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“Bridging health care and the work place”:

From intervention development & evaluation to exploring implementation in daily practice

Content

- Background
- Development & evaluation of the BRUG*-intervention: patient perspective
- BRUG- intervention
  - Stepwise development (4 of 6 steps)
  - Results (BRUG-intervention)
- Practice Based Evidence: health-care professionals perspective
  - Aims & Design
  - Research (in progress)
- References

*EN: Bridging health care and the workplace

Background

- Restore/maintain participation in society is of high importance:
  - Return to work in Belgium
    - Not successful for +/- 40% (Neyt et al., 2006)
    - +/- 60 % others : able to maintain their occupations ?
  - Being able to work is part of quality of life (Rommel et al., 2012)
  - Personal, social and financial reasons (Tiedtke,2011)
  - Need for support is eminent (Tiedtke,2013)
    - No (systematic organised) after care
    - No specific legislation (in care, in work,…)

Background

- Current medical approach focuses on dis-ability (Pauwels et al., 2011)
  - Curative care :
    - indication for RTW from medical point of view
    - Argues for reimbursement of dis-ability
  - Medical advisor (Social Insurance):
    - Indication for RTW from insurance point of view
    - Gatekeeper on reimbursement of sickness-absence
  - Occupational physician employer :
    - Spec. legislation OSH
    - Gatekeeper on health, safety and wellbeing from company's point of view
  - occupational physician unemployment office
    - Indication for right on allowance "un-employed"
    - Gatekeeper for "entrance to labour-market"
- A systematic approach is necessary, but not yet available in Belgium (Tiedtke et al, 2012)

BRUG

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Bridging Health care and work for breast cancer survivors: “BRUG*” intervention

H. Désiron[1,2],
E. Smeers[1], Angelique De Rijk [3], E. Van Hoof [4], J. Mebis [5,6], L. Godderis[1,7]

(1) Environment and Health, Department of Public Health and Primary Care KU Leuven,
(2) Department of Healthcare, University College Limburg PXL
(3) Department of Social Medicine, Care and Public Health Research Institute (CAPHRI), Faculty of Health, Medicine and Life Sciences, Maastricht University
(4) Department of Developmental and Lifespan Psychology (KLEP), Faculty of Psychological and Educational Science, Vrije Universiteit Brussel
(5) Department of Medical Oncology, Jessa Hospital, LOC
(6) Department of Medicine and Life Sciences, UHasselt,
(7) IDEWE, External Service for Prevention and Protection at Work,

* NL: Borstkanker Re-integratie vanUit Gezondheidszorg

Project partners

Wetenschappelijke ondersteuning:

- Prof dr. Angelique De Rijk , Maastricht University
- Prof dr. E. Van Hoof, VUB Brussels
- Dr. J. Mebis, U-Hasselt
- Prof. Dr P. Donceel (†) KULeuven
- Prof. Dr. L. Godderis, KULeuven

Main Objectives “BRUG”

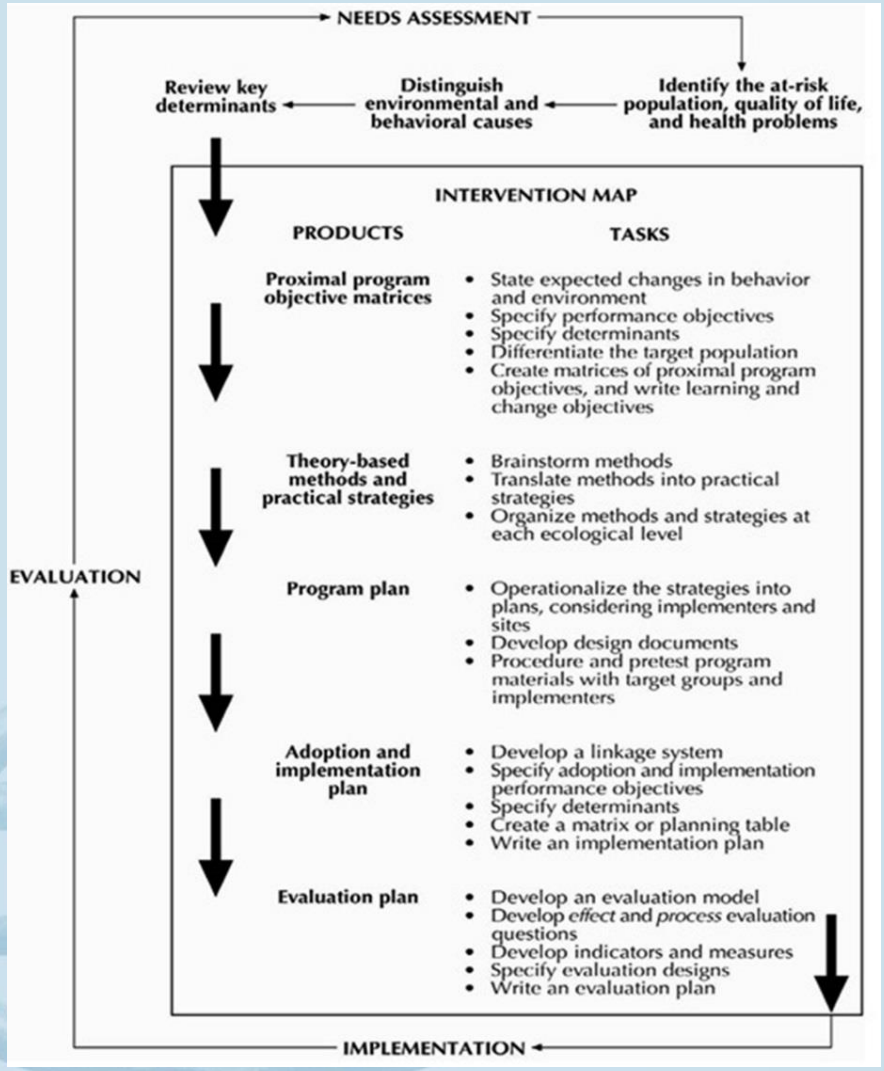
- Gather evidence on the efficacy of occupational therapy interventions on return to work (RTW) and, hereby, select the most efficient intervention of occupational therapy (OT) contributing to RTW
- Use patients’ perspectives to develop an early offered, trans-mural & stakeholder-inclusive OT intervention aiming on RTW for breast cancer patients
- Study of feasibility of the early trans-mural OT intervention aiming on RTW in stakeholders involved

“ …occupational therapy (OT) is a health care profession based on the knowledge that purposeful activity can promote health and well-being in all aspects of daily life.
The aims are to promote, develop, restore & maintain abilities needed to cope with daily activities; to prevent dysfunction.... “
(WFOT: World Federation of Occupational therapists)

Research Questions

- What is a qualitative OT-intervention aiming on RTW in BC?
- What is the added value of an OT-intervention provided for Belgian BC patients, aiming on RTW with enhancing QoL as final goal?
- What are results of an OT intervention provided to BC patients aiming on RTW with enhancing Quality of life as final goal?
- What are the experiences & perceptions of stakeholders involved in an OT intervention aiming on RTW with enhancing QoL as final goal?

Intervention Mapping



- 6 step protocol
- Enables a systematic and logically structured approach to develop a RTW intervention for BC patients
  - relates to employed BC patients who are on sick leave (needing to regain employment)
  - aims to support those BC patients that are combining work and treatment (needing to be enabled to remain at work)

Bartholomew LK, Parcel GS, Kok G, Gottlieb NH. Planning health promotion programs: an Intervention Mappping approach. San Francisco, CA: Jossey-Bass; 2006.

Development of “BRUG”-intervention

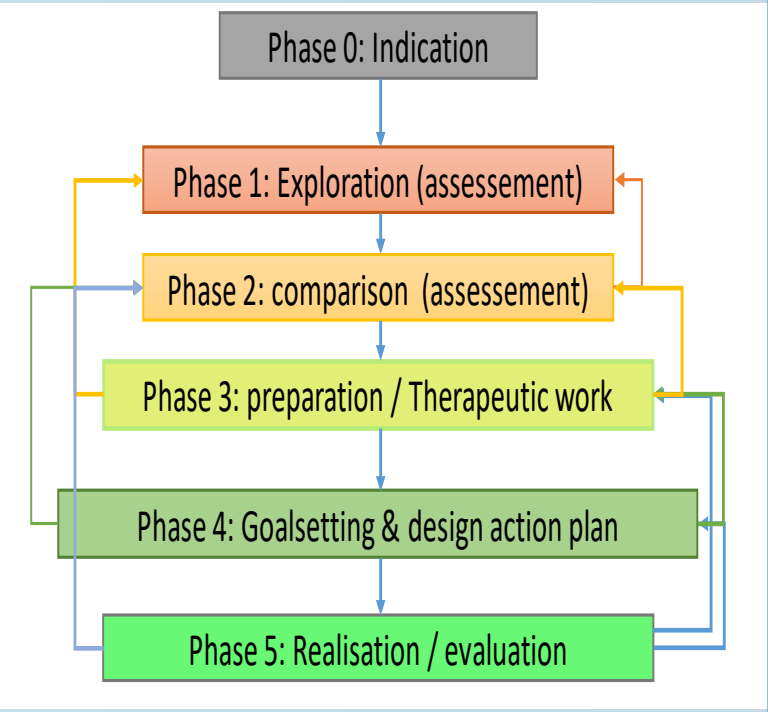
- BRUG: bridging the gap between healthcare and work starting at the hospital
  - Occupational therapy embedded in current Onco-care
  - Community oriented care
  - Linking all stakeholders to the RTW-process
  - Process follows patients’ evolution

- Method: Intervention Mapping (IM) protocol
  - Evidence regarding RTW in BC patients (evidence based practice)
  - Insights regarding OT and RTW (practice based evidence)

“BRUG”-intervention in practice

- Results:
  - BRUG- intervention: 5 phases
    - Phase 0: indication patients at need
    - Roadbook
    - Patient’s logbook
    - OT (case manager) logbook
  - OT embedded in MDT oncology
    - assessment instruments
    - goals / milestones
    - stakeholders

    } Per phase
  - Characteristics:
    - Engaging all stakeholders,
    - Goal-setting using shared decision making,
    - Progressively developing tailored actions,
    - Continuous evaluations and adjustments of goals and actions.



Stakeholder involvement

Evaluation …

- Step 6: Evaluation ➔ mimic RCT
  - Qualitative branch
    - Experiences patients
    - Experiences health care professionals
    - Logbook Bridge Case-manager
  - Quantitative branch
    - Quality of life
    - Days of sick-leave
      - Since diagnosis
      - Relapse
    - Time-use care givers

Evaluation : mimic RCT & qualit. study

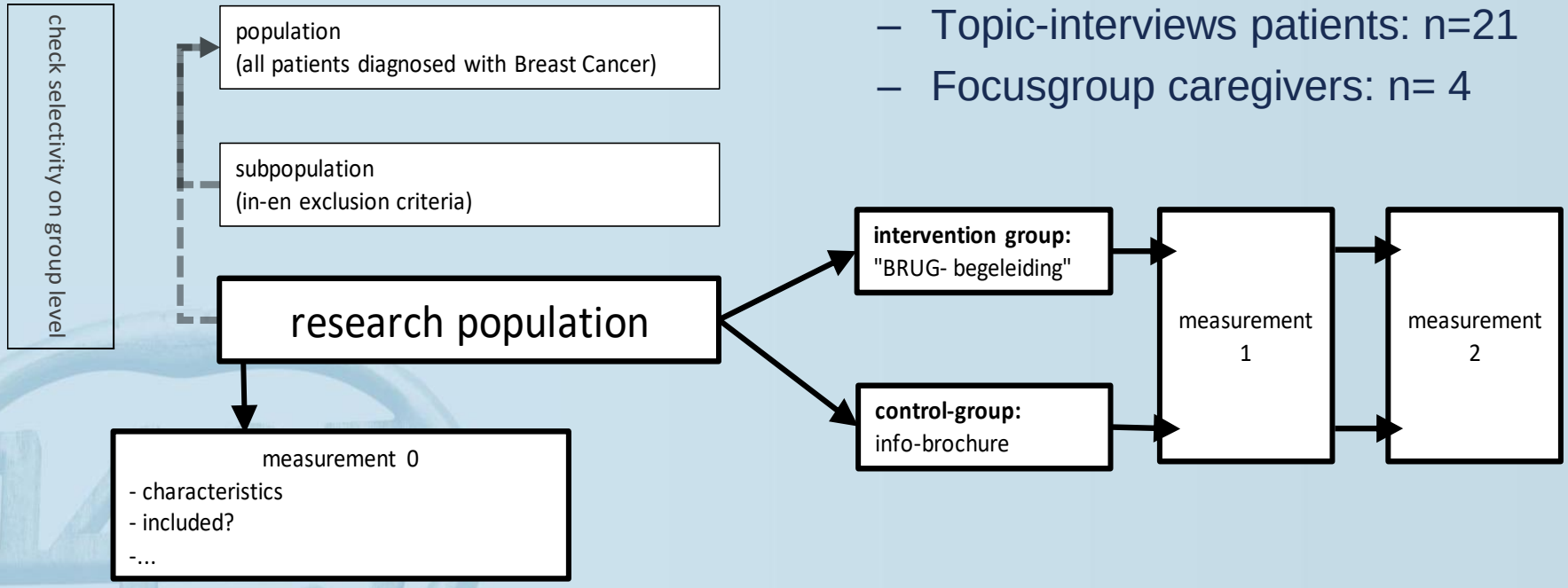
- **Fieldwork** “BRUG”-intervention
  - Setting : Oncologic multidisciplinary team in 2 hospitals
  - Inclusion criteria
    - Diagnosis BC
    - Age 25<>60
    - Employed at diagnosis
    - Informed consent signed
  - Exclusion criteria
    - Selfemployed / Unemployed at diagnosis
    - Ex. survival < 1 jaar
    - In sickleave for other reason

- **Method:**
  - Quantitative measurement
    - Quality of life
    - Days of sick-leave
      - Since diagnosis
      - Relapse
    - Time-use care givers
  - Qualitative measurement:
    - Perceptions of patients, caregivers, stakeholders
      - Research specific questionnaires
      - Questionnaire QoL

Mimic RCT

- Recruitment:
  - Start : 11/11/2015
  - End : 30/06/2017

- Number of participants : 79
  - Intervention-group: 43
  - Control-group: 36
- Qualitative research:
  - Topic-interviews patients: n=21
  - Focusgroup caregivers: n= 4



Results

- Evidence based findings are confirmed but also nuanced:
  - Information is needed (early, tailored)
  - Early start is important but differs widely between patients
    - Moment in treatment process
    - Start of support versus start of specific actions regarding RTW

      ➔ thoughtful follow-up
  - Knowing support that might be available is already helpful
  - Response / advice of health care staff is very influential (on RTW & NOT RTW)
    - Care-oriented (verbal and non-verbal) attitude tends to discourage RTW (protecting attitude)
    - Care-staff
      - has little insight in financial and social consequences of not-working
      - patients' job-requirements are not well known: ➔advice towards avoiding overload
    - Care-staff members rarely discuss pro-& contra RTW

Results

- Personal situation and socio-economic context (incl. social insurance) is highly influential for moment of RTW
- The RTW support by BRUG-professional was highly appreciated:
  - Targeting (indicative instrument)
  - Tailoring (content of each of the 5 phases)
  - Workplace visits
  - Stakeholder involvement
- To start RTW support early after diagnosis appeared to be difficult (targeting)

Results (by end of follow-up period)

Effect of BRUG-support	(n= 15)
Returned to work (partial, progressive, complete contract)	5
Preparing to RTW (agreements made, action plan finalised)	4
Decided not to RTW yet (due to medical issues, at the workplace, no approval by occupational physician or medical advisor,…)	3
Decided not to RTW (early retirement or retirement planned)	3

BRUG-professional's efforts

Per participant in the intervention -group	
Average number of contacten	8
Type of contact (tel, mail, home- or workplace visit…) per contact: ○ **Telephone** ○ **e-Mail** ○ **Mail by post** ○ **Home-or workplace visit** ○ **Other reunions (employer, soc.insurance,…)**	**Number of contacts / type** - min 5 – max 15 - min 8 – max 20 - / - min 1 – max 5 - av,. 2
Average use of time per contact (in minuts) ○ **Telephone** ○ **e-Mail** ○ **Mail by post** ○ **Home-or workplace visit** ○ **Other reunions (employer, soc.insurance,…)**	 - av, 15' - av, 10' - / - min 45' max 150' - min 30' max 180'
Average timeuse per participant (in hours)	16
Runtime of the intervention per patiënt (from start till stop) (in months)	Min 2 max 24

Lessons learned

- Importance of targeting and “thoughtful follow-up” during treatment period
  - Early start & targeting (thoughtful follow-up)
  - Tailoring (thoughtful follow-up)
  - Optimal moment to engage in RTW, no obliged time-frame
  - Optimal moment to get specific actions going (for all stakeholders)
  - Importance of support in administration
  - Attention for impact of (un-meant) advice by caregivers
  - Tailoring the RTW-process
- Stakeholder involvement tailored on
  - Patient’s situation (different perspectives)
  - Employer’s ability/motivation to provide progressive RTW
  - Role of supervisor / colleagues

Policy recommendations

- “RTW” should be an integrated part of caregiving (health, well being,…)
- Partial and progressive RTW should be facilitated during treatment period whenever possible, taking into account:
  - Patients’ abilities
  - Workplace adaptations possible (or not / safety & security at the workplace,…)
- BRUG from care to workplace (and back) should be reinforced by stimulation/facilitation by consultation moments
- This BRUG-project focused on BC, enlargement to all other types of cancer is necessary

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Inventory of "practice based evidence" on maintaining/regaining labour participation of cancer-patients in Belgium

Désiron, Huget [1,2,3] ;
De Rijk Angelique[4]; Van Hoof Elke[5]; Vandevelde Dominique[6],
Simons Berthold[1] ; Spooren Annemie[3]; Stéphane Camut[7] ;
Godderis Lode [2, 8] ; Decuman Saskia [9]

1) ACT-Desiron, Hasselt;
2) Centre for Environment and health, Dep. of Public Health and Primary Care, KULeuven;
3) Research-group innovation in health care, department of health care, University College PXL Hasselt;
4) Department of Social Medicine, Care and Public Health Research Institute (CAPHRI), Faculty of Health, Medicine and Life Sciences, Maastricht University, The Netherlands;
5) Department of Developmental and Lifespan Psychology (KLEP), Faculty of Psychological and Educational Science, Vrije Universiteit Brussel;
6) Masteropleiding ergotherapeutische wetenschappen, Universiteit Gent;
7) Bacheloropleiding ergotherapie Collège d' Ergothérapie de Brussel (CEBxl), Brussels;
8) IDEWE, External Service for Prevention and Protection at Work, Heverlee;
9) Ondersteunend expert onderzoek en ontwikkeling, Rijksinstituut voor ziekte- en invaliditeits-verzekering (RIZIV) Brussel

Project partners

- Project-coordination ACT Desiron ltd.
  - dr. H. Désiron (research content)
  - dr. B. Simons (project management)
- Scientific support
  - dr. S. Decuman (RIZIV)
  - Dr. Robberechts (RIZIV)
  - prof. Dr. Godderis (KULeuven)
- Field work:
  - PXL occupational therapy (dr. Spooren & mrs. Smeets)
  - CEBxl occupational therapy (dr. Meeus & mr. Camut)
  - Master in occupational Science (dr. Vandevelde)

Field work

- PXL occupational therapy
  - Pieter Jan Maes
  - Sophie Van Donghen
  - Thibeau Caes
  - Lotte Broeders
- CEBxL occupational therapy
  - Angèle Osbild
  - Aliette Bongrand
  - Camille Vallein

- Master of science in occupational therapy:
  - Justien Demeulenaere
  - Hélène Boeckmans

Healthcare professionals' perspective

- To check out the level of implementation of knowledge on "RTW & Cancer" :
  - Implementation in the field
  - Contribution to maintain/restore labour-participation for cancer-patients
- Perceptions of health care providers on (potential) success factors & bottle-necks that would influence implementation of scientific evidence:
  - Care providers that offer support in RTW for cancer patients
  - Care providers who have no experience on supporting RTW in cancer patients

Aims

- Inventory of the “gap” between research and practice:
  1. Patient needs and current response of health care
  2. Implementation of scientific knowledge regarding the focus of current care on (return to) labour participation
- Preparation for development of a evidence based guideline “ RTW & cancer”

Research questions

- What care providers (cancer care) offer support aiming on RTW?
  - What is het content of care based support of providers that do offer RTW support?
  - What reasons hinder providers that currently have no offer on RTW support?
- On what (scientific) base do care providers - offering RTW-support – ground the service they offer at cancer patients?

Research questions

- What facilitators & barriers influence the choices of health care providers (whether or not) to provide RTW-oriented support?
- What is – following health care providers – an ideal approach to contribute to sustainable (restoring of) labour participation and what is needed to realise such approach?

Method

- Qualitative – descriptive - research
  - Practice based evidence
  - Grounded theory (“*the systematic inquiry into a problem aiming to develop an overall theory based on personal experience*” , Hickson)

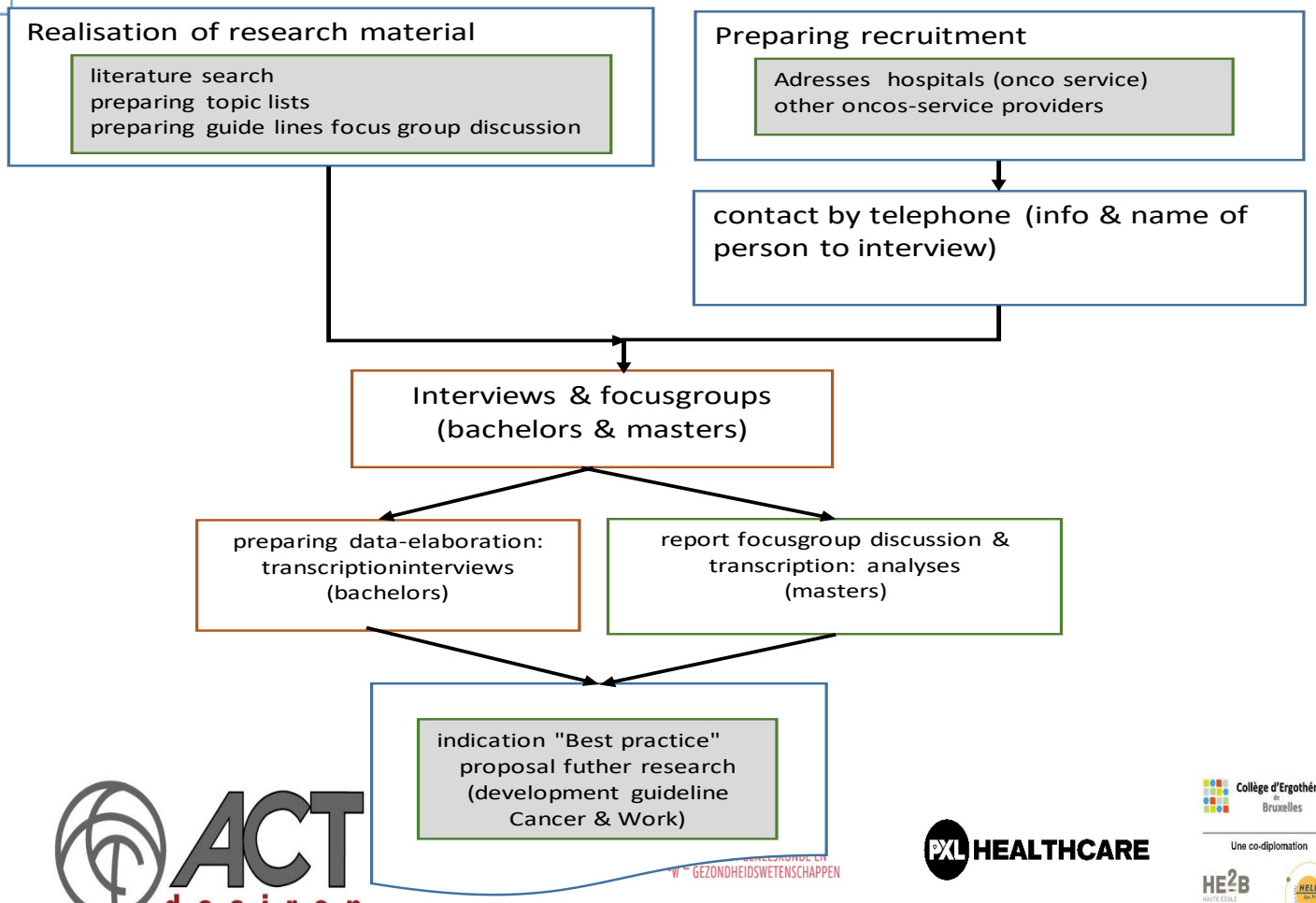
- Topic interviews (participants: care-service managers)
  - Individual contact (semi-gestructurerd interview)
  - Multidisciplinary (medical specialists, nurses, social workers,….)

- Focus-groups (participants: care professionals)
  - Heterogenic groups
  - Multidisciplinary participants

Output

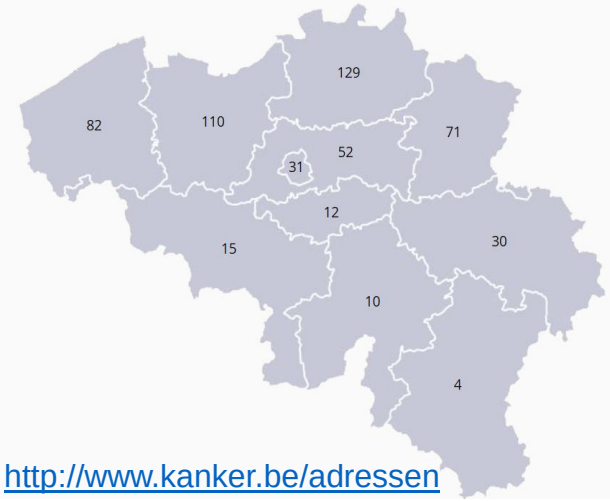
- Insights on current (lack of) efforts in daily care practice regarding RTW-support:
  - What can be seen as “best practice”
  - What actions have high chances of being implemented
- Base for continuous research regarding:
  - Scientific knowledge aiming to develop a “cancer & work” guideline for care providers
  - Investigate potential generalisation on usability of such a guideline for other patient-groups that are confronted with chronicity & high risk of long-term workdisability

Study-design



Participants & recruitment

- List of addresses of providers of cancer-care
  - Official
    - Governmental
    - Non-governmental
- Contact by telephone
  - Explanation on content and aim of the study
  - Appointment for interview
  - Agreement for participation on the focus-group discussion



http://www.kanker.be/adressen

Preliminar results

- Cancer care centres:
  - Flanders
  - Brussels
  - Wallonia
- Recruitment
  - Flanders
  - Brussels
  - Wallonia
- Participants
  - Medical specialists
  - Specialised nurses
  - Social workers
  - Psychologists

Preliminar results

Topic interviews

	totaal lijst	filialen	onafh	Toegewezen	afgerond	geweigerd	Verwerkt
Vl	79	22	57	35	24	3	6
Wa	46	9	37	32	15	4	4
BXL	20	11	9	8	5		1
BXL Vl	3	1	2	2	1		
BXL Fr	17	10	7	6	4		

Preliminar results

- Scientific literature (implementation research)
- Care providers:
  - Offering “some” RTW-support
  - In doubt whether or RTW-support is of their job
  - Arguments why they do not offer RTW-support
- Ongoing analysis (transcription of interviews)
  - RTW-support is offered:
    - Evidence base is very low; awareness this should be optimised
    - Development of approach based on practice / experience
  - RTW- support is occasionally offered
    - Not structured approach; case-oriented
    - Willingness to develop/adapt guideline
  - RTW support is not offered
    - Unit is to small, age of patient group is too high (+60 years on average)
    - RTW is not seen as part of care-tasks

Thanks

For your attention

&

feedback

BRUG: elke.smeers@kuleuven.be
BRUG & PBE: huget@act-desiron.be