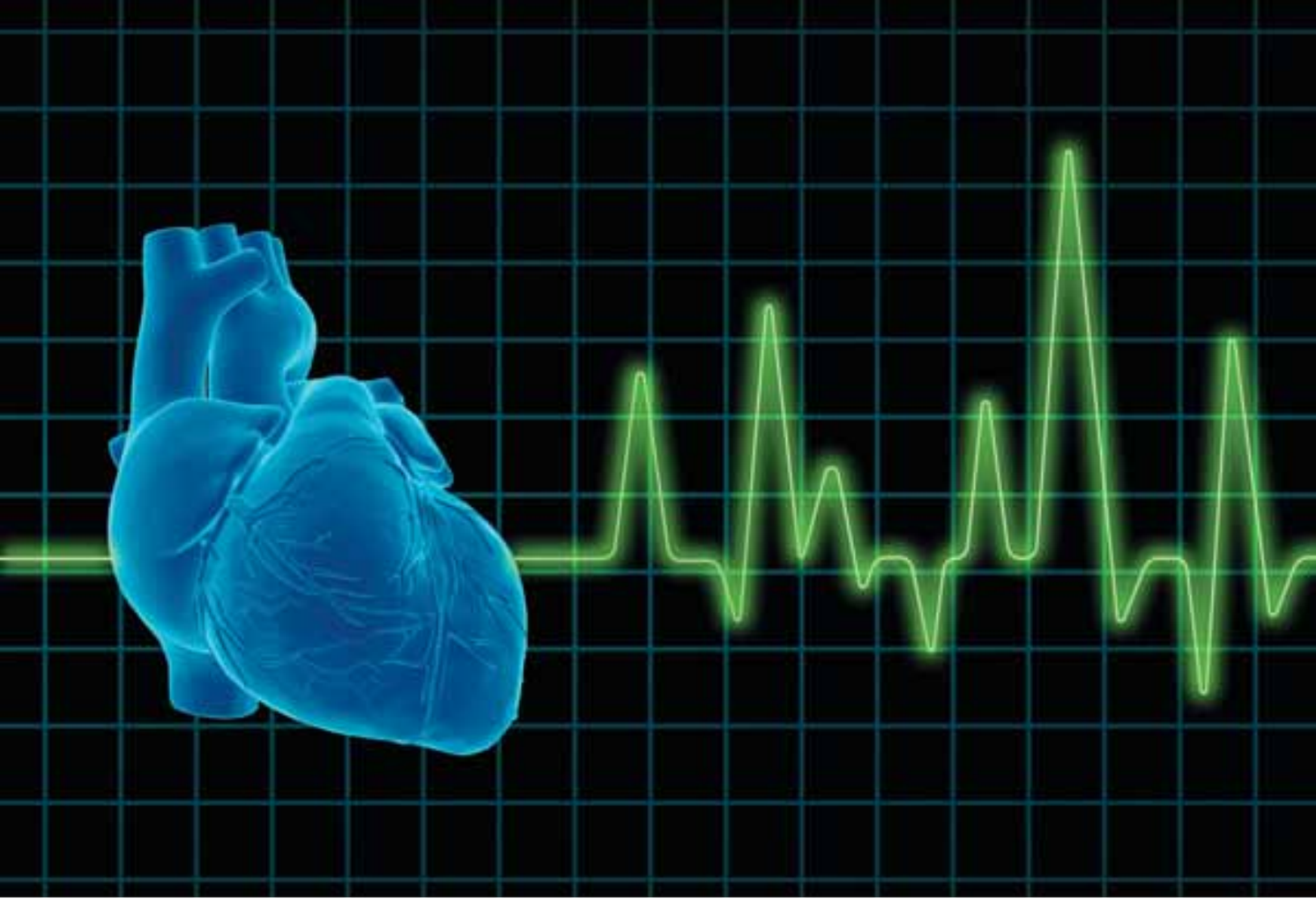

Perceived Versus Actual Heart Disease Risk in College Health and Kinesiology Students

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The purpose of this study was to determine if the perception of cardiac risk in college kinesiology students differs from actual risk as measured by selected physiological, familial, and lifestyle risk markers. Subjects were 134 undergraduates enrolled in a large research university fitness class required of all kinesiology majors during their freshman or sophomore year. All subjects completed a questionnaire which quantified perceived heart disease risk along with risk factors. Subjects then underwent physiologic testing. The results of the study suggest that college kinesiology majors who exercise more and have lower %FAT tend to perceive their heart disease risk as being lower than those who seldom exercise or have higher body fat percentages. There were no significant differences in each of the physiologic values among the different levels of risk perception.

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Introduction

The American Heart Association (2005), estimates that 1.2 million Americans had a first or recurrent heart attack in 2005, with almost half of these people dying as a result. It is now widely appreciated that atherosclerosis (the underlying cause of heart attacks) begins early in life [3, 10, 11]. It has also been shown that early perception of heart disease risk accompanied by corresponding changes in diet and physical activity may retard the atherosclerotic process and reduce the overall risk of a heart attack [6, 8, 9]. The key to the overall risk reduction process is the accurate perception by each individual of their unique heart disease risk.

Little research has been done in the area of perceived heart attack risk, especially among college-aged individuals. We have purported that college-aged men and women demonstrate an optimistic bias in the perception of heart attack risk, suggesting the presence of youth optimism [7]. The next logical line of inquiry for this segment of the population should be to determine whether or not, and to what extent, there are disparities between levels of actual risk markers for heart disease and corresponding risk perception. Therefore, the purpose of this study was to determine if risk perception scores differ with respect to levels of actual heart disease risk.

Methods

The institutional review board for human subjects provided approval for all testing procedures and participants gave written informed consent to participate in the study. The study sample was composed exclusively of sophomore or freshmen health and kinesiology majors (76 women and 56 men) of a 40, 000 student enrolment, who had received no formal instruction concerning the pathology, physiology, or risks for heart disease. The subjects did not receive any awards or benefit and participation was not mandatory or part of class requirements. The 43.3% male sample was ethnically diverse, with a mean age of 20.1 years. These statistics are congruous with the composition of the university student body as listed on their website {2002 1478 /id}.

The principle investigator asked all subjects to fill out a questionnaire designed to obtain each individual's perception of heart disease risk. This person also remained present while the subjects completed the questionnaire in case the subjects had questions. The questionnaire has been validated and proved reliable, as previously described [7]. The items in that questionnaire that pertain to this analysis were as follows: "Compared to students of your own age and sex, how would you rate your risk of ever having a heart attack?" Answers consisted of a 4 point Likert type scale with the choices of "1. much lower," "2. lower," "3. higher" and "4. much higher." Self-reported physical activity levels were categorized using the following question: "In an average week, how many times do you engage in moderate to hard physical activity…" (defined as lasting 20 minutes and makes you breathe hard and your heart beat fast). Choices included: "1. less than once per week," "2. one or two times per week" and "3. at least three times per week". Subjects were also asked to respond to: "My smoking history (SMK) is: "1. never," "2. not for the last 10 years," "3. not for the last five years," "4. recently quit" and "5. still smoke." Finally, subjects were asked how many of their first-degree relatives had been diagnosed with heart disease at a significantly early age (FAMHIST) [1, 2].

After completion of the questionnaire, the subjects underwent testing to assess physiologic risk factors associated with heart disease per the American Heart Association and the American College of Sports Medicine. The assessments included measurements of total cholesterol (TC), HDL-cholesterol (HDL), and glucose (GLUC) to detect the presence of diabetes. CHOL, HDL, and GLUC were analyzed using a Cholestech™ blood analysis system (Health Management Systems Corp., Plano, TX), while %FAT was assessed by using contemporary hydrostatic weighing techniques at estimated residual volume [12]. SBP and DBP were assessed in a recumbent position after 5 minutes of rest using a mercury filled sphygmomanometer. Body fat percentage (%FAT), systolic blood pressure, (SBP) and diastolic blood pressure (DBP) were also assessed.

The particular physiological risk factors were chosen due to relatively inexpensive equipment, ease of assessment and no requirement for formal training or certification was required to conduct the procedures. Our study is therefore reproducible by almost any health and kinesiology department at a large university.

Data analysis was done using the SAS statistical package (version 8.01; SAS Institute, Cary, NC). Type I error rate was set at $p < .05$. General linear models and Chi square analysis was used to determine if there were any differences in familial, lifestyle, or physiological risk markers at different categories of heart disease risk perception.

Results

There was no significant difference in students' risk perception (five-point scale) of ever having a heart attack between Caucasians and Non-Caucasians (2.4 vs 2.7, $p>.05$) or between males and females (2.3 vs 2.6, $p>.05$). The data were therefore collapsed across both race and gender. As depicted in Table 1, 53% of student subjects rated their risk of ever having a heart attack as either "lower" or "much lower" than their peers, inferring an optimistic bias of just over half of the sample.

Table 1. Subjects' rating of their perceived heart attack risk

Risk Rating	***N***	***%***
Much Lower	18	13.4
Lower	53	39.6
Higher	46	34.3
Much Higher	17	12.7

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Chi square analysis revealed that of the 95 subjects who exercised at least three times per week, 65 of them (68.4%) correctly perceived themselves as having a "lower" or "much lower" risk of having a heart attack. Further, of the 39 subjects who did not exercise or exercised only one or twice a week, only six (15.4%) perceived their risk to be "lower" or "much lower" than that of their peers. (Chi square=56.3, df=6, p<.0001). This finding reflects a trend toward accurate perception. The contingency table depicting the Chi square analysis appears as Table 2.

Table 2. Contingency table for exercise frequency and perceived heart attack risk Chi square=56.3, df=6, p<.0001

Contingency Table Frequencies	Heart attack risk much lower	Heart attack risk lower	Heart attack risk higher	Heart attack risk much higher	total
Exercise less than once per week	0	0	0	4	4
Exercise 1 or 2 times per week	0	6	22	7	35
Exercise at least 3 times per week	18	47	24	6	95
TOTAL	18	53	46	17	134

Table 3 illustrates the finding that those with higher body fat percentages tend to perceive their risk higher than their slimmer peers ($p < .05$), inferring an accurate perception.

Table 3. Participants' Body Fat Percentage

Perceived Heart Attack Risk		
Risk Rating	***N***	***Body Fat %***
Much Lower	18	11.8 + 7.1 A
Lower	53	16.8 + 5.7 B
Higher	46	21.7+ 6.9 C
Much Higher	17	24.0 + 10.0 C

Values are means ± standard deviations. Means with the same letter are not significantly different p<.05.

Table 4. Physiological risk markers values according to risk grouping

HARISK = Much Lower		**HARISK = Lower**	
risk factor	M ± sd	risk factor	M + sd
TC (mg/dL)	188.8 ± 33.2	TC (mg/dL)	175.1 ± 30.8
HDL (mg/dL)	50.8 ± 13.5	HDL (mg/dL)	55.6 ± 16.5
GLUC (mg/dL)	97.7 ± 9.6	GLUC (mg/dL)	98.5 ± 11.4
SBP (mmHg)	116.6 ± 11.4	SBP (mmHg)	120.1 ± 13.7
DBP (mmHg)	73.8 ± 9.9	DBP (mmHg)	79.6 ± 9.3

HARISK = Higher		**HARISK = Much Higher**	
risk factor	M ± sd	risk factor	M + sd
TC (mg/dL)	178.7 ± 30.2	TC (mg/dL)	180.4 ± 38.9
HDL (mg/dL)	53.7 ± 16.7	HDL (mg/dL)	50.2 ± 12.5
GLUC (mg/dL)	96.7 ± 9.7	GLUC (mg/dL)	105.5 ± 24.7
SBP (mm/Hg)	119.8 ± 11.5	SBP (mmHg)	115.4 ± 11.6
DBP (mm/Hg)	76.6 ± 9.3	DBP (mmHg)	78.6 ± 9.1

Values are means + standard deviations. See text for abbreviations.

The means and standard deviation for the physiological risk variables are presented in Table 4. None were significantly different among the four risk perception categories.

Comment

A significant number of college students from our sample tended to underestimate their cardiac risk, as 53% of them viewed their risk as "lower" or "much lower" than their peers. This compares to 68% of our previous sample of a variety of majors from the same university [7]. The present sample was taken from group of kinesiology students which may account for the difference in this percentage, although they had not been exposed to any information in their kinesiology classes relating to heart disease risk. These students were, however, majoring in a discipline that may be composed of students who, apriori, were more attuned to their health and well being than the "average" college student. The possibility that this may predispose them to being more perceptive concerning heart disease risk cannot be discounted.

Our results support the findings of the only recent and comparable study that could be found. Collins, Dantico, Shearer, & Mossman, K. 2004, also concluded that most college students had a low level of heart disease risk awareness, but found that their greatest perceived disease threat was cancer. They also found that 43% of the sample perceived hypertension as the most potent risk factor. This is in contrast to our previous finding that college students perceived high cholesterol as the most potent risk factor with hypertension second [7]. Clearly, further study in this area is needed to determine which heart disease risk marker is accurately perceived as the most potent.

To the authors' knowledge, the present study is unique in its examination of the perception of heart disease risk as it relates to actual risk markers. The students in our sample who exercised more frequently correctly perceived their lower risk. It is note-worthy that 31% students who reported exercising "at least three times per week" perceived themselves to be at "higher" or 'much

higher' risk. This finding may be partially explained by subjects who, recognizing that they are at risk and accurately perceiving that exercise reduces that risk, began to engage in an exercise regimen.

Since both the print and visual media of today is replete with warnings about the health risks associated with obesity, it would seem no surprise that those with higher body fat percentages correctly perceive themselves at a greater risk for heart disease. It is interesting to note that this same logic does not seem to apply to the risks associated with smoking, which perhaps has even greater media exposure than the risk associated with obesity. In our study, however, only 14 of our subjects had ever smoked, which left some of the cells blank in the Chi square contingency table analysis. This may have adversely affected this particular statistical test.

Forty-eight percent of those subjects who had never smoked perceived their heart disease risk as 'lower' or 'much lower' while 41% of those who had never smoked ranked their risk as 'higher' or 'much higher'. This finding may reflect either a lack of knowledge concerning the risks of smoking, which is unlikely given the media exposure, or the interaction and presence of other risk factors influencing subject perception.

Since neither the media nor the education systems have distributed significant amounts of information concerning family history as a risk marker for heart disease, the fact that the subjects did not perceive its significance was not unexpected. This result clearly demonstrates the need for more informational and educational resources being directed to this area because family history is one of the more potent of the risk factors for coronary heart disease. A recent study suggests the hazard ratio of a positive family history is second only to diabetes[5]. The fact that none of the physiological risk markers (SBP, DBP, TC, HDL, GLUC) were significantly different among the risk perception categories can be attributed to the fact the subjects were most likely not aware of their values. It should be remembered that subjects completed the questionnaire items before they were given any of their physiological risk marker numbers. Moreover, all of the means of these markers were within acceptable health ranges.

In conclusion, the results of this study suggest that college kinesiology students at a large university who exercise more and have lower body fat percentages tend to accurately perceive their heart disease risk as being less than those who seldom exercise or have higher body fat percentages. However, smoking, having a family history of heart disease, nor any of the physiological risk-marker values were associated with a more accurate risk perception. These results point to a need for further more in-depth investigation and quantification of how young college-aged students pursuing a career in a movement science perceive their heart disease risk and to what extent perception differs from actual physiological risk. Further research is also needed to make more complete comparisons of the findings of this study to a similar sample of young college students of all majors. ●

THE KEY TO THE OVERALL RISK REDUCTION PROCESS IS THE ACCURATE PERCEPTION BY EACH INDIVIDUAL OF THEIR UNIQUE HEART DISEASE RISK.

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Employers' Rights to Manage Absence and Sick Leave Programs.

By Karen Drysdale-Chung B.Sc.,C.K., MA (candidate)

Absenteeism in Canada costs employers more than their regular payrolls. Addressing and effectively managing all types of employee absenteeism is therefore a business priority. There are many considerations in absence and sick time management, and information regarding best practices for employers is increasingly available. Despite the availability of this information, the use of external experts can assist in achieving good outcomes. There are benefits to all workplace parties when absenteeism is effectively and consistently managed.

Absenteeism

The Labour Force Survey (2000) showed employees are absent an average of eight days per year[1, 13]. This had increased from an average of 7.6 days per year in 1998 per Canada Survey. This represented 19 million lost work days. The direct cost of unscheduled absence for Canadian employers is estimated at $10 billion annually[8].The 2003 Watson Wyatt Staying at Work Study indicated that employee absence costs employers $16 billion in direct and indirect costs[13], and Langan (2006) indicated a one day absence costs $2,500.

Indirect costs include scheduling, retraining, productivity, decreased employee morale, turnover and opportunity costs. The indirect costs in employee absence exceed the direct costs of payment for employee wages and benefits[2].

Absenteeism rates differ between employment sectors and industries. Many studies have shown increased rates of absence for public, health care, manual labour and unionized

Les droits de l'employeur relativement à la gestion des programmes d'absences et de congés de maladie

Par Karen Drysdale-Chung, B.Sc., C.K., candidate à la maîtrise

Au Canada, l'absentéisme coûte plus cher aux employeurs que leur masse salariale. Par conséquent, les entreprises doivent aborder ce problème et gérer efficacement toutes les formes d'absentéisme. Même s'il existe de plus en plus de documentation portant sur les pratiques exemplaires en matière de gestion des absences et des congés de maladie, le recours à des spécialistes externes peut aider à atteindre des résultats favorables. Lorsque l'absentéisme est géré de façon efficace et uniforme, toutes les parties concernées dans l'entreprise peuvent en tirer profit.

L'absentéisme

L'Enquête sur la population active (2000) a révélé que les employés s'absentaient du travail en moyenne huit jours par année[1, 13]. Statistique Canada, ce chiffre a d'absences en 1998[11]. Au total, cela représente 19 millions de journées de travail perdues. On estime le coût direct des absences non planifiées à 10 milliards de dollars par année[8]. Les résultats de l'étude de Watson Wyatt (2003), intitulée *Staying at Work Study*, ont révélé que l'absentéisme coûtait aux employeurs 16 milliards de dollars en coûts directs et indirects[13], et Langan (2006) a indiqué qu'une journée d'absence coûtait 2 500 $.

Les coûts indirects comprennent l'établissement des horaires de travail, la formation d'appoint, la productivité, la diminution du moral des employés, le roulement du personnel et les coûts de substitution. Les coûts indirects liés à l'absentéisme sont supérieurs aux coûts directs liés aux salaires et aux avan par rapport à une moyenne de 7,8 jours[2]

employees[1]. Geographic location also appears to be a factor as Saskatchewan and Nova Scotia, had higher average incidences of absence, whereas PEI, Ontario and Alberta had the least. Employees in cities, workers who are paid more and those who have more education demonstrate lower rates of absenteeism.

Increasingly, researchers have turned their attention to examining the causes of absenteeism. Tomlinson (2002) cited the Canadian Policy Research Network Work Life Balance in the New Millennium study, for example. This study concluded that individuals with a high work to life conflict had increased rates of absenteeism (13.2 versus 5.9 days per annum) and were three times more likely to incur heart disease, sickness or injury. They encouraged employers to examine the factors contributing to absenteeism and implement measures to address these at the front end including child care programs, providing nutritious food options and flexible work schedules.

Given the high costs, effectively managing absence is a top priority for employers. In this ever-increasingly competitive global marketplace, optimally managing all costs and resources is imperative.

Potential Pitfalls

Bilson (2003) examined policies and rules designed to monitor absenteeism and correct patterns inconsistent with company interests, including systematic recording and trigger thresholds for consequences regarding how these fared at arbitration. He said these policies have been upheld as legitimate if they are consistent with the collective agreement and rules are not altered mid-contract. He noted that employers need to address how programs are monitored and administered.

O'Reilley (2002) indicated the manner in which plan sponsors manage Short Term Disability (STD) has a profound impact on the Long Term Disability (LTD) costs and employee integration into the workplace. Mismanagement may open the employer up to human rights issues and suits for wrongful dismissal. He noted that a lot of employers who try to manage STD programs internally are self-insured. In these cases, he encouraged the use of external experts to validate doctor's notes for STD, assist with reintegration into the workplace and if required, progression to LTD.

Employers attempting to manage absence internally need to be aware that medical information received may not be helpful. Doctors may not feel they are adequately compensated for preparing lengthy reports and see part of their role as advocates for their patients. An employer also runs the risk of acting on invalid or incomplete information.

The potential pitfalls for employers instituting or managing absence management programs are significant; however, the benefits outweigh the risks. Employers have achieved successful outcomes by following established best practices.

Recommendations

Researchers who focus on absence management have outlined best practices employers should consider when putting together,

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Le taux d'absentéisme varie en fonction des emplois et des secteurs d'activités. De nombreuses études ont démontré un taux élevé d'absentéisme chez les employés syndiqués ou travaillant dans le secteur public, les soins de santé ou les travaux manuels[1]. Le lieu géographique semble également jouer un rôle puisque les provinces de la Saskatchewan et de la Nouvelle-Écosse ont démontré une incidence moyenne plus élevée comparativement aux provinces de l'Île-du-Prince-Édouard, de l'Ontario et de l'Alberta, qui comptent la moins grande incidence. Le taux d'absentéisme est également plus bas chez les travailleurs en milieu urbain et les employés qui gagnent un meilleur salaire et détiennent un plus grand nombre d'années de scolarité.

Les chercheurs se penchent de plus en plus sur les causes de l'absentéisme. Par exemple, Tomlinson (2002) a fait référence à la politique canadienne portant sur le réseau de recherche en conciliation travail et vie personnelle dans l'étude du nouveau millénaire (New Millenium Study). Les résultats de cette étude ont révélé que les personnes éprouvant un niveau élevé de conflits entre le travail et la vie personnelle montraient un taux d'absentéisme annuel plus élevé que d'autres personnes (13,2 jours par rapport à 5,9 jours), et celles-ci couraient trois fois plus de risques de souffrir d'une maladie du coeur, de d'affection ou de blessure. Les chercheurs ont incité les employeurs à examiner les facteurs qui contribuent à l'absentéisme et à mettre sur pied des mesures visant à résoudre ces problèmes (p. ex., programmes de garderie, apport adéquat d'aliments nutritifs et horaires variables).

En raison des coûts élevés de l'absentéisme, la gestion efficace des absences constitue une priorité pour les employeurs. Étant donné que la compétitivité à l'échelle mondiale ne cesse de croître, ces derniers doivent impérativement gérer de façon optimale tous les coûts et toutes les ressources.

Embûches possibles

Bilson (2003) a examiné les politiques et règles conçues pour surveiller l'absentéisme et les motifs valables qui allaient à l'encontre des intérêts de l'entreprise, y compris l'enregistrement systématique et les seuils critiques des conséquences et leurs résultats à l'arbitrage. Il a remarqué que ces motifs avaient été jugés légitimes lorsqu'ils étaient conformes à la convention collective et que les règles n'avaient pas été modifiées à mi-parcours de la convention. Il a ajouté que les employeurs devaient examiner leur façon de surveiller et de gérer leurs programmes.

O'Reilley (2002) a avancé que les méthodes utilisées par les promoteurs de régime pour gérer les invalidités de courte durée (ICD) avaient des conséquences profondes sur les coûts d'invalidités de longue durée (ILD) ainsi que sur la réintégration au travail. Dans certaines situations, une mauvaise gestion de la part de l'employeur pourrait ouvrir la porte à des questions de droit de la personne et des poursuites pour congédiement injustifié. O'Reilley a rapporté que bon nombre d'employeurs qui tentaient de gérer les programmes d'ICD à l'interne détenaient un régime autogéré d'assurance. Dans de telles situations, il a invité les entreprises à faire appel à des services de spécialistes externes afin de valider l'ordonnance médicale pour une ICD, de faciliter la réintégration au travail et, s'il y a lieu, de transférer le cas à l'ILD.

Le employeur qui tente de gérer les absences à l'interne doit être con-scient que les informations médicales obtenues ne s'avèrent pas toujours

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revising or evaluating their absence management policies and programs.

The wording and presentation of an absence or sick leave management program to employees is paramount in terms of the acceptance, applicability and consistency of the program. D'Andrea, Corry & Forester (2005) recommend that employers have insurer review booklets, collective agreements and policies that describe insurance coverage to assist in this regard. In addition, they suggest the addition of a clause in the booklet that indicates the document does not fully outline the policy, nor should be used to determine resolution to disagreements regarding the program and coverage, and refers the reader to the actual policy, which the employer will make available upon request.

Employers need to ensure policies are in accordance with legislation, including employment standards, Occupational Health and Safety, and Worker's Compensation Acts. The provisions for application of the policy must allow flexibility, the ability to address individual circumstances, and not impose arbitrary thresholds. It should also be within the provisions of any collective agreements.

Employers need to recognize when they may not have the required expertise internally to effectively manage an absence management program. O'Reilley (2002) recommended that employers who are self insured for STD use external experts to assess the validity of claims. Young (2003) outlined the key elements of a successful absence management program to include selecting a third-party company. This third party's expertise will result in cost-effective management, provide meaningful support to the employee, a consistent approach to the application of the return to work program, integrated data reporting and analysis to assist in identifying appropriate initiatives, including employee assistance and consistent and effective management. Disability management professional support can assist with efficiently managing employee absence.

Upon employment or when initiating an absence management plan for their employees, employers need to inform their employees that disability benefits will be provided upon the condition they consent to review of their claim by an expert appointed by the employer. A consent form will be required and should be included on the application form. The employee's privacy is therefore protected as the employer only receives information regarding the validity of the claim, prognosis and recommendations such as a return to work plan. Employees benefit from their needs being addressed, and this leads to successful outcomes. Employers are also assured they are taking action based on valid claims through the evaluation of objective medical documentation.

Employers often experience frustration during interactions and attempting to gather information from physicians. To improve the value of these interactions, it is recommended for physicians to be more involved in the process and coordinate with the employee and employer. This may be facilitated by providing more information to the physician in terms of support available at the employer, plus information on which to base their recommendations includ

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utiles. Il peut arriver qu'un médecin estime que sa rémunération est insuffisante pour remplir les longs rapports et qu'il voie une partie de son rôle comme défenseur de ses patients. Par conséquent, l'employeur qui se fie à ces informations risque de prendre des mesures en fonction de renseignements erronés ou incomplets.

Même si les embûches possibles sont nombreuses pour un employeur qui décide d'instaurer ou de gérer un programme de gestion des absences, les avantages surpassent les risques. D'ailleurs, de nombreux employeurs ont atteints des résultats favorables en adoptant des pratiques exemplaires.

Recommandations

Les chercheurs qui s'intéressent surtout à la gestion des absences ont décrit les grandes lignes en matière de pratiques exemplaires que les employeurs devraient adopter dans l'élaboration, la révision ou l'évaluation des politiques et des programmes de gestion des absences.

La formulation et la présentation du programme de gestion des absences et des congés de maladie sont des facteurs fondamentaux en termes d'acceptabilité, d'applicabilité et d'uniformité du programme. D'Andrea, Corry et Forester (2005) recommandent aux employeurs d'utiliser le guide des prestations de l'assureur, la convention collective et les politiques qui décrivent la couverture d'assurance afin de faciliter cet aspect. De plus, ils proposent d'ajouter une clause dans le guide qui stipule que le document ne décrit pas entièrement le programme et ne doit pas servir à résoudre des mésententes concernant le programme ou la couverture. La clause doit référer le lecteur à la politique courante, que l'employeur remettra aux employés qui en font la demande.

L'employeur doit s'assurer que les politiques sont conformes aux lois, y compris : les lois sur les normes d'emploi, la santé et la sécurité au travail, les indemnités d'accidents du travail et le Code du travail. Les conditions régissant l'application de la politique doivent être souples et adaptables à des situations individuelles et ne doivent pas imposer de seuil arbitraire. Elles doivent être conformes à la convention collective.

L'employeur doit être en mesure de reconnaître qu'il ne possède pas toujours l'expertise nécessaire à l'interne afin de gérer efficacement un programme de gestion des absences. O'Reilley (2002) recommande à l'employeur qui détient un régime autogéré d'assurance pour les ICD de faire appel à des experts externes afin qu'ils puissent analyser la validité des demandes. Young (2003) décrit les éléments clés d'un bon programme de gestion des absences comme étant : le choix approprié de l'entreprise de consultants, dont l'expertise entraînera une gestion rentable pour l'employeur et dont les conseils fourniront un soutien concret à l'employé; une démarche uniforme qui comprend la mise en application d'un programme de retour au travail; des rapports et des analyses intégrés de données afin d'aider à identifier les initiatives appropriées dont le Programme d'aide aux employés (PAE); et la gestion uniforme et efficace. Les professionnels en gestion des dossiers d'invalidité peuvent contribuer à gérer efficacement l'absentéisme.

Au moment de l'embauche d'un employé ou lors de l'établissement d'un programme de gestion des absences, l'employeur doit aviser ses employés que les prestations d'invalidité ne seront octroyées qu'en vertu de leur consentement obtenu pour que leur demande soit examinée par

ing job descriptions, physical demands analyses and available modifications.

In addition to policy and program considerations, employers must clearly document the steps taken to accommodate employees where a request is made or need identified through the absence management process.

Conclusion

Employers have the right to manage their business resources, which includes their employees. The employers set the terms of employment based on bona fide occupational requirements. Absence management is a significant issue for employers due to the substantial human costs, plus direct and indirect costs. Thoughtfully and carefully designed and outlined attendance management policies that are in keeping with collective agreements, the terms of employment and legislation are an effective tool for employers and will stand up to challenges, grievances and claims. Involvement of professionals to review the wording and assist in the management of the process should be considered, as employers often do not have the expertise to effectively manage claims – whether self-insured or covered through an insurer.

Effectively managing absenteeism benefits all workplace parties and can improve overall morale and team spirit. Data analysis may be used to determine root causes of absence then institute preventative and supportive programs for employees.

These programs adhere to legislation, have the commitment of all levels of the organization, employ best practices and effective record-keeping and foster open communication. While individual rights have been at the forefront of legislation in the last few decades, employers should not shy away from effectively managing their resources. A comprehensive Absence Management program is one tool that, if properly designed and managed, will enhance any company's operations. ●

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un expert désigné par l'employeur. L'employé devra signer un formulaire de consentement qui doit être inclus dans le formulaire de demande d'emploi. Ainsi, l'employeur assure la protection de la vie privée de l'employé en ne recevant que l'information ayant trait à la validité de la demande, au pronostic et aux recommandations, dont un plan de retour au travail. En répondant aux besoins des employés, cela entraîne des résultats favorables et l'employeur est également assuré que les mesures entreprises sont fondées sur une réclamation valide qui repose sur une évaluation objective du dossier médical.

Souvent, les employeurs éprouvent de la frustration lorsqu'ils tentent de discuter avec les médecins ou d'obtenir des renseignements. Dans le but d'améliorer le dialogue entre les deux intervenants, on recommande de faire participer davantage le médecin au processus et à la coordination du programme avec l'employé et l'employeur. Cela peut se faire en fournissant de l'information supplémentaire au médecin en termes de soutien offert à l'employé et de renseignements sur lesquels il peut fonder ses recommandations (p. ex., une description d'emploi, une analyse des exigences physiques et les modifications proposées).

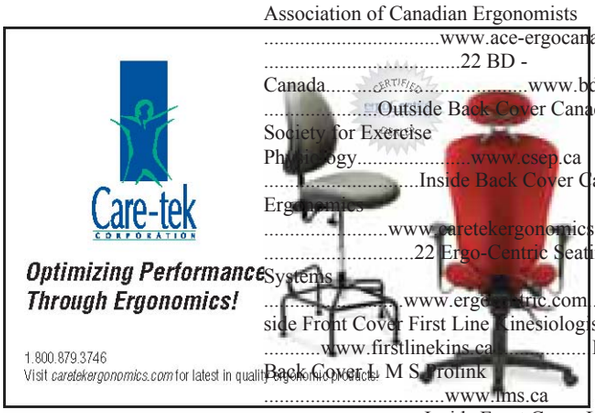
Enfin, dans les politiques et le programme, l'employeur doit clairement consigner les étapes entreprises pour répondre à la demande d'un employé ou à ses besoins qui sont précisés dans le processus de gestion des absences.

Conclusion

L'employeur a le droit de gérer ses activités et ses ressources, y compris ses employés. Il établit les modalités d'emploi en fonction des exigences professionnelles justifiées. La gestion des absences représente un dossier majeur pour l'employeur en raison des coûts directs, indirects et liés aux ressources humaines qui sont onéreux. Des politiques de gestion bien conçues et définies, ainsi que conformes à la convention collective, aux modalités d'emploi et aux règlements, constituent des outils efficaces pour l'employeur afin de pouvoir résister aux difficultés, aux griefs et aux réclamations. Même si l'employeur détient un régime autogéré d'assurance ou est couvert par un assureur, il est toujours préférable qu'il fasse appel à des professionnels, qui examineront la formulation du programme et l'aideront dans la gestion de la démarche, car ce dernier ne possède pas nécessairement l'expertise pour gérer efficacement les réclamations.

La gestion efficace des absences est profitable pour toutes les parties concernées dans l'entreprise et peut améliorer le moral et l'esprit d'équipe des travailleurs. L'analyse des données peut servir à déterminer les causes profondes de l'absence et à instaurer les programmes de prévention et de soutien pour les employés.

En conclusion, un programme efficace de gestion des absences doit être en mesure de tenir compte des éléments suivants : respecter les lois, obtenir l'engagement à tous les paliers de l'organisation, utiliser des pratiques exemplaires, faire un bon suivi des dossiers et favoriser la communication ouverte. Même si au cours des dernières décennies les droits de la personne ont occupé un rôle de premier plan dans la législation, l'employeur ne doit pas s'effrayer à l'idée de gérer efficacement ses ressources. Un programme intégré de gestion des absences est un outil qui améliorera toutes les activités de l'entreprise s'il est conçu et géré avec efficacité. ●



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