SBCI UPDATE

June 2017 *NEWSLETTER*

MESSAGE FROM THE CHAIRPERSON

SBCI's Annual General Meeting was held on Friday, April 7. At this meeting, an amendment was made to one section of the SBCI Bylaws, relating to signatures for expenditure. No problem had surfaced which caused this amendment. The SBCI Board just felt that the wording, written in 1993, was out of date.

At the AGM, it was reported that SBCI had an excellent year, financially, with our accumulated surplus rising to over $200,000. However, the three Assistance Programs are beginning to struggle due to the very low investment returns and to the extension of conditions covered by the WSIB as workers' compensation claims. As you will read in an article in this newsletter, the Provincial Government is extending WSIB coverage to include chronic mental stress incurred in the workplace. This will increase the likelihood of claims requiring discretionary payments under the Assistance Programs.

After 6 years on SBCI's Board of Directors, Maura Quish has decided to retire from our Board. Maura was my predecessor as Chair of SBCI and I am very grateful for the advice that she provided to me and for all her insights and perspectives while a Director of SBCI. Thank you, Maura.

Just before the AGM, Carole Audet stepped down from the SBCI Board of Directors. We thank Carole for her contribution to our discussions at the Board table.

We are pleased to announce that Karen Cantin, Directrice des ressources humaines at Conseil scolaire de district catholique Franco-Nord, has agreed to fulfil the balance of Carole's term. Further, that Grace Rogers, Disability Management Officer at Thames Valley DSB has been acclaimed at the AGM to fill the place vacated by Maura. We welcome Grace and Karen.

Since I last had the opportunity to provide a Chair's Message, Louise Ellis has left SBCI. Louise was the Department Leader for our Attendance Support services. On Louise's departure, Kathleen Gratton has taken over as Department Leader. One of Kathleen's first actions was to select a new Attendance Support Consultant to bring the complement back to 3 people. As a result, Ermelinda Faria has joined the Attendance Support team, starting in May. Our congratulations and best wishes to Ermelinda and Kathleen.

If you have any questions, comments or ideas regarding the Co-operative, please give me a call or send me an email. Our aim is always to improve the services that we provide to you. I can be reached at jamie.gunn1@outlook.com or 519-443-4164.

Meanwhile, I hope that everyone has an enjoyable and safe summer vacation.

Jamie Gunn, SBCI Chair

IN THIS ISSUE

CONCUSSIONS

There has been a great deal of research done in relation to concussion caused in sports. Sporting bodies have clamoured for clear and practical guidelines to determine recovery tactics and safe return to play for athletes following a concussion.

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Every three to four years, the world's sport concussion experts meet to consider what the current medical evidence is indicating with respect to concussions. The last meeting of these experts took place in October 2016 in Berlin.

In preparation for that meeting, approximately 60,000 published articles were screened by expert panels. On April 26, 2017, the experts released their updated "Consensus Statement on Concussion in Sport" designed to assist health care professionals with the management of sports-related concussions.

While these experts focus on sports-related concussions, their conclusions are transferable, in large part, to concussion management in general. The full document can be accessed at the following website address. Key findings which may be of interest to school boards are summarized below.

http://bjsm.bmj.com/content/bjsports/early/2017/04/28/bjsports-2017-097699.full.pdf

Re causation:

- Concussions can be caused by a blow to the head or anywhere on the body "with an impulsive force transmitted to the head."
- Having a prior concussion is a risk for having a future concussion.

Re initial symptoms:

- Concussion is an "evolving injury in the acute phase, with rapidly changing clinical signs and symptoms."
- Concussions "can result in diverse symptoms and problems, and can be associated with concurrent injury to the cervical spine and peripheral vestibular system."

Re testing:

- Concussions may result in neuropathological changes "but the acute clinical signs and symptoms largely reflect a functional disturbance rather than a structural injury and, as such, no abnormality is seen on standard structural neuroimaging studies."
- "Advanced neuroimaging, fluid biomarkers [such as blood, saliva and cerebrospinal fluid testing] and genetic testing are important research tools, but require further validation to determine their ultimate clinical utility in evaluation" of concussions.

Re treatment:

- "After a brief period of rest during the acute phase (24-48 hours) after injury, patients can be encouraged to become gradually and progressively more active while staying below their cognitive and physical exacerbation thresholds (i.e., activity level should not bring on or worsen their symptoms)."
- "A variety of treatments may be required for ongoing or persistent symptoms and impairments following injury. The data support[s] interventions including psychological, cervical and vestibular rehabilitation."
- "In addition, closely monitored active rehabilitation programmes involving controlled sub-symptom-threshold, submaximal exercise have been shown to be safe and may be of benefit in facilitating recovery."
- "Treatment should be individualised and target specific medical, physical and psychosocial factors identified on assessment.
- There is preliminary evidence supporting the use of:
  - an individualised system-limited aerobic exercise program… and
  - a targeted physical therapy program in patients with cervical spine or vestibular dysfunction, and
  - a collaborative approach including cognitive behavioural therapy to deal with persistent mood or behavioral issues."
- "Currently, there is limited evidence to support the use of Pharmacotherapy."

Re recovery:

- Most individuals recover in 10-14 days (4 weeks for children). However, "physiological time to recovery may outlast the time for clinical recovery."

Re change in diagnosis to post-concussive syndrome:

- The report suggests that the diagnosis of concussion should change to a diagnosis of persistent post-concussive symptoms when recovery is not reached within normal clinical recovery time frame that is 10-14 days for adults and 4 weeks for children.
- "Persistent symptoms" describes a "constellation of non-specific post-traumatic symptoms."

Predictors of slow recovery:

- Having a prior concussion is associated with slower recovery from the next concussion.
- Having pre-existing migraines is a risk for having symptoms for more than one month.
- The strongest and most consistent predictor of slower recovery from concussion is the severity of a person's initial symptoms in the initial days following injury.
- "There is a growing body of literature indicating that psychological factors play a significant role in symptom recovery and contribute to risk of persistent symptoms in some cases."
- If symptoms last more than one month, likely the person will develop migraines or depression as well.

Tips for school boards:

The Berlin "Consensus Statement on Concussion in Sport" and other evidence based materials, by implication, provide the following tips for school boards:

- Not all concussions resolve, so prevention efforts are vital.
- After the first 24-48 hours, rehabilitation includes activity, but activity needs to be done on an as tolerated basis. Once an activity

level is found to be tolerable, additional activity can be tried. If the symptoms worsen, the activity level needs to be reduced.

- It is important to attend to the person's mental health throughout their recovery and that includes encouraging positive and usual social interactions. Thus, where a quiet room is provided, it should not be used to cut the person off, socially, from their peers. In addition, it is necessary to encourage and allow a person to attend school social events without jumping to the conclusion that because the person can attend a social event they can do the full range of their duties.
- There have been over 60 concussion related symptoms identified, ranging from the obvious ones (such as headache and nausea) to symptoms that are not well known to the general public such as under arousal which can lead to magnified reactions and excessive drinking. Thus, it is important to provide patience, understanding and sometimes mediation between workplace parties in relation to these difficult cases.

Further resources to take note of include the following:

- Parachutecanada.org: Parachute provides evidence-based information on a range of topics, including head injury and concussion. The organisation is guided by a number of medical experts, including Dr. Charles Tator, a Professor of Neurosurgery at the University of Toronto and a participant in the Berlin "Consensus Statement on Concussion in Sport."
- CDC.gov: The Centre for Disease Control and Prevention provides information on a variety of topics including concussion.
- PPM 158: This is a Ministry of Education document applicable to students with concussions. However, the information is transferable to other concussion situations as well. It is evidence based and regularly updated to account for updated research.

VIOLENCE PREVENTION IN THE HOSPITAL SECTOR AND PARALLELS TO THE EDUCATION SECTOR

If you have visited a hospital lately you may have noticed a poster reminding patients, friends and families of the need to treat hospital staff with respect and noting that violence of any kind will not be tolerated. It is common to see uniformed security personnel near Hospital Emergency areas and in other parts of hospitals.

There are over 300,000 people employed in Ontario Hospitals and Long-Term Care facilities. In 2014-15, there were approximately 6,500 incidents of violence in Hospitals and Long-Term Care Homes involving health care, lost time or first aid. Approximately 10% of all hospital claims involve violence. Hospitals, in fact, had more incidents of violence than correctional facilities in the province.

The Ministry of Labour and the Ministry of Health and Long-Term Care, the Ontario Hospital Association, the Ontario Nurses Association and other health care sector unions are involved in a three year project to reduce the incidence of violence in Hospitals and Long-Term Care Homes. There are twenty-three recommendations that were developed by a task force that will be addressed. The official kick off to the program was announced in late May 2017.

In the first year some of the work will focus on providing information to patients and families outlining expectations. There will be mandatory reporting of violent incidents. One of the key themes will be accountability together with roles and responsibilities. A toolkit will be prepared to assist in the development of leading practices. Each facility will be required to do staff surveys every two years on the risk of violence and provide the opportunity for staff input. There will be a Violence Prevention Committee established at each facility, separate and apart from the Joint Health and Safety Committee. Patient care plans will include information on things that may trigger violence on the part of the patient. There will be a training matrix prepared outlining what types of training different employee groups require. The types of training will vary depending on the level of employee interaction with patients including patients with a higher potential for aggression. Staff will also be taught the importance of being mindful of their own behaviours that may inadvertently trigger aggression. This training will require significant funding from the Ministry of Health and Long-Term Care in order to be implemented.

Patient care plans will include a mandatory section that includes an individual client risk assessment for violence. There will be increased requirements for communication between Long-Term Care Facilities and Hospitals when transferring patients. Too often a facility has received a new patient but has no warning that the patient had a history of violence.

There will be mandatory violence prevention training required as part of the curriculum offered at Colleges and Universities for new doctors, nurses, physiotherapists and Personal Support Workers (PSWs) etc.

Quality improvement plans for hospitals will include mandatory violence prevention programs for staff. Hospitals and Long-Term Care Homes seeking accreditation will need to include steps on violence prevention as part of their required operational priorities.

There will be revised environmental standards for new buildings to allow for better sight lines for security and safety purposes.

The Ontario Nurses Association is particularly interested in the provision of personal safety alarms for its members. The quality and price of personal safety alarms vary greatly. There are personal safety alarms that make a loud noise and they are relatively inexpensive but they may trigger further violent behavior. There

are personal safety alarms that can be linked to a facilities security system but these are much more expensive and have their own problems with false alarms. The challenge remains how do you provide 24/7 emergency assistance to staff in all of the facilities if there is a violent incident?

Hospitals and Long-Term Care Homes will be expected to adopt the CSA Z1003 standard for Psychologically Safe and Healthy workplaces. There will be minor changes to the Occupational Health and Safety Act that will require a worker member of the Joint Health and Safety committee to be involved in every violence investigation.

There will be a gradual phase in of this work with the first phase focused on nurses in hospitals and the second phase on all workers in hospitals and long-term care homes. The third phase will be focused on all workers in the broader healthcare sector.

In addition to providing a safe and secure environment for staff Hospitals and Long-Term Care Homes are looking at training programs to help staff to become more resilient. This is not easy as some staff are feeling tired and worn out from long shifts. These programs will emphasize the importance of looking after yourself first before you help others.

The long-term goal of these programs is to raise awareness of violence in the hospital sector, provide staff with the training and tools to better manage it and have that approach integrated and accepted by society. The work being done for the Hospital sector is at least six months ahead of what is being worked on for the Education sector.

Education Sector

PSHSA is working with representatives of the Ministry of Education, the Ministry of Labour, school boards, unions and SBCI to produce a Provincial Risk Assessment process, a Reporting Process and a toolkit that school boards can use to enhance their violence prevention programs. This work has many similarities to what has been developed in the Hospital sector. There is plenty of good work being done but to implement the program fully will require additional funding for staff training and other initiatives. Hopefully the Ministry of Education will agree to provide additional new funding for this expanded program.

We will provide you with further information on work being done with the PSHSA on violence prevention in the school board sector in future articles.

WSIB – ONTARIO GOVERNMENT EXPANDS ENTITLEMENT TO INCLUDE CHRONIC MENTAL STRESS

On May 17, 2017, Bill 127, "An Act to implement Budget measures and to enact, amend and repeal various statutes" received Royal Assent and was passed into law. This bill included a provision expanding entitlement to WSIB benefits to include "chronic mental stress arising out of and in the course of the worker's employment." Previously in Ontario, entitlement for mental stress was limited to situations that were a psychological reaction to an event or situation that was objectively traumatic and unexpected in the normal course of a worker's employment. Entitlement was also available where a worker had a psychological reaction to a physical work-related injury or treatment of that physical work-related injury.

On January 1, 2018 subsection 13(4) of the Workplace Safety and Insurance Act will be repealed and the following substituted:

"Mental stress

13 (4) Subject to subsection (5), a worker is entitled to benefits under the insurance plan for chronic or traumatic mental stress arising out of and in the course of the worker's employment.

(5) A worker is not entitled to benefits for mental stress caused by decisions or actions of the worker's employer, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the employment."

On May 4, 2017, the WSIB announced that they would be undertaking a consultation process with workers and employers with respect to the proposed expansion of entitlement to include chronic mental stress that was contained in the Ontario Government Budget Bill 127. The WSIB has released some background information and a draft policy, both of which we would be pleased to provide to you.

The WSIB is inviting written submissions until July 2017 so the period for consultation is very short. SBCI will be working with other employer groups to advocate for a policy that limits chronic mental stress entitlement to situations that are objectively serious and are well above the normal day to day stresses that are encountered in individual occupations in the workplace.

In the draft policy, the WSIB introduces the concept of "substantial work-related stressor". The draft policy provides as follows:
"A work-related stressor will generally be considered substantial if it is excessive in intensity and/or duration in comparison to the normal pressures and tensions experienced by workers in similar circumstances."

The WSIB draft policy as written would still allow chronic mental stress entitlement in occupations with a high degree of routine stress. The policy provides as follows:
"However, a claim for chronic mental stress made by a worker employed in an occupation, or a category of jobs within an occupation, reasonably characterized by a high degree of routine stress should not be denied simply because all workers employed in that occupation or category of jobs within that occupation are normally exposed to a high level of stress. In some cases, therefore, a high level of routine stress combined with significant duration, may qualify as a substantial work-related stressor."

We will keep you advised of further developments and should you have

ideas or suggestions that you would like to see provided to the WSIB please share them with your SBCI Claims Manager.

2017 SCHEDULE 2 EMPLOYERS' GROUP CONFERENCE

On October 18 & 19, 2017, the Schedule 2 Employers' Group is holding its 28th annual conference. This will take place at the Sheraton Parkway Hotel and Conference Centre in Richmond Hill. The conference committee is finalizing the agenda and it is expected that registration will open in mid-July.

The conference will feature a number of keynote presentations, a panel discussion and over 30 workshops with an emphasis on employee mental health and mental stress claims. There will be presentations on a variety of topics including:

- Personal wellness and resiliency
- Mental health strategies for public sector employers
- RTW planning in cases of physical and psychological impairment
- Asbestos related diseases and cost mitigation through US Asbestos trusts
- Medical Marijuana – when it this an appropriate accommodation
- The impact of new prescription drugs on employee benefit plans
- WSIB/WSIAT Appeals with complex evidence
- Conducting Legally Defensible Harassment Investigations
- Schedule 2 invoices, accounts and administration fees
- Psychological factors in the RTW Experience
- Managing Fatigue –an emerging health and safety issue
- PTSD cases – how do you help employees to RTW
- Managing Risks of Frontline Worker Safety – the UK perspective

For update information on the conference please periodically go to the website which may be found at www.s2egroup.com.

ONTARIO'S MINISTRY OF LABOUR HAS EXTENDED A DEADLINE FOR WORKING AT HEIGHTS TRAINING

In response to employer requests, Ontario's Ministry of Labour has extended a deadline for working at heights training. The extension applies only to workers who, before April 1, 2015, met the fall protection training requirements set out in subsection 26.2(1) of O. Reg. 213/91.

The original deadline for this training was April 1, 2017. Now these workers have until October 1, 2017 so long as the following conditions are met:

- the worker(s) in question must have completed fall protection training that met the requirements of section 26.3(1) of O.Reg.213/91 (Construction Projects) before April 1, 2015 (as indicated above)
- the worker is enrolled in a working at heights training program scheduled for completion before October 1, 2017
- the employer has written proof of enrolment, which must be made available to an inspector on request

Proof of enrolment must include these four items:

- worker's name
- training provider's name
- date on which the training will be completed
- name of approved training program

Who is affected?

The regulatory requirement for working at heights training applies to:

1. Workers on Construction Projects who may use these methods of fall protection:
    - travel restraint system
    - fall restricting system
    - fall arrest system
    - safety net
    - work belt
    - safety belt

2. Workplaces undertaking any of these projects, and the projects involve working at heights:
    - moving a building or structure
    - installing machinery
    - constructing a building, bridge, structure, industrial establishment, mining plant, shaft, tunnel, caisson, trench, excavation, highway, railway, street, runway, parking lot, cofferdam, conduit, sewer, watermain, service connection, telephone or electrical cable, pipeline, duct or well, or any combination thereof

If you are the constructor for any of these projects, you have to make sure that every employer and every worker performing work on the project complies with the Occupation Health and Safety Act and the regulations, including O. Reg. 297/13 covering working at heights training.

Even if you have outsourced the construction work to a general contractor, you still have a shared responsibility as the project owner.

The Ministry of Labour begins a fall prevention inspection blitz on October 2, 2017.

For more information, please visit, https://www.labour.gov.on.ca/english/hs/faqs/wah.php

PERSONAL PROTECTIVE EQUIPMENT (PPE)

What is personal protective equipment?
Personal protective equipment (PPE) is any device worn by a worker to protect against hazards.

Some examples are: respirators, gloves, ear plugs, hard hats, safety goggles, and safety shoes or boots.

What does the law say?
Section 25(1) under the Occupational Health and Safety Act (OHSA) requires employers to:

- Provide equipment, materials and protective devices
- Make sure they are used as prescribed
- Maintain them in good condition

The OHSA also requires workers to use or wear the equipment, protective

devices or clothing that has been prescribed.

How personal protective equipment affects your business.
The best way to manage hazards in the workplace is to find ways to eliminate them.

Sometimes, however, when engineering control cannot be implemented, the use of personal protective equipment becomes the only option to prevent injury or illness and to protect workers from those hazards. Injuries and illness can affect your employees' morale, your production and quality.

- An average WSIB claim is $11,771
- Factor in other costs like lost productivity and staff replacement, and the cost can be as much as four times more - approximately $59,000 per injury

What you can do?
PPE is considered the last line of defense against a workplace hazard, and is to be used only if the hazard cannot be eliminated or controlled in other ways.

Ensure your PPE program:

- Considers the hazards that require PPE,
- Establishes policies, procedures, guidelines, or best practices for the selection, fitting, maintenance, storage, monitoring use and training.

Your SBCI Health & Safety Specialists and Consultants can assist you with this.

This information was provided by: http://www.wsps.ca/Information-Resources/Topics/PPE.aspx

MANAGING ACCOMMODATION REQUESTS

School boards have a role and a responsibility to support employees and to maintain a workplace culture of wellness and quality which can result in improved attendance. This can also demonstrate compliance with the Ontario Human Rights Code.

When employees request an accommodation, it is important to assess if the accommodation can be implemented without undue hardship to the board, considering the following three criteria:

- Cost
- Outside sources of funding
- Health and safety requirements

If it is determined that an accommodation can be made to assist the employee in either remaining at work or returning to work, then a formalized document should be produced. This is typically referred to as a Graduated Return to Work (GRTW) Plan or an Accommodation Plan. In creating the plan, information relating to the employee's restrictions and limitations should be provided by the employee's Health Care Practitioner (HCP). The HCP may also indicate whether the restrictions and limitations are temporary or permanent in nature.

When creating the GRTW/Accommodation Plan, the following should be included:

- The employee's current restrictions and limitations
- Clear start and end dates for the plan
- Clear outline of accommodation (i.e., modified duties and/or hours)
- Progression of hours if the employee is working modified hours
- A plan for monitoring progress/next review date

The document should also include a space for all parties involved to sign and date that they have reviewed the document together and understand the accommodation outlined, including the duration of the accommodation and when it will be reviewed next.

It is important that both the employee and their manager follow the outlined plan and connect immediately if the plan is not progressing. This will allow both parties to revisit the Plan and determine if changes are required. Follow up on specific target dates also ensures that all parties involved do not lose track of the accommodation and are continuously reassessing the situation to ensure that the employee is receiving the appropriate care required to sustain his/her healthy stay at work effort.

At the targeted review date, if the employee has:

- Improved to the point that the accommodation is no longer required
- The accommodation is determined to have ceased and the employee is now able to resume his/her regular duties and hours

Both the employee and their manager should sign and date the plan acknowledging that they have reviewed the document and that accommodation is no longer required.

- If, at the targeted review date (or any time before that), the employee has:
- Not been progressing well and it is determined that additional information may be required
- The employee's restrictions are considered permanent

The manager should immediately notify the Disability Management (DM) Officer so that the Plan can be reviewed and updated medical information can be requested. The employee's HCP may provide additional details, including current restrictions and limitations, for further review.

Should an employee be identified as requiring permanent accommodations, an Accommodation Plan should be created with a requirement that the employee provide updated medical information on a yearly basis for further review. This will ensure that the school board is up to date on the employee's restrictions and limitations and that, if the condition worsens, the plan can be adjusted accordingly.
SBCI can work with you to provide training and support in accommodation requests. SBCI can also assist with obtaining medical information required to assist with implementing GRTW/Accommodation Plans in complex cases as well as setting up ergonomic or other assessments, if required.

DATES OF BOARD OF DIRECTORS MEETINGS

August 21, 2017
October 27, 2017
December 15, 2017
February 2, 2018
March 2, 2018
April 13, 2018
May 1, 2018

SBCI BOARD OF DIRECTORS

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Karen Cantin
Judi Goldsworthy
Jamie Gunn (Chair)
Janice McCoy
Deirdre Pyke
Roger Richard
Grace Rogers
James Rowe
Mary Lynn Schauer (Vice-Chair)

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Lynn Porplycia, Chief Operating Officer
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Joe Huang, Actuarial Analyst
Justin Lee, Actuarial Analyst
Gary Stoller, Actuarial Consultant
Christopher James, Senior Claims Manager & Lawyer
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Michelle Montgomery, Senior Health & Safety Specialist
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Ermelinda Faria, Attendance Support Consultant
Anna Sequeira, Attendance Support Consultant
Zahra Haji, Manager of Finance
Karen Bertrand, Accounting Clerk
Erin McLennan, Manager, HR and Administration
Lily Li, Executive Assistant
Mika Dowson, Executive Assistant
Melissa Hewit, Manager, Data Management
Sylvie David, Bilingual Data Management Assistant
Micheline Desjardins, Bilingual Data Entry Clerk
Audrey O'Connor, Data Entry Clerk
Lindsay Tonelli, Bilingual Data Management Assistant
Rana Khalaf, IT Manager
Anwar Khalil, Programmer/Analyst
Gavin King, Programmer/Analyst