, Claims & Rehabilitation, Metro Ontario Inc.
- Gino DiCiocco B.A., M.S.Ed., OCT, Executive Assistant, OECTA
- Pilar Gomez OT reg (Ont.), Return to Work coordinator, St. Michael's Hospital
- Janet Kerr BA, RSW, RRP, CCRC, Project Coordinator, Northern Lights Canada
- Jamie McDermid, Associate Director, Employment Services - Ontario March of Dimes
- Doug Morrison, Chief Physician, Hydro One Health Services
- Anne Nicoll, Vice President of Business Development, Homewood Corporation
- Janice Ray B.Sc.Kin, CK, RRP, CCRC, CRTWC, Owner, Ray Rehabilitation & ErgonoWorks Unlimited
- Helen Redican, Human Resources and Skill Development, Canada

**Group L agrees that Recommendation #9 should be implemented in Ontario with the following changes to the sub recommendations a – e:**

a. Instead of "require", Encourage, educate and incentivize employers to use transitional work programs
b. Encourage employers to adopt clearly written policies and procedures that instruct and direct people in carrying out their responsibilities, fit the workplace culture and reflect the specific workplace environment
c. Senior leadership holds supervisors accountable for encouraging and supporting meaningful and timely SAW/RTW opportunities; and senior leadership removes the cost of benefits for temporary transitional work as a barrier for supervisors

d. Consult with unions, workers and health and safety committees to design on-the-job recovery programs
e. Require the workplace parties to establish and participate in a dispute resolution mechanism within their program to guard against abuse

Group L focused on the sub-recommendations to reflect business elements and lines of accountabilities

Here are some strategies for how to make this recommendation become standard practice in our own organizations or community – 3 Real Time Availability strategies listed below are critical:

1. The focus is to educate at least 2 audiences, the employer (OHS committee through subject matter experts) and the community (spokesperson, testimonials, ways to get families and children involved
2. Real Time Availability strategies are
   a. Immediate/early contact with employee and immediate accommodations
   b. Have a ready pool/list of modified job options – use a 2 step process for
      i. immediate accident or illness
      ii time to decide longer term needs and info gathering
   c. Stay in hurry up mode policy/guidelines

The key steps involved in making that happen are:

1. Develop a guidance document for employers on what to do
   a. before the illness/injury
   b. day of illness/injury
   c. days 2 through 5
   d. day 5+ etc.

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. Use a tool like a checklist to remind and facilitate meaningful early contact by supervisors in their 1st discussion with the employee about the injury or illness. This will cover what to say and not to say, do's and don'ts for supervisors so they become confident in their dialog with employees
2. Pool of jobs: create a standard format for JDAs that are plain language and can be understood by all parties so know what to accommodate. In order to truly be able to understand what accommodations are made we need to work toward a common language we need guidelines
3. Early meeting with employee: develop guide for decision making during meeting with the employee, employer "here's your job, a series of tasks, what you can do and can't do to help you continue to work". Review the JDA and ask employee what they can do and what changes are needed

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

1. See what we all have in house for these 3 tools by tomorrow and get permission to share documents to identify samples as a starting point.
2. Review results of other summits to see if they have any examples within 30 days. Go to 60 summits team to obtain information – our facilitators will gather. Our goal is to ensure that we have the broadest scope of ideas to feed development of best practice tools
3. Strike a Task Force to review information and build the best practices. Our goal is to have practical tools that small to medium employers can use
    a. Group L needs to be involved and we would reconvene to start crafting a first draft of the guidance document for small and medium sized employers
    b. Invite additional employers, both small and medium for input

# Appendix H

## Personal Commitments

As part of the Summit day, participants were encouraged to make personal commitments of actions to undertake on their own once the Summit concluded. Many participants saw new opportunities to make a difference in their own organizations and communities as the Summit progressed, and the Personal Commitment form captured these.

The 60 Summits staff promised to keep these commitments private, so that people would feel free to make bigger and more specific promises than they might publicly. To honor this promise, the commitments listed below have been anonymized – names removed, and any other identifying information modified.

Personal commitment forms were received from a little more than half of all participants.

The form asked participants to address three topics. Responses appear in the table below.

- "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 is:"
- "Here's what I personally intend to do about this tomorrow or this week:"

A careful read of the responses to these questions shows that participants could fairly easily see many meaningful concrete actions they could take to begin making a difference as soon as the Summit concluded! A prime focus of the Summit was to exhort participants to act now rather than deliberate / commiserate and promise to do something later, or lay the responsibility for action on others. These commitments show that participants took that advice to heart.

In general, many people planned to reread or review the ACOEM report and then share it with their immediate circle of professional colleagues. Most planned to do this first at the local level, and within their own organizations, before expanding to wider audiences. Most people saw opportunities for, and value in, continuing to communicate the goals and recommendations of the ACOEM report over the long haul.

Additionally, many people expressed an interest in staying in touch with their workgroups going forward, and undertaking joint activities with their co-participants.

| *Person* | *Internal Opportunity* | *External Opportunity* | *Immediate Action* |
|---|---|---|---|
| 1 | • To prioritize the questions I ask employees and supervisors when I get involved in accommodation.<br>• Focus on what can you do, what works for the workplace. THEN, is there medical support. | • My associations –OKA – at AGM; working group here.<br>• Employers in my area.<br>• Colleagues in roles similar to me in my region. | • Frame conversations with employees and supervisors around abilities – talk less about medical.<br>• Simplifying what I am asking the doctor for.<br>• Keep it simple – when it can be – between employee and supervisor.<br>• Facilitate – don't take charge. |
| 2 | • Share the ACOEM report with my team.<br>• Work with the team to refocus our processes on preventing workplace disability, e.g. new checklist for communication with employees for 1. Supervisor, 2. Nurse Facilitator to ask about non-medical issues/ social/ support etc. | • Include the principles of Preventing Needless Work Disability in our response to current provincial review/ consultation paper or OLTS in Ontario. | • Educate my peers and professional colleagues by sharing this new paradigm. |
| 3 | • Email tomorrow first VP and IR and Manager; in time to send to SLT by midday.<br>• Chat with (May 21) person A and person B re: "How to do it? – Alberta" | • Send note my May 21 to HMA, …, WCD (Alta) and AMA. | • Engage with persons A, B, and C.<br>• Engage with persons D, E, and F. |
| 4 | • Circulate ACOEM document among all clinical staff.<br>• Prepare informational package for health care providers we interact with.<br>• Develop plan to concretely change our own clinical processes. | • ? Possibly identify forums to do presentations on the ACOEM process.<br>• Set date to have first draft of core message 6/15 – done.<br>• | • Compile package of information to provide to our staff – next week.<br>• Plan staff development sessions to improve our processes. |
| 5 | • Share Dr. Christian's slides etc. with my two major employers (20,000 employees) with a view to internal audit and change. | • Support message that work is part of both health and recovery. | |

| | | | |
|---|---|---|---|
| 6 | • Prepare and present briefing to all manager and employee groups. | • Through CEHSO/ AUHRA and RIMS – University Sector/ Risk and Insurance Management Sector. | • Next week – Prepare university action plan for work disability prevention policy and program. |
| 7 | • Enhance current training material that promotes the SAW/ RTW process.<br>• Contribute to development of services we offer to employers to facilitate SAW/ RTW process -> reduce social, financial, and other costs associate with prolonged absence from work. | • Join the Summit 60 in BC; contribute to action plans previously developed at this summit. | • Will be delivering a series of training sessions the last 2 weeks of May that I will enhance with material I learned at the Summit. This will assist in educating and empowering our network in being committed to this belief system and process. |
| 8 | • Improve overall communication between management and employees when occup/ non-occupational injury occurs. | • Develop new framework for disability prevention for employees.<br>• Offer training/ consultant. | • Call an employee who is off of work |
| 9 | • Share this new definition of prevention with the WSH prevention team.<br>• Share learnings (reinforce current process steps) with Sr. VP of HR and G.M. of Comp. | • Improve manager and supervisor ability to communicate with front line employees. | • Speak with my corporate sponsors on the change and roadmap. |
| 10 | • Go back to my own department (Disability Management consultants) and have them contact injured employees off work to have a discussion. | • Discuss some of the key tools to facilitate urgency to help in the RTW/ SAW process. | • Go back to my department and have them work on communications with injured workers/ improve on fear of isolation. |
| 11 | • Set prevention priorities with my key clients.<br>• Keep providing feedback on how we adjudicate disability claims to my teams. | | |
| 12 | • To set measureable goals – to get out information – educate – share information – more importantly to take action. | • Start to take individual action – look at how to apply knowledge to my work environment – learn and capitalize on information from others. | • Meet with my supervisor to look at next steps.<br>• Review homework for next action group meeting/ conference call. |

| | | | |
|---|---|---|---|
| 13 | • Review Hydro form specific<br>• Review links in documents and evaluate<br>• Learn best practices. | • Communicate to personal/ company stakeholders to implement support for change.<br>• Media support/ organizational/ province opportunities. | • Disseminate to own department/ physician.<br>• Scan and send tools I practice. |
| 14 | • Organizational level:<br>• 1. Key down or eliminate isolation.<br>• 2. Assist employees with filling forms.<br>• 3. Educate employees of the importance of SAW/ RTW. | • Discuss these (above) key points with my group. | • Facilitate these points in my working group. |
| 15 | • Instill sense of urgency re: timeliness re: RTW/ SAW with colleagues at staff meeting 6/4.<br>• Encourage advocacy to referral sources – re: timeliness.<br>• Encourage communication between employers and employees (our clients). | • Stay involved with 60 Summits project! – build/ sustain energy and commitment.<br>• Stay involved with breakout group to follow through on actions. | • Communicate findings from today at next staff meeting.<br>• Maintain better communication with clients (less isolation).<br>• Encourage/ educate clients/ employers/ lawyers/ insurers re: improved communication and timeliness. |
| 16 | • Present to Sr. Management my recommendation that early outreach calls be integrated into our approach to RTW/ SAW case management - that this call will predict some normal reactions and prepare the person to for their experience when off work. | • To use my public speaking opportunities to include the information “that 12 weeks is maximum RTW window” – “Hurry Up” mode. | • Talk to my own team, share slides.<br>• Put web link to 60 Summits on our site. |
| 17 | • Meet with Occ Health re: learnings of Summit 60 and outcomes. –To share info, offer suggestions to change process.<br>• Do an educational for own team. | • Join 60 Summits follow-up group.<br>• Bring new learnings to day-to-day work. | • Research this area to gain more knowledge to be a more effective advocate of change. |

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| 18 | • Share my experience here at 60 Summits and clearly show where more involvement from CMHA can help facilitate the process. | • In MHW give the broader look at "work" disability (use of some of the slides from some of the presentations). | • Put in my strategic planning process to ensure time is allotted to this issue in a broader context beyond current practice (i.e join a lobbying group on behalf of CMHA) |
| 19 | • Recommend contract language for expanding RTW model. | • To lobby government for changes within WSIB for a policy that adjusters must follow -> to consider workplace realities in their decision making process. Raise expanding RTW Model to employers to develop processes that sincerely consider and react and support workplace reactions and realities. | • Discuss this with a large HC employer in a new RTW Pilot Project that we are engaging in. |
| 20 | • Review our company disability and RTW-related policies and resources. | • Raise this topic at a future SWA Advisory Committee meeting. Share policy and program template. | • Meet with my staff as share 60 Summits information and ACOEM recommendation.<br>• Work into organizational objectives to review and revise current policies and procedures to align with recommendations. |
| 21 | • Lobby government/ WSID STD LTD/ try to get more people involved in my organization to move this agenda forward. | • Talk to my community leaders and grow to the larger community. | • Educate myself more on the 60 Summits. Grow the organizational part of 60 Summits even if it's one person. |
| 22 | • Review 60 Summits paper with my team -> incorporate key points into our process flow. | • Introduce my clients (patients) to the physician communication forms on Mood Disorders Assoc website.<br>• Continue to support 60 Summits through task forces. | • Incorporate new learning into my Masters of DM program.<br>• Keep in touch with members of my group. |

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| 23 | | • I am willing to contribute my expertise in designing screeners, psychological assessment and diagnosis of psychiatric diagnosis and deliver of evidence-based psychological treatments to a working group going forward. | |
| 24 | • As I develop my interdisciplinary treatment (psychiatric) centre, I will turn to stakeholders I met today to inform me of best practices for SAW/ RTW. | • My centre will provide SAW/ RTW-oriented care to hundreds of employees in the Ottawa area. | • Book follow-up meetings with each of the stakeholders I met in my group today. |
| 25 | • Incorporate disability prevention strategies into our strategic plan in a more robust format. | • Work to eliminate “silo” mentality between stakeholders. | • Review current strategic plan and philosophy for opportunities. |
| 26 | • Continue to educate managers about recognizing and addressing mental health issues.<br>• Continue to screen all clients for MH issues and function. | • Provide information about readily available resources to support employer and employee. | • Discuss research proposal for development and evaluation of early intervention functionally-based service for work disability cases with comorbidities. |
| 27 | • Promote information related to:<br>• Psych tools for WPPs<br>• Promote check up from the neck up as part of a Bill 168 Risk Assessment. | • Work with Occupational Doctors to develop treatment protocols. | • Meeting with health care groups.<br>• Develop protocols for WPPS re: Psych issues.<br>• Develop protocols for Occ Drs re: facilitated medicals, urgent medicals. |
| 28 | • Share knowledge about 60 Summits and presentations and resources and group work. | • Promote mental health in workplace; and raise public awareness of psychological distress in workplace; and ways to facilitate return-to-work and reduce disability. | • Consult with my team at work.<br>• I am a health consultant/ blogger for CTV med news express and I plan to write on these topics further to raise public awareness. |
| 29 | • Dispel the myths of mental illness.<br>• Be supportive and being aware of any employee looking overly stressed or “down”. | • Participate in speaking engagements to spread the word and dispel the myth of mental illness in the workplace. | • Support the work of 60 Summits.<br>• Carry forward some of the ideas which are applicable. |

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| 30 | • Review medical request forms. Select ones I like/ ones I don't.<br>• Report on discussions amongst stakeholders to my colleagues on Doctor's forms/ RTW/ SAW. | • Hopefully, create a template which can be used province-wide. | • Start on it. |
| 31 | • Share the Ontario Summit experiences with colleagues. | • Obtain commitment from my professional association (OMA). | • Maintain contact with participants. |
| 32 | • Regular meetings with key stakeholders in the RTW process.<br>• Begin micro meetings to engage key players in file/ injury/ illness management early(er). | • Continue communication with the team members I collaborated with today to continue working relationships towards building on these recommendations from the Summit discussions. | • Meet with my team to discuss Summit event/ outcome.<br>• Literature review for identification of validated questionnaire. |
| 33 | • Emphasize the concept of "Swing groups".<br>• Adopt the general recommendations. | | • Present the highlights of conference to the Medical Director. |
| 34 | • Be cognizant of the impact of SAW and speedy RTW and ensure by my words, actions, recommendations, that I impact this - with my peers. | • Informally spread the word for the value of SAW, RTW and eliminating hurdles/ improve collaboration of stakeholders. | • Continue to research and learn about RTW processes and disability practices so that I am not only opinionated, but also educated. |
| 35 | • Review questions we ask physicians to see if they are the proper ones.<br>• Develop template to communicate to MDs:<br>• Essential duties of job.<br>• Willingness to accommodate modified hours/ duties.<br>• Workplace or personal issues impacting RTW. | • Engage OMA in discussions?<br>• Promote "work is healthy" dialogue with Drs.<br>• | • Engage SUL/ SM in best practices discussion. |
| 36 | • Involving other professions in disability prevention – form/ training/ certification. | • Other professions involved. | • Engage the Ontario Rehab Coalition in the process. |

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| 37 | • Integrate principles of thee ACOEM into our services.<br>• Communicate them to our clients. | • Support Group F in getting payment standards for health care practitioners to co-operate in SAW/ RTW programs. | |
| 38 | • To address the issue of urgency, particularly on individual absences we manage, is to revisit issue of managing more absences without medical and increased focus on case manager discussion with absent member particularly on function. | • Participate in working group from this Summit. | • Put name forward as a volunteer resource to a group from Summit who may need assistance/ resourcing. |
| 39 | • Present the slides to my clients.<br>• Participate in ongoing working group creating a fee structure. | • Bring the output of the working group to the O.M.A. | • Send out OMA free guide to my work group. |
| 40 | • Build on concepts with my northerly clients. | • Introduce these new concepts at my seminar presentation.<br>• Introduce these concepts for brainstorming with my Cowan team. | • Provide leadership to our working group – coordinating assumed responsibilities of individuals. |
| 41 | • Promote a greater involvement by our disability support group and Sr leaders in partnering with employees with respect to SAW/ RTW. | | • Consider recommendations to improve our disability support program. |
| 42 | • Meet this coming week to better define roles of Corporate Health Services/ Disability Management/ Return-to-Work Nurses to better define roles. | • Improve tools for communicating illness and injury.<br>• Increase caring around disability.<br>• Increase prevention activities. | • Meet with my group as above this week.<br>• Meet with providers to discuss issues. |
| 43 | • Continued involvement and follow progress of 60 Summits. | • Promote and take information to my professional association members – VRA Canada. | • Appoint a member of VRA Canada to participate in this process for Ontario. |

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| 44 | • Keep our industry commitments to improve processes, services and products. | • Continue to lobby and speak out on relevant issues. | • Continue to take steps to encourage our industry every week to do the right things for disabled employees. |
| 45 | | • Present to my community OHN support group some of our findings. | |
| 46 | • Promote and implement effective RTW practices that incorporate Disability Prevention practices and therapeutic RTW. | • Same as to the left. | • Engage workplace leadership to discuss how to best facilitate a Disability Prevention model. |
| 47 | • Continue to raise the issues surrounding RTW & Disability Prevention while attending multi-stakeholder meeting, labor union conventions/ conferences and educationals. | • Continue discussions with Workplace Safety & Insurance Board and other stakeholder groups. | • Report back to my committee at work and, hopefully, encourage broader interest. |
| 48 | • Bring back information to organization to consider implementation into Disability materials. | • Promote the best practice guidelines to workplace parties concerned. | • Report to our organization on key finding of Summit that may be feasible to incorporate into our educational materials. |
| 49 | • Work with my project leaders to ensure that we are utilizing evidence-based practice models. | • Promote 60 Summits concepts to my professional association (Ontario Kinesiology Association) | • Present inservice to senior staff at mid ¼ meeting on Monday, May 17/ 2010. |
| 50 | • Encourage the utilization of evidence-based best practices and sharing of the material. | • To assist with the dissemination of research; and foster awareness that the evidence-based (best practices material) exists and encourage utilization. | • Follow up with Dr. A (scientist at IWH) to obtain current practices in place re: interface of their research with key treatment team members (i.e. Doctors, Allied Therapy, employers) |
| 51 | • Present to the health units I work with the need to pass on to physicians the evidence-based guidelines for the specific problem the employee is affected with. | • Present the Summit message to College of Family Physicians of Ontario! | • Brief message to CEO Ontario Chapter College of Family Physicians of Ontario. |

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| 52 | • Approach the disability management of STD claims using a non-medical model where appropriate.<br>• I can also start promoting this philosophy to my colleagues and clients, with the goal of changing practice. | • Promote, maintain involvement and live this initiative. | • Follow through on my assigned tasks. |
| 53 | • Review/ discuss guidelines within dept/ organization.<br>• Identify with group, initially, 1 or 2 areas of change within practice/ process, i.e. good unless gp – ensure thoughtful, kind, helpful, interaction; bad unless gp – ensure expectations are enforced re: participating in RTW. | • Participate in Group H follow up. | • Distribute guidelines and initiate discussions to DMC.<br>• Book time next project day to review and discuss with OH team. |
| 54 | • Ensure employees are given a RTW or SAW action plan to bring to their doctor. | • Reaching out to the RCC to have them advocate change at the WSIB for the physician forms to make them more comprehensive. | • Reach out to the RCC to start the conversations.<br>• Start coaching my staff on the RTW/ SAW action plans for MD/ Health Practitioner. |
| 55 | • Update my supervisor training material to reflect recommendations. | • Work with my employer clients to align their policies, processes and programs with this SAW/ RTW vision. | • Update my presentations.<br>• Participate in the initiative to standardize information exchange methods. |
| 56 | • Market the ideas and principles of the Guidelines. | • Incorporate the principles of the Guidelines into the strategic planning I do with my customers. | • Create links to the 60 Summits and ACOEM sites on my website.<br>• Write a blog article about the Summit. |
| 57 | • Listen harder.<br>• Share the successes of others. | • Bend the ears of business and political leaders. | • Call Chair of WSIB. |
| 58 | • Developing SAW/ RTW process for my clients (best practices).<br>• Share today's insights with my colleagues, clients. | • To include RTH/ SAW w/s at our Assoc of Canada ergonomists National Conference in 2011. | • Do additional research into other documents that were mentioned during this summit to further my education/ abilities in this area. |

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| 59 | • Job descriptions and PDA's for all jobs with clients we insure.<br>• Ask the right questions of Drs – train my team and company on this info. | • Educate employer and doctors during roadshow presentations. | • Set up training schedule for my team and Sr. management. |
| 60 | • Focus on working with doctors.<br>• PDD goes out with absence justification to insurer or, with employee along with EAF and letter.<br>• Modified work letter with non-occ as well. | • Continue to work with 60 Summits action groups. | • Share 60 Summits ideas with EHS and my team at RIM. |
| 61 | • Share and attain existing resources. | • Engage with other organizations in piloting primary and secondary prevention efforts and share findings. | • Schedule a meeting to push the pilot forward. |
| 62 | • Discuss Report with VP and obtain Executive commitment.<br>• Investigate "how to train" paradigm change to Branch Managers and then consultants – put together materials including relevant research. | • Volunteer to inform groups that can make a difference – local OHN group (next Tuesday at Spring Meeting).<br>• Provide copies of the report to the OHN's for feedback and suggestions on how to take action in their roles. | • Read over info – digest group responses and decide what I can achieve personally in my work role. |
| 63 | • Understand/ better evaluate personal circumstances – roles/ abilities -> stresses of the work environment in which I am part in and do what I can to reduce absenteeism and to promote RTW/ SAW. | • Remain involved within this 60 Summits project.<br>• Share the knowledge and experience learned. | • Share all information with my peers and personal contacts. |
| 64 | • To share the data in Jennifer's presentation with my HR colleagues and with the AVP of one of the University divisions where there are many absences due to needless work disability. | • By continuing to support this initiative through direct support from my office. | • Meet with my manager AVP HR to report on today's activities. |

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| 65 | • Pass on the recommendations to my VP of HR and Manager of Occupational Health.<br>• Incorporate recommendations as topics in our research seminars. | • Conduct and complete research and disseminate results. | • Consulting with the research knowledge translation seminar committee about how to use the recommendations as a guide for planning the seminar series. |
| 66 | • I will meet with the manager in charge of disability management at the university and provide a briefing on the Guidelines as well as a copy. | • I will brief the local workplace wellness committee of the public health unit on the Guidelines and request that they be linked or placed on the website. | • Meet with the disability manager at the university on May 20th.<br>• Call Person A at the Ontario Psychological Association to see where this Guideline is on the radar. |
| 67 | • Educate staff/ customers about the Guidelines. | • Implement the SAW/ RTW Guidelines within the business process of our private rehab company. | • Send email to staff/ mgt on the SWA/ RTW Guidelines and request one action item from each recipient. |
| 68 | • I will contact the University Health Network Occ. Health dept. and discuss the ACOEM Guidelines with them. | • Contact the 60 Summits workgroup and volunteer.<br>• Contact Dr. A at OEMAC to collaborate on Guideline dissemination. | • See to the left. |
| 69 | • Mental illness claims increase:<br>• Assist nurses/ Worksafe Specialists to utilize specific tools (RTW/ SAW) for mental illness.<br>• Do a “deep dive” into files related to mental illness, root cause analysis how progression from STD to LTD can be avoided. | • Promote workplace mental health. | • Develop assessment tool with Dr. B to use for file reviews (files related to mental illness).<br>• Ask RTW Branch to review ACOEM Guidelines to identify gaps in our programs. |
| 70 | • Go back to work with my employer to develop JDA’s, a transitional work process. | • Continue to work with 60 Summits to move forward with the work started in Ontario. | • To begin to gather the background information to contribute to our working group for developing the tools we have identified for development. |
| 71 | • Review steps discussed to decrease time/ speed up SAW/ RTW process with my clients ( and also at workplace – OM physician) | • My team at work and through provinces network organisms (maybe working group through professional association). | • Share this info with my team and perhaps pilot – try to implement (try) the steps discussed to speed the RTW/ SAW process. |

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| 72 | • Communicate at all employer sites the new paradigm.<br>• Scan employers for who may be able to be involved in a focus group. | • Participate in work groups with an ongoing commitment to bring my background and experience.<br>• Speak in the new 'language' of this paradigm. | • Review available resources for JDA and communication tools with employers.<br>• Review this day with my COO and colleagues/ share the knowledge. |
| 73 | • Determine what tools are in place in workplace to support "L" recommendation. | • Share #5 with OFL WCB Committee. | • Complete a presentation (PowerPoint) designed to assist a local unit officer who is helping a member who has suffered a workplace accident. |
| 74 | • Audit my company policy and practices versus best practices revealed at Summit conference. | • As per Group action plan:<br>• Research 60 Summits website – best practices in SDA, first contact with employee, collaborative decision-making model. | • Follow up on websites and references cited in conference materials.<br>• Select best practices in areas of focus from Group L report. |
| 75 | • Disseminate the information to the association members.<br>• Build awareness for the commitment to SAW/ RTW programs in Ontario. | • Use this commitment/ knowledge to facilitate clients to improve SAW/ RTW when ergonomically accommodating workstations. | • Review JDA's for universal format that could be used as a starting point for establishing transitional JDA guideline to ensure options are available for SAW or RTW. |
| 76 | • To develop a best practices document on transitional/ stay-at-work programs. | | • Search for documents to support my group. |

# Appendix I

# Evaluations

Participants were asked to complete an evaluation form at the conclusion of the Summit day. 85 forms were submitted, representing about 60% of those who attended. Below is an analysis of the responses to evaluation questions, followed by a full list of the comments submitted.

In general the evaluations showed a high degree of satisfaction with all aspects of the Summit. On almost all of the key measures, 70 to 80% agreed or strongly agreed that the Summit was excellent. Only the panel discussion was assessed by less than 50% as excellent.

Quite a few people expressed frustration, either in their rating or their comments, at the acoustics, lighting, and physical comfort of the facility. This aspect of the Summit garnered the largest percentage of "disagree" plus "strongly disagree" responses (16%). So while the facility was visually very distinguished and attractive, it also had significant practical drawbacks for many. It seems likely that some of the other satisfaction scores were negatively impacted by this factor as well, though as stated above the evaluations are overwhelmingly positive.

## Summary of Evaluation Results (85 respondents)

<u>Items # 1-3 addressed meeting preparations</u>

Meeting preparations were excellent, specifically …

1. The email invitation

| | |
|---|---|
| 29 % | Strongly Agree |
| 51 % | Agree |
| 13 % | Neutral |
| 4 % | Disagree |
| 1 % | Strongly Disagree |
| 2 % | NA (no answer) |

2. The phone call or personal invitation you received

| | |
|---|---|
| 20 % | Strongly Agree |
| 39 % | Agree |
| 27 % | Neutral |
| 5 % | Disagree |
| 1 % | Strongly Disagree |
| 8 % | NA |

3. The survey and reading materials sent ahead of time

| | |
|---|---|
| 38 % | Strongly Agree |
| 46 % | Agree |
| 7 % | Neutral |
| 6 % | Disagree |
| 1 % | Strongly Disagree |
| 2 % | NA |

Item #4 addressed logistics and venue

Logistics and venue were excellent, specifically the…

4. Location and facility (meeting room, food)

| | |
|---|---|
| 18 % | Strongly Agree |
| 42 % | Agree |
| 23 % | Neutral |
| 14 % | Disagree |
| 2 % | Strongly Disagree |
| 1 % | NA |

Items #5-7 addressed flow of the meeting

Meeting flowed well, specifically the…

5. Overall plan for the meeting; the agenda

| | |
|---|---|
| 13 % | Strongly Agree |
| 54 % | Agree |
| 21 % | Neutral |
| 10 % | Disagree |
| 1 % | Strongly Disagree |
| 1 % | NA |

6. Conduct of the meeting; facilitation of general sessions

| | |
|---|---|
| 22 % | Strongly Agree |
| 57 % | Agree |
| 15 % | Neutral |
| 4 % | Disagree |
| 0 % | Strongly Disagree |
| 2 % | NA |

7. Value of small group facilitators

| | |
|---|---|
| 42 % | Strongly Agree |
| 39 % | Agree |
| 11 % | Neutral |
| 2 % | Disagree |
| 1 % | Strongly Disagree |
| 5 % | NA |

Items #8-14 addressed meeting events

Meeting events were excellent, specifically the…

8. Wednesday reception & speakers (Ryan, Arnold, Brown)

| | |
|---|---|
| 25 % | Strongly Agree |
| 52 % | Agree |
| 15 % | Neutral |
| 1 % | Disagree |
| 0 % | Strongly Disagree |
| 7 % | NA |

9. Thursday's Ontario speakers (Fonseca, Wilkerson, Mahoney)

| | |
|---|---|
| 23 % | Strongly Agree |
| 41 % | Agree |
| 25 % | Neutral |
| 8 % | Disagree |
| 1 % | Strongly Disagree |
| 2 % | NA |

10. Keynote presentation by Dr. Jennifer Christian

| | |
|---|---|
| 43 % | Strongly Agree |
| 45 % | Agree |
| 7 % | Neutral |
| 4 % | Disagree |
| 0 % | Strongly Disagree |
| 1 % | NA |

11. Multi-stakeholder small group deliberations

| | |
|---|---|
| 35 % | Strongly Agree |
| 47 % | Agree |
| 11 % | Neutral |
| 4 % | Disagree |
| 1 % | Strongly Disagree |
| 2 % | NA |

12. Reports from multi-stakeholder groups

| | |
|---|---|
| 13 % | Strongly Agree |
| 49 % | Agree |
| 26 % | Neutral |
| 7 % | Disagree |
| 0 % | Strongly Disagree |
| 5 % | NA |

13. Stakeholder panel session

NOTE: We are uncertain why there is such a high number of "No Answers" to this question, since most participants were in attendance through this part of the Summit.

| | |
|---|---|
| 11 % | Strongly Agree |
| 37 % | Agree |
| 15 % | Neutral |
| 2 % | Disagree |
| 0 % | Strongly Disagree |
| 35 % | NA |

14. Future planning session

NOTE: The Summit adjourned without spending much time on this activity, and that is the likely explanation for the large number of "No Answers" to this question.

| | |
|---|---|
| 5 % | Strongly Agree |
| 30 % | Agree |
| 14 % | Neutral |
| 2 % | Disagree |
| 1 % | Strongly Disagree |
| 48 % | NA |

Items # 15-20 were responses to "I'm very happy I attended this Summit because…"

15. The information presented was very interesting to me

| | |
|---|---|
| 43 % | Strongly Agree |
| 53 % | Agree |
| 1 % | Neutral |
| 0 % | Disagree |
| 1 % | Strongly Disagree |
| 2 % | NA |

16. Having met the people here will help me in the future

| | |
|---|---|
| 39 % | Strongly Agree |
| 48 % | Agree |
| 12 % | Neutral |
| 0 % | Disagree |
| 0 % | Strongly Disagree |
| 1 % | NA |

17. This new angle or approach has made me think differently about some important things.

| | |
|---|---|
| 31 % | Strongly Agree |
| 42 % | Agree |
| 21 % | Neutral |
| 4 % | Disagree |
| 1 % | Strongly Disagree |
| 1 % | NA |

18. I have come away with some practical next steps I can put to use to improve my part of the SAW/ RTW process

| | |
|---|---|
| 27 % | Strongly Agree |
| 49 % | Agree |
| 21 % | Neutral |
| 1 % | Disagree |
| 1 % | Strongly Disagree |
| 1 % | NA |

19. This workshop was a good use of my time and effort

| | |
|---|---|
| 31 % | Strongly Agree |
| 56 % | Agree |
| 10 % | Neutral |
| 1 % | Disagree |
| 1 % | Strongly Disagree |
| 1 % | NA |

20. I think this workshop will really bear fruit in the future

| | |
|---|---|
| 28 % | Strongly Agree |
| 52 % | Agree |
| 14 % | Neutral |
| 2 % | Disagree |
| 1 % | Strongly Disagree |
| 3 % | NA |

**Anything you want to say to us?** Best part? Worst part? Suggestions for improvement? Next steps?

| ID | Comments |
|---|---|
| 2 | - I hope the steering committee can pull the working group action steps together in a readable form and keep each group accountable for their commitments. |
| 3 | - I thought our group assignment was very challenging, but was impressed by the group recommendations.<br>- A very positive experience. |
| 5 | re: Conduct of meeting: a lot to jam in.<br>re: Reports from groups: people have a hard time being specific.<br>- Time crunched - perhaps less speakers on working day. (or do over lunch) |
| 6 | Thanks! We'll be in touch! |
| 7 | re: Having met the people here will help me in the future - breaks and lunches cut too short to allow.<br>re: New angle made me think differently - I was there.<br>- Keynote speaker regurgitated the presentation from the night before for the sake of 8 people who did not attend Wed night.<br>- Would have like more interaction.<br>- Would have liked to see a better balance - too many 3rd party service providers, not enough employers.<br>- Too long sitting<br>- Chairs<br>- Should have kept to the committed timing<br>- Would have liked to have seen WSIB as a participant in solutions (representation in group work) - as opposed to pontificating. |
| 8 | Keep going! |
| 10 | A bit more time for sessions. |

| | |
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| 11 | re: Overall plan - long - should be over 2 days as a lot of info.<br>re: Thurs speakers - too much of political speaking.<br>re: Keynote - too repetitive from night before.<br>re: Reports from groups - needs to be summarized on website.<br>- I thought the concept of moving beyond information to planning next steps.<br>- I think that the focus groups should be better balanced to include multiple approaches which are more holistic and less medical.<br>- Jennifer has a strong approach to things, but at times can be too strong!<br>- Less political speeches who don't understand that it is about more than workers potentially dying on the job. |
| 13 | - Worst part - political speakers<br>- Best part - understanding need for paradigm shift.<br>- Felt very rushed. Perhaps 2 full days would have been better. |
| 15 | re: Survey and reading materials - too late<br>re: Facility - food great<br>- Dr. Christian should become more familiar with Canadian ideals/ systems - some of the American recommendations are not as appropriate in Canada as in USA. |
| 16 | - Wilkerson was great!<br>- Mahoney - no value add - what is he doing personally - today, tomorrow, etc. |
| 17 | re: Email invitation - v. unclear what this was about<br>re: Facility - v. noisy room<br>re: Thurs speakers (Fonseca - 2; Wilkerson - 5; Mahoney - 1)<br>- More working time is needed.<br>- Recommend: only 1 local speaker on the evening before. Then, full setup from Jennifer for the work of the conference.<br>- Jennifer: the only speaker on the full day. Begin working break-out sessions at 8am on the second day.<br>- Should be 3 working group sessions in order to come closer to real action plans.<br>- Speakers were not the attraction for me. Working with colleagues to produce outcomes is the attraction. |
| 18 | The College of Family Physicians needs to be involved. |
| 20 | I was disappointed that we were not provided with the outcome and recommendations of the prior 19 Summits - particularly the BC group. |
| 25 | re: Facility - acoustics, seats, lack of breakout rooms<br>re: Future planning session - not enough info on |
| 27 | re: Speakers - Arnold and Wilkerson were excellent.<br>Amazing energy! Very practical - great idea - personal commitment forms. |
| 29 | - Facility difficult to reach for out-of-towners - would be better closer to Union Station.<br>- Seating very uncomfortable.<br>- We were advised Wed night that there are follow-up meetings scheduled - this should have been provided in the original invitation.. |

| | |
|---|---|
| 30 | - Small group deliberations - wandered a lot and missed main point - bit frustrating/ stressful - clearer explanation/ facilitation would have been helpful.<br>- Speaker presentations were consistently excellent and motivating.<br>- Break-out groups - hard to hear for discussion. |
| 31 | re: Keynote presentation - too slow<br>- Dr. Christian seemed to be 'U.S.' focused. Our Canadian context is much more collaborative, depends less on MDs as stakeholders. She may wish to dialogue more before presenting again in Canada to reflect this. |
| 33 | re: Facility - I love U. of T<br>re: Overall plan - TOO FAST!<br>- Confirms I have been taking this approach for years!<br>- Time to get OMA and lawyers on board too. |
| 34 | - A little rushed - need a few minutes to respond to urgent voice mail and email. |
| 35 | re: Speaker - Wilkerson – Good<br>re: Venue for meeting:<br>- Not appropriate<br>- Physically not comfortable<br>- Small group discussions difficult with open room.<br>- Needs to be accessible to everyone. |
| 36 | - Guest speakers were very good and knowledgeable.<br>- Too long of a delay until lunch - resulted in brain saturation.<br>- The rooms were not conducive to discussion. Too much echo. |
| 37 | re: Conduct of the meeting - Rushed. |
| 38 | - Venue - beautiful and prestigious building gave the event real class, BUT it was uncomfortable. |
| 40 | - Jennifer Christian - I question the value of repeating presentation Wed and Thurs. |
| 44 | - Wasn't terribly happy being the group I was in - which I felt limited my ability to participate. |
| 45 | re: Reading materials - sent too late<br>- I got the sense that there was still too much of a focus on Worker fraud and that concerns me.<br>- Plus little emphasis on having regard for the OHSA in all processes of the SAW/ RTW model, but there were many interesting points that I will be able to use. |
| 48 | - Two major criticisms:<br>1. Process - completely determined by 1 person - no room for disagreement.<br>2. Hypothesis - disagree with the basic hypothesis - no real perspective on the situation of workers - nor workers' rights. |

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| 50 | re: Overall plan – rushed<br>- Dr. Christian is excellent presenter overall, but don't like some of her approaches.<br>- Did not like venue.<br>- Collection of delegates was excellent and my facilitator was excellent.<br>- Opportunity for networking outside of the tasks good evening before. Great way to network. |
| 51 | re: Facility - even though we were at U of T, I'm not sure the Great Hall was the best venue - or perhaps I'm just too familiar with its problems<br>re: Conduct of meeting - rushed + too much information<br>re: Facilitators - David Cassidy was excellent<br>re: Thurs speakers - Mahoney - 1; Wilkerson – 5<br>- Thank you for all your hard work to bring all of us together and bring focus to this very important issue. |
| 52 | - Set up email group of attendees to share future successes. |
| 53 | - Not enough time to discuss and determine objectives based on Canadian realities. |
| 54 | re: Future planning session - time is a problem for me<br>- Great!<br>- More time for workshop groups.<br>- Workshop rooms too noisy, but good group- Where is WSIB?<br>- Disjoint between - Group recommendations and action plan - said what can you do, but may not have authority to make do "must changes". What should be done in Ontario is the task.<br>- Got lost in what "letter" were presenting back to us. Prefer that the "letter" is announced consistently.<br>- Great session!<br>- Action plan: Maybe make a chart form to make it easier. |
| 55 | - Should be on a 2-day session. |
| 57 | - Provide clearer instruction at start of the day for subgroup work and expected outcome. - Less critical feedback in the open forum on stage.<br>- Networking was fantastic - meeting like minds. |
| 61 | - American content - no - we should be using Canadian data.<br>- This should be a 2-day conference - not enough time.<br>- Uncomfortable seating, cramped, awkward, noisy.<br>- I did not appreciate my workgroup. |
| 64 | - Jennifer - Please do not assume to know the experience of injured/ disabled workers simply because you are "human" any more than they can know your experience as a powerful professional. |
| 65 | - Venue was not perfect, but adequate. |

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| 66 | re: Facility - 5*****<br>re: Multi-stakeholder group deliberations - needed to have more<br>re: Workshop bear fruit - I hope so!<br>- Too little time for discussion.<br>- I would like to continue to be involved, but not for the topic I was placed in. |
| 67 | - Time constraints really limited the workshops. |
| 68 | re: Facility - a little hot<br>re: Meeting flow - need to stay on-time<br>re: Wed reception - too hot<br>re: Multi-stakeholder deliberations - sloppy, not enough direction<br>- Please respect the need for breaks - allows downtime, networking, go to bathroom. |
| 69 | re: Reading materials sent ahead - more time would be appreciated<br>- It was ambitious - it was great.<br>- More time would have been beneficial, but it worked d/t the f/u plans. |
| 71 | re: Workshop bear fruit - not sure |
| 72 | re: Workshop bear fruit – hopeful<br>- Needed to be a 2-day or multi-day process to be able to develop meaningful plans. The development of a joint process that builds long-term, continued involvement will be the benefit of the process. I see the plans as a 'flavor' of what type of work can come out of a collaborative approach. |
| 73 | - A bit too much reporting from each group to digest and focus on. |
| 74 | - Good material, useful and interesting.<br>- Rushed !!<br>- Room layout very poor in afternoon. |
| 75 | - Overall the experience was valuable, but strongly suggest a different facility in the future. Volume issues, temperature issues and chairs were uncomfortable. |
| 76 | - Great group, wonderful dynamics - fast paced. |
| 79 | re: Facility - attractive, but crowded, noisy<br>re: Overall plan - need more time<br>re: Wed speakers - not all were good; CIBC best<br>- Day 1 - room small/ crowded.<br>- Key speakers didn't understand the purpose of the conference - government minister &WSIB talking about workplace safety. |
| 80 | - Provide lunch EARLIER! |
| 81 | - Knowledge of difference between U.S./ Canadian Healthcare/ Stakeholder groups. |

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| 83 | - For future reference: on a day like this, physical comfort is paramount. Delayed lunch, cacophonous rooms made it difficult for me to participate, esp. in the afternoon.<br>- Too many speakers. Needed FAR more time to connect and work, not listen to more of what the problems are.<br>- Missed opportunity for networking outside of our workgroups, because we were so pressed for time. Should have been 2 full days.<br>- The day made it difficult to engage in self-care. Someone said to me - a person with a disability would have a hard time with the pace and circumstances of this day. True!! |
| 84 | re: Wilkerson – great<br>- Small groups – great<br>- Perhaps needs to be longer (but recognize busy schedules and costs factor in) |
| 85 | - The morning session should only be Jennifer's presentation - there needs to be more time for workgroups. |

# Appendix J

## Sign-Up Sheet Results

Participants were asked to provide their contact information on a sign up sheet if they were interested in participating in the Action Group to be formed to continue the work of the Summit, or to stay on the Ontario Summit email list or the overall 60 Summits Project email list.

Results indicated a very high level of interest in staying engaged:

74 ( 53 %) wanted to participate in the Action Group

77 ( 55 %) wanted to be placed on the 60 Summits Project email list

90 ( 64 %) wanted to be placed on the Ontario Summit email list

# Appendix K

## Endorsement Letters

A number of prominent organizations provided letters of endorsement for the Ontario Summit, indicating widespread regard for the topic, support for the Summit effort itself, appreciation of the work done by the Steering Committee, and a desire for concrete actions to result from the Summit and the Action Group formed to help implement the ideas generated in the Summit.

The letters are attached.