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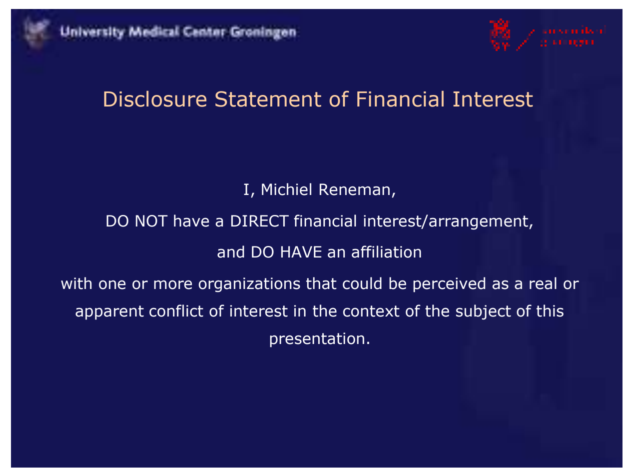
EFIC
SIP
Working on work;
best practice examples from the Netherlands
Michiel Reneman
expand
REHABILITATION MEDICINE / CENTER FOR REHABILITATION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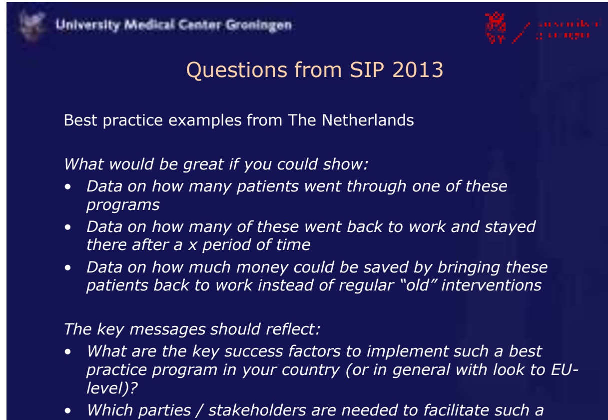
Disclosure Statement of Financial Interest
I, Michiel Reneman,
DO NOT have a DIRECT financial interest/arrangement,
and DO HAVE an affiliation
with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.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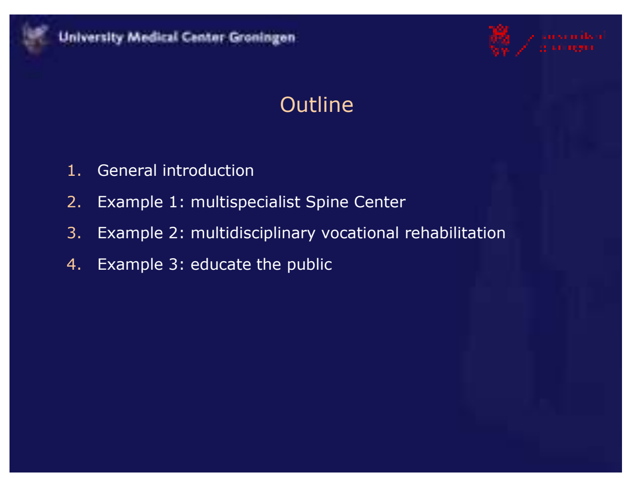
Questions from SIP 2013
Best practice examples from The Netherlands
What would be great if you could show:
• Data on how many patients went through one of these programs
• Data on how many of these went back to work and stayed there after a x period of time
• Data on how much money could be saved by bringing these patients back to work instead of regular "old" interventions
The key messages should reflect:
• What are the key success factors to implement such a best practice program in your country (or in general with look to EU-level)?
• Which parties / stakeholders are needed to facilitate such a project?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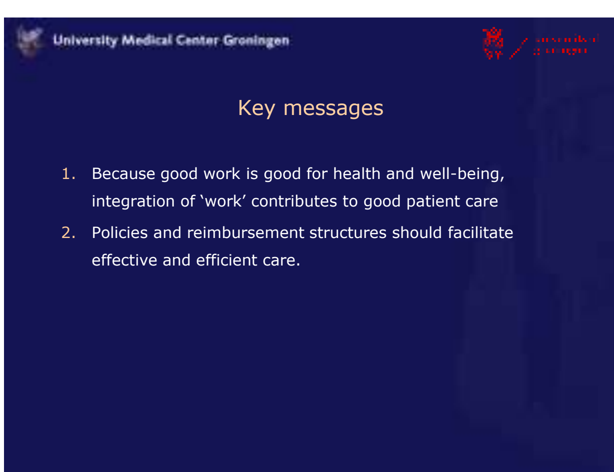
Outline
1. General introduction
2. Example 1: multispecialist Spine Center
3. Example 2: multidisciplinary vocational rehabilitation
4. Example 3: educate the public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Key messages
1. Because good work is good for health and well-being, integration of 'work' contributes to good patient care
2. Policies and reimbursement structures should facilitate effective and efficient care.

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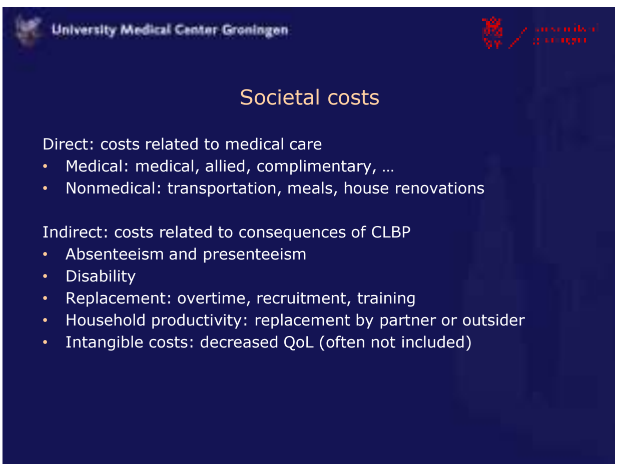
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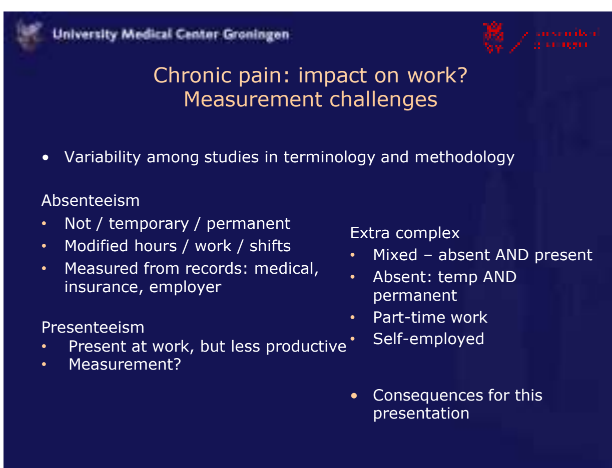
Societal costs
Direct: costs related to medical care
• Medical: medical, allied, complimentary, …
• Nonmedical: transportation, meals, house renovations
Indirect: costs related to consequences of CLBP
• Absenteeism and presenteeism
• Disability
• Replacement: overtime, recruitment, training
• Household productivity: replacement by partner or outsider
• Intangible costs: decreased QoL (often not included)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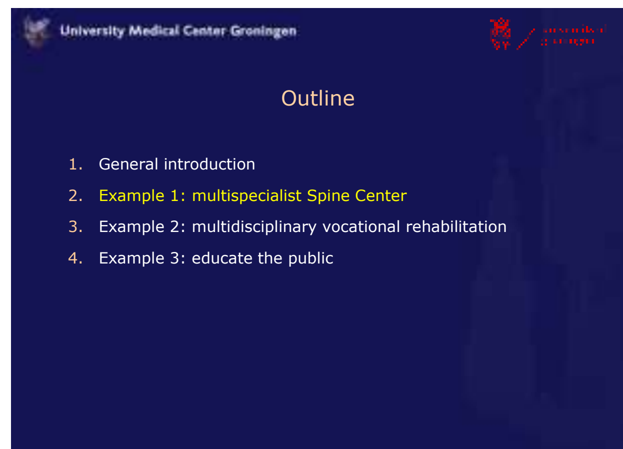
Chronic pain: impact on work?
Measurement challenges
• Variability among studies in terminology and methodology
Absenteeism
• Not / temporary / permanent
• Modified hours / work / shifts
• Measured from records: medical, insurance, employer
Presenteeism
• Present at work, but less productive
• Measurement?
Extra complex
• Mixed – absent AND present
• Absent: temp AND permanent
• Part-time work
• Self-employed
• Consequences for this presentation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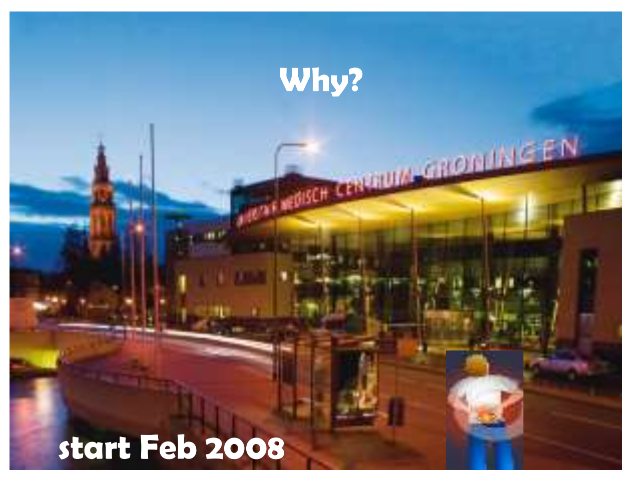
Why?
start Feb 2008

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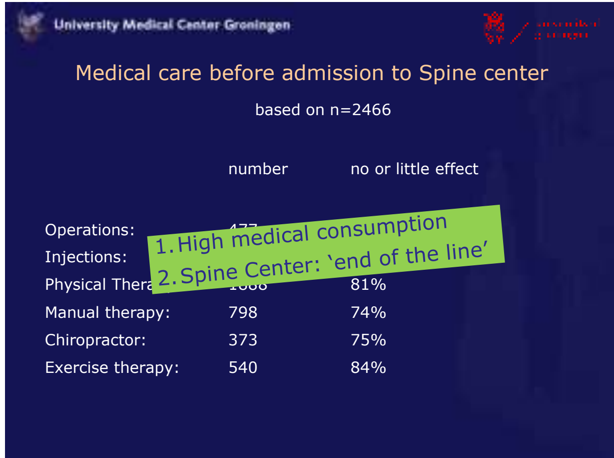
Who can help me?
Huisarts
Revalidatie
Orthopedie
Anesthesiologie
Traumatologie
Neurologie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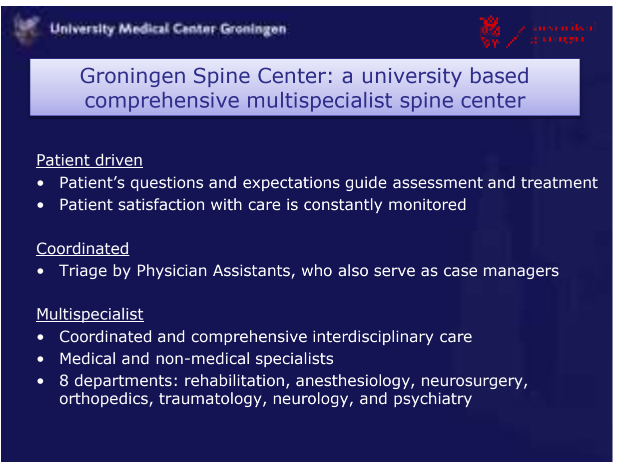
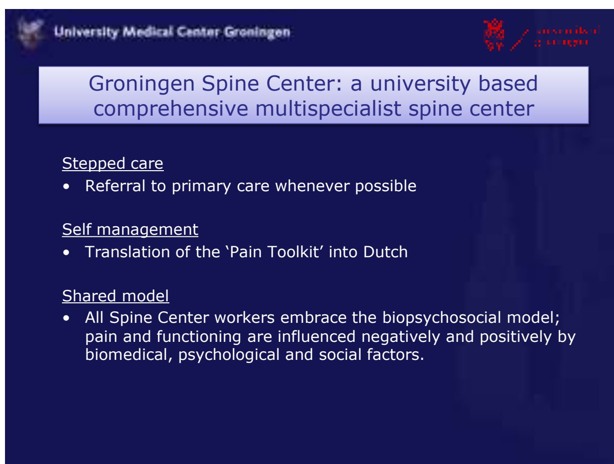
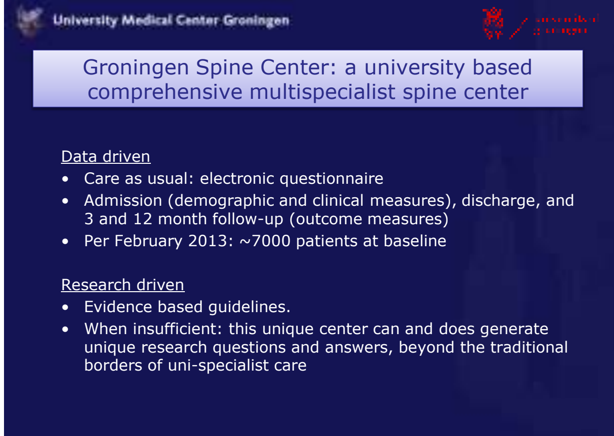
Medical care before admission to Spine center
based on n=2466
number
no or little effect
Operations:
Injections:
Physical Thera
81%
Manual therapy: 798 74%
Chiropractor: 373 75%
Exercise therapy: 540 84%
1. High medical consumption
2. Spine Center: 'end of the line'


University Medical Center Groningen
Groningen Spine Center: a university based comprehensive multispecialist spine center
Patient driven
Patient's questions and expectations guide assessment and treatment
Patient satisfaction with care is constantly monitored
Coordinated
Triage by Physician Assistants, who also serve as case managers
Multispecialist
Coordinated and comprehensive interdisciplinary care
Medical and non-medical specialists
8 departments: rehabilitation, anesthesiology, neurosurgery, orthopedics, traumatology, neurology, and psychiatry


University Medical Center Groningen
Groningen Spine Center: a university based comprehensive multispecialist spine center
Stepped care
Referral to primary care whenever possible
Self management
Translation of the 'Pain Toolkit' into Dutch
Shared model
All Spine Center workers embrace the biopsychosocial model; pain and functioning are influenced negatively and positively by biomedical, psychological and social factors.


University Medical Center Groningen
Groningen Spine Center: a university based comprehensive multispecialist spine center
Data driven
Care as usual: electronic questionnaire
Admission (demographic and clinical measures), discharge, and 3 and 12 month follow-up (outcome measures)
Per February 2013: ~7000 patients at baseline
Research driven
Evidence based guidelines.
When insufficient: this unique center can and does generate unique research questions and answers, beyond the traditional borders of uni-specialist care

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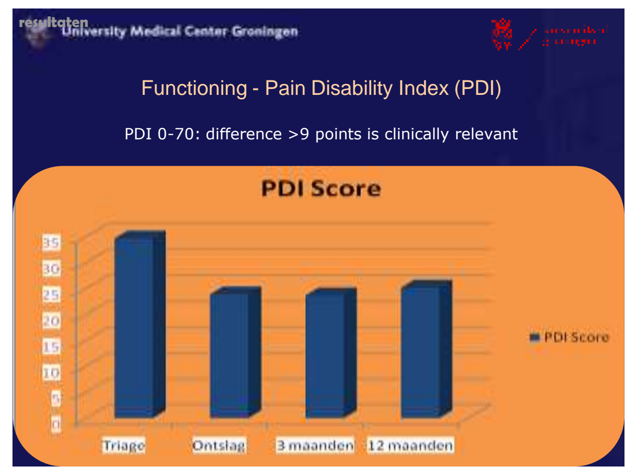
Groningen Spine Center: a university based comprehensive multispecialist spine center
Results
1. Pain disability
2. Work status
3. Quality of life
4. Outcomes – societal level


resultaten
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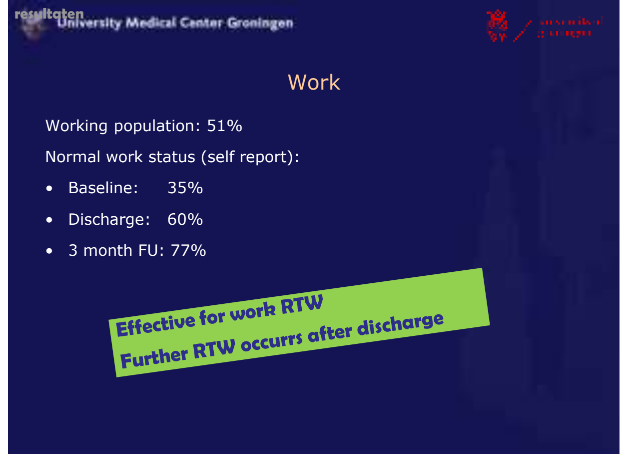
Functioning - Pain Disability Index (PDI)
PDI 0-70: difference >9 points is clinically relevant
PDI Score
35
30
25
20
15
10
5
0
Triage
Ontslag
3 maanden
12 maanden
PDI Score


resultaten
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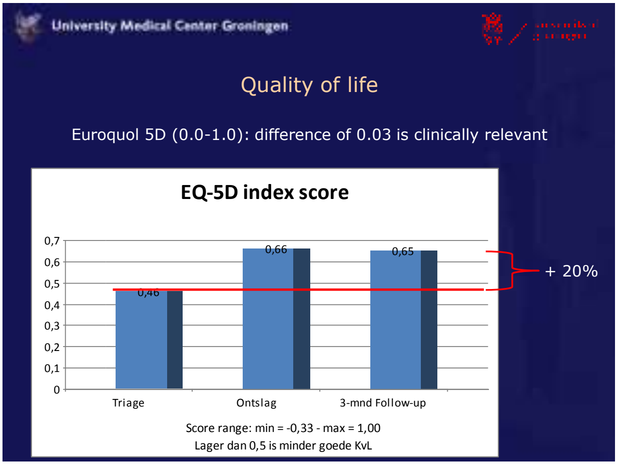
Work
Working population: 51%
Normal work status (self report):
Baseline: 35%
Discharge: 60%
3 month FU: 77%
Effective for work RTW
Further RTW occurs after discharge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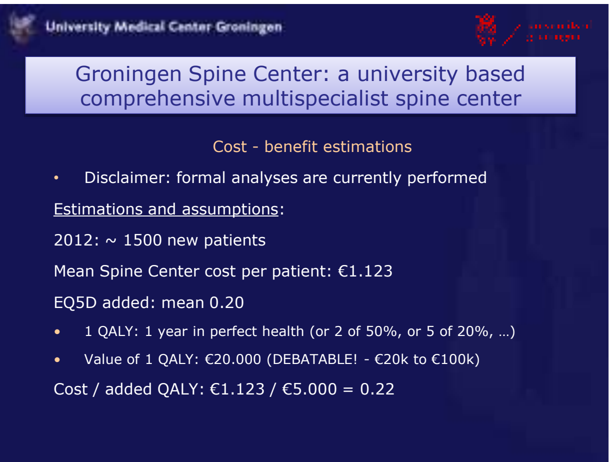
Quality of life
Euroquol 5D (0.0-1.0): difference of 0.03 is clinically relevant
EQ-5D index score
0,7
0,6
0,5
0,4
0,3
0,2
0,1
0
0,46
0,66
0,65
Triage
Ontslag
3-mnd Follow-up
+ 20%
Score range: min = -0,33 - max = 1,00
Lager dan 0,5 is minder goede KvL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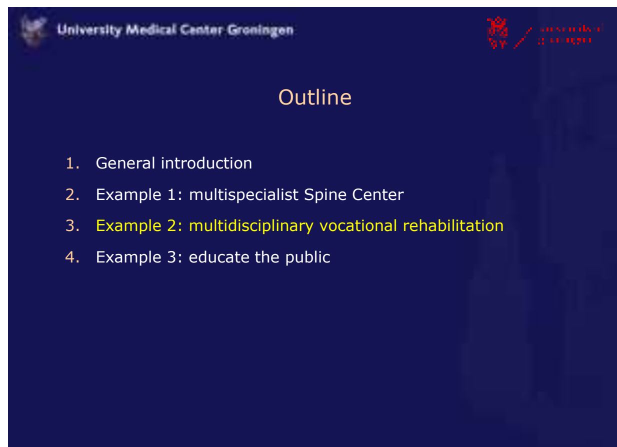
Groningen Spine Center: a university based comprehensive multispecialist spine center
Cost - benefit estimations
Disclaimer: formal analyses are currently performed
Estimations and assumptions:
2012: ~ 1500 new patients
Mean Spine Center cost per patient: €1.123
EQ5D added: mean 0.20
1 QALY: 1 year in perfect health (or 2 of 50%, or 5 of 20%, …)
Value of 1 QALY: €20.000 (DEBATABLE! - €20k to €100k)
Cost / added QALY: €1.123 / €5.000 = 0.22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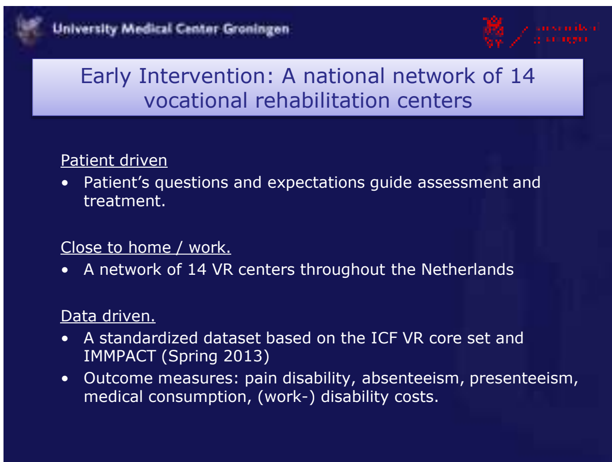
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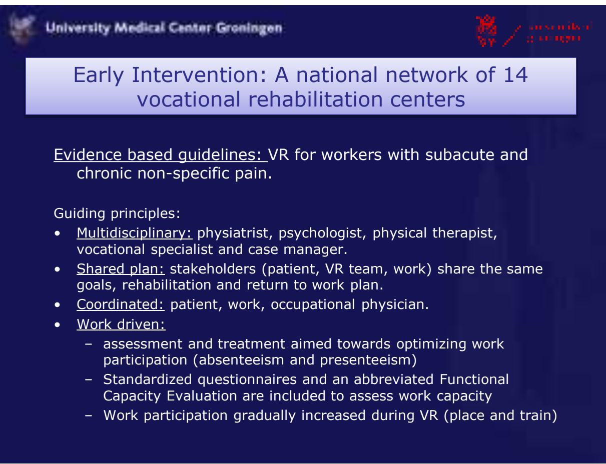
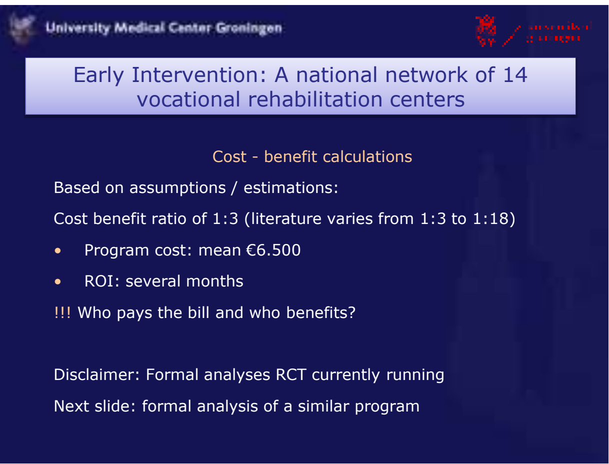
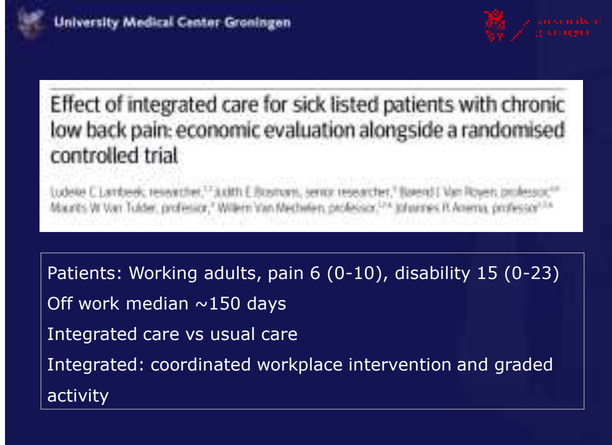
Early Intervention: A national network of 14 vocational rehabilitation centers
Patient driven
Patient's questions and expectations guide assessment and treatment.
Close to home / work.
A network of 14 VR centers throughout the Netherlands
Data driven.
A standardized dataset based on the ICF VR core set and IMMPACT (Spring 2013)
Outcome measures: pain disability, absenteeism, presenteeism, medical consumption, (work-) disability costs.


University Medical Center Groningen
Early Intervention: A national network of 14 vocational rehabilitation centers
Evidence based guidelines: VR for workers with subacute and chronic non-specific pain.
Guiding principles:
Multidisciplinary: physiatrist, psychologist, physical therapist, vocational specialist and case manager.
Shared plan: stakeholders (patient, VR team, work) share the same goals, rehabilitation and return to work plan.
Coordinated: patient, work, occupational physician.
Work driven:
– assessment and treatment aimed towards optimizing work participation (absenteeism and presenteeism)
– Standardized questionnaires and an abbreviated Functional Capacity Evaluation are included to assess work capacity
– Work participation gradually increased during VR (place and train)


University Medical Center Groningen
Early Intervention: A national network of 14 vocational rehabilitation centers
Cost - benefit calculations
Based on assumptions / estimations:
Cost benefit ratio of 1:3 (literature varies from 1:3 to 1:18)
Program cost: mean €6.500
ROI: several months
!!! Who pays the bill and who benefits?
Disclaimer: Formal analyses RCT currently running
Next slide: formal analysis of a similar program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Effect of integrated care for sick listed patients with chronic low back pain: economic evaluation alongside a randomised controlled trial
Patients: Working adults, pain 6 (0-10), disability 15 (0-23)
Off work median ~150 days
Integrated care vs usual care
Integrated: coordinated workplace intervention and graded activity

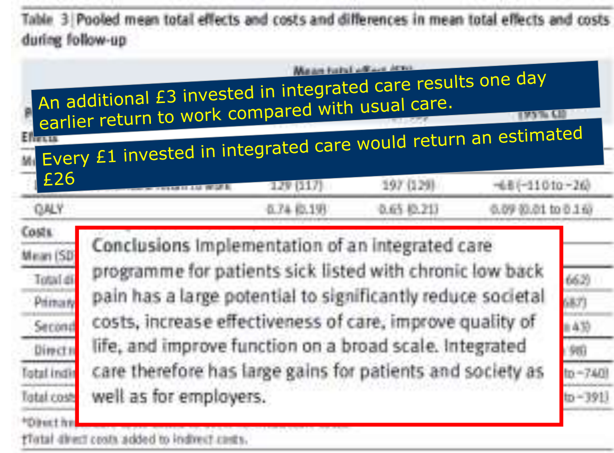
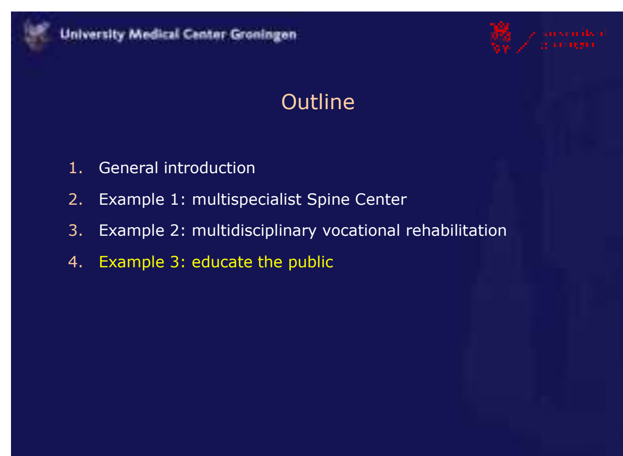


Table 3 | Pooled mean total effects and costs and differences in mean total effects and costs during follow-up
An additional £3 invested in integrated care results one day earlier return to work compared with usual care.
Every £1 invested in integrated care would return an estimated £26
QALY
Costs
Conclusions Implementation of an integrated care programme for patients sick listed with chronic low back pain has a large potential to significantly reduce societal costs, increase effectiveness of care, improve quality of life, and improve function on a broad scale. Integrated care therefore has large gains for patients and society as well as for employers.
†Total direct costs added to indirect costs.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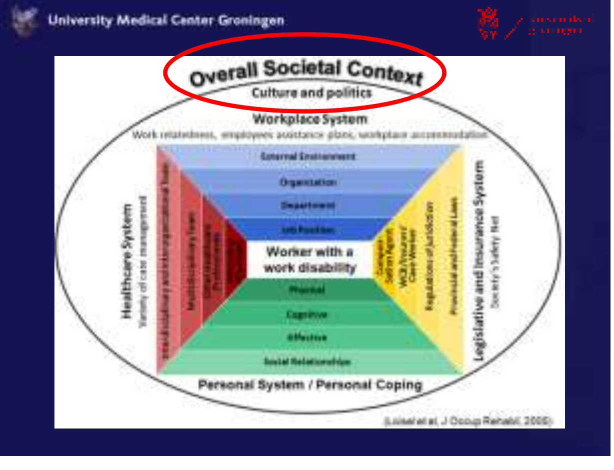
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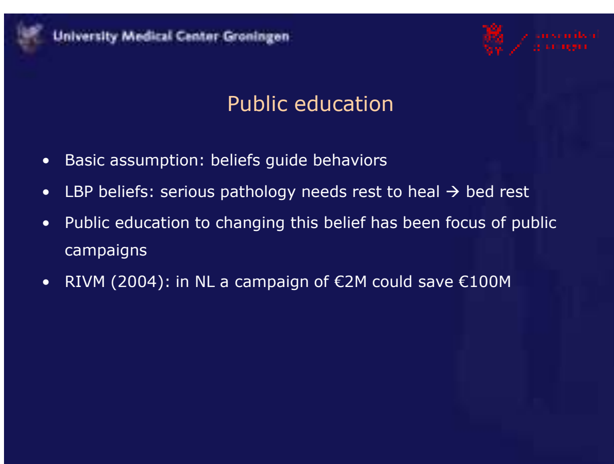
Overall Societal Context
Culture and politics
Workplace System
Worker with a work disability
Healthcare System
Legislative and Insurance System
Personal System / Personal Coping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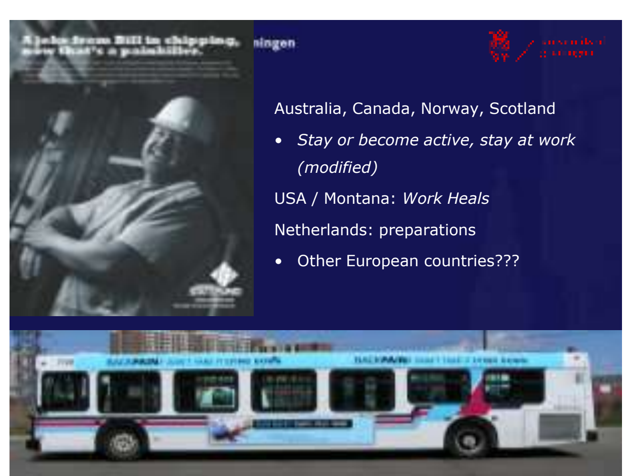
Public education
Basic assumption: beliefs guide behaviors
LBP beliefs: serious pathology needs rest to heal → bed rest
Public education to changing this belief has been focus of public campaigns
RIVM (2004): in NL a campaign of €2M could save €100M


Australia, Canada, Norway, Scotland
Stay or become active, stay at work (modified)
USA / Montana: Work Heals
Netherlands: preparations
Other European countries???

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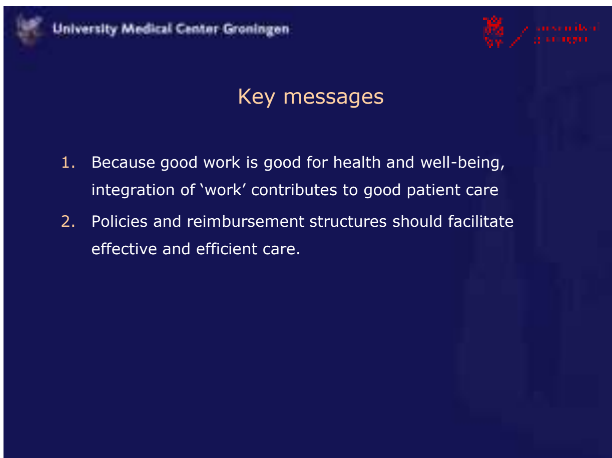
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Key messages
1. Because good work is good for health and well-being, integration of 'work' contributes to good patient care
2. Policies and reimbursement structures should facilitate effective and efficient care.

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Thank you
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