

Networking health care practitioners and OH prevention services for early rehabilitation of low back pain workers

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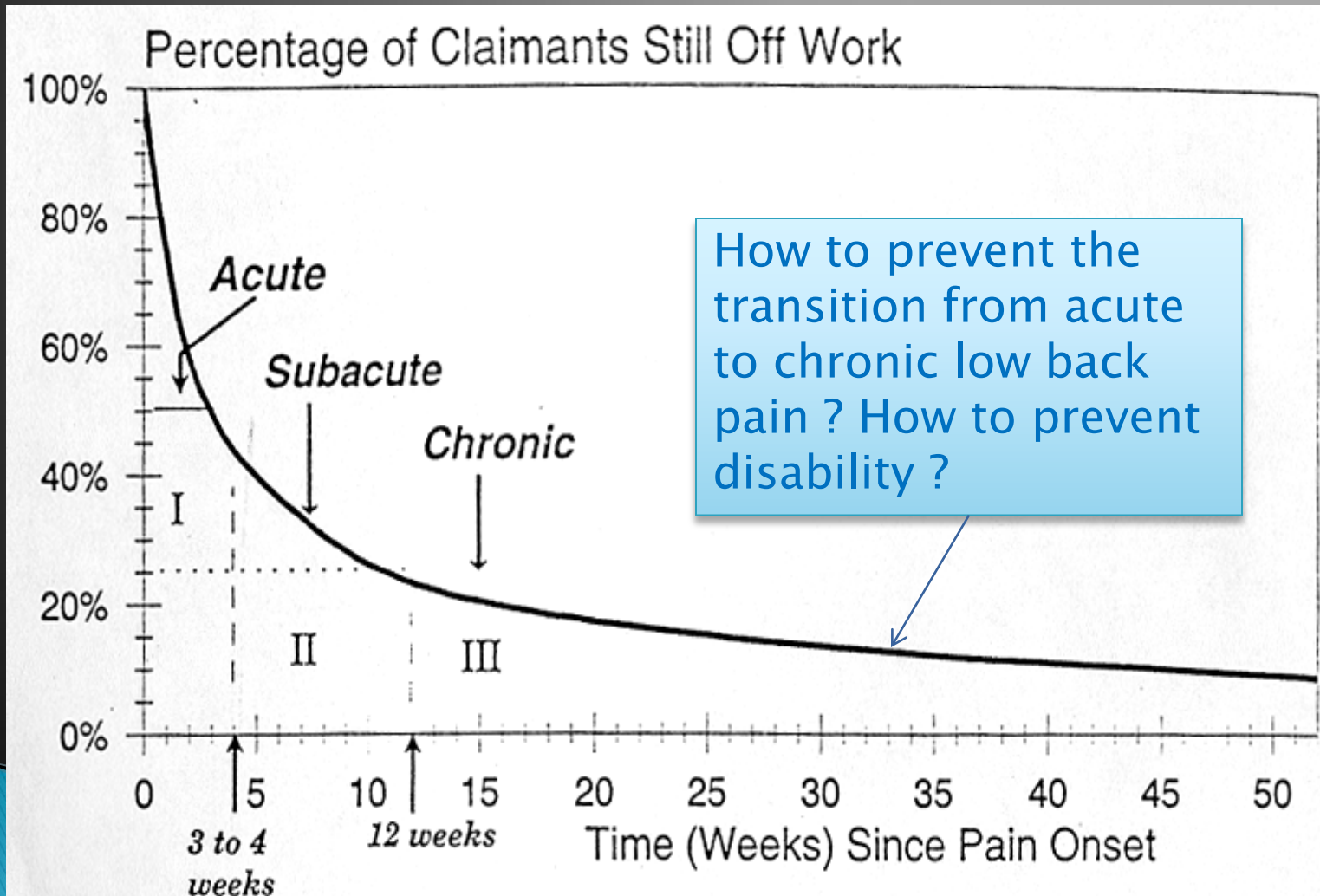


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Project background : the natural history of low back pain

(Frank et al. 1996)



Prevention of the transition to chronicity

Evidence based guidelines

- ▶ Better management of low back pain in its acute phase : react early !
 - target : physicians and general practitioners

- ▶ Speed up the return to work if worker still absent after 4–6 weeks through structured RTW intervention programs
 - target : GP's, but also employers, occupational health physicians (OP's), ergonomists, work injury insurers, ...

Effectiveness of RTW programs – Synthesis of evidence

Interventions for workers on sick leave for low back pain

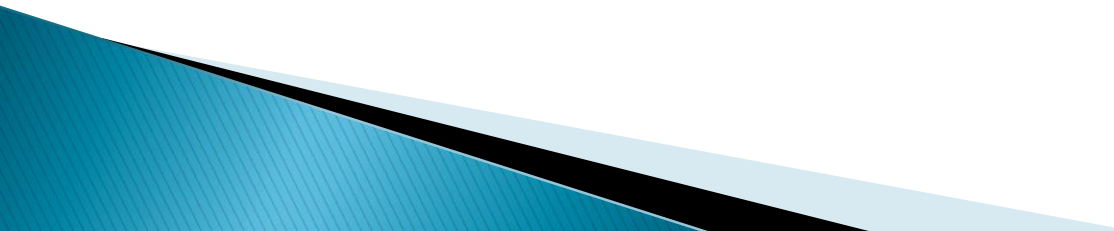
- ▶ Strong evidence that multidisciplinary treatment programs including intensive physical reconditioning improve pain and function and can reduce the numbers of lost days
- ▶ Strong evidence that work disability duration can be significantly reduced by work accommodation offers, a contact between health care provider and the workplace, a contact with the worker by the workplace provider or by ergonomic worksite visits

(see KCE report 48, 2006)

Prevention of chronic LBP

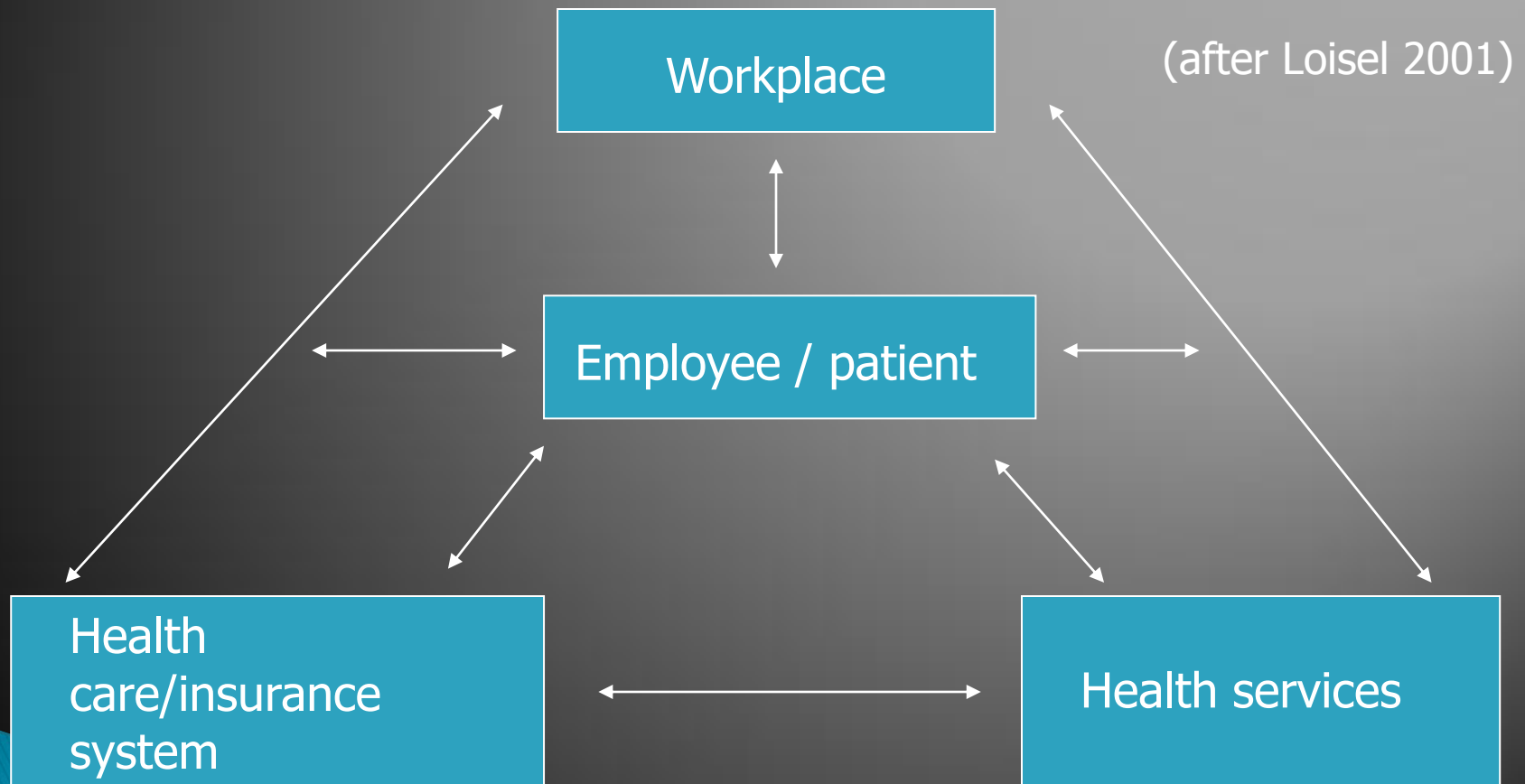
Why networking is crucial ?

Scientific evidence and international practice guidelines strongly advocate a combination of

- ▶ Multidisciplinary treatment programs of a medical nature (resources to be found in the health care sector)
 - ▶ AND
 - ▶ Workplace or ergonomics intervention (resources in OH prevention services and enterprises)
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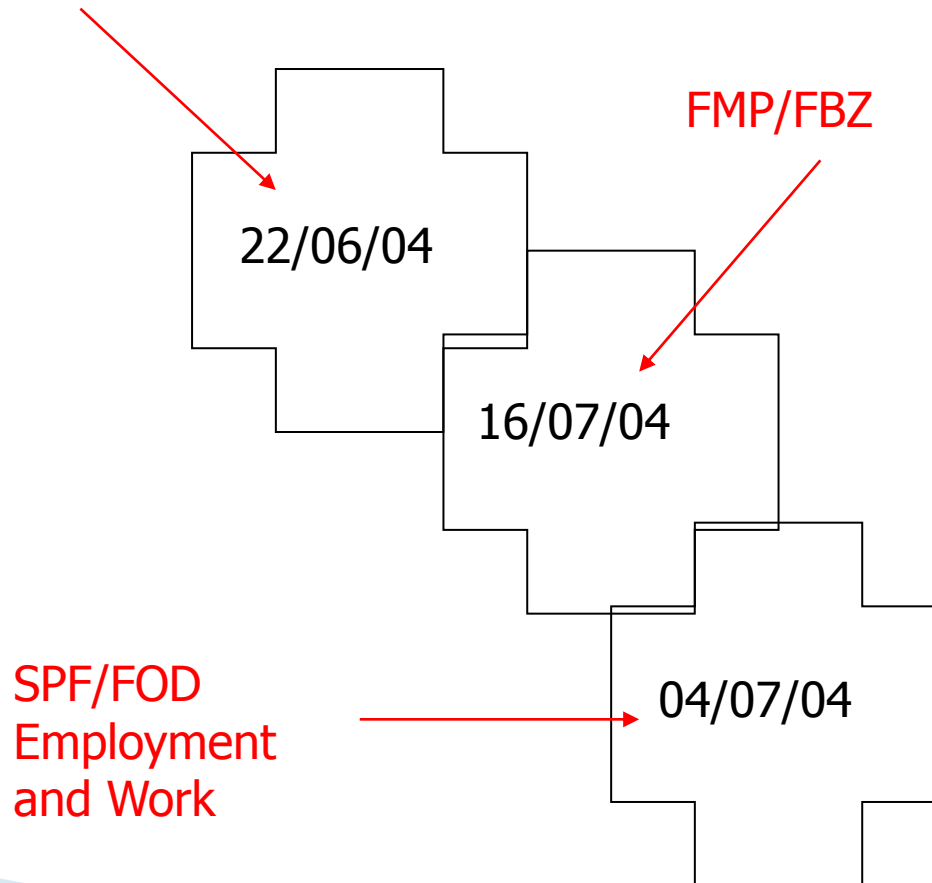
Prevention of chronic LBP and disability

Who should be involved ?



The Belgian back prevention project : putting together three pieces of a regulatory puzzle

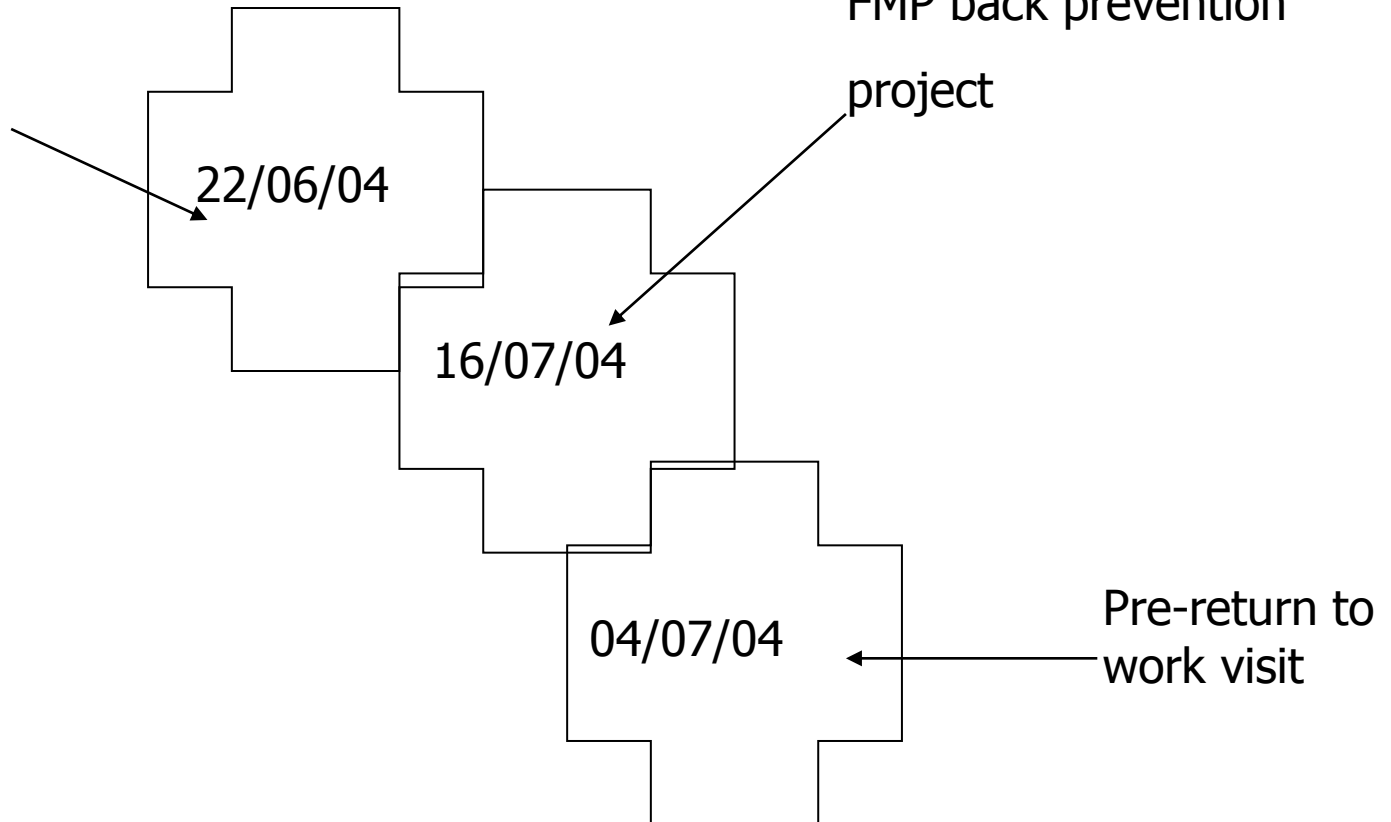
RIZIV
INAMI



The Belgian back prevention project : putting together three pieces of a regulatory puzzle

INAMI/RIZIV Back
rehabilitation
multidisciplinary

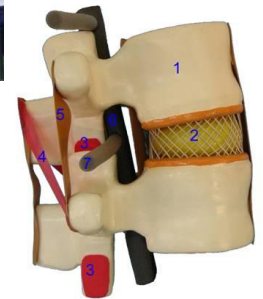
FMP back prevention
project



The INAMI health care multidisciplinary back rehabilitation program



36 sessions (max)
of 2 hr duration



+

Pain emotional
components by a
psychologist

Ergonomics module by a
trained team member

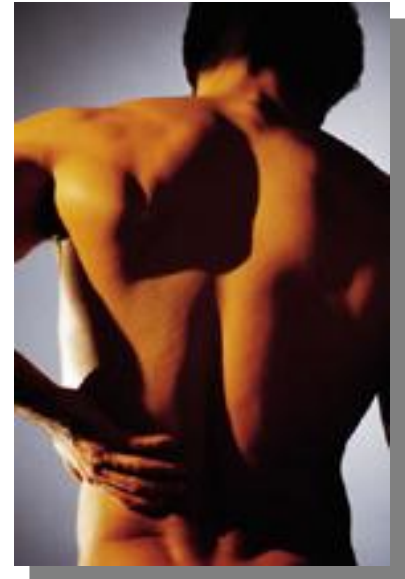


FMP–FBZ back prevention program background – 2004

- ▶ Back pain became the 1st recognised work-related disease (this new legal category may benefit from prevention programs but not from compensation allowances)
- ▶ a “Royal decree” allows the Fund for Occupational Diseases (FMP–FBZ) to launch a pilot project for back pain prevention
 - among nursing staff exposed to back pain risk factors in general or geriatric hospitals

The FMP back prevention program – target population

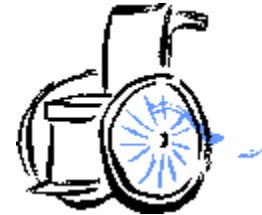
- **Hospital staff** performing manual handling of patients
- **AND being off work due to non-specific low back pain**
 - Since minimum 4 weeks and maximum 3 months
- **AND without a surgical indication or other medical conditions precluding the participation**
- **AND willing to participate on a voluntary basis**



The FMP back prevention program – a return to work program

→ Medical axis

- Incentives to the worker/patient for entering the INAMI/RIZIV back rehabilitation program (becomes free of charge for the patient)



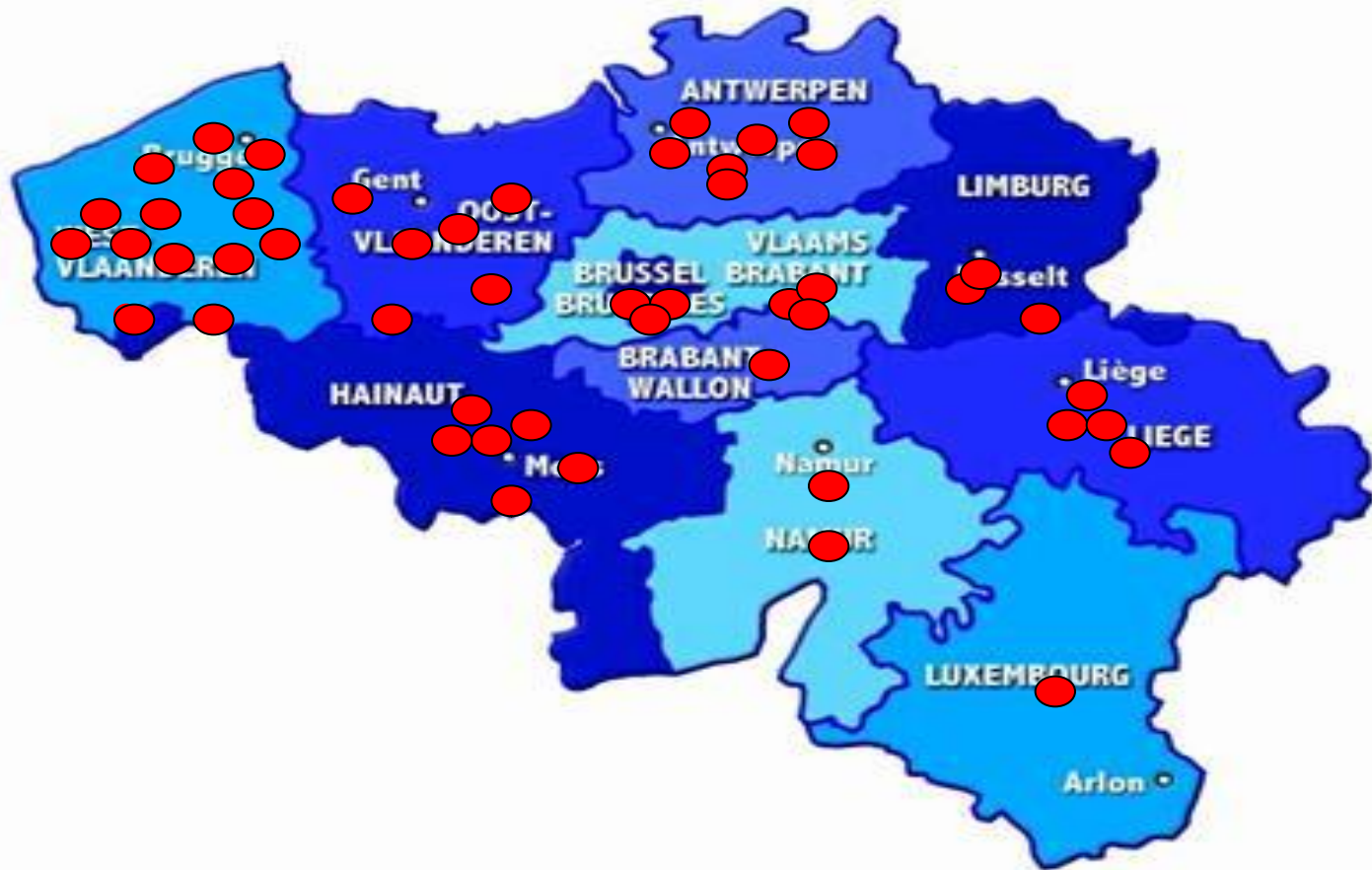
→ Workplace axis

- Promoting an **ergonomic analysis** of the worker tasks (250 € incentive for the employer)

→ Networking

- Caring physicians (GP's, rehabilitation physicians,...) and occupational health physicians (OP)

Medical axis : > 50 rehabilitation centres under contract with FMP-FBZ



Are providing the back program

FMP/FBZ back prevention project

→ Workplace axis

- OH service and occupational health physician tasks:
informing employers and target people, assessing inclusion criteria for applicants, stimulating ergonomics analysis, looking for work accommodations to facilitate RTW
- 15 OH services at the country level + various in-house company OH services, > 1000 OP's

→ Networking



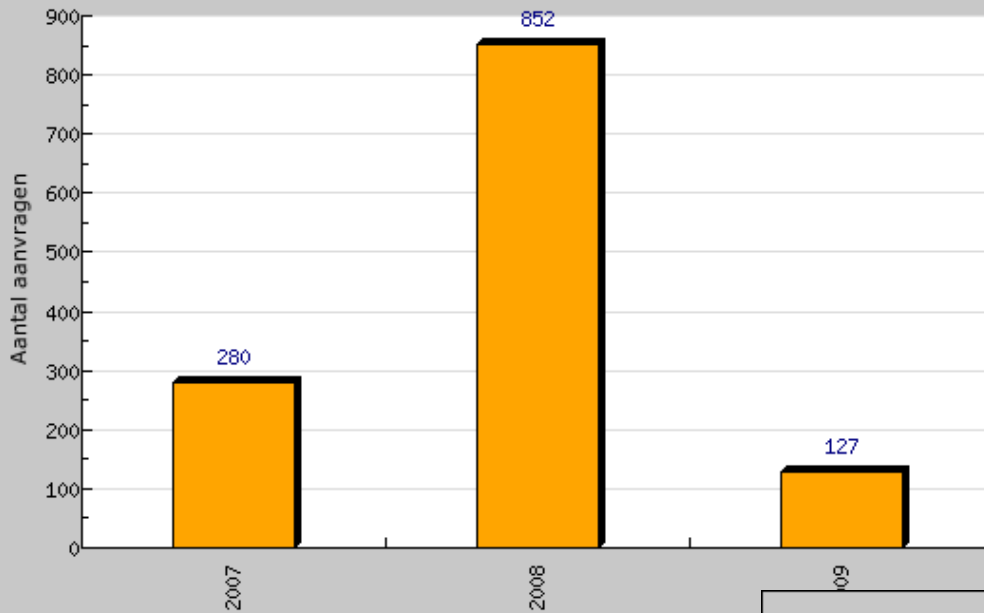
FMP/FBZ back prevention project – networking

- ▶ A Task force established within FMP/FBZ
- ▶ Many information sessions organised throughout Belgium for both caring physicians and preventive physicians (OP's)
- ▶ Yearly scientific meetings intended for both rehab. Teams and OH services teams
- ▶ Contact people asked in rehab. centers and OH services
- ▶ Contracts with rehab. centers promote early contact with the OP at the start of treatment, mid-term communication, and end treatment report sending to FMP and OP
- ▶ If contacted by the center, OP's are invited to communicate information about work conditions

Continuing story ...

- ▶ May 27th 2007 : Royal Decree
The “pilot” project is given permanent status
- ▶ Target population extended to all workers in Belgium, whatever the industry sector, exposed to back pain risk factors (manual handling, or whole body vibration)

Alle aanvragen : per jaar

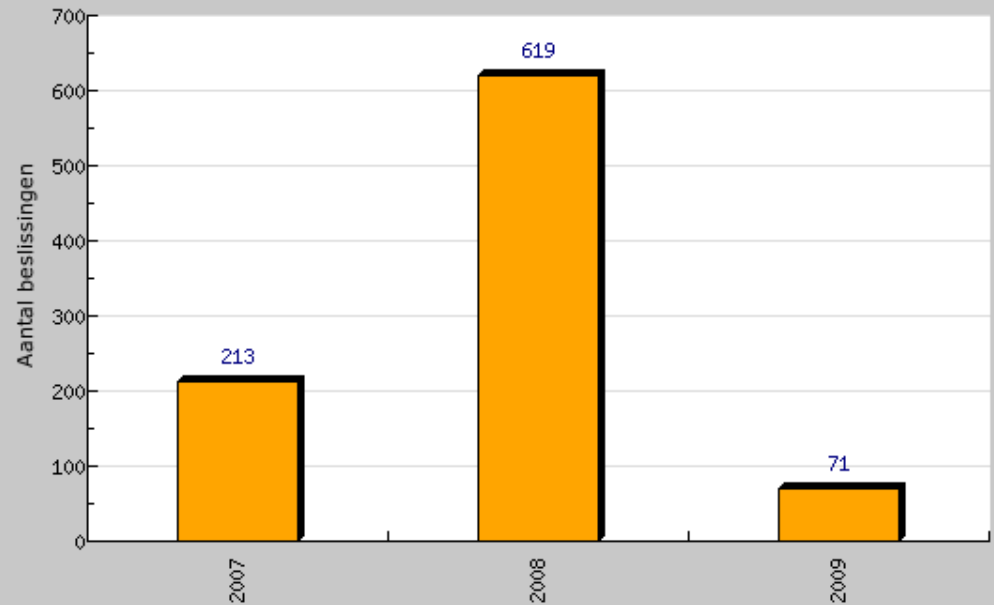


Applications :
1st yr : 102

2007, 2008, 2009 :
See figure

Program included
workers

Positief : per jaar



Monitoring of the program by the task force

- ▶ Data collection about the participants :
 - Application forms : demographic variables, low back pain history and clinical data at entry
 - End of rehabilitation reports; number treatment sessions received; RTW yes / no
 - Form completed at RTW by OP
 - Phone survey data (June–July 2006)
- ▶ Additional data collection :
 - Discussion transcripts of the information sessions organised in the country for promoting the program
 - Interviews with program stakeholders
 - Phone interviews of a random sample of general practitioners (Oct 2005)

Monitoring of the program by the task force

- ▶ Data collection about the OH physicians involvement :
 - Monitoring of the invoices received from the OH services to cover their ergonomic analyses
 - Questionnaire survey in Oct–Nov 2008
 - among OH physicians taking part to the professional association annual scientific meeting
 - through e-mail to the OP's working in the 15 OH services
 - 188 valid answers

Process evaluation

a few striking results

- ▶ A low rate of participation during the two first years (102 applications versus about 300 expected during 1st year)
- ▶ Since the enlargement to all economic sectors, marked increase in applications and included cases (619 in 2008)
- ▶ Imbalance in the program application :
medical component >> workplace
intervention (= < 5% ergonomic invoices)

Barriers to a balanced application of the program

- ▶ Medical rehabilitation component :
 - Benefits from the support given by the health care system : content and procedures precisely defined, standardised assessment tools, good return on investment if applied at a large scale
- ▶ Workplace intervention much less developed:
 - content not so well formalized
 - money incentives too low from the OHS point of view
 - difficult to carry out if a prevention policy has not been endorsed by the employer and the workers representatives
 - employers' culture of 100% fitness for work does not match the program aim : facilitating an early return to work

Barriers to participation : target population not aware of the program

- ▶ During the pilot phase (2005–2007) : a major information challenge !
- ▶ How to disseminate quickly information about an innovative program to 172 hospitals, hundreds of nursing homes for elderly people, about 90.000 nursing staff, 15 OH prevention services (and > 1000 OP's), 36 rehabilitation centers, hundreds of caring physicians, ...?

Barriers to participation and interprofessional collaboration

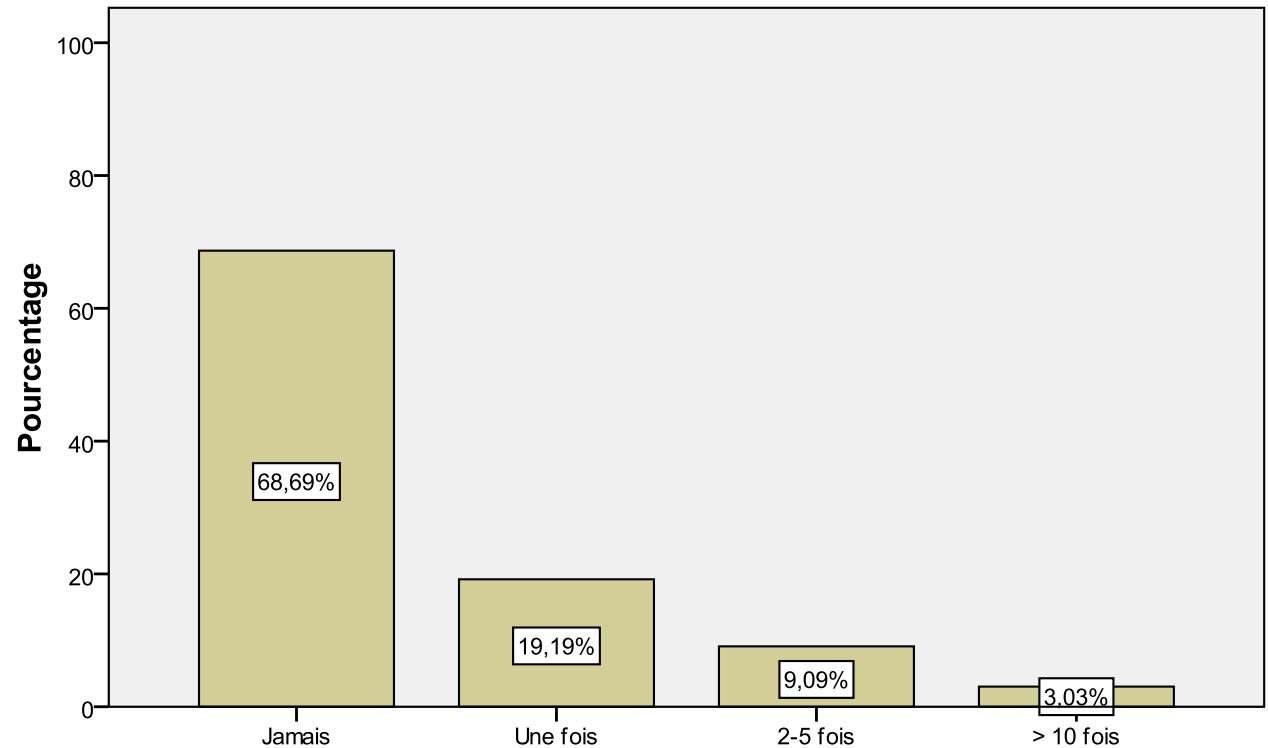
- ▶ For back pain sufferers :
 - The opportunity to meet the OP during the sickleave still not known by many workers
 - Wrong beliefs : “movement would aggravate my injury”
 - Privacy : “the rehab centre being in my own hospital, everybody will know my health problem and status”
- ▶ For GP's:
 - Some (many ?) are afraid not to get the patient back after the treatment in the rehab. centre or are putting more emphasis on passive treatments for LBP

Barriers to interprofessional collaboration

- ▶ For > 40 yrs caring GP'S and specialist physicians have been encouraged not to collaborate with OH physicians !!
- ▶ Within rehabilitation teams, the networking requests made by the FMP/FBZ are often unknown from the ergo- and physiotherapists who are treating the worker...
- ▶ The networking requests involve an extra administrative burden for the centers and the staff is asked to be productive...
- ▶ The program is still marginal in the daily tasks of both rehab. centers and OH services
- ▶ Contacting the worker OP is sometimes difficult

The network in practice – results from the survey among OP's

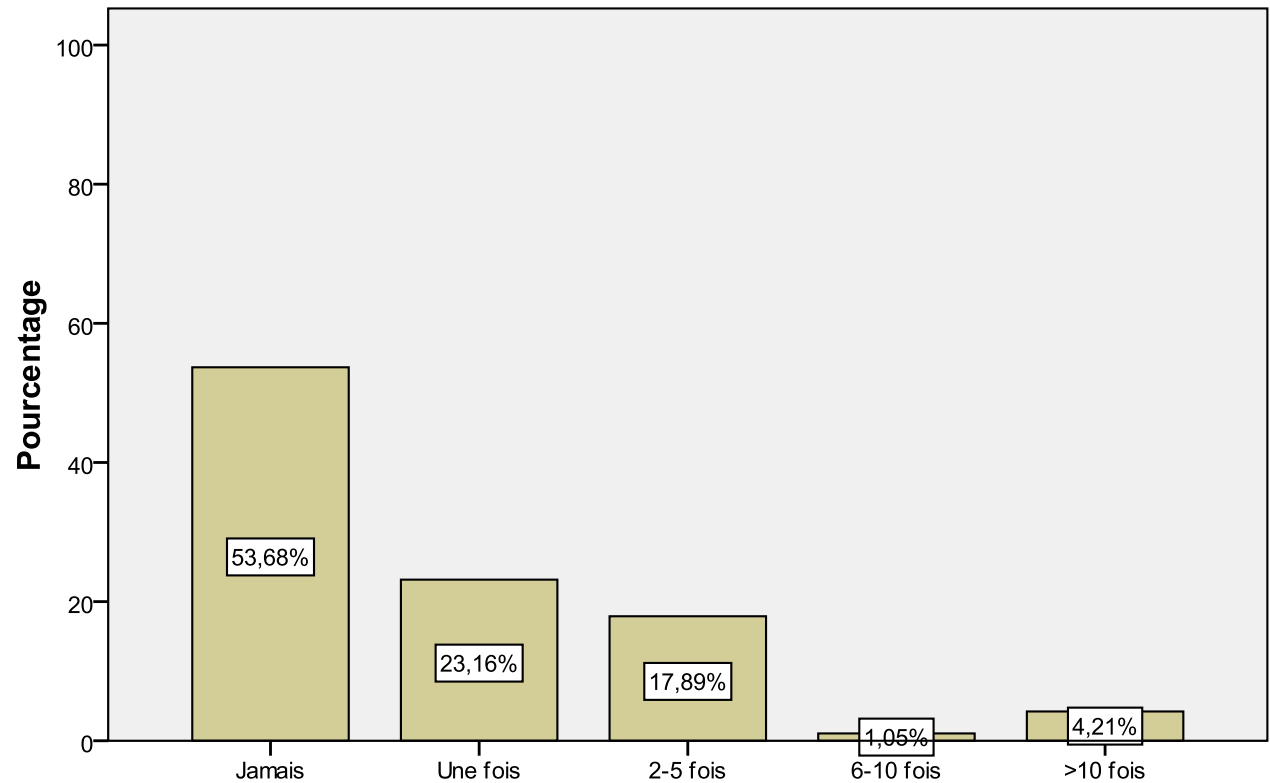
Avez-vous déjà été contacté par le centre de réadaptation prenant en charge le travailleur



Avez-vous déjà été contacté par le centre de réadaptation prenant en charge le travailleur

The network in practice – results from the survey among OP's

Avez-vous reçu un rapport de la part du centre à l'issu du traitement

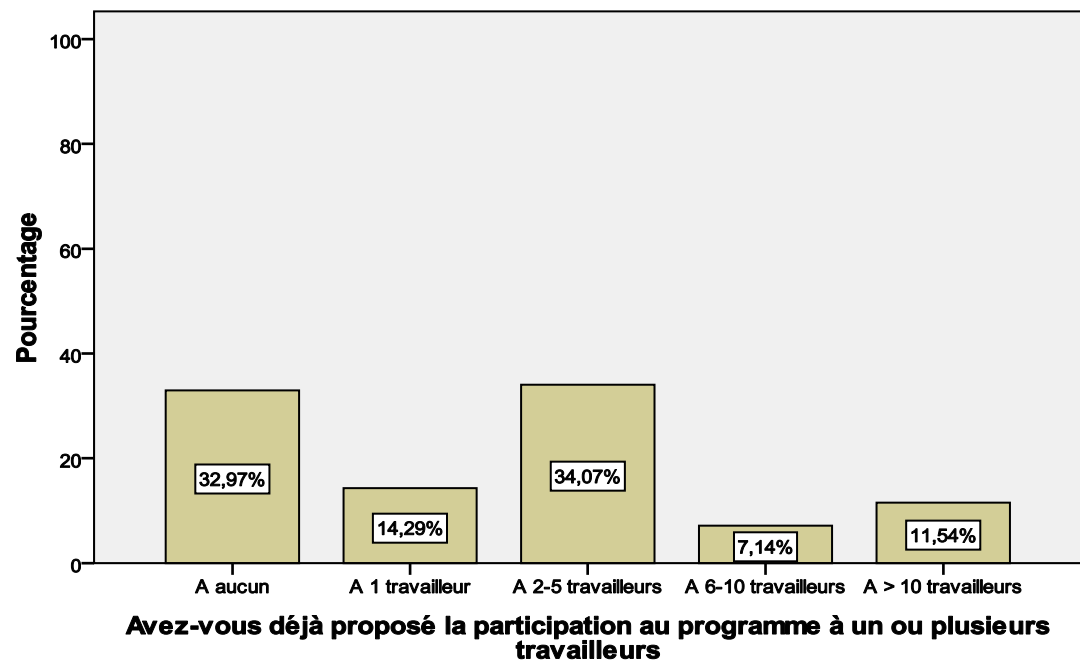


Avez-vous reçu un rapport de la part du centre à l'issu du traitement

The network in practice – results from the survey among OP's

- > Female OP's > Male ($\text{Chi}^2=11,376$; $p=0.023$)
- > Dutch speaking OP's > French speaking ($\text{Chi}^2=11,217$; $p=0,024$)

Avez-vous déjà proposé la participation au programme à un ou plusieurs travailleurs



Conclusion

- ▶ The implementation process of such an evidence-based intervention (like the Canadian Sherbrooke model) at a country level is a primer at the international level and warrants more research in the future
- ▶ An effective networking between physicians belonging to the curative sector and those active in preventive services would need
 - Time
 - Alterations of mutual misperceptions
 - Perception of benefits arising from this collaboration in the daily practice
 - Incentives from the health system

Thank you for your attention !

