

***WORKERS WITH DISABILITIES PROJECT,
EARLY ACCOMMODATION AND SUPPORT PROGRAM
RESOURCE MANUAL***

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INTRODUCTION

We received term funding from the Disabled Persons Participation Program to address concerns about accommodation and loss of employment by ill, injured and disabled workers in unionized workplaces. We believe that any employee with a chronic injury or illness is increasingly vulnerable to termination and long term unemployment. The advent of accommodation liability and a body of legal precedents is a recent development to address this trend.

Since the inception of the Workers with Disabilities Project in March of 1993, we have been collecting information about job retention, workplace-based health services, delivery system models and job accommodation costs. We believe that unionized workers may have a false sense of job security even though they appear to enjoy adequate health services and benefits as part of their collective agreements. What may not be evident is that these available health services are not used to encourage or support viable accommodation of chronically health affected workers. Our study and associated accommodation services may address the status quo in this area.

According to research from the Mennigher Foundation conducted by Hester and Decelles, " Of the nearly 600, 000 workers who become disabled every year, (USA) approximately 50% never return to work". The statistics for British Columbia may be interpreted in a similar manner as an "either/or" situation for significantly health affected workers. We believe that once you are identified as chronically ill or injured along a continuum to disabled; then, your options to remain employed become very limited. Essentially you return to work within a pre-determined time frame or you are terminated. The available and designated funding, service options, and other forms of available assistance appear to be rigidly controlled. For example, your health service funding is often determined by negotiated agreements between management groups and insurance carriers. These agreements can be characterized by the focus on funding and services for workers with physical health issues to the exclusion of other categories of illness, injury and disability. Further, these health services and monies vary according to the nature of your health issue and the your funding source. For example, if your health issue is a physical injury that is workplace induced, then you may receive funds and service from a public insurance organization such as Workers Compensation Board. If your health issue is a chronic illness that leads to "total disability" then your funding source may be a private insurance carrier. Regardless of the category of health issue and ultimate service agency that assists you, the outcomes appear to be "either/or" for a chronically health affected worker. You return to work within a "window" of time and within a "window" of pre-allocated/available funds or you may not work again. The problem seems to be with the conventional health services delivery systems and the lack of flexible service options. The delivery of assistance appears to be "reactionary" and not preventative. For example, the release of income benefits and rehabilitation services are initiated after a health affected worker has left the workplace. Further the worker must be compromised to the extent that they have a "total disability", prolonged absence(s) and can produce medical-legal opinion to support their status as health compromised or affected.

What if, there was an early assistance model and associated service options that could be accessed by a health affected worker in a preventative or anticipatory manner. For example, if a health affected worker knew that he or she would become mobility limited over the remainder of their career; would it be more effective to change tasks and the workspace to minimize this projected limitation. This is part of the rationale for early assistance or intervention in the field of workplace-based health service delivery. Can a worker be accommodated much sooner in the progression of their illness such that they can minimize health related problems. Would this lead to longer job retention, reduced emotional and financial hardship and a better use of pre-allocated health service funds ?

As mentioned, we secured term funding to design, implement and evaluate early accommodation in unionized workplaces. We also wanted to test the viability of an integration theme as reflected in a partnership approach to early assistance. The notion of including and involving co-workers as peers and partners may yield better outcomes for health affected workers. A combining of both themes could

be realized in a model of early intervention services for accommodation that features "co-worker" acceptance and involvement. Additional questions could be developed and addressed. For example, would this form of inclusive support enhance or facilitate measurably better outcomes for a chronically health affected worker. This idea of viewing accommodation as an "us" rather than "them" concept may represent significant benefits and advantages for all involved parties in the accommodation process. The challenge is to make the case that these combined themes are useful especially in a unionized workplace.

In April 1995, we launched the **Early Accommodation and Support Program** as a component of the Workers with Disabilities Project. The primary effort was to design and deliver cutting-edge, innovative services within a pilot program format in a unionized work environment. The latter was chosen as part of our belief that accommodation services are more available in unionized workplaces. We reasoned that an organized workplace may involve WCB funding and group insurance coverage from a private carrier. This situation is common in unionized worksettings. The primary objective was to make a defensible case for the utility and viability of an early assistance model of accommodation. We believe that we are well underway towards this goal and invite you evaluate our progress to date.

As well, we ask you to consider and use the materials in this resource manual to launch pilot initiatives in your workplaces and organizations. If we are confirmed in our belief that early accommodation is a better option, then you may be a direct beneficiary of a program that you help initiate. Further, your pilot program outcomes and cost figures could be used to strengthen the argument that "sooner is better than later" in terms of the delivery of assistance.

Thank you for the opportunity to present these materials and for your consideration.

EXECUTIVE SUMMARY

The following is a brief overview of our resource manual. Our summary mirrors the Table of Contents for the Resource Manual. We hope that you will continue to read our offering and are welcome to comment on any of our ideas and materials.

INTRODUCTION

We launched the ***Early Accommodation and Support Program*** as a research initiative within the Workers with Disabilities Project in April of 1995. We are sponsored by the Action Committee of People with Disabilities and the Victoria Labour Council. We are funded by the Disabled Persons Participation Program for the one year term of our current study.

Early Accommodation and Support Programs are based on an early and anticipatory approach to chronic illness, injury and disability in unionized workplaces. If a chronically health affected worker could request accommodation assistance before they physically left their jobs and worksettings; would they enjoy better outcomes. The perceived outcomes for many health affected workers is an "either/or" situation. The affected person returns to work and retains employment or they never work again in any meaningful capacity. Our study and pilot program for early accommodation is an attempt to address this difficult situation.

We are established in two host workplaces and are conducting basic data collection in each site. The goal is to anonymously profile and estimate the resident, chronically health affected population of co-workers in each site. This data will be used to identify, develop, deliver and evaluate innovative accommodation services.

PROGRAM MODEL DESIGN AND RATIONALE

We designed a basic looped service model that is characterized by phases: ***Contact, Contract, Placement and Retention Phases***. The key theme is that a chronic health issue is often long term to permanent depending on the affected worker and the nature of the issue(s). A co-worker may need on-going assistance and a service model should reflect this. The Contact phase is a period in which you, as an affected employee, can request assistance without penalty or negative consequence. You will not be fired after asking for help. The early assistance program features a resident, service group that will work with you. Using other key concepts such as co-worker support, partnership and social cohesion, we intend to enhance your chances to retain employment in your original job and current worksetting. The Contract phase is when naturally involved parties or "shareholders" assist you with a service plan, funds and direct assistance to use to modify your job, schedule and responsibilities. The Placement Phase is your resumption of job duties, acceptance of an alternate or modified job or any other trial position. We recommend that you retain your original job and worksetting as the best option. The Retention phase is the follow-up, monitoring and "fine-tuning" period. Early assistance and job retention should yield reduced hardship, costs and effort for all involved parties.

MARKETING AND NEGOTIATION

We worked for seven months to market our study proposal to 41 unionized businesses. We also contacted 51 labour groups that were associated with these

businesses. We entered into negotiations with decision makers in 11 businesses and were accepted in 3 workplaces. We recommend that any parties that want to setup a similar study or pilot program; first secure clearance from labour groups. Accommodation is primarily part of a labour agenda for job security and protection of employment.

We believe that our marketing and negotiations were protracted, complicated and frustrating. Again, we concluded that accommodation is a sensitive issue in a workplace and is poorly understood. We believe that there are numerous negative attitudes towards this service process that are worth researching.

Finally, unionized workplaces are under stress related to the Free Trade Agreements and subsequent downsizing of workforces. For example, one of our three host sites was involved in a workplace dispute that led to a loss of unionized positions. This site became invalid under our study parameters. There appears to be a British Columbia trend towards de-unionization as a means of controlling costs and to reduce the size of workforces. The dilemma may be that any form of accommodation may be less feasible as all employees face layoffs and termination due to loss of positions.

HOST SITE PROGRAM RESEARCH PHASE

We are completing research in two sites: the Corporation of the District of Saanich and the University of Victoria. The former features an established joint labour-management service group called the Rehabilitation Committee. The latter features a joint labour-labour service group entitled the Early Accommodation and Support Committee. We have an extra-ordinary opportunity to compare and contrast service development in each host site.

Our research is qualitative and quantitative using a defensible sociological research method. We are also using standardized survey, informational interview and data collection plan materials to facilitate research.

Our early data from pre-testing and interviews is disturbing. The estimated population of chronically health affected workers may be approximately of 15% of the total resident workforce. The most reported health issue may involve physical injury and later development of temporary and permanent disabilities. Since the numbers of health affected workers may be large, an early approach may be a more effective use of funds and available rehabilitation services. It may also be viewed as an opportunity to develop innovative services that involve and include non-health affected co-workers.

HOST SITE PROGRAM DELIVERY PHASE

We have developed training packages that utilize and promote co-worker input and involvement. We recommend that volunteer co-workers receive training in delivering employment support to health affected co-workers. We also

recommend that health affected employees participate in self-advocacy training to learn to self-direct their own accommodation. We believe that the more involved and educated you are in your own service process; the more likely you will enjoy better, more suitable outcomes. This belief is part of our study for this Phase. We are using evaluation criteria for innovative programs.

HOST SITE PROGRAM EVALUATION PHASE

This Phase is on-going and includes 7 categories of activities. Ideally we shall have captured data that will assist us to make the case that our service model, key concepts, data results and pilot program format are viable, repeatable and defensible. We want to support our hypothesis that early assistance is a better option than current service delivery systems. We also want to support our contention that accommodation is cost effective and a better use of pre-allocated funds from any source. Finally we want to show you comparatively, quantitatively and qualitatively that early accommodation represents measurable advantages to health affected and non-health affected co-workers regardless of their workplace status.

SUMMARY

As the public, social and health services safety net is eroded and under-funded there is an increasing reliance on a secondary safety net. We believe that Canadians are more frequently dependent on a workplace-based health services safety net as do American Workers. If you concede that this is a logical development, then you can understand the importance for a health affected worker to retain her/his employment. If you follow this line of reasoning then accommodation becomes the best available option among a decreasing menu of service options and benefits in our country. We believe that early assistance to chronically health affected workers for the purpose of accommodation to retain employment is the wiser and better direction for Canadians. If we can not afford or retain our public safety net then we need to develop and reinforce our workplace net of health services to avoid hardship and long term unemployment for very vulnerable workers. Thank you for the opportunity to summarize our Resource Manual. The following sections will be in accordance with the Table of Contents.

PROGRAM MODEL, DESIGN AND RATIONALE

As mentioned, there are disturbing trends supported by employment statistics dating to the early 1980s. Employees that we designate as Chronically Health-Affected are increasingly vulnerable to termination and long-term unemployment. In the cost conscious business climate of today, workers with health issues are not being accommodated. Their workspaces, tasks, work schedules and core duties are not being redefined to "fit" or match the needs, skills and abilities of health affected workers. The conventional or traditional rehabilitation service models are effective in distributing income benefits yet do

not appear to effectively fund accommodation. The funds are spent for off-worksites therapies, assessments and counselling that tend to separate the affected worker from his or her workplace. In our opinion, the longer an affected worker is out of their job and away from their work environment; the less likely they are to return to work. The point is that a health affected worker may be better served by remaining connected to their current employment and worksetting.

As well, there may be a negative dynamic that results in the affected worker learning and accepting a "sick" role. The affected person may come to believe that they are no longer competent to perform in a work environment. This may be a form of learned helplessness that is well documented among people who have experienced long term mental illness. The term is by Martin Seligman in his text, Helplessness: On depression, development and death, 1975. I believe that a similar social mechanism may be involved for people who are long term health service recipients. The point is to disrupt this progression towards emotional and financial hardship and dependency on Provincial and Federal social programs.

If you concede that conventional rehabilitation service models are time limited and deliver services away from the workplace, then an early assistance model may complement or enhance your conventional rehabilitation services. Please imagine yourself from the point of view of a chronically ill or injured worker. You know that your health issue will increasingly affect your workplace performance and may impose observable limitations on your functional capacity. The latter could be considered disabling and further increase the impact or effect on your performance. Would you prefer to come forward to an individual or a designated service group and ask for no-penalty assistance to retain your employment? Would you benefit by remaining connected to your original job within your current worksetting? We believe that an early assistance approach that features retention of a worker's current job in their current worksetting is a logical and effective alternative to the negative consequences associated with chronic health issues and employment.

For example, our research data and information suggests that the best option for a chronically health affected worker is to remain employed in their original or current position. There is a prevailing myth that our public safety net and insurance carriers will cooperate to provide an adequate income and other benefits for health affected workers who are no longer employed. We believe that no one agency or service provider can and will deliver income benefits and other advantages that we enjoy as employed, productive people. In our opinion, income assurance or benefits plans are either short term and/or funding limited. For example, Short Term Injury and Illness Benefits are in effect for a maximum of 6 months at 60-to-75% of your annual income. As well, Long Term Disability Benefits may be for an indefinite period but are usually for a maximum of two years at 60% of your annual income. At the end of your coverage period, you either return to work or you are terminated sometimes by default. If you could retain your original job and remain connected to your workplace, we believe you

would experience significantly reduced emotional and financial hardship. You may also avoid some of the dependency and negative consequences associated with being a long term service recipient such as learned helplessness and poverty.

PROGRAM MODEL:

For these reasons, we have developed and are field testing a service delivery model to include and retain a person with a disability or chronic health issue in their place of employment. An **Early Accommodation and Support Process Model**. This model is an early assistance approach based on individualized service options. We want to configure the model as a phased process consisting of: ***Contact, Contract, Placement and Retention Phases***.

Our model format features:

A partnership approach that includes identified "shareholders".

An integration theme that presents the benefits of acceptance and inclusion.

An equal concern for placement and retention.

A self-advocacy option in which the worker with the issues is a responsible partner in the accommodation process.

A no-fault, no-penalty arrangement to encourage the use of our service model by an employee with a disability.

A working agreement among shareholders who want to host our pilot initiative.

An invitation to private/public, union/non-unionized members of workplace-based groups to review and use our ideas.

A "train-the-trainers" theme to ensure that shareholders can deliver useful assistance while being a part of the service process.

Guidelines to outline a person-specific accommodation plan and goal(s).

A provision to ensure that the application of our model and materials will fit the person and the involved members of the workplace.

Our Process Model features four phases that are interconnected to form a looped structure. As mentioned these phases are **Contact, Contract, Placement and Retention**. The benefit to portraying an accommodation process as looped phases is flexibility. We believe that this phased model permits the users to complete one segment yet return to any portion of the process as needed. For example, I may have reported my need for accommodation, completed negotiations under a contract phase and accepted a customized accommodation

plan as part of my placement phase. I learn during the implementation of my Employment Continuance Plan that I have been accepted for a promotion. This new position may require that I return to the contract phase and negotiate a new accommodation services plan to fit my new position, tasks and responsibilities. Our looped process model ensures equity, access, and continuing communication among Shareholders. This on-going interaction is based on our experience in the area of work and disability. Quite simply, issues involving disability and health are not resolved when a person with these issues is employed. Disability and chronic health issues are constants in any social environment.

The services options that we believe could be used to deliver a reasonable accommodation and ensure social integration are outlined below. We believe that an in-house committee or group can use these services options in conjunction with existing rehabilitation services to build a person-specific accommodation plan. This plan would be compatible with the agendas of members of workplace-based groups and any existing collective agreement clauses for that workplace. These enhanced options are:

Graduated Employment Continuance.

Partial Employment with income supplement(s).

Permanent Supernumerary Employment as part of sheltered employment.

Training services for on-site Shareholders.

Designated in-service Case Manager to coordinate negotiations and delivery of support services.

Established Accommodation funds.

Delivery of comprehensive education to solicit on-site support for this process and associated services.

Job-site adaptations in the form of physical modifications/renovations, installation of adjuncts/tech aids and job restructuring.

Supported Employment through the training and use of co-worker job coaches and/or contracted community-based coaches.

Option to secure additional on-site and off-site training for the identified worker.

Use of co-worker job sharing as a form of employment continuance for workers with disabilities.

Reporting procedure and on-site contact people to facilitate assistance before an employee leaves the workplace.

Working Agreements Formats for Labour, Management, Co-Worker and Consumer workplace-based groups to use to negotiate individualized service plans.

DESIGN AND RATIONALE:

During the past three years, we have come to believe that programs and service delivery systems are often controlled or "driven" by one workplace-based group. The operating principle for doing so has been that this group provides and/or administers funding for workplace-based health services. We believe that a better option would be to expand the structure and composition of health service delivery by changing the relationships of decision makers and service recipients. We are recommending that an "integrated" and inclusive mandate for participants in workplace accommodation. We are also recommending a change in thinking about control and administration of health services.

Please consider conventional rehabilitation service delivery as reactive and restricted, then you may view the potential utility of an early assist for a health affected worker. Our model and study is designed to make the case that health services are more effective when these services are more accessible to the workers who need them. Also consider the notion of "co-worker support" as a social mechanism in a work environment. We believe that it is not appreciated by involved parties in a workplace. The notion of co-worker support is promoted by the authors of a manual from the Centre for Community in Sitka Alaska. Centre Staff, Bruce Anderson and Margaret Andrews wrote CREATING DIVERSITY: Organizing and sustaining workplaces that support employees with disabilities, (1990). They discuss natural supports and social relationships among employees in work environments as a means to assist workers with disabilities to integrate a workplace. We agree that co-worker derived and delivered assistance may be crucial to the performance and success of a health affected worker. Further, we believe that this form of peer support is a measurable indicator of social cohesion in a work environment. The level of concern and involvement for the health and wellness of an employee by his/her co-workers is an also an indicator of the connectedness of people within a work environment or setting. Clearly this peer support must be considered in transactions in a workplace especially in the area of accommodation and health services.

Our service model for accommodation is designed to promote and use this form of cohesion to promote acceptance and tolerance. We reasoned that including and involving co-workers in an accommodation service process should yield measurably better outcomes. At least, involved and affected co-workers would be informed and may not disrupt the delivery of accommodation assistance. We believe that the service process could be comparatively shorter in length, less expensive and yield longer term job retention when co-workers are included in this process. The challenge would be to track this process within our service model and compare our findings to results achieved within conventional rehabilitation service models. As well, we intend to train co-workers to become

direct service providers then determine if outcomes are more beneficial or positive. In our opinion this sense of belonging to a workplace-based group is a strength and a source of help for a chronically health affected worker.

The key concepts of early assistance, partnership, integration and co-worker support have been combined in our accommodation service model. We have also configured these ideas in a format that is compatible with collective agreements and the various agendas of workplace-based groups. Our service model must address concerns from labour, management and co-worker representatives. For example, a manager may object to perceived additional costs and increased workload involved with assisting a chronically ill co-worker. The belief may be that he/she should wait and use the established service options and funding from the private insurance carrier for this workplace. There may be concerns about liability, violating existing agreements and authority. In contrast, a labour representative may believe that a co-worker is better assisted through off-site services and as a recipient of long term disability benefits. Finally, a non-affected co-worker may resent the early delivery of assistance and view it as compromising them. The health affected co-worker may be viewed as a "burden" who will represent additional work for the non-health affected staff in a worksetting. We believe that we have addressed these concerns by designing a generic service model that can be "customized" to comply with the agendas of all participants in the service process.

We were also sensitive to the politics in work environments. We reasoned that the delivery of our service model within a pilot format may be more attractive. The pilot format contains a "termination with notice" provision for all involved parties. This is part of our acknowledgment that we are guests in any workplace that hosts us for our study. A second advantage to a termination clause is that there is an equality and a sharing of control over the implementation of accommodation service delivery. When any involved party can stop the study and activities within our early assistance program; then, in a sense, there is a shared responsibility for decision making.

Finally, we believe that any employee or worker should be considered basically competent because they have joined the social network of their workplace. If you are hired and employed then you have been judged to be competent to perform in a work environment. This rationale of capability meant that we could offer a generic early assistance model and invite participants to "customize" the model to be compatible with their workplace. The operating principle is that we would be utilizing the skills and knowledge of resident co-workers who have performed in this work environment. Their input and contribution of skills is beneficial. Again we would be promoting our basic themes such as partnership and integration. We believe that this would be yet another incentive for co-workers to accept our research and to implement our ideas. Rather than imposing a program, co-workers could create their own service delivery system with our assistance. In return we simply asked to study the setup and implementation of a "made-in-your-workplace" accommodation service.

All of these key themes were our best effort to anticipate responses to our request for sponsorship and host site status. They were our attempt to be sensitive to our status as outsiders in a unionized work environment in which many activities are determined by formally negotiated agreements. We approached the design of our early assistance model from a mutual benefits perspective for all potential participants. We identified three categories of participants and tried to anticipate their concerns according to our perception of their agendas. We believe that we have been successful and that the key concepts and themes are relevant and appropriate from the point of view of co-workers, labour representatives and management representatives. Finally we did not neglect to account for the point of view of a chronically health affected worker. Within and among our Program Advisory are chronically health affected and disabled individuals who served as quality assurance critics for the anticipated agenda of a health affected worker. Their ideas and professional experience has ensured that we included the values, needs and beliefs of chronically health affected workers. This is reflected in our opinion that the best option for a health affected worker is to retain employment in their current job and within their chosen profession or trade. We are recommending that a chronically health affected worker retain their current employment because it may be the best option to use to avoid long term unemployment.

In summary, our model, program format, development and rationale are based on practical experience in conducting research and delivering services in unionized workplaces. We shall discuss how these lessons were applied during the marketing and negotiation portion of our term.

MARKETING AND NEGOTIATION

This period of our term covered approximately seven months and represented a significant amount of work. We recommend that you be prepared to continue this activity on an on-going basis. The Free Trade Agreements and downsizing of businesses has led to instability that is particularly evident in unionized workplaces. This uncertainty has affected collective agreement negotiations and promoted layoffs. Our offer of research and testing of innovative services to retain jobs was contrary to the prevailing trend towards layoffs and downsizing. We could not have anticipated this situation.

To date , we have canvassed 41 unionized businesses in the private and public sector. The canvassing involved telephone contacts, faxes, mailouts and series of meetings to present a very simple offer. We asked labour and management representatives to serve as hosts for a study of accommodation through early assistance. As a complement to our formal canvassing, we also met with health affected workers in unionized workplaces. We confidentially collected information and often followed their lead in our offers of assistance to their co-workers. We were careful to not disclose the identity of a health affected worker that contacted us for assistance. Even with information from directly affected co-workers we were not prepared for the range of responses by decision makers.

Securing unionized workplaces to serve as host sites for our study proved to be very difficult, time consuming and frustrating.

For any research groups or workplace-based groups that want to initiate a study and pilot program, the following discussion should be of interest. We believe that there are attitudes and prevailing beliefs about accommodating health affected workers that appear to be discriminatory. These beliefs appear to be so widespread that a research group could justify a study to identify the source and rationale for such negative thinking. In honesty, we did not anticipate discriminatory reactions to our study proposal. Recall that we did try to build incentives and advantages into our service model and did recommend a pilot format. Even with the option for any participating individual or group to terminate us; we still encountered rejection and hostility. For example, we were challenged as biased based on the reputation of our sponsors and funding source. Even though we built a model on an integration theme and presented ourselves as an integrated study group; we were perceived as labour influenced.

We believe that chronic injury, illness and disability are perceived as expenses rather than co-worker health issues. Decision makers in unionized workplaces view health affected workers as liabilities and as cost prohibitive. Further the existing services and models in the 41 canvassed workplaces could be characterized as, primarily, claims management models. In the majority of workplaces there were the expected short term injury and illness funds; and , long term disability benefits options. Any direct assistance for rehabilitation was contracted by a manager and delivered off-site. Control and distribution of health services funding is a management group prerogative. Our partnership approach and recommendation for enhanced involvement by all co-workers was not well received.

The most frequently reported reason for rejecting our proposal offer was that there were adequate, existing services for chronically health affected workers such that a study or new program would not be needed. No one rejected the model or basic rationale for implementing our study. The concern about pending layoffs and downsizing initiatives were presented as reasons to reject our study in only one workplace. We concluded that the area of accommodation remains poorly understood and a non-priority among the canvassed workplaces. As well, we were approached by health affected workers and asked to contact decision makers in many of the workplaces that ultimately rejected our proposal. This apparent discrepancy was common and placed us in a dilemma. Since our operating principle is to not harm or compromise any health affected worker, we were not able to challenge or effectively persuade decision makers to accept us in their workplaces. The entire marketing process was protracted and frustrating.

Another observation about the marketing initiative was that we elected to adopt a union or labour "first" contact plan. We reasoned that accommodation and workplace health were issues that are very compatible with a labour agenda. Consider that job security, workplace safety and health are historically labour

group concerns. Accommodation is workplace health issue that is also part of promoting job security and protecting the rights of a worker in a unionized work environment. In our experience, any pilot program of innovative services should be cleared and endorsed first by a resident labour group to ensure a reasonable chance of success. Too often this preliminary contact and clearance is not secured and innovative initiatives do not succeed.

We can report that all labour groups that we contacted did clear us to approach other groups in their workplaces to request access for research on accommodation through early assistance. This clearance also gave us direction and leads on contacts in other workplace-based groups who may also support our offer. We were using a key concept of co-worker cohesion to evaluate the potential appeal of our service model for co-workers in a canvassed workplace. In our opinion, when a labour group member was not able to identify a sympathetic manager or supportive co-worker; we did not gain access to that workplace. If there was no social cohesion that crossed group boundaries then accommodation and any innovative initiatives appeared to be rejected in all cases. Again this may be an area for further study.

We did enter into negotiations with 11 workplace-based groups all within a joint labour-management structure or format. This working relationship is common for programs and services involving accommodation and health. There were no workplaces that we canvassed or negotiated with that featured non-management or non-labour based co-workers as members of committees or service groups in any of the 41 canvassed sites. The trend may be for co-workers to be excluded from decision making and service groups. This would be consistent with our understanding of conventional rehabilitation service delivery in unionized workplaces. The health affected worker has limited input and duties regarding her/his health services and accommodation.

Another trend among the 11 workplaces with whom we entered negotiations was that in the majority of cases we were accepted by local area individuals and workplace-based group members. The rejection of our study proposal came from individuals from outside our geographical area. This was particularly frustrating because we could not anticipate or even address the final decision makers. They were not physically present during negotiations in potential host sites. We were effectively blockaded from direct contact with upper level decision makers for these host sites. Again, we could not have made provisions for these outcomes. We simply had to start the entire marketing effort again until we could secure suitable workplaces to serve as host sites. Please contact us for advice and direction especially if you reach a negotiation stage with decision makers in your workplace. We believe that you will need to address very ingrained, negative attitudes towards the idea of workplace health, accommodation and responsibility.

We did secure clearance to launch our proposed study within a pilot program format in three unionized workplaces in the Greater Victoria area. These sites

represented hard earned clearance and are each quite different. By November of 1995 we had secured letters of understanding to launch our pilot initiatives at the Corporation of the District of Saanich, Horizon Air and the University of Victoria.

We had clearance to launch at Horizon Air in September of 1995. This was a particularly suitable site because of a history of long standing cooperation between our Project and this workplace. The Canadian Auto Workers Local 4234 Representatives and members of the host site management group could be characterized by excellent rapport and cohesion. They had cooperated in the past with us for an ergonomic assessment of their passenger service area at the Victoria International Airport. The workforce was established in a unionized, private sector environment and numbered 18 employees. The upper level decision makers were based in Seattle, Washington and had cleared us to develop a workplan, survey materials and start by October of 1995. Within days of our start date, the American Managers appeared to precipitate a workplace dispute over contracting out jobs.

The host site became inaccessible during a protracted dispute that ended in December of 1995. The outcome was that the CAW unionized workforce was reduced to 5 co-workers and work was contracted to non-union employees. This workplace no longer met our parameters and criteria as a host site. The loss of rapport, reduced workforce and continuing instability may eliminate this as a site for the foreseeable future.

The Horizon Air site is an example of the destabilization of unionized workplaces in our geographical area. We had a two year involvement with co-workers at Horizon Air. We had every expectation of proceeding with our research and program implementation. This private sector site would have been an excellent contrast to the other two hosts which are public sector work environments. If any conclusion can be made, be well advised to continue canvassing for research sites. Access and entry into workplaces for research and program implementation is complicated and vulnerable to unexpected disruption.

The Corporation of the District of Saanich is a municipal, public sector workplace. The resident union group is the Canadian Union of Public Employees, Local 374. We would characterize the rapport and social cohesion among co-workers as excellent. The workforce is approximately 720 employees. There is an established service group, the Rehabilitation Committee, that assists 400 co-workers among the total of 720. We completed negotiations by November of 1995 and started research in December. Please consider our workplan and associated materials as samples. You may notice that we are consistent in that our core themes are incorporated in these materials. The following documents will be presented to illustrate and confirm these ideas.

SAMPLE WORKPLAN FOR THE CORPORATION OF THE DISTRICT OF SAANICH

INTRODUCTION:

Thank you for agreeing to host our Early Accommodation and Support Program in your workplace. In the interest of efficiency and time savings, I want to offer you a tentative plan to use to setup and test early assistance for your co-workers. I shall outline the steps and services that I believe will benefit you while minimizing demands on your worktime and production. Please use this suggested plan as a menu of options that you may alter and edit to fit your workplace.

I like to use phases and time frames to track progress for setup and use of a program. The advantage is that we have a model and procedures to use to monitor development. We can also return to any phase and re-negotiate agreements and actions. The phases that I recommend are **Research, Delivery and Evaluation**. My suggested workplan outline is setup in three sections to match these phases. If you already have resident programs then we can model our pilot on these existing service models.

RESEARCH PHASE (one month time frame-may involve a series of joint meetings and co-worker information sessions.)

Participants in your pilot services committee will be the existing Rehabilitation Committee. Your working committee is a joint labour/management format. I have suggested that this be an open group that could include co-workers with skills and a natural involvement with health and disability in your workplace. Often people with the issues are an excellent resource because they know how to use their skills to self-direct their own accommodation. As well we have Contributors who may offer to directly assist your group by serving as a member. For example, our Staff Researcher, Tim Jepp or myself could attend your committee meetings as a participant.

There is also an option to poll or survey your interested co-workers for their ideas and input for a made-in-your workplace program. I recommend that you consider this as part of an educational offering for your co-workers. I believe that an after or during working hours, series of information and survey sessions would promote acceptance of pilot services. We need co-worker interest and support as part of a practical service model. This may be one way to secure co-worker acceptance and clearance.

The basic questions to answer are:

Do we agree to the research methodology as outlined in the information package?

Do we agree that E.A.S. P. Staff has clearance to collect background data on health services and accommodation of Municipality of Saanich Co-Workers ?

What are the existing health services options that are currently used to accommodate your co-workers?

What pilot services options are of interest to Committee Members ?

Do we agree that voluntary, pilot candidates for early assistance will deliver medical assessments to our working committee. This information will be used to protect the candidate and confirm that they have a limitation or restriction that affects their performance in our workplace.

Do we agree to the use of release and liability forms to ensure that we do **no harm** through our intent to assist and serve a candidate for our pilot program ?

What questions do Committee Members have about the research phase ?

COMMENTS:

In summary, This portion of the pilot is study and setup. I can share information about how other sites are doing. I would also be pleased to deliver educational/training sessions, conduct any written or verbal surveys and deliver materials, as required.

DELIVERY PHASE (time frame will be variable depending on the services to be delivered, number of participants and the needs of a participating co-worker. Our pilot is funded to April 1996 and I am committed to work with you for the remaining term of our project.)

We recommend that you start recruiting and offering services after your committee is in place. Ideally you will have identified service(s) and identified some potential candidate(s). You will now have the option of designing accommodation service plans that are based on accurate information. These individual plans include available services, take into account any available funds and any donated services available through our project. Basically you are matching candidate needs to available services and setting this to a schedule. The usual time frames for service plans are three to six months. A candidate is monitored and progress reports are written every one-to-two weeks. The monitoring is to ensure that the service plan is appropriate and that no harm is done. If co-worker training is requested then the service plan is written to account for this. As well if candidate training is required then this will also be included in the plan.

In general the delivery portion of our pilot is dependent on your decisions during the research and setup phase. You determine, with the assistance of our Advisors and Contributors, the most effective and reasonable services for your co-workers. The safeguard is that anyone can request a change or terminate the service especially if a person's health is being compromised or aggravated.

EVALUATION PHASE (time frame is continuous from the start of our research to the completion of the term of your pilot program.)

This phase is on-going because we are contributing to a workplace-based study of early assistance. For example I hope to record the way that you decide to cooperate as well as the actual outcomes for people that you choose to serve. I shall protect confidentiality of everyone in the pilot and ensure that accurate records are kept. This information will be written into a progress report format that will be available to you. Your comments and opinions should be included and you have the right of approval.

The reports are intended to outline the estimated and actual costs of training, delivered services, time spent and unanticipated events. We hope to show that your accommodation service model represents reduced hardship for your co-workers, less work disruption, a better use of any/all allocated funds, retained jobs and a more stable worksetting. The latter would be indicated by fewer unscheduled absences. Our focus is to document all the measurable benefits and compare them to costs and disadvantages. We also intend to compare our findings to available information on the costs and outcomes of more conventional rehabilitation services. This could be accomplished by comparing the statistics for pilot candidates to available statistics for chronically injured co-workers who have received off-site rehabilitation. We would need your approval to access this information.

In closing, you are part of an extraordinary effort that has not been tried in any other workplace. We have the opportunity to challenge conventional wisdom and attitudes about accommodation and workplace integration

Thank you for your openness and for this opportunity.

The **preceding document** is intended to provide you with an accepted working agreement for your potential use. We recommend a looped, phase model and suggest that you modify any workplan to comply with the concerns of participants in your workplace. Later in this manual, we shall discuss related materials that show compliance with this overall workplan. Finally, we suggest that you prepare to alter and re-negotiate your plan as data is collected and interpreted during the various phases. This should be an anticipated activity that will ensure that your workplan remains relevant to the information that you collect and interpret. The idea is quality assure your plan and results as part of evaluating an innovative program designed for your workplace. This on-going

evaluation may represent more work but will help you adjust your activities as required.

§The final site is in the University of Victoria. In this workplace, this is an extraordinary situation in that our sponsors are two resident labour groups. They are the Canadian Union of Public Employees, Locals 917 and 951. In essence, our research and program implementation is promoted and support within a joint labour format or structure. To our knowledge, this form of cooperation is unprecedented in British Columbia.

The history of this joint sponsorship is significant. As mentioned, we first secured clearance and support for our research proposal from labour contacts as part of an overall marketing strategy. We thought that there would be interest among co-workers because this work site did not offer conventional rehabilitation services that are common in unionized workplaces. The resident labour groups wanted more assistance and specific health services options to facilitate accommodation for their health affected members. We secured endorsement and approval to approach the resident management group members and followed the direction of the labour representatives. The latter identified the logically involved employer group members and arranged an information session.

We approached the resident management group representatives with a research proposal and request for access to their workplace. Project Staff and involved labour representatives participated in a series of meetings to present information and a formal request for clearance to conduct research within a pilot program format. Standardized workplans and related materials were discussed with interested and involved parties in this workplace. We believe that the management contacts could not agree to grant us access. Their reasons were not disclosed and significantly they adopted a position of non-involvement. We then elected to adjust the parameters of our study and participate in a labour driven pilot program.

In the University of Victoria work environment there are approximately 900 members of Locals 917 and 951. They do not enjoy any formal rehabilitation services such as injury and illness benefits or long term disability income benefits. They do have a jointly employee-employer funded sick bank benefits option. This is short term and funding limited such that the available moneys are used for income replacement. Unless a co-worker is an accepted claimant under the WCB Act; he/she is without funding for and access to accommodation and conventional rehabilitation services in this work environment.

The comparative points to make are that the Corporation of the District of Saanich has an established, resident service group that has been in operation for three years. The co-workers are functioning in a joint labour-management format that we recommend. We believe that an "integrated" service group is an application of principles that should promote greater involvement by other co-workers. For example, interested and health affected co-workers can and do

attend meetings of the Saanich resident service group, the Rehabilitation Committee. The key concept of social cohesion is evident in this work environment. By social cohesion, we mean the interconnectedness and level of tolerance among co-workers in a work environment. We believe that Saanich can be characterized by a significant level of social cohesion. We shall highlight this concept in the Research portion of this manual.

In contrast, the University of Victoria features combined, developing resident service groups called the Return to Work and Early Accommodation and Support Committees (R.T.W./E.A.S. Committee). This is a joint labour-labour format and, as mentioned, is atypical. The non-support and involvement from other workplace-based groups meant that we were limited in the ways that we could assist the Committee Members. We did not enjoy easy access to data and to the actual workplace but we could train Committee Members who do have access. Further, we may be able to include Managers and other co-workers at a later date. This outcome would strengthen our case that the delivery of health services for accommodation should be a integrated activity. The naturally involved parties or "shareholders" should cooperate and directly serve health affected workers. We were optimistic that other co-workers will attend Committee meetings and volunteer to deliver services. We were also hopeful that health records and other relevant information will be made available. We believe that peer pressure from co-workers would encourage decision makers to join in our research and program development. We made requests to managers for access to health services records and relevant data. When we completed the Research Phase for this workplace, our results may encourage broader participation. What may be evident is that there is not a sense of social cohesion in this workplace. We believe that the lack of health services that can be used to accommodate co-workers is a clear indication of this low level of social connectedness. We shall highlight this belief in a later portion of this manual.

Finally, we have continued to market our study and pilot program to unionized workplaces in Greater Victoria. The workplace instability as an apparent trend means that we have continued to serve as consultants for interested workplace-based groups. We deliver opinion on disability management programs and accommodation service plans to create interest and acceptance for our study. We recommend that any workplace group contact and form linkages with similar groups in other workplaces. Part of the appeal of our study is that we intentionally decided to compare pilot programs in host workplaces so as to highlight services and methods that appeared to be most effective. We could assist and save time for later host site groups by identifying mistakes and successes. This may bias outcomes and skew our study results yet the issue of accommodation is too important to refuse to share findings from host site to host site. The issue is that we are helping people to retain employment and avoid hardship. We would elect to table the same offer again especially if we could assist someone to remain employed in their original position and worksetting.

HOST SITE PROGRAM RESEARCH PHASE

As mentioned, we focused our study on two sites while continuing to canvass for further study hosts. We have completed data collection in the Corporation of the District of Saanich (CDS) and at the University of Victoria(UVIC) workplace. The operating principles for our data collection and interpretation were consistent with sociological survey methods. We shall include samples of our Research Methodology, pre-test survey results, our final survey format and our Data Collection Plan. As much as possible, we elected to standardize our materials. We also drafted our survey materials to secure data that is repeatable and defensible. The interpretation of data is crucial for participants in any subsequent pilot program for a simple and significant reason. We must have reliable information about the co-worker population that we want to include and serve in any pilot program of early accommodation. We need to know 1) who are the chronically health affected workers and 2) what health issue do they most frequently report. With this data we can develop, deliver and test innovative services that appeal to and assist a recipient population. Too often this basic needs analysis work is not completed or is based on very narrow parameters. For example, indicators such as absenteeism and WCB Claimant data may not be useful for estimating a chronically health affected worker populations in a work environment. We believe that many health affected workers are very reliable and do not access WCB funding. Regrettably, we may ultimately receive reports of significant illness and long term injury when these issues have become serious health problems. In a sense we are late in the process and it may be more difficult for a health affected worker to receive adequate accommodation within the existing rehabilitation service model for her/his workplace. Professional and thorough research is necessary to genuinely have a sense of who you want to serve in your workplace.

Please refer to the Appendix for a copy of the Research Methodology for the entire term of our study. We shall also include data collection plan samples and our actual written survey materials. Any interested groups are welcome to use the written survey materials to collect data in their workplaces. We recommend that you use a random sampling method to ensure repeatable and defensible results. We also suggest that you code the survey copies for maintain anonymity.

Further, we elected to pursue a two tier approach to information collection in the form of a quantitative survey and a qualitative informational interview format. The quantitative survey is a written opinion survey directed to members of CUPE 917, CUPE 951 and the workforce at the Corporation of the District of Saanich who are served by the Rehabilitation Committee. We chose to non-randomly survey the Saanich workforce in the interest of prescribed sociological survey criteria. We also elected to blanket survey the members of the CUPE Locals at University of Victoria. The work environment of the University co-workers is very difficult for us to conduct research in our preferred method. Consider that the numbers of workers and the diversity of work schedules present challenges for access and contact. We decided to distribute our coded survey copies in as many worksettings as possible and hope for a large return of completed forms. We did an earlier pre-test survey in the University of Victoria and realized that a blanket approach is the method to use for both workplaces. We completed generating

summary information about these two populations of co-workers that can be challenged as biased findings. Since you know our reasons for survey distribution; you should not have to correct for any differences in findings. The point is that we are studying an established recipient population of co-workers and a population who do not enjoy similar accommodation and rehabilitation assistance. They are inherently different based on the workplace cultures and differing social cohesion among each population. We anticipate that our survey reports will confirm our premise.

We also chose to conduct informational interviews of service group members for each workplace. Interviewing and collecting opinions is a form of a qualitative survey. This is also a simple way to gauge consensus and cohesion among group members. As well we can identify the service process for co-workers who have been or are being assisted by both groups. We have completed our series of interviews and shall include a combined report in the following section of this resource manual. Again we studying an established group and a developing group.

In our opinion, the Rehabilitation Committee in the Corporation of the District of Saanich is a viable, efficient and productive service group. We can report that this group has been in operation since 1993 with commendable success. They have open group boundaries and are socially integrated. As mentioned, any co-worker is welcome to and has attended Committee meetings. They enjoy a renewable annual operating fund in excess of \$ 20,000.00 to pay for contracted services for health affected co-workers. We believe that this service group is literally a "made-in-Canada" approach to accommodation. Their trial and error development of a service delivery system is very compatible with our early assistance model concepts. They have created a "made-in-Saanich" service model and delivery system. We shall also collect further data on direct and indirect service costs to make the case that accommodation in the Saanich workplace is extremely affordable. We are continuing our research work in this host site and shall include an updated report in our final draft of our Resource Manual.

The R.T.W./E.A.S. Committee in the University of Victoria is very much in the setup and development stage. The interviews of Committee Members are positive and reveal commitment on the part of service group members. The formation of the this service group has been protracted and delayed due to lack of available time by the Members. We believe that this service group may benefit from the history and activities of the Saanich Rehabilitation Committee.

We can discuss similarities among both service group members that may serve as general indicators of social cohesion for both workplaces. Generally, service group members from both groups have been continuously employed in their respective workplaces in excess of ten years. The groups are gender balanced and members of both groups range in age from 35 to 55. We believe that the more similar are the beliefs and goals of the service members, the more likely they are to work together and achieve viable service outcomes. We are determining group

member agendas. The most reported agenda or set of stated beliefs about the group is a "co-worker agenda". For example, the service group members report that they identify with the people that they serve and want to cooperate to retain co-workers in their workplaces. The focus is on the needs and interests of service recipients rather than on costs, politics or personal interests.

Finally, we interviewed current and previous co-workers who have received accommodation-related assistance. We worked from a checklist to generate a profile of a health affected service recipient in Saanich. We conducted a similar qualitative survey of health affected workers at the University of Victoria. The difference is that the latter have not been served or assisted by a resident service group. The R.T,W./E.A.S. Committee has only been operating since November of 1995 and has not yet acquired a longterm caseload. We shall present all reports in the following section.

In summary, we have completed the Research Phase of our Workplans. Based on written survey findings, individual interviews of service recipients and interviews of service group members; we can offer interpretations of our data. We believe that large numbers of co-workers are chronically health affected. The reported incidence of health issues has been formatted into profiles of categories of health affected workers. This data is reliable and defensible. We recommend further repeated surveys to establish a time-line. We currently believe that there are sufficient numbers of workers who have and/or are incurring health issues that have long term implications. This suggests that these workers will use any and all existing rehabilitation services and benefits. They may severely stress budgeted funds and services if they access assistance at relatively the same time. These workers may be more effectively helped if they can use some form of early accommodation to retain their current employment, make better use of allocated funding and avoid long term unemployment.

The following section contains the reports the we submitted to service group members in the Corporation of the District of Saanich and the University of Victoria. We consider the reports as the completion of the research phases for both host workplaces. The report findings are simplified for the consideration of the reader and to maintain confidentiality. The more detailed analysis and findings are reserved for the participating co-workers from both host sites. We shall present these reports as they were written for comment and interpretation by affected and involved participants. You are welcome to use our reporting fomats and categories. Please contact us for additional information, at your convenience.

***REHABILITATION COMMITTEE
FOR THE
CORPORATION OF THE DISTRICT OF SAANICH***

QUALITATIVE RESEARCH REPORT

INTRODUCTION

Our data collection plan for the Research Phase of our Workplan for this workplace is divided into two parts. We designed a written survey to serve as a quantitative research vehicle. We also designed two standardized checklists to use during informational interviews for two segments of this co-worker population. We interviewed five members of the Rehabilitation Committee and five chronically health affected co-workers. The latter were former and current employees who had been service recipients assisted by the Rehabilitation Committee. The following summary is our interpretation of service group members' agendas, roles, general or average profiles and overview of the group service process. The latter is based on a report format that will be included for your consideration.

We also summarized and interpreted the opinions of service recipients in the section entitled **Saanich Service Recipient Themes**.

We reviewed available caseload files, service records on costs, interviewed group members, interviewed served co-workers. We also recruited the assistance of the Saanich Payroll Staff to research indirect and direct costs. This time consuming and sensitive work is greatly appreciated. These expenditures will be presented at the end of this report. The Rehabilitation Committee for this workplace has delivered cost-effective and viable assistance to co-workers since 1992. They may represent a disability and health services management model that is genuinely "made-in-Canada". We believe that the following information will support our contention.

We shall present a general profile of the Members of the Rehabilitation Committee. This is a detailed overview of demographic factors for this group. We shall also deliver the same overview for the University of Victoria, Return To Work/Early Accommodation and Support Committee in a separate report. The latter report will follow this portion of our manual. A comparison of both service groups will also be presented for your consideration. As mentioned we shall also present informational interview findings for five service recipients who were assisted by the Rehabilitation Committee. A similar presentation for University of Victoria based co-workers will be included in our report on that workplace.

REHABILITATION COMMITTEE MEMBERS GENERAL PROFILE INFORMATION(based on five interviews to date and the best available background data on the members)

This seven member service group consists of five men and two women.

The group was formed in 1992 and contains the majority of the original members.

Their ages range from 35 to 55 years of age.

The majority of Members are long term employees who have been continuously employed for over ten years.

The workplace status designations of the members range from mid-level managers, to clerical worker, shop steward, Occupational Health & Safety Officer, contracted Vocational Consultant, labour and management Negotiation Committee Members, Recording Secretary and Human Resources Officer. This appears to be a diverse and well integrated workplace-based group.

The average length of membership with this group is 2.5 years.

The method most often used to enter this group is by invitation from an existing group member. This is interesting because in many work environments members are appointed to health services committees.

We have identified tentative trends that we are calling "themes". These themes are generalizations of the opinions that were reported by respondents. The difficulty with correlating and summarizing this information is that the data is rarely definitive. Our respondents appeared to report a range of opinions rather than an either/or outcome or event. Since this is the nature of our collected data, we chose to honestly report this occurrence and attempt to give you a sense or a generalization. We did not expect or anticipate this situation.

The following statements are themes relating to the accommodation service process that is directed by the Rehabilitation Committee. We shall be speaking about ranges of opinion and identifying a frequency or majority occurrence. Where feasible and relevant we shall qualify our themes.

We chose to survey for a majority or consensus opinion among the group members that we interviewed. The uniformity of agreement about roles, agendas, tasks, activities and outcomes may be used as indicators of the social cohesion within this workplace-based group. We believe that the greater or more uniform is the consensus then the more cohesive the group. The following themes appear to support our belief that the Rehabilitation Committee Members enjoy observable social cohesion as reflected by the reported similarity and uniformity of opinions about group structure and processes.

THEMES

All interviewees stated that they operated within more than one primary role in their Committee. The stated Member roles included Advisors, Negotiators, Communicators, Negotiators and Service Providers. Interestingly, none of the respondents indicated or stated that their workplace status determined their

roles in this service group. The most often identified role was that of Communicator. We believe that Committee Members accepted the role of group representative and supported communication to their co-workers about Committee activities and decisions. This appears to be very effective when you consider the outcomes and expenditures.

We created a list of potential "agendas" for committee members. By agenda we mean the collection of beliefs and values that a member may use to function within the Rehabilitation Committee. We also included the option to combine agendas or state another agenda such as a personal or philosophical one. Please refer to the Information Interview Format for Service Group Members in the Appendix.

The most often selected agenda was that of a Co-Worker Agenda. This means that the interests and needs of the health affected co-worker is the priority consideration by most of the respondents. The consensus opinion about this agenda is that the affected co-worker should be retained in the workplace through negotiated accommodation. One respondent indicated a secondary agenda that we describe as a "devils advocate". This member intentionally challenged the group position on planning and decisions as a method of quality assurance. This is acceptable behaviour in the Rehabilitation Committee.

PREFERENCES

We included four questions to gauge the social environment of the group according to the likes and dislikes of Rehabilitation Committee Member Respondents. This is also an indicator of social cohesion within this service group.

All interviewees liked the services and method of the delivery of services by the Rehabilitation Committee. They appeared to share a focus on action and outcomes. The Committee formally meets on a monthly basis. Members consult and implement group decisions on a more informal basis within their local worksettings.

The interviewed Members disclosed diverse dislikes and two did not have any negative opinions about any aspect or activity of the Rehabilitation Committee. We could not identify any theme or frequency of response by respondents that would indicate a majority negative or unfavourable opinion.

All interviewed Members stated that they would accept services and become service recipients of their group. This is the strongest indicator that there is a significant level of social cohesion within this service group. We would be intrigued by any refusal to accept assistance from a health services group in which you are a former or current member.

GROUP PROCESSES

The next series of questions were intended to be used to determine how the Rehabilitation Committee functions as a services group. We wanted to generate a picture of the internal workings of the collective. Please refer to the Interview Format for clarification.

The majority of the interviewed Members disclosed that their service group is "open". They believe that any co-worker or interested party is welcome to attend and monitor the meetings of their Committee. This is confirmed by following questions in which the Members disclosed that this service group is best described as "open" to input from non-group co-workers and interested parties. To further confirm this majority opinion, two Workers with Disabilities Staff Members regularly attend the Committee monthly meetings. We also enjoy clearance and access to co-workers in the Corporation of the District of Saanich. The interviewed Members report that decisions and planning within their service group is achieved by consensus. They believe that all Committee Members agree or disagree on an issue or agenda item and can do so without sanctioning or negative consequences. There appears to be an overall equality and sense of a democratic social environment within the service group.

Significantly, all five Committee Members disclosed that they would remain group members for the indefinite future. This frequency of satisfaction and support for the activities of the Rehabilitation Committee confirms our opinion about social cohesion. The reported majority opinions by Committee Members and unanimous commitment to the group are indicators of cohesion.

Our final question was intended to open the interview to freer comment and input from the participating Committee Members. We asked if there was anything that we did not ask or that we should know about the Rehabilitation Committee. Again, we received diverse comments that were individual and difficult to categorize as majority opinion. The only frequent comment was that Committee Members believe that non-group co-workers could benefit by a better understanding of Committee activities, decision-making constraints and group driven outcomes. The implication is that improvements in service group function and outcomes may occur if there was better co-worker support for the group. We agree and trust that this report and our findings will raise the profile of the Rehabilitation Committee in their workplace.

In summary, the Rehabilitation Committee appears to do a very good job of accommodating co-workers in the Corporation of the District of Saanich. They enjoy annual renewable funding and deliver affordable assistance that leads to practical outcomes. Co-workers remain employed and, to date, have not been terminated by default or design in this workplace. We consider this to be extraordinary.

SAANICH SERVICE RECIPIENT THEMES

Introduction

We interviewed five current and recent employees for this workplace. We shall not disclose their identities or workplace status to maintain confidentiality. We contacted these interviewees with the assistance of Rehabilitation Committee Members. The Members provided us with a list of volunteers from their caseload who were agreeable to being interviewed. We then contacted all the volunteers to maintain confidentiality. To our knowledge, the members of the Rehabilitation Committee do not know who participated in our interviews. Further, the interviewed service recipients do not know each other. The sensitive nature of this situation and the difficulties with recruiting interviewees necessitated this method.

We are delivering our opinion about the experiences of the respondents based on informational interviews. We attempted to standardize the format and questions by using a checklist entitled the Informational Interview Format For Individual Service Recipients. This list is in the Appendix. You are welcome to interpret our information as a theme or frequency of outcome. We shall also offer our opinions about the accommodation service process based on the responses of health affected interviewees.

SERVICE RECIPIENT PROFILE INFORMATION (based on findings from five volunteer, service recipients)

The majority of service respondents are male. The range of ages for this group is from 45 to over 55 years of age. All the respondents have been or had been employed for longer than 10 years. At the time of the interview, two respondents were employed in an original or preferred position. Two of the remaining employees were out of the workplace and one person was in temporary, sheltered employment within Saanich. The latter is an assigned job or position that is defined by the collective agreement and serves as a temporary light duties position. This assigned position can be characterized as a non-modified job. A measure of flexibility is accepted in this position in the form of an option to configure some tasks and performance of duties according to the personal or individual skills, abilities or health needs of the placed co-worker or employee. For example, if a co-worker in this sheltered position has lifting restrictions then he/she is not expected to move heavy objects. Further, the two non-sheltered respondents believe that they did have some input or the option to alter or modify their positions. We consider this input and option to be prime indicators of a viable accommodation process.

The accommodation process is defined as:

The physical renovation, restructuring or alteration of job tasks, schedules and work environments to "fit" or match the range of abilities of a co-worker with a chronic illness/injury or disability. These changes are based on medical/legal opinion and are to be confirmed through coordinated trial and error experiment on the part of the co-worker with chronic illness/injury or disability. The plan is to "build" the job to fit the person.

The majority of respondents reported a physical health issue as the primary or principal category of their illness, injury or disability. All the reported health issues were long term and involved medical treatment and support. These physical health issues were reported as being diagnosed by medical practitioners who confirmed these conditions in written letters and reports. We believe that all the respondents were credible candidates for accommodation-related assistance and services.

ACCOMMODATION SERVICE PROCESS OVERVIEW

The following is a generalization about the accommodation experiences and process as reported by five respondents. The participating respondents volunteered to discuss their experiences. The respondents represent the available interview sample for this report. The sensitive nature of the information and character or quality of their experience may yield a biased and a skewed sample. We acknowledge this possibility and elected to report our qualitative survey results as the best available information. We believe that our findings and themes will be of interest to co-workers who are striving to setup accommodation services in their workplaces. This information may be useful to a variety of interested parties.

The following is a series of summary paragraphs based on the questions in our Informational Interview Format For Individual Service Recipients in the Appendix. We are intent on giving you a sense of an accommodation experience from the point of view of the recipient. Our summary paragraphs follow the order of questions in our checklisted interview format. We shall include interview questions in bold font preceding each summary paragraph for your consideration.

Did you ask for assistance to continue being employed in your workplace ?

All five respondents contacted a range of co-workers for accommodation assistance. The minimum was 1 and the maximum was 4 contacted co-workers. There is a joint labour-management format for accommodation initiatives in this workplace that may expand the range of potential contact people. All respondents requested assistance from a management representative who was based in their local worksetting. A union representative was contacted by three of the five respondents during the initial or first request for accommodation assistance. A union representative was involved in the delivery of services for all the respondents. The remaining two categories of contacted co-workers are 1) Rehabilitation Consultant and 2) Health Services Manager. Both of these positions are occupied by a long term Rehabilitation Committee Member.

The range and variety of reported contacts suggests that health affected co-workers in Saanich have a choice about whom they contact for assistance. In contrast, many Victoria area workplaces have a designated contact person such as a Human Resources Staff Person or a Claims Manager. This role may also be co-opted by Occupational Health Nurses and Employee Services Staff. Further, a contracted Rehabilitation Consultant may serve as an initial contact and resource worker. We consider the enhanced range of contacts in Saanich to be an indicator of social cohesion in this workplace. Further, the unusually large range of potential service providers as contacts may encourage co-workers to come forward for assistance.

Were you served by a group of your co-workers ?

Three respondents reported that the Rehabilitation Committee managed or otherwise facilitated their request for accommodation service in this workplace. Our records indicate that all the respondents were assisted by members of the Rehabilitation Committee. This discrepancy may be related to a lack of knowledge about the activities and mandate of this service group by co-workers in Saanich. Four respondents disclosed that they were assisted by a resident Occupational, Health and Safety Committee Member. This is a credible opinion because Rehabilitation Committee Members also serve as OH&S Committee Members. There is cross-over and redundancy among service providers. Again this overlap may promote or facilitate requests for assistance from health affected co-workers.

What services did you receive from co-workers, group members or anyone connected to your workplace ?

All respondents reported that they did receive a range of four to five of the seven listed available conventional rehabilitation services that we believe are common in Victoria area workplaces. These services are 1) vocational counselling, 2) workplace assessments, 3) work hardening/readiness programs, 4) re-training courses (off-site), 5) Short term and Long Term Disability income benefits, 6) alternate employment placements and 7) return to work programs. We also included an eighth category, Other, to encourage respondents to identify unanticipated service options. Two respondents did identify psychiatric and psychological counselling as an extraordinary service option. Further, three respondents indicated that they received extraordinary service options such as recreational passes to attend fitness training programs.

All respondents used combinations of short term and long term disability benefits payments to minimize the financial hardship associated with chronic health issues and problems. Their personal estimates of the total amount of funds that they used ranged from **\$ 13, 000. to 34,500.** for a one to two year term of accommodation service. A portion of this estimated expenditure was for financial assistance in the form of sick leave and sick bank benefits payments that we consider short term disability assistance. Health affected co-workers in Saanich

have a five vehicle or income benefits model. These income benefits options are "integrated" such that a worker can draw on each vehicle as the term of their need for assistance increases. For example, I may request 1) Sick Leave as an initial short term benefit. As I exhaust allocated funds, I then request 2) Sick Bank Benefits. As my health issue becomes better understood and my needs are subsequently assessed, I can trigger longer term benefits such as 3) Long Term Disability. A co-worker in Saanich can also access 4) Workers Compensation income benefits and 5) receive a top-up of these benefits to 100 % of their current wage or salary. Saanich can be characterized as having a commendable variety and range of income benefits supports for a health affected co-worker.

Would you estimate how much money was spent on assistance, benefits and services as part of your rehabilitation or therapy package ?

As mentioned we asked respondents for estimates of the costs of services and income benefits that they had received. These estimates also included Long Term Disability Benefits and WCB income benefits. Please refer to the summary statements about direct and indirect costs for service recipients at the end of this report. Our researched figures indicate that the respondents were credible in their estimates of the costs associated with their accommodation services at Saanich. This knowledge among respondents is an indicator that service recipients may be viewed as responsible consumers. We noted that respondents cooperated with decision-makers in their workplace and were aware of the costs of delivered services. In our opinion, they did not mis-use income benefits or otherwise manipulate service providers for personal gain. For example, no service recipients were placed in a position that afforded better income when compared to their previous job. We believe that there were no deals or significant advantages for co-workers who disclose a health issue or disability that affects their workplace performance, access and potential reliability.

The following discussion will support our belief that service recipients would prefer more input into decision making and a wider range of service options. This may be a predictable situation as service recipients become more educated and aware of accommodation services in their workplaces. The implication is that health affected co-workers believe that they should be more included in their service process.

What services would you want if you had another chance at keeping your original job, returning to work or continuing your employment in your workplace?

We listed 8 extra-ordinary service options that are not commonly available in Victoria area workplaces Please refer to question # 10 in the Interview Format in our Appendix.

All respondents reported a request to work in a sheltered or designated job for chronically health affected workers. Among eight suggested examples of accommodation services, the option to work in a sheltered job was most often selected. By "sheltered" we mean a stable, long term position that is designed for a health affected or disabled worker. This is in contrast to the previously mentioned sheltered light duties position that is available in Saanich. The more permanent sheltered job is assigned to the worker and is a collection of tasks that he/she can competently perform. The high frequency of request for this option suggests that all respondents preferred to continue working at Saanich.

The next most frequently requested extra-ordinary or non-conventional service option was for a job coach. This could be a trained co-worker or non-resident service provider who delivered supported employment assistance according to a service plan. The goal is for the affected worker and coach to cooperatively learn and perform tasks associated with an assigned position or a return to the worker's original position. Over a pre-determined time frame the coach fades and clears the affected worker to assume more if not all the tasks. Service respondents reported that this method of resuming or returning to work would have reduced their emotional hardship and distress. The majority of respondents believe that they incurred their health issues in their jobs and worksettings. A job coach and clearance to re-learn job related tasks may have eased their concerns about re-injury and aggravation of long term health conditions associated with any return to work.

In addition to job coaching and sheltered employment, we listed graduated return to work, vocational counselling/job assessments, job site adaptations, income benefits allocated to subsidize partial employment, job sharing and Other. The latter is to give respondents the choice to identify any non-listed service options. The most frequently requested "Other" service option was for the delivery of information sessions to immediately affected co-workers who would share the worksetting with the health affected co-worker. The intent of these sessions would be to inform and promote tolerance of the accommodation service process. Three of the five respondents reported negative attitudes and verbal comments from non-health affected co-workers about the delivered assistance and accommodation effort. The message may be that health affected workers wanted co-worker support in the form of tolerance and acceptance of accommodation related assistance.

The next most frequently requested service option was to use allocated funding and income benefits as "top-ups" or wage subsidies. The idea is for health affected co-workers to maintain employment on a part-time basis and use allocated monies to ensure a continuing, viable take home wage. This minimizes the financial hardship of the affected co-worker, ensures that he/she can continue working and creates a learning opportunity. Ideally, the very negative stress and disruption associated with reporting a health issue can be decreased and controlled when very real concerns about income and employment are addressed. We believe that when a health affected worker understands that they

are not job threatened and will maintain employment security; then he/she can concentrate on recovery and achieving stable health. They can learn to accommodate their health issues without the additional distress of pending job termination and financial hardship. In accordance with this line of reasoning, respondents also opted for flexible job sharing schemes and schedules. Again these service options would require and represent clearance and increased input for health affected co-workers in decision-making and job setup.

What problems, concerns or issues do you have about your accommodation experience(s) in your workplace ?

By way of confirmation, four of five respondents specifically reported that they wanted more involvement in decision making about their return to work and their offered job placements. None of the five respondents reported problems with their accommodation service experience. They did have concerns such as personal guilt about collected income benefits. Respondents also reported a lack of continuity of communication among involved parties. The latter occurred when decision makers in their immediate worksetting did not understand the service plans and goals of the respondent and the Members of the Rehabilitation Committee. Three respondents reported a need for more sharing of information between involved parties to promote better cooperation.

Do you believe that you received adequate assistance from designated individuals and/or service group members in your workplace ?

All five respondents reported that they believed that they received adequate assistance and were satisfied with the outcomes from their accommodation service process. The message is that the process is inherently sound and viable. The delivery of assistance and the means of cooperation among involved parties could be enhanced. The way to enhance cooperation and delivery may be to include health affected workers in their service process while also securing the support of non-health affected co-workers.

The final set of questions are designed to confirm and check the uniformity of responses of the five respondents. If there is an incongruity or inconsistency in the pattern of responses then the reliability of the respondent and interviewer can be challenged. One question is included to collect opinions about the direct and indirect costs of the entire accommodation service process from the point of view of the service recipient. The range of costs of delivered services was discussed earlier in this report.

Do you believe that you are capable of working in your last or previous position in your workplace?

One out of five respondents disclosed an opinion that they were capable and willing to work in their original positions in their current worksetting. This person did return to their original or pre-disclosure position in Saanich. A second respondent is currently working in a full-time alternate position and reports that he/she could not retain their original or pre-disclosure job. The remaining three respondents are divided into two groups. All three are continuing to receive long term disability income benefits. One person is working in a temporary sheltered position in a job sharing scheme with another health affected co-worker. This worker's partial wage income is deducted from her/his long term disability income benefits. Therefore there is no wage subsidy or top up for this respondent. The longer term outcome for this worker is not yet determined. The remaining two respondents are no longer employed in Saanich and are receiving long term income benefits until they retire at age 65. These latter respondents have the option, in writing, to return to work pending a change in their health status. In effect they remain connected to their workplace by receiving income benefits and the option to attempt to return to employment. We consider this situation to be remarkable and extraordinary. As mentioned all five respondents agreed with the outcomes from their accommodation service process.

We asked two final questions as consistency checks about the respondent's reported beliefs that they were adequately assisted during their accommodation experiences. The three respondents who are receiving long term income benefits believe that they could not perform the majority of and core tasks in their original or pre-disclosure jobs. They believe that the impact of their health issues would decrease their performance of tasks. They opted for sheltered employment and the option to decide which tasks and schedule are suitable for them. The remaining two respondents were asked to identify any and all tasks that they believed they could perform in their **original** jobs. One respondent had returned to her/his original position. The other respondent identified sufficient tasks to create partial employment in her/his original position and worksetting. We believe that given a choice, health affected co-workers at Saanich may benefit from clearance to participate in the modification of tasks and schedule of performance of tasks in their original or pre-disclosure positions. In effect they would operate from a peer relationship with service providers and involved parties. This would represent a preferred arrangement. This suggests a theme among the respondents of **self-directed accommodation**. When all five respondents reported a desire for more input, better communication of relevant information, better cooperation among involved parties and inclusion in decision making; then we can make a case for testing self-directed accommodation. We can also make a case for enhanced use of co-worker support and involvement based on the frequency of request for better understanding and tolerance among non-health affected co-workers.

The advantages for involved parties may be tangible and measurable. Consider that seniority becomes a non-issue when serving a health affected co-worker to retain their original jobs because they already occupy this position. As well, workplace disruptions are minimized due to localized service delivery in the

health affected person's original worksetting. Further, non-health affected co-workers may be more receptive to accepting and tolerating modifications to a position when they share the work environment with the participating worker. Recall that all respondents had 10 or more years of continuous employment in a workplace. They have established themselves as part of the social network of their workplaces. Their status is long term and established. This situation and potential social cohesion may be a strength and an asset to the accommodation service process.

In summary, we believe that the co-workers and Rehabilitation Committee Members of the Corporation of the District of Saanich do a commendable job of accommodation of health affected co-workers. Their record speaks for itself. Our report and the comments of respondents should not be viewed as anything but an affirmation of their work in Saanich. The suggested options of greater inclusion of health affected co-workers and non-affected co-workers is our interpretation of responses. These are themes that Saanich workers may want to consider. Overall, we believe that the Rehabilitation Committee, Saanich Co-workers and involved parties may represent a British Columbian approach to accommodation that could work anywhere in our country. The outcomes and costs appear to be more than affordable in the short and long term.

SERVICE RECIPIENT DATA FORMAT

TOTAL CASES (1992-TO-PRESENT).....35

**CASES
RESOLVED.....25**

**CASES
UNRESOLVED.....10**

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RESOLVED CASE OUTCOMES: (25-recipients who are no longer served and/or have self-terminated)

**RETAINED EMPLOYMENT IN THEIR PRE-SERVICE POSITIONS
AND PRE-SERVICE
WORKSETTINGS.....9**

RETAINED EMPLOYMENT IN ALTERNATE POSITIONS, DIFFERENT WORKSETTINGS.....8

TERMINATED THROUGH PERSONAL CHOICE, RETIREMENT.....8

N.B. there are no records of involuntary terminations related to employee health.

TOTAL.....25

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UNRESOLVED CASE OUTCOMES: (10 still receiving service or no longer present in the work environment)

SERVICE RECIPIENT IS OUT OF THE WORKPLACE.....10

SERVICE RECIPIENT RECEIVING OFF-SITE THERAPY.....4 (work hardening, vocational assessment and counselling, physiotherapy)

SERVICE RECIPIENT RECEIVING OTHER ASSISTANCE.....10

(off-site training courses, psychological counselling, placement in another organization)

TOTAL.....10

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22 OUT OF 25 C.D.S. REHABILITATION COMMITTEE CASES WERE RESOLVED WITHIN ONE YEAR. THIS REPRESENTS AN ANNUAL RESOLUTION RATE OF.....88%

3 OUT OF 25 C.D.S. REHABILITATION COMMITTEE CASES WERE RESOLVED WITHIN TWO YEARS. THIS REPRESENTS A BI-ANNUAL RESOLUTION RATE OF.....12%

TOTAL RESOLUTION PERCENTAGE FOR 25 C.D.S. CO-WORKERS.....100%

10 OUT OF 10 C.D.S. CO-WORKERS ARE CURRENTLY UNRESOLVED CASES BEFORE THE REHABILITATION COMMITTEE.

3 OUT OF 10 REHABILITATION COMMITTEE CASES HAVE BEEN RECEIVING ASSISTANCE FOR TWO YEARS. THIS REPRESENTS AN ACTIVE RATE PERCENTAGE OF.....30%

7 OUT OF 10 REHABILITATION COMMITTEE CASES HAVE BEEN RECEIVING ASSISTANCE FOR ONE YEAR AS OF DECEMBER 1995. THIS REPRESENTS AN ACTIVE RATE PERCENTAGE OF70%

TOTAL NON-RESOLUTION PERCENTAGE FOR 10 C.D.S. CO-WORKERS.....100%

APPROXIMATE AVERAGE LENGTH OF SERVICE PER RESOLVED CASE OUTCOME.....1.15 YEARS

APPROXIMATE AVERAGE LENGTH OF SERVICE PER UNRESOLVED CASE OUTCOME...1.3 YEARS

APPROXIMATE AVERAGE LENGTH OF SERVICE FOR ALL RECIPIENTS.....1.17 YEARS

(resolved and unresolved case outcomes)

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AVERAGE DIRECT COST PER RECIPIENT PAID BY THE REHABILITATION COMMITTEE (based on 20 cases).....1708.89

(includes Rehabilitation Committee contracted programs, sponsorship for education, passes for service recipients)

AVERAGE DIRECT COST PER RECIPIENT AS PAID BY THE SAANICH EMPLOYER (based on 10 cases).....11,475.07

(Sick Bank Benefits, Sick Leave Benefits, Long Term Disability Benefits and WCB Benefits-employer portion)

AVERAGE INDIRECT COST PER RECIPIENT AS PAID BY THE SAANICH EMPLOYER (based on 10 cases).....13,690.17

(This indirect cost is exclusively the WCB Benefits received by a health affected workers among our sample. WCB Benefits are "integrated" in accounting formats. WCB pays the major portion and the employer covers the difference to 100% of a service recipients normal wages. The former cost is "indirect" and is accounted for in the above category. The latter portion of the integrated cost is a direct cost that is included in the figures in the previous category on direct costs)

N.B. costs figures are based on records for 1993, 1994 and 1995. We elected to frame direct/indirect costs as averages for 10 cases because we are referring to a total of costs for a three year period. All 10 cases involved WCB indirect and direct costs, whereas the remaining caseload of 10 did not incur WCB assistance. This difference in delivered income benefits is expected and consistent with the individualized nature of accommodation. The figures for the above categories should be considered as indications of costs for a selected sample of service recipients. Not all service recipients received all five categories of income benefits. We therefore elected to present 10 cases where all service recipients received WCB income benefits and a subsequent mix of four other income benefits to give you a sense of both types of costs. This is the best available data from the Saanich Payroll Staff and we are grateful for their assistance.

INTERPRETATIONS:

These costs are for a range of service or term of assistance from one-to-two years. They represent a maximum average such that costs for all service recipients across five income benefits categories may be lower.

Employer direct costs exceed indirect costs among our sample of ten service recipients. This is not the case for all service recipients in our sample. We did not account for premium payments to WCB because that information was not available. Premium costs for WCB and LTD would increase direct employer costs.

Adding Rehabilitation Committee direct costs to direct employer paid costs would not be accurate due to the differing sizes of samples.

Overall the Corporation of the District of Saanich, based on the best available data, presents a very affordable picture of accommodation in this workplace. When you consider that the majority of service recipients 1) retained employment, 2) were served within a maximum two year term, 3) remained in their current/original jobs as often as they secured alternate employment, 4) tended to disclose satisfaction with their accommodation service experience, and 5) achieved these outcomes for average direct costs that are currently affordable; then Saanich is to be commended.

We believe that the service recipient group of co-workers can be categorized as physically health affected.

We have no records of any involuntary termination, layoff or cash-out for any co-workers served by the Rehabilitation Committee.

***RETURN TO WORK/EARLY ACCOMMODATION
AND SUPPORT COMMITTEE
FOR THE UNIVERSITY OF VICTORIA
QUALITATIVE RESEARCH REPORT***

INTRODUCTION

Our data collection plan for the **Research Phase** of our **Workplan** for this workplace is divided into two parts. We designed a written survey to serve as a quantitative research vehicle. We also designed two standardized checklists to use during informational interviews for two segments of a co-worker population. These checklists are the collection formats for the qualitative research portion of our study. The following report is based on the disclosures and opinion of University of Victoria Employees. We interviewed five members of the joint labour Return to Work and Early Accommodation and Support Committee and six chronically health affected co-workers. The latter tended to be former and current employees. They tended to have been assisted by Representatives from their Union Locals rather than an on-site service group members or joint labour-management rehabilitation committee. In one instance a co-worker was assisted solely by their worksetting-based manager and co-workers.

The following summary is our interpretation of the developing joint labour-labour service group members' agendas, roles, general profile and overview of the group service process. We shall refer to this service group as the RTW/EAS Committee. This summary is necessarily less thorough than the materials for the Corporation of the District of Saanich. We did not enjoy unrestricted access to the

University work environment. We did use the same interview checklists and methods for both host sites.

We interviewed service group members, interviewed health affected co-workers and came to a simple conclusion. The CUPE Local 917 **Return to Work** and CUPE Local 951 **Early Accommodation and Support Committees** have worked diligently to research and deliver assistance to co-workers since 1994. They are to be commended for taking on the responsibility for the welfare and employment of health affected co-workers. Both groups amalgamated to form a joint labour-labour service group in October of 1995. This recent effort has meant that we can monitor and record the development of their service group as part of our study. The presence of a joint labour service group is unprecedented and atypical in our experience.

In our opinion, there is no recorded, viable accommodation service model or delivery system for the University of Victoria Workplace. There has been the recent acceptance of accommodation language in the collective agreements for CUPE Locals 917 and 951. The language has not been tested nor has any formal accommodation services program been implemented at the time of the release of this report.

We shall present a general profile of five Members from both Committees. This is a detailed overview of demographic factors and subjective variables for this group. We have also delivered a similar overview for the Rehabilitation Committee in the Corporation of the District of Saanich in a separate report. The latter report precedes this portion of our manual. A comparison of both service groups will also be presented for your consideration.

RTW/EAS COMMITTEE MEMBERS GENERAL PROFILE INFORMATION

The five member service group consists of three men and two women.

The group was formed in 1995 and contains the original members.

Their ages range from 35 to 60 years of age.

The majority of Members are long term employees who have been continuously employed for over ten years. Two Members have been employed for over 16 years.

The workplace status designations of the members can be divided into two categories of blue collar and white collar workers. This means that the service group members can also be divided into outside and inside workers according to their worksettings. Blue collar workers are exclusively employed in out-of-doors worksettings. White collar workers are employed within a built environment or inside worksetting.

The majority of RTW/EAS Committee Members are blue collar workers. The occupational and union local status-designations for this service group consists of shop steward, Occupational Health & Safety Committee Member, labour-based Negotiation Committee Members, Clerical Workers and Tradespersons. This appears to be a cohesive workplace-based group in that all the members are affiliated within an umbrella union network-the Canadian Union of Public Employees.

The average length of membership with this group is four months in the joint labour-labour format. The Return to Work portion of the joint committee has been in operation for one year. The service group members within the EAS Committee have been assisting co-workers for approximately two years. Each labour group has separately assisted their union local members within their worksettings. This situation may change as the RTW/EAS Committee begins serving co-workers within a joint group structure.

The method most often used to enter this group is by invitation from an existing group member. This is interesting because in many work environments members are appointed to health services committees.

We have identified tentative trends that we are calling "themes". These themes are generalizations of the opinions that were reported by respondents. The difficulty with correlating and summarizing this information is that the data is rarely definitive. Our respondents appeared to report a range of opinions rather than an either/or outcome or event. Since this is the nature of our collected data, we chose to honestly report this occurrence and attempt to give you a sense or a generalization. We did not expect or anticipate this situation.

The following statements are themes relating to the accommodation service process that is directed by the RTW/EAS Committee. We shall be speaking about ranges of opinion and identifying a frequency or majority occurrence. Where feasible and relevant we shall qualify our themes.

We chose to survey for a majority or consensus opinion among the group members that we interviewed. The uniformity of agreement about roles, agendas, tasks, activities and outcomes may be used as indicators of the social cohesion within this workplace-based group. We believe that the greater or more uniform is the consensus then the more cohesive the group. The following themes appear to support our belief that the RTW/EASC Members are developing observable social cohesion as reflected by the reported similarity and uniformity of opinions about group structure and processes. We believe that they are not yet socially cohesive to the extent observed among the Saanich Rehabilitation Committee Members.

THEMES

All interviewees stated that they are currently operating as Service Providers within their separate and joint labour Committees. Please note the Members retain a primary identity and affiliation with either the RTW or EAS Committees. The integration of both Committees into a joint labour format or structure is still occurring. The stated joint and separate Committee Member roles included Generalist, Negotiators, Communicators; and, Service Providers. Interestingly, none of the respondents indicated or stated that their workplace status determined their roles in this service group. Briefly, a Generalist performs all and any tasks, makes decisions and participates in group processes from a wide range of roles. He/she literally does it all. Negotiators are the bargainers and deal-makers who secure clearances and arrange transactions in their workplaces. Communicators distribute and record the business of the joint Committee. Service Providers are the action people who directly serve health affected co-workers.

The most often identified roles were Service Provider and Communicator. We believe that Committee Members may have accepted the role of service provider as a practical necessity. As stated we could not identify any formal accommodation service model, process or rehabilitation service model for this workplaces. The union local Committee Members appear to have voluntarily taken on the tasks and responsibilities to drive accommodation for health affected co-workers at the University of Victoria.

We created a list of potential "agendas" for RTW/EAS Committee Members. By agenda we mean the collection of beliefs and values that a member may use to function within the joint labour-labour committee format. We also included the option to combine agendas or state another agenda such as a personal or philosophical one. Please refer to the Informational Interview Format for Service Group Members in the Appendix.

The most often selected agenda was that of a ***Co-Worker Agenda***. This means that the interests and needs of the health affected co-worker is the priority consideration by most of the respondents. The consensus opinion about this agenda is that the affected co-worker should be retained in the workplace through negotiated accommodation. The second most frequently reported agenda was that of a ***Labour Agenda***. The focus for this ideological position is that of protection and maintenance of job security for the health affected co-worker. The difference is that the Labour Agenda tended to be specific to a co-workers union affiliation. In contrast, a Co-worker agenda tends to cross all group boundaries and distinctions.

PREFERENCES

We included four questions to gauge the social environment of the group according to the likes and dislikes of RTW/EAS Committee Member Respondents. This is also an indicator of social cohesion within this service group.

All interviewees liked the educational opportunities and potential direction of their joint labour-labour Committee. That direction is towards the implementation of a "made-in-the-University" accommodation service process. We identified a shared belief among Members that a formal accommodation process, resident service group and access to funding are being secured for University of Victoria Co-workers. Members also appeared to share a focus on action and outcomes. The Committee formally meets on an adhoc, semi-monthly basis. Members consult and implement group decisions on a more informal basis within their local worksettings.

The interviewed Committee Members disclosed dislikes that are consistent with a developing service group. The responses tended to focus on the perceived need for greater reliability and better communication within the joint RTW/EAS Committee. We believe that the existing group boundaries and division along union local affiliation may contribute to the shared concerns about contact and communication. We also note that these separations among Committee Members do not represent barriers or significant impediments to cooperation. What appears to occur is that information and goals are freely shared among Committee Members. A good example of this is that joint RTW/EAS Committee Members were instrumental in negotiating accommodation language clauses in their separate collective agreements. They used their pooled expertise to serve as Negotiators for their separate worksettings. We believe that this is a significant development for this workplace.

All interviewed Committee Members stated that they would accept services and become service recipients of their joint labour-labour group. This is the strongest indicator that there is a significant level of social cohesion within this service group. We would be intrigued by any refusal of assistance from a health services group in which you are a former or current member.

GROUP PROCESSES

The next series of questions were intended to be used to determine how the RTW/EAS Committee functions as a service group. We wanted to generate a picture of the internal workings of the collective. Please refer to the Informational Interview Format for clarification.

The majority of the interviewed Members disclosed that their service group is not yet an integrated body. Committee Members believe that their group is primarily labour driven and controlled. They believe that any co-worker or interested party is welcome to attend and monitor the meetings of their Committee. The difficulty is that the resident management group does not participate in service group activities. We believe that the exclusion of any and all naturally involved representatives from the University of Victoria management group is not intentional. This is confirmed by responses to questions in which the Members disclosed that this service group is best described as "open" to input from non-group co-workers and interested parties. To further confirm this majority

opinion, two Workers with Disabilities Staff Members regularly attend the Committee meetings to observe and monitor group development. We also enjoy access to co-workers in the University of Victoria through the Committee Members and both union local social networks. We believe that other decision makers are welcome to attend RTW/EAS Committee meetings and workplace-based activities such as information sessions for interested co-workers. Further, letters of invitation have been drafted and sent to management group decision makers to attend joint committee meetings and functions. To date no management group members have attended or participated in service group functions.

The interviewed Committee Members report a diversity of opinion about how their joint service group conducts planning and decision making. The most frequently reported opinion or belief is that decisions and planning are achieved within each separate union subgroup or local. Decision making appears to be accomplished through nominal leaders of each labour subgroup presenting a position on a service group issue. A group agreement is achieved through negotiation among the nominal leaders that results in a consensus decision. The process is democratic in that all members can speak to the issue in a joint labour-labour meeting. The decision making process is somewhat protracted due to the separation into two sub-groups. Consider that this is a developing service group, then the continuation of decision making along union local affiliation is consistent and historical. Group processes and decisions tend to continue according to precedent. We anticipate that the joint labour-labour format will evolve into a more integrated structure as more co-workers come forward for assistance and accommodation. We believe that Committee Members will work from their preferred co-worker agendas as they become more proficient as a workplace-based service group. If the management or employer group representatives accept invitations to participate then the RTW/EAS Committee may develop towards a joint labour-management format.

Significantly, all five Committee Members disclosed that they would remain group members for the indefinite future. This frequency of commitment and support for the activities of their joint Committee supports our opinion about social cohesion. The reported opinions by Committee Members and unanimous commitment to the group are indicators of social cohesion. We expect that this "connectedness" will be enhanced as this service group becomes more established and gains experience in accommodation for their co-workers.

Our final question was intended to open the interview to freer comment and input from the participating Committee Members. We asked if there was anything that we did not ask or that we should know about the RTW/EAS Committee. Again, we received diverse comments that were individual and difficult to categorize as majority opinion. The most supportable majority opinion was that this service group is a "good start". The Committee Members appear to be positive and optimistic that accommodation and job retention for health affected co-workers will be enhanced. There is a sense of moving from an

informal and undefined service process to a more formal and potentially productive program.

In summary, the RTW/EAS Committee appears to be in a learning stage about how to accommodate co-workers in the University of Victoria. The previous work done in support of union local members by their local representatives is commendable. The action to move accommodation to a larger forum and drive the process through a joint committee may yield better outcomes. The following is an overview of the accommodation service process at the University of Victoria from the perspective of seven chronically health affected co-workers from both CUPE Locals.

UNIVERSITY OF VICTORIA SERVICE RECIPIENT THEMES

Introduction

We interviewed six current and former employees for this workplace. We shall not disclose their identities or workplace status to maintain confidentiality. Since we believe that there is no formal, written accommodation program; we do not want to contribute to any negative consequences for the interviewed employees. We are not alleging any wrongdoing or lack of effort to accommodate at this workplace. We are delivering our opinion about the experiences of the respondents. You are welcome to interpret our information as a theme or frequency of outcome. We shall also offer our opinions about the accommodation service process based on the responses of health affected interviewees.

We contacted these interviewees with the assistance of the RTW/EAS Committee Members. They provided us with lists of volunteer co-workers. We then contacted all potential interviewees such that RTW/EAS Committee Members do not know the identities of the interviewees. Further the interviewees do not know each other's identities. The sensitive nature of this situation and the difficulties with recruiting interviewees necessitated this method. We employed a similar methodology for the sample of respondents from the Corporation of the District of Saanich.

We are delivering our opinion about the experiences of the respondents based on informational interviews. We attempted to standardize the format and questions by using a checklist entitled the Informational Interview Format For Individual Service Recipients.

SERVICE RECIPIENT PROFILE INFORMATION

The majority of service respondents are female. The range of ages for this group from 35 to over 55 years of age. All the respondents have been or had been employed for longer than 10 years. Three respondents are employed in an original or alternate position while the remaining employees were either out of the workplace or placed in a non-preferred, assigned position. The latter is a pre-

determined, standardized job or position that is defined by the collective agreement and assigned by a workplace-based management group member. The assigned positions can be characterized as non-modified or unaltered according to the personal or individual skills, abilities or health needs of the placed co-worker or employee. Respondents in assigned positions believe that they did not have significant input or the option to alter or modify their assigned positions. The three respondents in original and/or alternate positions reported that they tended to drive or self-facilitate their accommodation process. This is understandable due to the protracted length of time involved and the lack of a formal service program in this workplace. The three apparently accommodated respondents tended to be assertive, informed about their health needs and established employees. They enjoyed a high profile in their local worksettings. The three non-accommodated co-workers appeared to also be assertive and informed. We could not identify any discernable differences in status, skills or personal qualities that may serve as indicators for the different outcomes for these co-workers. The crucial difference may be in the relationships between each respondent and their immediate supervisors. We believe that the accommodated co-workers enjoyed support from their immediate local managers and co-workers. The option to deliver input to a decision-maker in a work environment is a prime indicator of a viable accommodation process. We shall deliver more information on this theme during the remainder of our report.

The accommodation process is defined as:

the physical renovation, restructuring or alteration of job tasks, schedules and work environments to "fit" or match the range of abilities of a co-worker with a chronic illness/injury or disability. These changes are based on medical/legal opinion and are to be confirmed through coordinated trial and error experiment on the part of the co-worker with chronic illness/injury or disability. The plan is to "build" the job to fit the person.

The majority of respondents reported a physical health issue as the primary or principal category of their illness, injury or disability. All the reported health issues were long term and involved medical treatment and support. These physical health issues were reported as being diagnosed by medical practitioners who confirmed these conditions in written letters and reports. We believe that all six respondents are credible and competent in their understanding of their reported health issues.

ACCOMMODATION SERVICE PROCESS OVERVIEW

The following is a generalization about the accommodation experiences and process as reported by these six respondents. They represent the available interview sample for this report. The sensitive nature of the information and character or quality of their experience may be viewed as biased and to have yielded a skewed sample. We acknowledge this possibility and elected to report our qualitative survey results as the best available information. We believe that

our findings and themes will be of interest to co-workers who are striving to setup accommodation services in their workplaces. This information may be useful to a variety of interested parties.

The following is a series of summary paragraphs based on the questions in our Informational Interview Format For Individual Service Recipients in the Appendix. We are intent on giving you a sense of an accommodation experience from the point of view of the service recipient. Our summary paragraphs follow the order of questions in our checklisted interview format. We shall include interview questions in bold font preceding each summary paragraph for your consideration.

Did you ask for assistance to continue being employed in your workplace ?

All respondents contacted a range of co-workers for accommodation assistance. The minimum was 2 and the maximum was 4 contacted co-workers. All respondents requested assistance from a management representative who was based in their local worksetting. A union representative was contacted by three of the six respondents during the initial or first request for accommodation assistance. This is consistent with a union presence that has been available for 1-to-2 years. We are considering and discussing a three to ten year window of duration as the time frame of accommodation experiences reported by our respondents. The limited Union involvement in this process for three respondents is understandable.

None of the respondents reported that a designated, resident service group managed or otherwise facilitated their request for accommodation service in this workplace. This confirms our opinion that there has not a resident service group that drives or facilitates accommodation. Individual co-workers appear to deliver support services that may be characterized as limited. For example, union representatives did file grievances and make formal requests for accommodation. Three respondents reported that these requests were not acknowledged or implemented by decision makers in this workplace. Three respondents, as mentioned, facilitated their own service process within the environment of their local worksettings. Three interviewees reported their belief that they were not accommodated as per their requests.

Were you served by a group of your co-workers ?

No respondents identified any resident service group that assisted them in their accommodation service process.

What service did you receive from co-workers, group members or anyone connected to your workplace ?

Three respondents reported that they did not receive any or all of the seven listed conventional rehabilitation services that we believe are common in Victoria area workplaces. These services are 1) vocational counselling, 2) workplace assessments, 3) work hardening/readiness programs, 4) re-training courses (off-site), 5) Short term and Long Term Disability income benefits, 6) alternate employment placements and 7) Return to Work Programs. We also include an eighth category, Other, to encourage respondents to identify unanticipated service options. For example, two respondents funded their own services through their Physician. Both made use of an off-site service agency. One respondent as mentioned accepted or arranged for an alternate employment placement.

Under the Other category of services, three respondents used Sick Bank Benefits to facilitate accommodation by leaving their worksettings for varying periods of time. We do not consider *illness related income benefits* as equivalent to Short Term Disability income benefits. Two respondents did receive workplace aids and adaptations. They characterized the delivery of this assistance as protracted series of negotiations. In one case, a community-based service agency supported the respondent's request for adaptations to her/his worksetting. The trend that we identify is that self-directive respondents secured more satisfactory outcomes. Further, co-worker support appears to be a decisive factor in securing accommodation in this workplace. The overall lack of reported services and the use of resource people is an indicator that there is no formal program or identified services to accommodate a health affected worker in the University of Victoria. We believe that, to date, the health affected co-worker has benefited by facilitating their accommodation process with co-worker support. The latter is enhanced when a local manager or worksite decision-maker is part of this co-worker support. We believe that accommodation outcomes for co-workers tends to vary according to worksettings and co-workers in those settings. This inconsistency should be further studied and confirmed.

What services would you want if you had another chance at keeping your original job, returning to work or continuing your employment in your workplace ?

Five respondents reported a request for a sheltered or designated jobs for chronically health affected workers. Of all suggested examples of accommodation services, the option to work in a sheltered job was most often selected. By "sheltered" we mean a stable, long term position that is designed for a health affected or disabled worker. The job is assigned to the worker and is a collection of tasks that he/she can competently perform. Two respondents considered their original or preferred jobs as suitable for classification as sheltered or designated. In essence, these co-workers believed that they could perform adequately and competitively in their previous jobs. Their accommodation would have involved the clearance or permission to remain employed in their original, preferred jobs. This appears to be a simple, cost-effective way to accommodate someone by accepting the status quo. The second most requested service was for adjuncts and worksetting adaptations that would permit better access to and use of the co-

worker's job space or environment. Examples of requested equipment are ergonomically configured chairs and foot rests at standing area counters. The third most requested service option was a formal, written Return to Work Program or Plan. This request tends to confirm our opinion that health affected co-workers have driven their return to work experiences without the benefit of an established format.

What problems, concerns or issues do you have about your accommodation experience(s) in your workplace ?

Five respondents reported that their accommodation experiences were problematic. Three of the respondents believe that they were not accommodated in that they did not have input nor the option to work in a modified, alternate or designated position. Three of the six respondents disclosed a lack of cooperation on the part of management group members who they deemed as naturally involved and responsible to assist them. These three respondents all shared a similar worksetting. Two respondents characterized their accommodation experiences as protracted and contentious. They cited a lack of co-worker acceptance and tolerance of their need to be accommodated. One respondent characterized her/his experience as positive with adequate cooperation and co-worker support. This respondent's experience is atypical compared to the other five respondents.

As mentioned, three respondents reported the belief that they were not accommodated by designated or responsible co-workers. Two respondents did acknowledge the assistance and effort delivered by their union representatives. One respondent cited the union for non-involvement in their service process. The theme for the majority of respondents can be characterized as an accommodation process that is an "either/or" dynamic. We believe that respondents were expected to continue employment and/or return to work and resume all assigned tasks and duties. If this was not feasible due to health issues and limitations; then they were given limited-to-no other options to use to modify their jobs, tasks, and schedules.. Two respondents did report an opinion that they had been accommodated over a protracted period. One co-worker reported that the process involved grievances and formal negotiation. This respondent reported that alternate employment was the eventual outcome. A sixth respondent self funded their accommodation and was satisfied with assistance from her/his co-workers.

Five respondents disclosed an opinion that they were capable and willing to work in their original positions in their current worksettings. In fact two respondents did retain employment in their original or pre-disclosure jobs. This would represent a preferred arrangement. Three of the five respondents wanted their original jobs to be deemed as sheltered or designated. In effect the job would become attached to the worker. A fourth respondent reported a functional inability to remain in her/his original employment. This suggests a theme among the respondents of **self-directed accommodation**. In all accommodation experiences, respondents wanted or, in two cases, were cleared to remain

employed in their original or pre-disclosure jobs. This begs the question as to why all respondents were dissuaded or otherwise not cleared to remain in their original jobs. We believe that modifying pre-disclosure positions would be the least disruptive and an affordable means to accommodate co-workers in this sample. The majority of co-workers who were accommodated did so by remaining in their original jobs with one person securing alternate employment. The estimated cost for this respondent was covered by an outside agency rather than by co-workers, management or union representatives.

Do you believe that you received adequate assistance from designated individuals and/or service group members in your workplace ? If not, why not.

Five respondents reported that they believe that they did not receive adequate assistance. The sixth co-worker secured and funded her/his assistance from primarily off-site service providers. This respondent was satisfied with any assistance that he/she received. This suggests that the co-worker may not have an expectation of on-site assistance from co-workers. The overall theme from the majority of respondents was that their local managers and decision-makers either would not comply with their requests for accommodation or did so on an informal basis. This suggests that each respondent's accommodation experience was worksetting specific in that the outcome depended on the involved co-workers. For example, if your local manager was not supportive and cooperative then you tended to report inadequate assistance and an unsatisfactory outcome. As well two respondents funded their service in whole or part while only one respondent reported expenditures by an outside agency. This pattern supports our opinion that there are no formally identified and designated accommodation service funds for this workplace.

Do you believe that you are capable of working in your last or previous position in your workplace ? If yes, please explain.

Only one respondents reported a complete inability to work in their pre-disclosure position due to disability. Two respondents asked to remain in their original or pre-disclosure jobs as part of their accommodation requests and were required to work in alternate, assigned positions on a rotational basis. Two respondent retained their original positions with limited modifications to their workspaces and tasks. For example, one respondent was cleared to refrain from heavy lifting in her/his worksetting. One respondent left the workplace due to disability. This person reported the belief that they were refused reasonable accommodation and this contributed to their decision to voluntarily self-terminate. We believe that all six respondents may have benefited from the clearly outlined option to modify their original or pre-disclosure jobs as part of their accommodation process. Further we agree with the self-terminated respondent in that he/she should have the option to remain in an original job as part of a reasonable accommodation request.

Would you estimate how much money was spent on assistance and services as part of your rehabilitation or therapy package ?

This question was not relevant in that respondents funded part of if not all their service costs. As well, the respondent who secured off-site assistance was unclear about the cost. For example, one respondent who received off-site, physician directed physiotherapy and a worksite assessment spent approximately \$ 1600. A second respondent who partially financed her/his treatments paid \$ 200. then used holiday time, sick time and sick bank benefits to maintain employment. Sick Bank Benefits are jointly funded by the employer and employees while Sick Time is accumulated and funded by the employer. This pattern of using illness-related monies and holiday pay funding appears to be common. These funds are the only available monies in this workplace to use to cover accommodation-related absences at work. The difficulty is that illness related income benefits are not designed to cover accommodation. The use of these monies requires recurring and often long term absences from a worksetting. The health affected co-worker is essentially managing their employment accommodation without the input and assistance of co-workers. This may contribute to negative attitudes and consequences for the affected worker. The worst case situation is when a health affected worker exhausts these limited income benefits and continues to require assistance to remain employed. The predictable outcome would be self-termination. Another option would be for a health affected co-worker to secure stable income benefits monies through an agency such as the Workers' Compensation Board. The challenge would be to prove or make a case that the chronic health issue is directly workplace related or induced through accident or injury. None of the sample respondents received income benefits from Workers' Compensation Board Offices.

The average amount of Sick Leave and Sick Bank Benefits received as estimated by three respondents was \$ 3600. The remaining respondents did not report drawing these benefits. They appear to have continued working as they became progressively disabled. We wanted to collect more accurate records but did not have access to this data. There is no Long Term Disability income benefits insurance vehicle or option for this workplace. The only other available income benefits option is Workers Compensation Board Benefits which were not received by any sample respondents. The respondents assumed responsibility for their health issues and did not represent excessive or prohibitive costs to anyone in this workplace. With the exception of the terminated co-worker, respondents appear to have facilitated their own accommodation in cooperation with union and local management representatives. The lack of satisfactory outcomes for the majority of respondents suggests remedies.

What was the outcome for you, after all or any available assistance was delivered ?

One respondent negotiated alternate employment in her/his original worksetting. As mentioned, one respondent self-terminated due to disability and perceived

refusal to be accommodated. Two respondents retained their original or pre-disclosure positions. We believe that informal negotiations yielded rescheduled tasks and limited worksetting adaptations for these two respondents. Finally, two respondents requested to remain in their original positions yet were assigned alternate positions in different worksettings. They both preferred to remain in their pre-disclosure jobs and believe that they were not reasonably accommodated. The long term outcomes for the five employed respondents is not known at this time. In our opinion, respondents are continuing to work in settings without formal service options. This may ultimately leave them with self-termination as a remaining option.

If you could continue working in your previous work area or setting, what job and tasks could you perform ? Please list them.

The respondent who negotiated alternative employment reported that he/she could not perform any tasks from their pre-disclosure position. The respondent who self-terminated believes that he/she could perform the majority of tasks from her/his original position. Two respondents are currently working in their original positions with some alteration of tasks.. The final two respondents reported that they could perform the majority of tasks in their original positions. They reported that formal clearance to avoid specific tasks would represent a viable accommodation in both cases. Recall, that two respondents did receive clearance to alter the schedule and type of tasks that were normally included in their original positions. Therefore a precedent is established in one worksetting for two sample respondents.

In summary, the accommodation service process as reported by six service recipients appears to vary according to local worksetting and co-workers in those settings. The lack of designated funding, a centralized labour-management service group and formal programs may contribute to this diversity of experiences among the sample of respondents. The lack of credible data on accommodation costs is regrettable and nulifies comparisons to the Corporation of the District of Saanich. We could only provide direct cost estimates which indicates that further research is needed. We can comment on the outcomes and the opinions of the sample respondents. Five of six respondents did retain employment. Two respondents were satisfied with employment while the remaining three employed respondents were not satisfied. The self-terminated respondent was also not satisfied with her/his outcome. We are unwilling to suggest remedies based on limited data and a sample of six interviewees. We believe that the developing joint labour service group will identify remedies and act on their findings. We are encouraged by recent developments in which CUPE Locals 917 and 951 negotiated contract language to start a more formal method of accommodating University of Victoria Co-workers. We are also encouraged by a recent agreement by management representatives to research and supply financial data similar to the records we secured from the Corporation of the District of Saanich. Unfortunately, we can not extend our study to include this pending information. We can recommend that University of Victoria co-workers

develop a joint labour-management forum, provide accommodation funding and copy the service model employed by Saanich.

**COMPARATIVE QUANTITATIVE REPORT
ON THE CORPORATION OF THE DISTRICT OF SAANICH
AND
THE UNIVERSITY OF VICTORIA, CUPE LOCALS 917 & 951**

INTRODUCTION

We designed, pre-tested and delivered a written survey to three groups of co-workers in the Corporation of the District of Saanich and at the University of Victoria. The intent of our survey is to design and evaluate a user-friendly data collection tool for any and all interested parties in work environments. Our survey goal is to anonymously profile yet not individually identify four categories of co-workers. These categories represent distinct sub-groups of workers. These groups of co-workers can be placed along a continuum based on the extent and nature of their **reported** health issues. The important issue is that our survey is an opinion survey that is dependent on disclosure by survey participants. To ensure that survey respondents are reliable and credible, we include questions that are confirmation checks.

Our continuum model represents an increasing impact or "affect" from chronic to disabled. This affect or impact is reflected in the response that a worker reports on his/her attendance, accident rate, illness and injury. The respondents' personal opinions about their demographic status in their workplace are comparatively referenced to these responses to generate a profile. We believe that we are able to collect sufficient data to profile chronically health affected co-workers along this continuum. We also designed "credibility" or confirmation checks to confirm the reliability of health-affected respondents. Overall, the sample of respondents who reported chronically affected health were very reliable historians. If they reported a chronic illness or injury then they knew the nature and extent of their health issue(s). Further, our survey answers are based on variables and labels that are intended to profile respondents as **Category A, B and C co-workers** (these categories are described below). There is sufficient data to profile a fourth, **Category D co-worker**. We elected to focus on A-to-C co-workers because they reported data that is relevant to early accommodation. Data on these sub-groups of workers would serve as a baseline or reference that may be useful in determining accommodation services and programs. This outcome is consistent with the Workplan format within our overall study. Please refer to the manual section on study parameters and planning.

The categories of health affected co-worker are defined as:

Category A, the respondent is currently ill or injured for longer than two weeks. Further these workers also report recurring illness and injury. These co-workers are prime candidates for early accommodation.

Category B, the respondent reports the belief that they are becoming disabled due to illness or injury. They tend to not report recurring illness and injury because they appear to us as being continuously health affected. More significantly, respondents in this category deliver credible knowledge of a variety of health issue(s) that are disabling. As well, we can separate B co-workers from A co-workers within our sample of respondents. We shall expand on this later in our study.

Category C, the respondents report one or more categories of disability. Significantly, these respondents can also report the nature and type of illness, injury and/or medical condition that is consistent with disabilities. Again these respondents appear to be very reliable historians about their health issues and/or disabling condition.

The following discussion concerns the utility of these profiles and an outline of our reasoning for the divisions of workers into sub-groups. We shall also offer direction on how to use our survey and our collection methods. For example, we highly recommend information sessions that encourage respondents to accurately complete all survey questions. We also suggest that you combine information sessions with actual delivery and completion of your survey forms. We further recommend that you include an information sheet on terminology so as to promote uniformity of concepts and understanding among sample respondents. We shall include a copy of our terminology in the appendix for your attention.

Our survey is basic and relatively simple. It is a three part document that is designed to collect data for the profiling of four categories of workers in a work environment. We shall present each portion of the survey and explain our reasoning for the setup and format. The actual survey questionnaire will be presented in bold font for your consideration. We shall edit names and contact numbers to maintain the confidentiality of study participants. You are welcome to use our survey to collect data in your workplace. We ask that you contact us for scoring and coding procedures. We also ask that you send us a copy of your database. We want to collect information about a large number of workplaces. This will allow us to improve our survey and strengthen our arguments about the utility of the survey format.

The following is the introductory portion of our survey. We highly recommend that you explain the value of answering all questions. We further suggest that respondents refer to an included terminology sheet. This encourages consistency and enhances the summarizing of resultant data. Since our survey is essentially an opinion survey, there is significant value to ensuring that respondents understand your definitions, survey goals and requirements.

**WORKERS WITH DISABILITIES PROJECT
EARLY ACCOMMODATION AND SUPPORT PROGRAM**

INTRODUCTION:

Please answer the following questions to help us complete our study. We need the information to create a profile of the average chronically ill/injured and disabled co-worker in the District of Saanich. This profile will be used as a baseline for comparison to co-workers in your pilot program. Please do not sign this paper or identify yourself. If you want clarification or more information about the survey and pilot study; call Duane Hoffman at # 384-8331 (voice). You are also welcome to contact XXX XXXXXX, XXXX XXXXXXXXX and XXX XXXXXX on the Rehabilitation Committee.

Please note that you may decide to refuse to answer any question. We ask that you check all the boxes for the question to show your refusal.

The purpose of the introduction is to provide contact and resource people who are co-workers of survey participants. We suggest that you identify labour and management representatives as contact people so as to offer a range of choices. We believe that personal health information is extremely sensitive and has an obvious impact on a worker's employment status. The introduction is your opportunity to assure and confirm that survey participants can report their health issues and workplace status in confidence. You may want to confirm that they have a choice about whom to contact for assistance and information. This introduction may also contain information about collecting completed forms. For convenience and consistency, we suggest that survey forms be completed and collected on one occasion. Otherwise you may setup a distribution and collection system using your listed contacts. You may need to do both to ensure that you collect sufficient completed forms to ensure a useable sample. Finally, you may not have unrestricted access to your workplace and to your co-workers. This may necessitate that you setup and fund a mailing return for completed forms. We had considerable success when we distributed survey forms in payroll envelopes as part of the usual distribution of materials. Also, we co-opted Rehabilitation Committee Members to serve as collectors for completed forms. Confidentiality was maintained by folding completed forms and leaving a drop box in a work area. The Committee Member simply collected forms from the box then we collected completed forms from the Members.

Finally we must emphasize that you will require a number of months to collect sufficient forms that represent a useable sample. As a rule of thumb, the more co-workers who participate the more representative your sample. When little is known about the health issues in your workforce; then there is no simple rule for sample sizes. We recommend that you distribute sufficient survey forms to give everyone in your workplace the opportunity to participate. The message is to keep all your activities and actions open to scrutiny such that you can develop trust. We suggest that you take a "multi-partisan" approach to your collection of data. Emphasize that you are surveying health affected co-workers to collect profile information to use for planning. Survey participants may be more cooperative if

they understand that this data may be used to enhance services and develop programs for co-workers and ultimately themselves.

The following section concerns basic demographic information on all survey participants. It is useful for making general summary statements about your entire sample of respondents. This gives you an overall profile that can be used to compare to sub-groups of co-workers. We suggest that you exercise caution about any data that you collect for the two variables of Occupation and Age. If your sample of survey respondents is large and your workplace population is similar in size to your sample; then someone may be able to identify minority individuals. This could lead to the identification of health affected co-workers and a violation of confidentiality. We suggest that you only speak about occupation in generalities especially for health affected co-workers. For example, the majority of respondents in these samples were primarily blue collar workers. We intentionally avoided specifying anyone by age and occupation.

GENERAL SURVEY INFORMATION: (Please check one)

Are you male or female

Are you between the ages of : 15-24 , 25-34 , 35-44 , 45-54 , 55+

Are you an Outside Worker , Clerical Worker , Fire/Police , other, please write your Classification

Have you been employed here for: 1-5 years , 6-10 years , 11-15 years ,

16+ years

The general information section can be expanded to include more variables. For purposes of simplicity we selected ***Age, Gender, Categories of Occupation and Ranges of Tenure***. When these general data categories are compared to categories of sub-groups of co-workers using statistical computer software; you can build co-worker profiles. We believe that these profiles are general enough to not serve to identify individuals. They are used to provide you with a sense of demographics and a general overview of the health needs of your co-workers. For example, our data suggests approximately 6% of sample respondents from one host workplace are Category A co-workers. They are currently and repeatedly ill and/or injured. While some caution should be taken transferring this percentage

to your entire co-worker population, you can use this percentage as a baseline figure. We encourage you to conduct follow-up surveys of your co-workers to collect more accurate numbers by revising your survey with more variables on chronic and repeated illness and injury. You may also be able to research other sources of data such as absenteeism statistics and WCB claims. We believe that patterns of absences and leaves are conventional indicators and identifiers of health affected workers. In addition, we believe that Category A co-workers are early in the progression towards temporary and permanent disability. We believe that early support for this group of workers may minimize the hardship and negative impact of their health issues. We shall discuss this further in the following section. The important message is that you need the demographic data to generate profiles of health affected and non-health affected co-workers. This basic data is your platform from which you can build more detailed profiles of sample respondents. The following set of variables are designed to solicit information about the frequency of occurrence of health issues as well as measurable consequences such as missed shifts and accident rates. Again the focus is on reported episodes or occurrences.

PROFILE SURVEY INFORMATION: (Please refer to the attached Definition of Terms) *N.B. All questions are edited and intended to serve as examples, only.*

Are you currently ill or injured yes [], no [], don't know []

Are you ill or injured again and again, yes [], no [], don't know []

If yes, please estimate

_____ **don't know []**.

How many work days or shifts did you miss due to repeated illness or injury during the last work year

_____ **don't know []**

How many accident reports have you made during the last work year

_____ **don't know []**

The preceding section of questions is intended to secure sufficient information to portray a sample respondent as a **Category A co-worker**. The key variables are the questions concerning current illness/injury and repeated illness/injury. We believe that a yes answer to both of the questions suggests that you are chronically health affected. If you are currently ill or injured for longer than two weeks you can be described as chronically health affected. When you also report

recurring/repeated illness and/or injury then you present as a longer term health affected worker in comparison to mainstream or Category D co-workers. The implication is that you as a Category A co-worker have an established illness or chronic injury that is or will be long term. The remaining variables for this set are confirmation checks. We reasoned that you may know how many times that you are repeatedly ill/injured. As well you may report higher rates of absenteeism compared to Category D co-workers. Finally we included a variable to clarify the popular misconception that health affected and disabled workers represent a safety concern in our work environments. Overall these "**confirmation check variables**" served to reinforce our concept of Category A co-workers. We shall discuss this further in our presentation of sample statistics. We can state that health affected co-workers who were in categories A and B did report higher rates of absenteeism over the previous work year. Category C co-workers or disabled workers did not report higher rates of absenteeism. As well, no category A, B and C co-workers reported unusual or extraordinary accident or WCB claims rates compared to non-health affected or Category D co-workers. The message is that disabled workers, in particular, are safe and reliable employees according to our sample respondent data.

Finally we chose to compare A co-workers to category B and C through the use of crosstab charts. As mentioned the least reliable or useful variable was on accident rates because it did not contribute to any noticeable differences among co-worker groups. In contrast, the variable asking about missed shifts is more significant based on the frequency of replies we received on this question. When you compare and correlate current, chronic illness/injury and repeated illness/injury and shifts missed due to repeated illness/injury; you can identify differing rates of absenteeism among health affected workers. In particular among category A and B co-workers. These differences represent significant qualifiers to be used to profile sub-groups of co-workers into categories.

Do you believe that you have a disability yes [], no [], don't know []

If yes, please explain _____ don't know []

Is your disability physical, yes [], no [], don't know [], does not apply []

Is your disability mental, yes [], no [], don't know [], does not apply []

Is your disability sensory, yes [], no [], don't know [], does not apply []

The preceding section is self-evident. If you report disability then you are more credible if you can identify your disabling condition(s). This tended to be the case

with all respondents from both study sites. Respondents appeared to know which categorie(s) of disability were self-applicable. They were conscientious and reliable reporters. The value of dividing disabled respondents by category of disability is to assist you with accommodation planning and budgeting. Again, a sample of disabled respondents only approximates the entire population of co-workers. The sample gives you an indication and a focus for further research.

We employed a simple method to identify Category C co-workers. We asked for the worker's opinion and elected to consider that opinion was accurate. We reasoned that respondents would be basically competent by virtue of their ability to retain active employment status in a host workplace. The respondent has been continuously employed such that this history is an indication of competency and reliability.. To continue this reasoning, when a disabled worker is able to retain employment while managing or facilitating their health needs; then we also viewed this situation as an indicator of capability and competence. Category C workers are survivors. Recall that all survey respondents are continuous employees in both host sites. We believe that there is no actual or perceived advantage for a respondent to anonymously disclose a disabling health issue. In essence, there should also be no perceived advantage to disclosing a disability especially in an anonymous survey. Yet, we received disclosures and reports of disability that were higher than we anticipated. We believe that disabled workers wanted to be counted in our survey. The final support for our line of reasoning was the significant correlation between "if then" variables and a disclosure of disability. In the vast majority of cases, if a respondent reported disability then he/she knew which category of disability was applicable.

In addition, Category C co-workers did not report responses that would place them into other co-worker categories. Survey respondents tended to be exclusive to one category or another. For example, disabled C co-workers did not also report that they were chronically ill/injured or that they were becoming disabled. This exclusivity was a uniform reporting pattern for most survey respondents who reported that they were health affected.

Finally, conventional wisdom in human resource management is that you simply check a worker population for patterns of extended and recurring absences. A pattern of recurring and increasing term of absences are a means to flag health affected workers. We believe that you can not reliably identify a disabled worker or chronically health affected worker based on absenteeism alone. The theme of increasing absenteeism did not apply to sample respondents who reported disabilities. Conversely, a pattern of recurring absences may be prevalent in work environments where there are negative consequences and penalties associated with workplace disability. An affected worker would leave the work environment to minimize or otherwise accommodate their health and not invite attention to their situation. In public sector work environments there are sufficient benefits options to provide needed breaks from work without disclosing health as a reason. We believe that our survey specifically addresses this situation by asking a survey respondent to disclose only absenteeism caused by injury, illness or

disability. Again, since there are no negative consequences, then we accept the reliability of the health affected survey respondents. We also noted that category B and C co-workers reported higher rates of lost time than disabled or Category C co-workers.

A second trend is reflected in our belief that the majority of disabled workers will have been identified and have received limited assistance in your workplace or they will have been screened out. For example, we noted few reports of disability among workers who were 55 years or older and long term employees of host workplaces. We interpreted this finding as predictable and consistent with a lack of accommodation service in many work environments. We believe that there is an "either/or" dynamic in many workplaces. A worker accommodates their own health issues without extraordinary attention or assistance **or** they leave their workplace. Further our findings tend to confirm that termination remains the usual or expected outcome for disabled workers when they do not have access to formal accommodation services.

Do you believe that your current health issue will become a disability, yes [], no [], don't know []

This last question is to solicit an opinion from respondents as to their belief about pending disability. The confirmation check, "if yes" question is a credibility check on the reliability and knowledge of the respondent. Again, not surprisingly, sample respondents tended to know the type and nature of the illness, injury or condition that was progressively disabling. We suggest that this question be relocated to precede the question on temporary or permanent disability. The sense of a progression of stages is better reflected if the variables also reflect a progression of stages in disability. We were perhaps too clever in locating this question towards the end of the survey. Our reasoning was to again check for reliability. This is not necessary. Sample respondents were reliable and conscientious to the extent that this may be a positive bias in our sample. We noted that Category D or non health affected co-workers tended to not answer any variables related to Category A, B and C information once they had reported their lack or absence of health issue(s). In contrast, health affected co-workers tended to report their issues and did not leave blank spaces on the survey forms. Health affected co-workers may reported more data because they want assistance and services. There may be a perceived benefit to contributing data because it will be used to promote the development of accommodation services. This is definitely an area for further study and a positive aspect of surveying health affected co-workers.

This information will be used to identify and test accommodation services for co-workers and possibly for you. Your information is a contribution that may help chronically ill and injured co-workers remain employed. Thank you.

COMMENTS: You are welcome to write your ideas, concerns and problems regarding this survey in the provided space. We believe that our study is one-of-a-kind research such that we can benefit from your suggestions on directions for further research.

We highly recommend that the summary statement about the intended use of data and interpreted findings be explained during the information and survey delivery session. You may encourage survey participants to more carefully complete and provide needed responses.

The comments section was well used by sample respondents. The idea is to again trust in the basic competency of your co-workers by inviting their ideas and to solicit additional information for further research directions. We shall include an overview of sample respondent comments for your consideration later in this report.

You now have an overview of how the survey is designed and how it is intended to work. We included explanatory examples and information to give you our ideas about the overall utility of the survey. The categories of co-workers can be used to generate profiles for both host sites using simple combinations of variable scores. These scores are coded responses which permit statistical software to group responses and compare case records.

Our scoring method allowed us to code our survey responses to permit our software application to identify and group answers according to the frequency or # of times respondents reported the same answers. For example, we can collect all of the "don't knows" for all sample respondents for each question by scoring a "don't know" as a number. We can also collect all the missing responses by coding any and all missing checks, numbers and replies. We suggest that you contact us for further information. You can email us at **duane_hoffman@bc.sympatico.ca** or visit our webpage **<www.islandnet.com/~aappt >**. The codes must be consistent with whatever statistical software application that you choose to use. The alternative method is to score the completed survey forms by hand which is time consuming and error prone.

In summary, our written survey yielded sufficient data on four categories of co-workers to allow us to generate profile information. We were able to note a progression of health affect among three of these four categories. This impact can be measured by co-workers absences and frequency of reported illness and injury. More importantly, we believe that you can generate an overview of your co-worker population in that you have some sense of the numbers and kinds of health issues that are resident in your workplace. This preliminary information can be used to further survey your co-workers to collect more solid or harder data about the numbers of co-workers who are reporting health issues that will affect their workplace attendance, performance and health services consumption. More significantly, you may be able to use this refined data to design, plan, deliver and

evaluate accommodation services for your workplace. Finally, you may follow our recommendation and workplans to develop early accommodation services that reduce hardship, costs, absenteeism and termination for co-workers and possibly for yourselves.

***COMPARATIVE WRITTEN SURVEY FINDINGS
FOR
THE CORPORATION OF THE DISTRICT OF SAANICH
AND
THE UNIVERSITY OF VICTORIA, CUPE LOCALS 917/951 MERGED***

INTRODUCTION

The following information is our interpretation of survey response data from two samples of 409 respondents. The first sample to be presented is collected from the co-worker population of the Corporation of the District of Saanich. The sample size is 159 the approximate size of the entire worker population is 1000. The sample size for the University of Victoria is 250 cases from an approximate co-worker population of 900. We collected all survey data over a four month period ending in April of 1996. There were only two flawed survey forms which we chose to not include in this sample.

As mentioned we pre-tested our survey with the assistance of co-workers from CUPE Local 917 at the University of Victoria.. This pre-test sample involved 146 respondents. We used the findings from this distribution to upgrade our written survey and expand the number of variable labels. We elected to collect more detailed information to better profile health affected co-workers along the previously mentioned continuum. We believe that further refinements would allow researchers to estimate numbers of co-workers in each category. For the purposes of our study and to comply with our intent to keep this survey as a user-friendly instrument, we decided to release this version. We welcome any ideas and comments about how to improve the utility of our survey. Please contact us at your convenience.

The University of Victoria sample is a merged database from both survey respondent populations, CUPE Locals 917 and 951 groups of co-workers. These labour groups at the University of Victoria were relatively inaccessible due to the non-involvement of resident managers. Although we refer to respondents by their union affiliation, all the sample respondents are resident co-workers at the University of Victoria. Their union affiliation crosses worksettings and environments. We also elected to open our survey distribution to all co-workers at the University and did receive a wide spectrum of participation. Due to our request for anonymity, we are not able to estimate the numbers of non-union affiliated co-workers in this sample of respondents. This openness of participation is another similarity to the sample respondents at the Corporation of the District of Saanich.

We elected to combine survey data from both University of Victoria CUPE Locals due to a limited response by CUPE 917 affiliated co-workers. Recall that we pre-tested 917 and received a high rate of response. The revised version of our survey yielded only 40 completed forms on a second distribution to CUPE 917 Members. We could not combine pre-test survey data and second distribution survey data due to differences in coding and extra variables. The merged database tends to minimize union affiliation as a difference and yields a larger sample size of 250 cases.

We shall present general demographic information on each sample respondent population in a comparative format for your consideration. Where relevant we shall explain how we interpreted data to yield our findings. We want to make the case that our survey is useful and works as intended. Further we believe that our survey yields a surplus of data such that we are not able to display the extent and depth of summarized frequencies for your consideration. We would prefer to limit these interpretations to the directly relevant study variables to maintain confidentiality. We shall make our case that the combination of quantitative and qualitative survey materials will serve to give you useful, detailed data that is currently unavailable in many work environments. We hope that our survey materials and request to share information will yield a large database on accommodation. We would be very interested in how any readers use our materials and in their data. For purposes of convenience, we shall refer to the Corporation of the District of Saanich sample data as **CDS** and the merged 917/951 sample data as **UVICD**. We shall present our findings in a row format for ease of comparison. The findings and interpretation of data about all categories of co-workers are based on crosstab charts and summary frequencies. This data display method is simple and reliable. Again we elected to use methods that should be readily available and easy to use by interested parties. Please contact us for information about more sophisticated statistical analysis.

OVERVIEW OF BOTH HOST STUDY SITES IN A COMPARATIVE FORMAT

CDS:UVICD:

Sample size 159 Sample size 250

Total worker population 720. Total worker population 900.

Total sample size is 409

Both study workplaces are unionized, public sector work environments. Further similarities are that CUPE is the main resident union in both sites. The categories and spectrum of occupations are similar and will be outlined in the following presentation.

Comparative Demographic Information based on Age, Gender, Occupation and Tenure for the overall samples from both host worksites.

CDS: Age Ranges and Sub-Groups within each Category of Age Range.

The age range for the majority of the 154 respondents is 35-to-54 years of age. Fifty-two sample respondents comprise co-workers in this age range.

The next most frequently reported age range is for co-workers between the ages of 45-to-54, fifty-one respondents comprise this age category.

The third most reported age range of respondents is for the ages of 25-to-34, twenty-five respondents from our sample of 154.

We interpret these age ranges and corresponding numbers of co-workers as a reflection of a relatively young sample of respondents. The concentration of respondents in the 35-to-44 and 45-to-54 year old categories may reflect Canada-wide demographics.

UVIC

The age range for the majority of this reporting sample of 239 respondents is 45-to-54. Eighty-five respondents comprise co-workers in this age range.

The next most frequently reported age range for this sample is 35-to-44, seventy-four respondents comprise this age category.

The third most reported age range of respondents is 25-to-34 years of age with forty-eight co-workers in this age category.

We interpret these age ranges and corresponding numbers of co-workers to reflect a slightly older population of respondents at University of Victoria when compared to the Corporation of the District of Saanich.

CDS: sample respondents by Gender

The majority of our sample respondents are male for this host study workplace.

UVIC: sample respondents by Gender

The majority of sample respondents are female for this host study workplace.

CDS: sample respondents by Occupation

The majority of sample respondents report employment in occupational categories that are consistent with an office environment. The next most frequently reported employment is in traditional blue collar/trades categories. The third most frequently report employment is in a technical occupational categories.

We interpret these responses to indicate that office tasks and clerical duties are the most frequently reported work performed among our sample respondents. Please refer to the listed categories of occupations on our written survey forms. The categories of occupations are necessarily different for both host worksites. We believe that detailed demographic information would not be relevant and useful. Further, as mentioned, we are being intentionally general about demographics as part of our commitment to confidentiality. We believe that the variables of age and occupation in combination with other variables in our database can be used to identify small groups health affected workers. As well it is part of our agenda to present interpreted findings as proof of utility and concept. The very detailed information that can be generated from the survey materials should be kept private in accordance with ethics and professional responsibility to survey respondents.

CSDS sample respondents by tenure

The majority of our sample respondents have been employed at Saanich for 16 years or more. The number of respondents in this tenure category is fifty-two.

The next largest number of reporting co-workers is forty-one individuals who have been employed from 1-to-5 years.

The third largest group of reporting co-workers is thirty-six who have been employed for 6-to-10 years.

We anticipated that municipal public sector workers would tend to remain employed for longer terms. The stable work patterns and competitive wage rates would encourage workers to remain employed in these work environments.

UVICD sample respondents by tenure

The majority of our sample respondents have been employed at the University for 1-to-5 years. The number of respondents in this tenure category is ninety-seven.

The next largest number of reporting co-workers is fifty-three respondents who have been employed for 16 years or more.

The third largest group of reporting co-workers is forty-four who have been continuously employed for 6-to-10 years.

We did not anticipate the large number of respondents in the tenure category of 1-to-5 years. The worker population at the University has increased as a result of development of the built environment and increasing student enrollment. These shorter tenured workers tend to be older workers.

In summary, the Corporation of the District of Saanich and the University of Victoria work environments, range of occupations, co-worker populations, union affiliations and public sector status suggests an ease of comparison. The only significant difference is that the majority of sample respondents for Saanich are male in contrast to the majority of reporting co-workers for University of Victoria being female. We do not know if this contrasting situation is transferable to the entire worker populations in each host workplace. We do not have sufficient data. In general, we are fortunate to be able to compare our findings from each site. Finally there is one significant difference between both sites. The Corporation of the District of Saanich has a resident service group that has been established for four years. The University of Victoria has two labour-based service groups that have been in operation for one and two years, respectively. We believe the presence of service groups and service delivery for accommodation may be reflected in the comparative numbers of sample respondents whom we consider Category A, B and C co-workers.

PROFILES OF CATEGORY A, B AND C CO-WORKERS FOR BOTH HOST WORKPLACES

INTRODUCTION

As mentioned we believe that we can cross reference and interpret respondent data to place co-workers along a continuum of increasing health affect or impact. This continuum commences with co-workers who are currently, chronically ill and injured. This sub-group of workers also reports recurring or repeated episodes of illness and injury. They are classified as category A workers.

CDSO ON CATEGORY A CO-WORKERS

We identified **8** out of a respondent sample of 153 Saanich Co-workers who report current, chronic illness/injury and/or recurring, repeated illness and injury. This sub-group tends to remain stable within comparative samples. By this, we mean that 8 co-workers tend to report chronic health affect when compared to non-health affected(Category D) and to Category B and C co-workers in the sample of Saanich respondent workers. This sub-group represents 5% of the sample respondent population of 153 with 6 missing observations. The low number of missing observations.

The 6 out of 8 chronically health affected workers who report that they have missed shifts or work days over the past year totaled 100. This represents an average of 16.6 missed shifts per year per Category A Co-worker who reported absences. When compared to all other categories of co-workers at Saanich who

report absences the average shifts missed are **9.7** per year per B, C, D co-workers. The respondent population of all non-A co-workers is 32.

UVICD ON CATEGORY A CO-WORKERS

We identified 20 out of a respondent sample of 241 Victoria Co-workers who report current, chronic illness/injury and/or recurring, repeated illness and injury. These numbers are the low end of a range to 23. We elected to accept the figure of 20 because these co-workers were also able to report no missed shifts or specific numbers of missed shifts. The reporting of data for absences and non-absences verified the reliability of the respondents. The other variables such as the frequency or number of times of illness tended to be less reliable for Category A co-workers.

We recorded **12 of the 20** chronically health affected workers who reported that they have missed an average of **22.7** shifts per year. Conversely **8** Category A Co-workers did not miss shifts during the past work year. All non Category A co-workers who reported non absences and missed shifts are 169 workers from a sample population of 213 respondents. Of these 169 Victoria respondents, 106 did not report any absences while 63 did report specific numbers of missed shifts for the past year. These **63** University of Victoria co-workers reported an average of **8.4** missed shifts per year. The ratio of missed shifts among the two groups of reporting co-workers is nearly 3-to-1. Conversely, significantly large numbers of Category A and non-A co-workers do not miss shifts. Therefore, we relied primarily on self-reporting in conjunction with other variables as the key identifier of Category A co-workers. .

For example, if you use missed shifts as a comparative variable with self reporting of two other identifying variables, we believe that our numbers of Category A co-workers for each host site are defensible. These numbers of potential category A co-workers are stable across our crosstab charts and summary frequencies.

In summary, the comparatively low number of Category A co-workers in Saanich versus the University of Victoria may be directly attributable to the existence of a viable service group. There may also be a trickle down effect due to the success achieved by assisting health affected co-workers. This may encourage co-workers to come forward and self-identify yielding reduced numbers within our sample because these workers may have transferred into other categories. For example, a Category A co-workers in one host site may be identified and moved into Category B in another host site. There may be a causal dynamic in effect that could explain the difference in numbers. We shall see if this comparative difference carries forward for Category B and C co-workers. .

CDSO ON CATEGORY A CO-WORKERS PROFILED BY AGE RANGE

We analyzed age range responses for currently ill and repeatedly ill Saanich co-workers because there are linkages. We reasoned that an episode of recurring

illness/injury may be current and be indicated as a positive response to our current illness/injury question. This appears to be the case. Category A co-workers report current and episodic illness and injury situations. By age ranges the majority of the 8 category A workers are in the 35-to-44 years old range. We anticipated that co-workers who were incurring or presenting longer term health issues who were "early" along a continuum would tend to be middle-aged to younger workers.

UVICD ON CATEGORY A CO-WORKERS PROFILED BY AGE RANGE

The breakdown for the 20 category A workers at University of Victoria represents an even distribution among three categories of age ranges. Seven co-workers are between the ages of 25-to-34, seven co-workers are in the 35-to-44 range and five co-workers are in the 45-to 54 range. The remaining co-worker is over 55 years of age. This distribution calls conventional thinking into question. The older or more mature worker does not present as health affected in comparison to her/his peers.

CDSO ON CATEGORY A CO-WORKERS PROFILED BY GENDER

The majority of Category A co-workers are male.

UVICD ON CATEGORY A CO-WORKERS PROFILED BY GENDER

The majority of Category A co-workers for U of Vic are female.

CDSO ON CATEGORY A CO-WORKERS PROFILED BY OCCUPATION

The majority respondents are employed in an office environment. The remainder of respondents are employed in traditionally blue collar occupations. As mentioned, we are intentionally delivering limited details on occupational categories. We shall not directly correlate or discuss co-variance for occupation, age and tenure.

UVICD ON CATEGORY A CO-WORKERS PROFILED BY OCCUPATION

The majority of respondents are employed again in an office environment. The remainder of respondents are employed in traditional and modern blue collar occupational categories.

There were less than 8 missing observations for both sub-groups of Category A respondents in our samples. The small number of missing observations is a significant indicator of the reliability of all sample respondents.

CDSO ON CATEGORY A CO-WORKERS PROFILED BY TENURE

Category A workers in Saanich tend to be employed for less than ten years. We chose to refrain from discussing more detailed information to maintain confidentiality.

UVICD ON CATEGORY A CO-WORKERS PROFILED BY TENURE

Category A workers at the University of Victoria are evenly distributed among all categories of tenure. Co-workers who have worked for 16 years or more, represent the lowest number of health affected workers for this sample. We believe this distribution may be interpreted as an unexpected frequency of occurrence. We presumed that longer term workers would report greater frequencies of health issues in public sector workplaces. We presumed that tenure would co-vary with age and this has not been the pattern.

In summary, while we elected to retain more detailed information we are confident that we have made the case for a Category A worker. The stable pattern of reported responses in conjunction with confirming variables such as reported absences suggests Category A co-workers for each host site. The comparison to non A co-workers reinforces our projected numbers when viewed using crosstab charts. There may be linkages and overlap between Categories A, B and C yet we did not see responses that suggested redundant reporting. If you reported A category responses then you tend to continue to report confirming responses in other variables. **Finally we consider A co-workers to be vulnerable and comparatively recent along our continuum to progressive health affect and disability.** The profiles of B and C co-workers that are exclusive of A workers should further support our interpretation of summary frequencies of data.

PROFILE OF CATEGORY B CO-WORKERS FOR BOTH HOST SITES

INTRODUCTION

We again used the self-identifying variable to secure a range of responses on a co-worker's belief about pending disability. We accepted a "yes" response as we did with Category A co-workers. We also included a confirmation check by placing an "if then" variable that followed our question on a co-worker's opinion about pending disability. In 5 cases out a sample respondent population of 104, Saanich co-workers disclosed supportable conditions that are consistent with our opinions about disabling health issues. Further we compared this initial sub-group of 5 co-workers for Saanich and cross referenced them with A and D co-workers. This sub-group of five tended to not report recurring illness and injury. We suspect that Category B co-workers have progressed along our health continuum such that their conditions are established and continuous rather than episodic and recent. As we develop our profile you may note that B co-workers report frequencies of occurrence that are different from Category A co-workers.

We shall highlight these differences to make a case for excluding this B workers from other sub-groups.

CDSO ON CATEGORY B CO-WORKERS

As mentioned we determined that five Saanich workers have reported their opinion on pending disabilities and have identified their disabling illness, injury and/or medical conditions. When we comparatively cross-referenced these workers to other categories of co-workers, they appeared to be exclusive. For example, none of the five Saanich B workers reported recurring illness/injury that we considered to be episodic. More significantly category B workers differ in comparisons by variable to other co-workers. For example, 3 out of five B workers reported no missed shifts during the previous work year. The remaining two co-workers missed an average of **4.5** shifts per worker per year. **This average is below the average of 9.7 for all other categories of Saanich workers.**

UVICD ON CATEGORY B CO-WORKERS

We determined 21 co-workers at the University of Victoria who may be Category B co-workers.. These 21 workers were able to report a potentially disabling illness, injury and/or condition. Our range of B workers is from a sample respondent population of over 160. We determined that 11 B workers reported no missed shifts or absences during the past work year. The remaining category B workers reported an average of **17.5** missed shifts per worker per year. This figure is notably higher than **8.4** average of missed shifts for all other categories of University of Victoria co-workers. Recall that all of our figures are relative to the sample size and respondents. They are best understood as purely indicators and reference points for further research. Significantly, the average for potential Category B co-workers is less than the average missed shifts figure of **22.7** for Category A co-workers. Overall we anticipated that co-workers would report less absences, accidents and frequencies of affected health as they moved along our continuum. We shall discuss this opinion after viewing the demographics of Category B co-workers from both host sites.

CDSO ON CATEGORY B CO-WORKERS PROFILED BY AGE RANGE

We analyzed age range responses of Saanich co-workers with pending disabilities and discovered that demographic information is varied. We did identify five category B cases in the 35-to-44 year age range category. This suggests that B workers in Saanich are relatively young. Recall that the overall majority of sample respondents for this host site are within this age range category. The suggestion that B workers in Saanich are comparatively similar in age to all other categories of sample respondents may be related to Canada wide population demographic distributions.

UVICD ON CATEGORY B CO-WORKERS PROFILED BY AGE RANGE

The breakdown for the 21 category B workers at University of Victoria yields a concentration of workers in the 45-to-54 year old range category. The next largest group of B-worker sample respondents are in the 35-to-44 range category. We believe that this distribution of Category B co-workers is comparable to the overall demographic distribution of all other co-workers by age for this host site. As mentioned with Category A co-workers, the reported age ranges of health affected workers appear to challenge conventional thinking.

CDSO ON CATEGORY B CO-WORKERS PROFILED BY GENDER

The distribution of Category B co-workers are evenly split between female and male.

UVIC ON CATEGORY B CO-WORKERS PROFILED BY GENDER

The majority of Category B co-workers for U of Vic are female. This is comparable and consistent with Category A workers in this host site.

CDSO ON CATEGORY B CO-WORKERS PROFILED BY OCCUPATION

The majority of B worker respondents are employed in office environments.. As mentioned, we are intentionally delivering limited details on occupational categories. We shall not directly correlate or discuss co-variance for occupation, age and tenure.

UVIC ON CATEGORY B CO-WORKERS PROFILED BY OCCUPATION

The majority of respondents are employed again in an office environment. The remainder of respondents are employed evenly across the remaining occupational categories.

There were 72 missing observations for Category B respondents in our samples. The large number of missing observations is a significant indicator that non B workers are not including themselves in this category. We believe that when the variable does not apply then respondents do not check off the variable.

CDSO ON CATEGORY B CO-WORKERS PROFILED BY TENURE

Category B workers in Saanich are evenly distributed across three categories of tenure: 6-to-10, 11-to-15 and 16 plus years. We found that B workers are concentrated in the longer term tenure categories.

UVIC ON CATEGORY B CO-WORKERS PROFILED BY TENURE

Category B workers at the University of Victoria are concentrated in the 11-to 15 year tenure category. Conversely, the remaining range of B workers are evenly distributed among the remaining categories of tenure.

Our interpretation of findings for both host sites suggests a picture of a longer term worker who is reluctant to ask for assistance. Category B co-workers may be senior employees who also tend to be older or more mature workers. We believe that they are also in transition in terms of their health and the impact of their health needs in their workplaces.

In summary, we can make a case for the existence of Category B co-workers in both sites. We believe that the disparity of size between categories of co-workers in both sites is noteworthy. For example, the Saanich B workers are a smaller group than the Category A workers in the same site. As well, our crosstab charts and frequencies suggest that these two groups of co-workers are mutually exclusive. We note that the University of Victoria sample Category B workers tend to present as a similar size to Category A. At least 15 of the potential 21 Category B co-workers are not in Category A. This suggests to us that this distribution along our continuum will yield an equal to larger group of Category C co-workers. The crucial difference among host sites tends to be the presence of a long term service group.

PROFILE OF CATEGORY C CO-WORKERS FOR BOTH HOST SITES

INTRODUCTION

This final section of our report concerns co-workers who report disabilities. We were consistent in our acceptance of self-disclosure. If you reported that you are currently, temporarily or permanently disabled, then we agreed with your opinion. We included confirmation checks by next asking co-workers to disclose their disabling condition(s). We also asked co-workers to select one or more categories of disabilities among three general categories: mental, physical and sensory. We reasoned that most respondents would report a disabling condition and identify at least one category of disability. We anticipated that a category of physical disability would be most often disclosed or reported.

CDSO ON CATEGORY C CO-WORKERS

We determined a sub-group of **23** Saanich co-workers out of a sample respondent population of over 145. There were few missing observations among our respondent samples. This size tends to recur in our comparisons of frequencies and in our crosstab charts. Not surprisingly, this number compares favourably to the recorded caseload size that we determined in our qualitative report on this workplace. The most reported kind or category of disability was physical. Among disabled Saanich co-workers, **11 out of 23** did not report absences or missed shifts. The remaining 12 Category C Saanich workers reported an average of **12** missed shifts per work year with two C workers excluded as "don't know" respondents. By comparison the average for non-disabled workers ranges from **7.5 to 9.7** shifts per work year depending on the sample population. The reason for ranges of averages for missed shifts is that we have slightly

different respondent populations for each category of co-worker. We anticipated a benchmark of an average of 10 shifts missed per worker per work year as an industry average. This information source is the British Columbia Workers' Compensation Board.

UVICD ON CATEGORY C CO-WORKERS

We determined that **55** University of Victoria co-workers who reported disability as well as one or more categories of disability are potential Category C co-workers. They were identified from a sample respondent population of 239. We noted that Category C co-workers in this site reported more than one kind of disability. The most reported kind or category of disability was physical. Among disabled workers, 19 reported no missed shifts or absences during the previous work year. The remaining respondents when added to 19 total 54 for a difference of 1 unaccounted Category C co-worker. The 27 disabled co-workers who reported missed shifts averaged **19** missed shifts per case per work year. Comparatively, non category C co-workers in this sample population of 215, reported an average of **5.4** missed shifts per case per work year. These figures are extremely relative yet important. The comparative ratio is nearly 4-to-1. Recall that there is a pattern of higher frequencies or incidence of missed shifts among Category A, B and now C co-workers in this host site.

The size of Category C sub-groups for both sites suggests a "bubble" effect. There may be a "bulge" of disabled workers who are similar in age and tenure that are moving through a time continuum within both work environments. We believe that the comparatively larger size of C workers may be a factor of timing and general demographics. The disabled workers sub-groups preceded and supersede any and all service groups and accommodation assistance in each host site. There may have been sufficient time and factors to yield these numbers of Category C co-workers. Further, disabled workers may have progressed along our continuum yet managed to retain employment through advancement or promotion into more suitable jobs. They may also have terminated and would not be part of this sample population. We do not have sufficient data to explain the larger numbers of disabled workers relative to other categories of health affected co-workers in these sample populations.

CDSO ON CATEGORY C CO-WORKERS PROFILED BY AGE RANGE

We analyzed age range responses of Saanich co-workers with disabilities and discovered that demographic information is consistent with our "bubble" effect concept. The majority of disabled workers are concentrated in two age ranges: 35-to-44 and 45-to-54. Less than 9% of this sample of co-workers are over 55 years of age.

UVICD ON CATEGORY C CO-WORKERS PROFILED BY AGE RANGE

Again the majority of disabled workers in the University of Victoria sample are in two age ranges: 35-to-44 and 45-to-54. Less than 9% of this sample of co-workers are over 55 years of age. The similarities among both host sites for age range concentrations are notable.

CDSO ON CATEGORY C CO-WORKERS PROFILED BY GENDER

The majority of Category C co-workers are male.

UVICD ON CATEGORY C CO-WORKERS PROFILED BY GENDER

The majority of Category C co-workers for U of Vic are female.

CDSO ON CATEGORY C CO-WORKERS PROFILED BY OCCUPATION

The largest number of C worker respondents are employed in an office environments. The second largest concentration of Category C co-workers are employed in non-built environments.

UVICD ON CATEGORY C CO-WORKERS PROFILED BY OCCUPATION

The majority of respondents are employed again in an office or built environment. There is an even distribution of disabled workers across the remaining occupational categories.

CDSO ON CATEGORY C CO-WORKERS PROFILED BY TENURE

Category C workers in Saanich are concentrated in longer term tenure categories. Again this is an indication that a bubble or demographic bulge model may be applicable to this sample of respondents as a means of understanding their workplace status and affected health.

UVICD ON CATEGORY C CO-WORKERS PROFILED BY TENURE

Category C workers at the University of Victoria are atypical. We anticipated a similar distribution of sample co-workers to Saanich. We found that workers in the lowest category of tenure, the 11-to-15 year range and those co-workers employed longer than 16 years range presented similar numbers of disabled workers. The lowest concentration of disabled workers is in the 6-to-10 year tenure category.

Our interpretation of findings for both host sites suggests the disabled workers in Saanich have benefited from available rehabilitation services. They are assisted as they move or age through their workplace. Their numbers are lower than their sample counterparts in the University of Victoria. Workers from this latter work environment present a troubling picture to us. Their numbers, age and tenure suggests that disabled workers are increasing in numbers and in the significance

of their reported health issues. The University of Victoria disabled workers may represent a predictable occurrence or development when accommodation assistance and services are limited, undefined or not available.

In summary, we can make a case for the existence of Category C co-workers in both sites. We believe that the Saanich C workers demonstrated greater exclusivity across categories of co-workers. They were easier to profile using our survey data and analysis methods. The University of Victoria C workers were challenging to profile. We had difficulty delineating clear exclusivity among categories of co-workers. In both sites, more detailed surveys that capture better data on each sub-group of co-worker would yield more refined interpretations. Our survey data is useful as a solid start and first perspective on health affect among co-workers in your workplace. At the least, you can compare frequencies and findings to both study sites by using them as baselines. You can also use survey data to cross reference and compare sub-groups within your workplaces. We look forward to working with you. We found that our survey captured a wealth of information that we chose to not discuss in this report. Essentially, there is too much information and we had to practice restraint in our analysis. We hope that you will involve us in your data collection to take advantage of our experience.

HOST SITE PROGRAM DELIVERY PHASE

We have completed our baseline collection and interpretation of data that is crucial for entering the Delivery Phases of our Workplans. We have also developed two innovative services that may be useful to discuss. We intended to offer training in ***supported employment techniques*** and in ***self advocacy***. Unfortunately, we exhausted our funding and available term of our pilot initiative. We elected to include our intended activities in the event that any readers wanted to continue with our workplans for their workplaces. The following discussion will be on these two service options and our reasons for offering them.

Supported employment is an established concept that is associated with assistance for individuals with developmental delays and mental disabilities. The concept is well documented and involves a skilled job coach working directly with a service recipient in a worksetting or environment. The Coach learns the tasks, schedule and responsibilities of a position and teaches a person how to perform at a productive, pre-determined rate. As the service recipient becomes more competent, the Coach "fades" until he/she can simply monitor the performance of the service recipient. The supportive process usually progresses according to a plan and time table that includes comment from the affected co-worker.

Our training package features an innovative concept within a supported employment learning process. We believe that a resident, non-health affected co-worker can be trained to serve as a "**Co-worker Job Coach**" for a service recipient. We believe that this situation is viable because:

A resident Co-Worker Job Coach already knows the job tasks and relevant information by association with the host workplace.

Co-worker support may be present and can be used to defuse objections to the accommodation process. The health affected co-worker is already established in this workplace and may be more readily assisted and accepted.

The costs and workstream disruptions can be minimized because participants in the

accommodation process are informed and knowledgeable about the workplace.

Social integration of a health affected worker has been accomplished because the affected co-worker retains their status as a current member of the workforce.

We believe that discrimination and negative attitudes based on misunderstanding are the primary reasons that health affected workers do not retain their employment. Our data and findings from employment studies of disabled workers suggests that integration and accommodation are extremely affordable. The renovation of workspace, modification of tasks and schedules are readily effected in a work environment. The promotion of tolerance and acceptance for the accommodation and for the health affected co-worker is the real barrier to integration. We believe that training and involvement by co-workers as service providers is a meaningful and effective way to ensure social and physical integration.

Our second innovative service has been designed around these same key concepts. We believe that a trained and informed co-worker can self-direct their accommodation process in a unionized workplace. We believe that the person with health issues and need for accommodation is the most competent person to "drive" their services. The apparent trend is for the affected worker to accept or reject rehabilitation services from relatively closed service groups. The affected person is a passive recipient who is generally excluded. The accommodation process is negotiated based on agreements that are biased towards cost control and claims management. If the chronically health affected worker understood the agreements, available service options and was included; he/she may enjoy a better chance for job retention and long term employment. This same approach could also be used by an employment candidate with a disability or health issue. Imagine how much more effectively a person could be integrated into an environment if they initiated and were included in the process. Granted an assertive, motivated service recipient may challenge professional service providers and service group members to cooperate and generate outcomes. We

believe that this situation is positive. Conversely, when a service recipient is treated as a competent peer and not a client, then there may be more reliable information and better service related decisions. To our knowledge we are the only research group who are recommending self-advocacy to facilitate accommodation in a work environment.

Finally, had we completed the Delivery Phases for both sites , we would have a set of records, costs, services and outcomes. We can compare this data to the baseline findings that we collected during our earlier Research Phases. We believe that innovative services that we test within a pilot program format would represent a complement to existing conventional health and rehabilitation services in unionized work environments. If these innovative services represent similar direct costs yet produce measurable advantages; then we have made the case for early accommodation. For example, if a participant in our early assistance pilot program experiences better job retention rates and longer term employment; then we have made our case again. We anticipate comparable costs, reduced emotional and financial hardship and better job retention rates for pilot candidates. We anticipate that indirect costs for accommodation and rehabilitation assistance will decrease. Fewer co-workers will leave the physical workspace and will not experience disruptions in income. This should result in an overall reduction in costs for income benefits, off-site re-education and out placements. We intended to deliver reports during and upon completion of this portion of our study as part of our evaluation of training.

In summary, we wanted to comply with the directions of both service groups regarding which services to test. We planned to offer our training packages as an incentive for co-workers to become involved and to promote tolerance. We believe that early assistance to accommodate workers is a viable and complementary to conventional health service delivery.

HOST SITE PROGRAM EVALUATION PHASE

Each host site has an evaluation phase as part of their workplan. Please refer to the workplan sample for our current host sites. The effectiveness of services, details on estimated and actual costs, details on outcomes and monitoring reports have been collected for use as indicators of efficiency and accountability in each host site. Ideally an outside party or a participant in each pilot format can monitor our work according to our efficiency and production in each site. We asked co-workers on both service committees to offer comment and their interpretations of our findings and work. For example, copies of qualitative and quantitative reports were submitted for appraisal to service group members and interested parties. As mentioned, regular progress reports were released for comment to participants in each site. We also captured costs and outcomes for

previously delivered health services in each host site. We were able to profile previously accommodated co-workers and potential pilot candidates for accommodation services. We also established profiles for three categories of chronically health-affected co-workers for each site. The baseline data and our pilot candidate data were to be compared by cost and outcome, where possible. If we are, at least, similar for costs yet our outcomes are more favourable; then, our pilot format, model and services would be viable. Please refer to our Research Methodology materials.

We have also offered to share our model, methods and data interpretations with research and service agencies in British Columbia. We have linkages with the Department of Sociology at the University of Victoria, the Canadian Labour Congress, the Federal and Provincial Governments and a variety of community-based service organizations. Further, we support sixteen individuals and agencies who have agreed to donate opinion and expertise as Program Contributors. As well, we continued to serve as researchers, advisors and consultants for any individual or agency that requests information about accommodation in unionized worksettings. We invite comment and ideas from members of our large professional network which includes management representatives, labour contacts and individuals with disabilities and chronic health issues. Finally we elected to submit extraordinary reports about our activities to our sponsors, the Action Committee of People with Disabilities, Victoria Labour Council and to Human Resource Development Canada. To date, we have accepted and acknowledged any and all contributions to our study in writing. We believe that the source of information and of any reprinted materials should be identified as a courtesy and for continuity.

The following documents are copies of progress report materials for your consideration. We believe that accountability and on-going evaluation are crucial to professional research. We want our methods and findings to be quality assured and defensible in any forum or milieu. As mentioned, we were able to complete the intended Research Phases for both host sites. Please consider our proposed project evaluation workplan.

SAMPLE PROJECT EVALUATION WORKPLAN

Project evaluation is divided into two parts: Host Workplace Evaluations and Workers with Disabilities Project Evaluation.

HOST WORKPLACE EVALUATIONS

Each host site has an evaluation phase as part of their workplan. Please refer to the sample workplan for the current host sites. The outcomes of services, details on estimated and actual costs, details on outcomes and monitoring reports will be collected for use as indicators of effectiveness, efficiency and accountability in each host site. Ideally an outside party or a participant in each pilot format can monitor our work according to our efficiency and production in each site. As mentioned, regular progress reports will be released for comment to participants in each site. We shall also be capturing costs and outcomes for previously delivered health services in each host site. We can establish a baseline for two categories of co-worker for each site: 1) previously accommodated co-workers and 2) pilot candidates. We shall also establish a profile of an average chronically health-affected co-worker for each site. The baseline data and our pilot candidate data will be compared by cost and outcome, where possible. If we are, at least, similar for costs yet our outcomes are more favourable; then, our pilot format, model and services are viable. Please refer to our Research Methodology materials.

WORKERS WITH DISABILITIES PROJECT EVALUATION FORMAT

The second part of an overall evaluation format is to examine our work and processes used to coordinate, administer and manage our project activities. Specifically we shall provide a breakdown of costs and outcomes for project activities in seven areas: **marketing, educational materials development and use, pilot participant comment/opinion, recruitment of contributors, maintenance of our Advisory, direct involvement with and support of service groups; and, the cost/benefits of our project expenditures.** The latter will include our opinion about our effectiveness at compliance with the Description of Project and Statement of Work Agreement. we believe that we have been extremely cost effective. Marketing and project development will be considered one category due to the nature of our pilot program format. we specified that a customized, "made-in-your-workplace" pilot program is a core principle in our research effort. In effect, our research, support work and worksite output has been to assist host site participants to build their own pilot accommodation programs. We want to account for this in any evaluation of project activities.

Another factor to consider about our project activities are the prevailing political and social attitudes about workplace accommodation. This area of health and work appears to be contentious and sensitive. We believe that interest and willingness to host research in this area has been predominately featured in one workplace group and among health affected individuals. We believe that mainstream co-workers and members of management groups have not readily accepted research initiatives for their work environments. An additional factor in evaluating our results is the unfeasibility of comparing us to any other similar program or project. We are literally a one-of-a-kind initiative. Our inability to

compare our study to any existing initiatives may have reinforced reluctance to host our project. Basically, We would prefer to use standard benchmarks or guidelines for comparison only we have not been able to locate any benchmarks..

Further factors to consider are our dependence on contributions-in-kind, limited funding, limited resources, a single staff-person and the challenge of creating an unprecedented pilot program. For example, we canvassed 41 businesses and associated management groups. We entered into negotiations with ten workplaces. These negotiations and associated tasks involved time consuming delays, repeated communications and approximately 45 meetings. The effort yielded three host worksites. we believe that we considered and integrated values and ideas that would appeal to and assure members of workplace groups about the intent and ethics of our research. Further, we presented incentives to members of these groups to encourage acceptance of our work. we do not clearly understand the reasons for rejection from 38 businesses.

The point is that we could not have anticipated the cohesion and rapport of these businesses. We needed to enter negotiations and work within the parameters of the available negotiation process. Even after drafting materials and securing incentives to encourage acceptance of our research offer; we were rejected. The refusal to host us came late in the negotiations and represented further delays. The uncertainty of being accepted also necessitated that we continue canvassing for alternate hosts. All this effort went into marketing a research pilot program that could not be confirmed through comparison to any existing programs or service models. Our challenge is to account for this protracted effort in an overall project activities evaluation format.

Finally, the critical assessment of our model, services, marketing and final results is based on criteria that is appropriate for innovative programs. Our source is **Evaluation: A Systematic Approach**, by Howard Freeman and Peter Rossi. These authors suggest that evaluation of unprecedented programs is not easily done. The usual guidelines and parameters often do not apply because comparison to previous programs is not feasible. I accepted the authors' ideas by electing to make evaluation a continuing phase in all the workplans for all host sites. The notion of continuous scrutiny, detailed reporting, updates and consultation with interested parties should ensure credible data. As well our results should be able to be repeated for similar costs in related work environments.

The evaluation of our overall Project activities in the seven areas is very challenging. As mentioned we do not have any similar projects to use for comparison. We have requested quality assurance and comment from the Department of Sociology at the University of Victoria. We have received and utilized input from a volunteer researcher working in the area of the sociology of health and work. Further, we have consistently shared materials, development plans and ideas with any and all interested parties. We believe that our model, work to date, materials and plans are defensible and reasonable. We also believe

that this evaluation workplan format makes us accountable for our actions, activities, expenditures and final outcomes.

PROJECT EVALUATION STATEMENTS

Host Workplace Evaluations

We complied with the sample document parameters for evaluating our activities. We submitted draft versions of reports, edited our reports and formally invited comment primarily from service group members in the Rehabilitation Committee and the RTW/EAS Committees. The reports were accepted by study participants in both host sites. The response from Saanich service group members has been positive. They have elected to shift their focus onto early intervention. They have also decided to develop linkages to other workplace-based committees by joining these committees as members. Their actions and comments suggests that our findings were credible and accepted. The responses to our reports at the University of Victoria were also positive. Our survey findings were contributory to the negotiation process at this site for new collective agreement language on accommodation. Both CUPE 917 and 951 Locals secured parallel agreements. We were consulted and delivered direct input to CUPE Negotiators about service options and co-workers who would be candidates for accommodation. More importantly, we did meet with University of Victoria Management Representatives to request financial data for the Qualitative Report on this host study site. This data will not be available for this edition of our manual. We shall add this information as we receive it.

This is also an appropriate place to give you an overview of the written survey comments that we collected from Saanich and University of Victoria survey respondents. Their directions, suggestions and ideas are direct evaluations of our survey work.

THE CORPORATION OF THE DISTRICT OF SAANICH SURVEY RESPONDENT COMMENTS OVERVIEW:

We received 29 written responses to the comments section of our written survey.

Seven respondents alleged abuse or misuse of existing rehabilitation services by co-workers.

Two respondent delivered useful suggestions to improve our survey and distribution methods.

Nine respondents were sympathetic and supportive of our survey.

Two respondents wanted to read our findings and interpretations.

Two respondents disclosed their disabilities and offered personal opinions about accommodation at Saanich.

Two respondents criticized the survey as redundant and not focussed on non-disabled co-workers.

The remaining five respondents reported workplace health and safety issues that they deemed relevant to workplace disabilities.

THE UNIVERSITY OF VICTORIA SURVEY RESPONDENT COMMENTS OVERVIEW:

Thirty-five survey respondents reported written comments on our survey forms.

Eighteen respondents disclosed additional information about their disabilities.

Four respondents offered direction and suggestions to expand and improve our survey.

Two respondents outlined their accommodation efforts and outcomes.

Three respondents directed us to study workplace health and safety concerns that were affecting their health and performance.

Two respondents believed that disability correlates with aging and can not be exclusive of this causal factor.

One respondent complimented our survey and wanted to know the findings.

Five respondents reported that they were not disabled yet agreed with accommodation programs for disabled workers.

The high rate of response and the overall detail of these reports suggests to us that we enjoyed support and interest among the respondents. The lack of negative comments coupled with suggestions to use for further study also indicates solid support and interest. We have incorporated these suggestions into our survey format and distribution methods. We believe that, overall our survey and research effort was well received by survey participants.

We also appreciated the work done by service group members to quality assure, distribute and collect completed written forms. Key individuals in each group volunteered their time to assist with this time consuming work. We also want to publicly acknowledge the contributions of Mr. Tim Jepp, our volunteer Researcher. Further, the critiques and comment of Project Advisors helped us retain our focus and productivity.

In addition, the high level of completed survey forms, the lack of flawed forms and the number of respondents who delivered written comment is an important indicator of co-worker acceptance in both sites. We consider this acceptance to be an acknowledgement of the quality of our survey in both host sites. We believe that overall we enjoyed measurable support for our research activities and appreciate the clearance to conduct our study.

Finally, we have the option to conduct follow-up surveys in both host sites. The baseline profiles of co-workers that we conceived can be tested for reliability. We intend to conduct additional surveys and make the results available in later editions of this manual.

Workers with Disabilities Project Evaluation Format:

As mentioned, we did not complete the Workplans for each host site. We experienced unanticipated delays due to protracted marketing and negotiations. As well one of our three host sites became unavailable and unsuitable due to labour-management disputes. We necessarily re-focussed on completing the research phases of the workplans. We also elected to complete this manual as one of the outcomes that we achieved during our year of funding.

The seven evaluative areas of **marketing, educational materials development and use, pilot participant comment/opinion, recruitment of contributors, maintenance of our Advisory, direct involvement with and support of service groups; and, the cost/benefits of our project expenditures** will be discussed. Some of our activities in these areas have already been explained such that we shall summarize our efforts.

MARKETING: As mentioned, we canvassed 41 businesses using letters, FAXES, direct telephone calls and meetings. We conducted an intensive and extensive campaign to secure host study workplaces that ultimately yielded three sites. The two sites that accepted us were ideal for study purposes. We could not have asked for a better mix of contrast and compatible variables across both study sites. The costs for marketing were competitive. We found our greatest expense was for FAXed communication. We suggest that an investment in a fax/modem would have significantly reduced these costs. We only stopped canvassing for study sites after being formally accepted in Saanich and the University of Victoria.

EDUCATIONAL MATERIALS:

We drafted two learning kits, agendas and teaching plans for two service options. These kits were intended to be used to teach self-advocacy and co-worker job support methods. We also extended an offer to service group members to identify areas that we could research for service development. For example, we compiled materials to use for information sessions that were venues for the distribution of written surveys. Finally, the sum of our materials were for educational and

research purposes. We necessarily had to teach study participants about our ideas and plans as we developed them. For example, the reports and interpretations of summary data were relevant to an overall educational strategy. This strategy is central to any pilot, innovative initiative.

PARTICIPANT COMMENT AND OPINION:

We covered this area as part of our discussion on host site evaluation. We also worked closely service group members on service plans and collective agreement language. To our knowledge, we did not receive negative comment about our activities, materials and reports. We continue to enjoy access and involvement in both host sites. As mentioned, we hope to assist with follow-up surveys and data interpretation for both sites. Finally, the University of Victoria Management Group met with us in June of 1996 to offer financial data on accommodation costs. Recall that this is the data that we were not able to collect due to non-involvement by this group. We shall include this data in later editions of this manual for your consideration.

RECRUITMENT OF CONTRIBUTORS:

We believe that we were successful at locating and including skilled contributors to our project as needed. For example, the long term involvement of our Researcher is an indication of our success. Another example of our activities is the donation of time and effort by the Corporation of the District of Saanich Payroll Staff. They provided much of the integrated and direct cost data for this workplace. We also want to acknowledge the Executive of both CUPE Locals 917 and 951 for their assistance and donation of time. As guests in these workplaces, we had to secure cooperation and output from resident co-workers or we could not have completed our research phase. We did not have funding to use to cover lost time or associated expenses incurred by project contributors. Their commitment and donations are genuinely appreciated.

PROJECT ADVISORY MAINTENANCE:

We retained the involvement of our existing Project Advisors. They willingly assisted us with ideas, research information and in quality assurance. The best indicator of our ability to maintain our Advisory is that our Members will continue to work with us in the future. The majority of Advisors have worked with us for longer than three years.

DIRECT INVOLVEMENT AND SUPPORT OF SERVICE GROUPS:

We attended group meetings on a regular and, as needed, basis. We enjoyed easy access to service group members at work and often at their homes. We were included in sensitive communications and many of the activities of their workplaces. We believe that we could not have completed the Research Phases of

this study without this level of inclusion and subsequent trust. We continue to work with the Rehabilitation Committee and the RTW/EAS Committees.

COST/BENEFITS OF OUR PROJECT EXPENDITURES:

We had an operating budget of approximately \$ 75,000. for 14 months. We had initially planned to operate for 12 months yet were cleared to work an additional six weeks. Our largest budget item was the Coordinator's salary. The next largest operating expense was for office support and rental. Our office equipment, some supplies, office assistant support and miscellaneous costs were covered by contributions-in-kind from our sponsors. When the single largest cost is for one full-time generalist staff member then this is a very affordable project. In addition, when you consider the level of support from shareholders and involved parties then our project has been very cost effective. We believe that the limited funding and annual time frame forced us to be extremely creative and efficient in our use of time and money. We hope that this manual, survey materials, planning materials and innovative concepts will be used by a wide spectrum of interested parties. The utility of our manual will be the best confirmation of our opinion that this project represents money well spent. Please contact us for more detailed information about budgeting and the setup of financial statements. We submitted detail statements of expenditures with all progress reports sent to Disabled Persons Participation Program Staff. We highly recommend that you follow our example and keep detailed records.

SUMMARY

We have did not complete all the phases of our workplan. We believe that our materials, strategy, key concepts and service model are useful in real world workplaces. We believe that our statistical survey tools and categorization of health affected workers is unprecedented. We invite you to use our ideas and materials to setup your own accommodation services. More importantly, use our statistical tools to identify co-workers by profiles and budget accordingly. Our research methods and evaluation activities should ensure that you will know if your program is viable for your workplace and for your health affected co-workers. Please contact us for clarification and additional information about any of our activities and materials. Best of luck and we hope to hear from you.

APPENDIX

The following materials are copies of working agreements and plans that have been designed for unionized workplaces. We believe that they are also suitable for any workplace where co-workers enjoy social cohesion, co-worker support and a commitment of accommodation.

EARLY ACCOMMODATION AND SUPPORT PROGRAM

RESEARCH METHODOLOGY OUTLINE

INTRODUCTION:

The following outline is intended to establish a format to ensure the collection of relevant and useful data. We need measurable criteria and collectable information for a proof of concept of our early accommodation and support model. We want to make the case that our early assistance model is, at least, as viable and useful as existing conventional rehabilitation service delivery models. The latter are already being used in public and private sector, unionized work environments.

Our **hypothesis** is that the delivery of early assistance to a chronically ill or injured worker is a better use of available or allocated health services funding. We also believe that early assistance in the form of accommodation and co-worker support offers a better opportunity for a chronically ill or injured worker to remain employed especially in their original or current employment position. The final part of our hypothesis is that job continuance and long term job retention with coordinated therapy is cost effective and represents reduced emotional and financial hardship for chronically ill/injured workers.

Our research goals are to identify **Accommodation-Services costs** and **Accommodation Services outcomes** for two categories of co-workers. These categories are 1) previously identified or existing co-workers with chronic illness/injury and disability; and, 2) not yet identified co-workers with these health issues. We believe that the latter category of worker will voluntarily self-identify during the term of the worksite pilot program. This pilot program is the **Early Accommodation and Support Program** (please refer to the Appendix). We believe that **A-S Costs** will be recorded as rehabilitation expenses, renovations, purchased aids/adjuncts, service provider fees and consultation costs. We believe that **A-S Outcomes** will be recorded as alternate employment, completed re-training(on and off-worksite), accepted partial employment, job sharing, cash-outs and terminated employment. The latter option is the expected outcome or result for the majority of co-workers with chronic health issues and disabilities. We base this assertion on the a study by Hester and Decelles.

"Of the nearly 600, 000 workers who become disabled every year, (USA) approximately 50 % never return to work". (1)

This "either/or" dynamic for identified chronically ill/injured and disabled workers appears to be a trend across North America. We believe that a person with these health issues returns to full equivalency employment within the term of their benefit/services time frame or they do not retain employment. Early assistance to cope with chronic health issues may disrupt this dynamic. This form of accommodation may represent the best available option for any chronically affected worker.

We define Workplace Accommodation as:

the physical renovation, restructuring or alteration of job tasks, schedules and work environments to "fit" or match the range of abilities of a co-worker with a chronic illness/injury or disability. These changes are based on medical/legal opinion and are to be confirmed through coordinated trial and error experiment on the part of the co-worker with chronic illness/injury or disability. The plan is to "build" the job to fit the person.

Within a program format we want to compare associated pilot program services **costs** to the conventional or existing services costs of accommodation in host workplaces. These work environments are: 1) unionized, 2) private and public sector based, and 3) range from a total of 16 co-workers to 300 employees. The co-workers in these site have a diversity of available health-related services.

We shall also assess and evaluate **outcomes** that are directly related to the impact of accommodation services that we deliver or facilitate for a voluntary "pilot program candidate". These outcomes for pilot candidates will concern 1) job retention of original or pre-pilot positions, 2) assessments of the levels of emotional and financial consequences of any accommodation service process and 3) self-disclosure about the utility of services that pilot candidates have received. We can also weigh the utility of services with a cost/benefit approach for each participating candidate. For example, we can state that for x dollars we delivered a trial placement that included the assistance of a job coach during a three month term. The long range outcome was that the pilot candidate elected to retain employment on a part-time basis with the option to gradually secure more hours to achieve and resume full time equivalency.

Finally we want to collect data about previous and/or current accommodation related assistance for identified co-workers with chronic illness and injury. We want to establish a knowledge base of the **average per co-worker costs and outcomes**. We believe that this information may be available through Occupational Health and Safety records. We may also be able to survey and interview identified co-workers who may volunteer information.

Once we achieve our research goals then we can employ a comparative analysis format that may further highlight the utility of our early assistance model. If we can support our opinion that our early assistance model represents similar costs to currently available services while yielding job continuance/retention outcomes; then our model may be considered more effective and useful for a chronically injured co-worker. There may also be collateral advantages for participating co-workers, service providers and funding resource people. The latter may be a public insurance carrier such as Workers Compensation Board or a private insurance company. We may also compare data between participating worksites to identify which services are delivered most often and for what comparative costs.

We believe that a comparison of specific variables in a study or host workplace would indicate measurable advantages to using our early assistance model.

These variables are:

COSTS

- 1) average annual health services costs for a co-worker in a study or "host" workplace.
- 2) average accommodation services costs for a co-worker in a study or "host" workplace.
- 3) average accommodation services costs for a co-worker in our pilot accommodation services program. *

OUTCOMES

- 1) disclosures/reports/records of the effectiveness of accommodation assistance for mainstream or non-pilot program co-workers.
- 2) average length of time that an previously accommodated co-worker retains her/his employment in a work environment.
- 3) average annual number of co-workers who have received accommodation assistance in a host workplace.
- 4) number of co-workers who participate as "pilot candidates" for accommodation assistance within our pilot program.
- 5) disclosures/reports/records of the effectiveness of accommodation assistance for pilot candidates in our pilot program.
- 6) predictions and data on the retention of employment by pilot candidates on our program.

COMPARATIVE ANALYSIS FORMAT

Our comparative analysis is intended to display statistics for two categories of co-workers. As mentioned pre-pilot co-workers and pilot candidate co-workers would be matched by cost and outcomes. Our model could be deemed viable or successful if services costs are less or equal to funds spent on co-workers served under more conventional rehabilitation delivery systems. A further indicator of success would be data from both categories that suggested trends towards longer

term, more stable work performance for pilot candidates compared to pre or non-pilot co-workers. For example, should pilot candidates experience fewer unscheduled absences with less impact on associated co-workers; then, again our model may be considered more beneficial. This is measurable within a cost-benefits ratio approach.

We may also collect sufficient information to conduct a comparative analysis across all participating worksites. This data could be used to identify which services were effective across work environments based on costs, co-worker support and job retention. In closing, our research will be relatively short term due to funding constraints and workplan schedules. We believe that collected data, our methodology and comparative analysis may serve as a platform for further work.

(1) The source of our information on American Workers and disability is,

The Worker Who Becomes Physically Disabled: The Handbook of Incidences and Outcomes, Hester E., Decelles P. , The Menniger Foundation, 1985.

* Due to donated and volunteer assistance we shall estimate costs and add them to actual costs where applicable.

REFERENCE MATERIALS

Disability Management in Industry: A Joint Labour-Management Process, Bruyere, S.M., Shrey, D.E., Rehabilitation Counselling Bulletin/ March 1991/ Vol. 34 No.3.

Evaluation: A Systematic Approach, Freeman, Howard and Rossi, Peter, Sage Publications Inc., Beverly Hills, CA, 1985.

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Incidences and Outcomes, Hester E., Decelles P. , The Menniger

Foundation, 1985.

***DATA COLLECTION PLAN
FOR
THE CORPORATION OF THE DISTRICT OF SAANICH***

INTRODUCTION:

This is a public sector, unionized work environment located at 660 Vernon Avenue in Victoria, BC. There is one resident union, Canadian Union of Public Employees, Local 374 which has jurisdiction in this worksetting.

There is a joint labour/management group that is responsible for health services delivery in this work environment, the **Rehabilitation Committee**. It consists of seven members who meet on a regular basis. There is not a resident attending physician attached to this group. There is a resident Rehabilitation Counsellor who is a Member of this Committee.

Relevant Information:

The population of host site Co-Workers who are served by the Rehabilitation Committee is approximately **400**. There are a further **130** Police, **130** Fire and **60** "exempt" co-workers who are primarily Managers. These **320** employees are not served by this Committee.

We began collecting information on this host site in November of 1995. We began a series of meetings with xxxxxxxx on November 23rd to assess available records on Rehabilitation Committee Activities and Cases. Tim Jepp, Researcher, has scanned the minutes for the Rehab. Committee. for 1995.

Soft data to date is that 20 co-workers were served by the Rehab. Comm. during 1995 to November. Approximately, 10 cases were Return to Work to alternate positions outcomes, 2 cases were terminations, more data will be collected and confirmed. We want to backtrack to 1992 for a representative range.

Data Collection Information:

1) As mentioned, we are evaluating existing records through the Rehabilitation Committee. Further, xxxxxxxx, Rehab. Comm. Member is collecting records on expenses, costs and fees for contracted services such as: work hardening programs, functional capacity assessments, consults, counselling sessions. We also want to collect hours for Rehab Comm. Members for monthly meetings. Finally we shall collect costs for a resident Rehabilitation Counsellor. The total costs divided by the # of cases should give us a rough average cost.

2) We have submitted survey materials for editing and approval to xxxxxxx and Rehab Comm. Members. We want to combine the survey with educational/informational sessions.

The key is to distribute and collect the completed forms for efficient data management. The forms will be numbered and treated in confidence.

3) Innovative data collection ideas:

Informational Interviewing of affected people.

Individual Interviewing of Rehab. Committee Members, past and present.

Cross referencing health services records in payroll, accounting, Occupational Health and Safety minutes/files and any not yet identified sources.

COMMENTS:

DATA COLLECTION GOALS:

As agreed by Tim Jepp and myself, we would like to collect as much data as is available. We can condense and discard information as required to complete our Research Phase. The **preliminary goal** is to capture data that we shall use to construct a profile of an average chronically health affected-to-disabled co-worker for the Corporation of the District of Saanich.

Associated goals are to collect and interpret the direct and indirect costs of health services delivery through the Rehabilitation Committee Members. In essence we want to know the actual costs of health services for co-workers served by the Rehab. Committee. These costs should include the expenses associated with accommodation such as training, counselling , etc.

We are also interested in data such as wage loss funding for Rehab Committee Service Recipient (RSCR). This may be available as a record through Payroll/Personnel and is a direct cost. An indirect cost would be the hours that were allocated and funded to replace a RCS Recipient during her/his absence

from their job. These direct and indirect costs combine to present a realistic picture of expenditures by and associated with the Rehab. Committee.

Finally, the data that we collect during the Research Phase will suggest or identify outcomes or resolutions for RCSR Co-Workers. The capture and interpretation of these outcomes is as important as expenditures. When we combine information about costs and outcomes we can then interpret cost efficiency and utility of outcomes. The latter may suggest services that we could implement during our Delivery Phase.

The costs/outcomes should be collected, categorized and interpreted to suggest which services are effective. Further this organized data should be setup to use to identify further services for the next phase of our Workplan for this site. This coordination of effort and activities will be assessed as part of our on-going project evaluation.

A **final goal** involves collecting information about a hidden and vulnerable group in our workplaces. There is a not yet identified co-worker who may emerge during the research phase. Our data collection goal will involve generating estimates or projections of the numbers of chronically health affected who choose to not disclose. The reason for estimating this co-worker population is that these individuals are potential candidates and participants in our pilot program. They may become the co-worker service providers as well as the pilot program service recipients. We believe that hard data about this group will not be available or easily collected due to the very sensitive nature of this information. Our survey materials are designed to collect and anonymously categorize chronically health affected individuals. We should be able to extrapolate from survey data to produce a host population estimate.

COMMENTS:

***INFORMATION INTERVIEW FORMATS
and
WORKPLACE HEALTH SURVEY FORMATS***

We elected to not release these documents for general use. We have revised these formats and continue to use them in our current **Accommodation and Partnership Training Course**. If you require more information about scoring, analysis and updated materials; please contact Duane Hoffman through my email address, **duane_hoffman@bc.sympatico.ca**

or through our project webpage <www.islandnet.com/~aappt>. We prefer to maintain control over the use and distribution of these research tools to ensure

our intellectual property rights. Further, we ask to be included in any databases that are generated through the use of our research materials. Thank you for your interest. Again, please contact us for additional information.

TERMINOLOGY

ACCOMMODATION:

the physical renovation, restructuring or alteration of job tasks, schedules and work environments to "fit" or match the range of abilities of a co-worker with a chronic illness/injury or disability. These changes are based on medical/legal opinion and are to be confirmed through coordinated trial and error experiment on the part of the co-worker with chronic illness/injury or disability. The plan is to "build" the job to fit the person.

CHRONIC ILLNESS/INJURY:

any medical condition, disease or bodily damage that is recurring and/or long term. A co-worker in this situation may also experience episodic bouts of illness with a long term prognosis of eventual temporary or permanent disability.

CO-WORKER:

any person who is hired and employed in a host worksite or work environment.

DISABILITY:

is a temporary or permanent series or single limitation acquired or imposed on an individual. This limitation may impact a person in three general areas: mentally, physically and/or sensorial. The limitation is usually measured and displayed in terms of functional capacity and performance.

HEALTH SERVICES:

are any and all alternate positions, direct assists, counselling, income benefits, leaves of absences, training and worksite adjunct, aids, renovations to promote wellness of a co-worker in a host worksite.

SOCIAL COHESION:

the interconnectedness and level of tolerance among co-workers in a work environment. Co-worker relationships are less affected by workplace status and characterized as person-to-person.

WORKPLACE:

is the physical and/or built environment in which co-workers reside to perform tasks and responsibilities that are measurable behaviours. The social environment associated with this physical setting is also a component of a work area or space.

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