EVALUATING THE RECOVER MODEL AS
AN EFFECTIVE EARLY INTERVENTION PROGRAM

by

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Abstract

This project report is part of an overall evaluation of the RECOVER pilot expansion. RECOVER is an example of an employer-driven early intervention initiative that relied on the development of collaborative working relationships between Fraser Health, WorkSafeBC, and community physiotherapy providers. The pilot’s aim was to minimize lengthy delays to appropriate treatment, and to keep the injured workers connected to the workplace during their time of recovery. In this report, a population of eligible Fraser Health employees who experienced an acute, musculoskeletal injury while completing their duties at work (n=127) was compared in terms of this population group’s sample of eligible employees who voluntarily chose to accept the employer’s offer to participate in the pilot (n=82) versus those who voluntarily declined the employer’s offer, even though they were eligible for participation (n=45). Variables for comparison included the employees’ age, occupational group, work status, and WSBC SDL office managing their file. Qualitative instruments were also used to obtain mean satisfaction values from pilot participants and RECOVER service providers. Findings from this mixed-methods evaluation indicated that as of four months post-pilot expansion, RECOVER demonstrated that it was an effective way of delivering early intervention services to injured employees with an acute, work-related musculoskeletal injury. This was observed through a high rate of voluntary employee acceptance for pilot participation, and through high mean satisfaction values received from RECOVER participants and service providers.
Chapter 1: Introduction

Introduction

The effective management of work-related musculoskeletal injuries continues to present organizations with many challenges. Issues that workplaces face include substantial economic losses to the employer; and significant physical, emotional, and financial losses for the employees. Interventions to assist with timely returns back to the workplace are frequently missed when an injured worker's access to early rehabilitative services - such as treatment from a certified physiotherapist, is delayed or non-existent.

To address these issues, some employers have started establishing close working relationships with various physiotherapy service providers. Oftentimes these partnerships are based on an agreement where an employer is able to directly refer their injured employee to a provider for immediate assessment and treatment. The service provider then collaborates with the employer in identifying timely opportunities that could assist with the employee’s safe and early transition back into the workplace. Research supports the need for timely physiotherapy interventions, as prompt access to treatment has been shown to produce favourable occupational outcomes in terms of an injured employee’s improved ability to physically function post-injury, self-manage their reported pain levels, and increase their perceptions of self-efficacy and control (Shaw et al., 2006).

PEARS (Prevention and Early, Active Return to Work Safely) Plus is an example of a workplace-initiated early intervention program that was piloted under a collaborative effort between Fraser Health (FH) and WorkSafeBC (WSBC). This program was trialed between May 1, 2007 and April 30, 2008 in the ‘East’ Fraser Health region (Abbotsford WSBC...
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Service Delivery Location (SDL) and relied upon the services from external, community physiotherapy providers. Primary goals for the PEARs Plus pilot were to remove the delays associated with the referral to and the worker’s receipt of appropriate treatment; and to provide employees with medically appropriate opportunities that could help them recover from their musculoskeletal injury while they remained in the workplace. Service expectations that were outlined in the pilot included: the guaranteed provision of physiotherapy treatment within one week of the employee’s initial request for services, that the initial physiotherapy assessment report was provided to both FH and WSBC within three business days of the employee’s initial visit, and that the physiotherapy treatment plan be collaborative and focused on identifying supportive stay at work and/or return to work efforts.

Findings from a quasi-experimental study design that was performed on the PEARs Plus pilot demonstrated that the employer’s provision of timely physiotherapy services was associated with significant cost savings and a reduction in employee short term disability duration (Dawson, 2009). To further examine the success and effectiveness of the PEARs Plus model, an agreement was reached to change the model’s name to RECOVER and expand the early intervention pilot across all FH regions and related WSBC SDLs. The purpose of doing this was to determine if the resulting pilot expansion data further supported the PEARs Plus model as a cost-effective, workplace-driven early intervention program. Pilot expansion could also better determine if the findings observed in the above-mentioned, quasi-experimental study were actually related to program interventions, or to individual claims management practices that may only occur in the “East” FH region (Abbotsford SDL).
**PEARs Plus in an Expanded State**

RECOVER (Rehabilitation and Early Connection to Occupation and Vocation for Effective Recovery) is another example of a collaborative, employer-driven, early intervention initiative. Similar to its predecessor PEARs Plus, the RECOVER pilot model combined elements of early intervention, physiotherapy, workplace connection and collaboration amongst the workplace (FH), insurer (WSBC), and community physiotherapy providers. The objective of RECOVER was to minimize the barriers associated with treatment delays by providing eligible Fraser Health employees (Appendix A) with an acute, work-related, musculoskeletal injury voluntary access to timely physiotherapy services. Upon receipt of services, employees could immediately begin to focus on regaining the functional levels needed to stay at or safely return back to their pre-injury position. A benefit of employee participation included the ability to immediately begin treatment for their injury after initial report of their workplace incident and prior to their initial visit with their family physician. Furthermore, all service costs associated with receipt of their physiotherapy treatments would be directly covered by either WSBC and/or FH, regardless of the resulting decision made on the employees’ claims. RECOVER operated under the assumption that if provided with the appropriate supportive resources, prompt claim adjudication, and employer support and re-engagement, individuals would likely return to work without delay (Dawson, 2009; Franche et al., 2005, 2007). This one-year early intervention pilot study was rolled out across all FH acute care hospitals, community care agencies, residential care facilities, and related WSBC SDLs on October 19, 2009; and will end on October 18, 2010.
Chapter 2: Literature Review

Over the past two decades, a growing number of organizations have started to invest more of their resources towards integrating various early intervention disability management initiatives into their operational practices (Robert & Stevens, 1997). These initiatives are introduced to help workplaces address and minimize high economic costs associated with lengthy employee absences following an unexpected work-related incident. It has been estimated that approximately 8-12% of a Canadian company’s payroll is accredited towards work-related disability costs; and that these disability costs were anticipated to increase at an estimated rate of 8% per year (Berger, 1998).

Lengthy employee absences have become a great concern to employers as findings indicate that the longer an employee remains away from the workplace, the more disengaged they become and the less likely it appears that they will successfully return back to work. Curtis & Scott, (2004); Krause et al., (1998); & NIDMAR, (1995) go on to further state that the likelihood of an employee ever returning back to their pre-injury position decreases with time and becomes very improbable once their work-related absence exceeds a period of six months. Dyck (2000), notes that the first 30 days following the onset of an employee’s absence is the most opportune time when workplaces should provide early intervention services to their employees. It is during this time that employers should make every effort to keep their employees connected to the workplace and provide them with appropriate opportunities that could help them safely recover from their injuries at work. Being at work in some capacity could not only help draw the injured worker’s attention away from negative issues such as pain and reduced level of function, but it could also prevent acute work-related injuries from developing into a chronic, long-term disablement (Staal et al.,
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2005). Additionally, employers that offer timely work accommodations are generally more successful at reducing long-term work absence duration for injured employees, particularly for those employees who accept the return to work offer (Franche et al., 2007).

Soft-tissue musculoskeletal injuries are the most commonly reported disability resulting in time away from the workplace. In Canada, these types of injuries account for nearly half of all reported time-loss incidents and continue to be a significant contributor to a company’s worker compensation and long term disability costs (AWCBC, 2001). Due to current ‘wait-and-see’ practices associated with the provision of and access to rehabilitative services, many workers are not receiving the timely treatment interventions they may need for appropriate management of their musculoskeletal injury. Delays in treatment for these types of injuries could thus contribute to the substantial economic losses that employers face and may increase the worker’s risks of experiencing significant physical, emotional, and financial losses and poorer recovery outcomes (Franche et al., 2007; Bekkering et al., 2005).

Physiotherapists as an Early Intervention Provider

To address disability costs associated with lengthy work-related absences, many employers have started examining the cost-effectiveness of providing injured employees early treatment interventions as a way of reducing their time loss (Staal et al., 2005). Considerable research has found that the immediate offer and employee acceptance of physiotherapy services following the worker’s soft-tissue musculoskeletal injury could assist with improving their functional status and decreasing injury duration (Badii et al., 2006; Bekkering et al., 2005; Cooper et al., 1996; Davis et al., 2004; Dawson, 2009; Franche et al.,
Early access to physiotherapy has also been found to reduce an injured worker’s reported level of pain (Bekkering et al., 2005; Cooper et al., 1996; Shaw et al., 2006; Tate et al., 1999) and perceptions of control and self-efficacy over their injury (Shaw et al., 2006; Schonstein et al., 2003; Sinclair et al., 1997). Injured employees usually expect treatment providers to present them with an explanation about the cause of their pain, advice on symptom management, and sickness certification that legitimizes their feelings of pain (Staal et al. 2005). Physiotherapists have the ability to work with injured employees to help desensitize any perceived feelings of helplessness and/or difficulties coping with their sudden removal from the workplace following their unexpected injury (Harder, 2003). Service providers could also educate their clients on the difference between pain and disablement. If this distinction is not made, then management of their patients’ treatment may be ineffective, resulting in prolonged disability and the potential contribution of chronic pain behaviors (Cooper et al., 1996).

Frank et al., (1998) however, disagree with the above-mentioned findings. In their study, the authors reported that the provision of early physiotherapy, exercise instruction and education programs were ineffective in changing long-term outcomes, such as reported pain and functional status levels. This was found to be especially true if treatment interventions were implemented within the first weeks of the individual’s initial onset of symptoms. Additionally, other researchers noted that there were no significant differences observed in the length of time an injured employee remained away from work, or in terms of the length of time that it took their claim to close, when individuals were referred for early treatment or
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programs (Shaw et al., 2006; Lemstra & Olszynski, 2004; Sinclair et al., 1997). There has been little success with clinical-based intervention programs, especially when they occur outside of and with no communication to the workplace. This is because oftentimes, programs are not targeted to meet the specific needs of the injured worker from an occupational standpoint. Rehabilitation is separated from the workplace and treatment/RTW interventions take place without direct communication and/or commitment from the employer (Badii et al., 2006; Davis et al., 2004).

The Changing Role of Physiotherapists

Historically, physiotherapists have carried out a clinical-based treatment plan when working with injured workers. Physiotherapists helped employees recondition to a higher level of functioning by improving their strength, endurance, flexibility, and cardiovascular fitness statuses. Recovery and return to work planning usually occurred outside of the workplace oftentimes with no direct communication and/or commitment from the employer (Badii et al., 2006; Davis et al., 2004). However, since developing more collaborative working relationships with employer groups, physiotherapists have redirected the focus of their treatment plans to that of a more collaborative, occupationally-based one. Recommended treatment during the acute stage of the injured worker’s recovery should consist of low-intensity, work-specific clinical interventions that ideally take place on-site at the employee’s worksite (Franche et al., 2005; Schonstein et al., 2003; Staaal et al., 2005). Therapists are also strongly encouraged to provide employers with pertinent information about the injured worker’s current functional status, to communicate and collaborate with employers and other stakeholder groups when establishing workplace-focused recovery plans, and to educate and reassure employees that they could recover in the workplace while
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participating in a temporary modification of hours, tasks, and intensity (Harder & Scott, 2005).

‘Proactive communication’ by physiotherapists; or the gathering of information about the requirements and duties of their client’s jobs, the imparting of advice on the prevention of re-injury, and the formation of direct lines of communication with workplaces when returning employees back to modified work is an important element of an individual’s rehabilitation process, and can contribute to higher levels of satisfaction and confidence with their form of treatment (Kosny et al., 2006). Proactive communication could also help physiotherapists clarify any uncertainties they may have regarding specific organizational factors that could influence or hinder a successful and durable return to work; and reduce the likelihood of therapists over-treating their clients, thereby delaying opportunities for timely workplace-based return to work interventions (Kosny et al., 2006; Lemstra & Olszynski, 2004).

Communication should be collaborative amongst all stakeholders participating in the process and the message that the injured worker receives should be consistent and aligned with keeping them attached to the workplace (Dawson, 2009; Franche et al., 2005, 2007; Frank et al., 1998; Harder & Scott, 2005). Doing so not only sets the worker’s and employer’s expectations about recovery and return to work readiness right from the start, but it could also help promote a culture of safety within the workplace. As a requirement for the PEARS and PEARS Plus pilot programs, ongoing communication between the employer, employee, physiotherapy provider and the insurer, WorkSafeBC, was mandatory. Findings from these pilots demonstrated that the success of these early intervention initiatives were primarily driven by the consistent messaging and collaborative reassurance and support that
the injured worker received from the stakeholders during their recovery process (Badii et al., 2006; Davis et al., 2004; Dawson, 2009). Collaborative joint efforts is also a program requirement for the RECOVER pilot, and it is anticipated that findings from this pilot will show similar success to its predecessors PEARS and PEARS Plus.

Chapter 3: Methods

Participants

There were three primary reference groups that participated in the pilot program and completed the qualitative surveys developed by the UNBC graduate student. The first two groups, RECOVER participants and non-participants, included healthcare workers that were employed by the Fraser Health Authority. This included all injured workers employed at a FH acute care hospital, residential care facility, or community health agency. Appropriate employees for project participation consisted of any worker who sustained an acute musculoskeletal injury and experienced an immediate onset of symptoms resulting from a single, identifiable incident or event that occurred while they were completing their work-related duties. Workplace musculoskeletal incidents of a chronic nature resulting from repetitive strain or those where the incident occurred while the employee was not at work were not considered appropriate for inclusion in this early intervention pilot project.

To be eligible for pilot participation, workers had to report their workplace incident to both FH and WSBC within 7 calendar days following their date of injury and comply with program parameters. Following report of their acute musculoskeletal injury, the employer offered eligible employees (n=127) voluntary access to participation in the RECOVER pilot between October 19, 2009 – February 26, 2010. An additional five
referrals were also made during this time, but these employees did not meet the eligibility criteria for inclusion in the pilot program and were excluded from the overall analyses.

Benefits of pilot participation included timely employer-initiated referrals to appropriate services from a RECOVER physiotherapy provider prior to WSBC’s claim decision, and prior to seeing their family physician. In order to continue participating in the pilot however, employees were required to follow up with their physician within the 5 days of their initial RECOVER physiotherapy assessment. Another benefit was the employees were not personally responsible for any of the service payments while participating in the pilot; as there was reassurance that all costs associated with the receipt of their physiotherapy treatment would be covered by either WSBC or FH. Injured employees who voluntarily accepted the employer’s referral to participate in the pilot were sub-categorized into the ‘RECOVER Participant’ evaluation group (n=82). These employees were entitled to up to a maximum of 8 weeks (or 22 visits) of physiotherapy treatment to assist them with their stay-at-work or safe and timely return to work efforts. If an employee was still unable to return to work after being discharged from the RECOVER pilot, WSBC would continue to manage their file in accordance to their regulation Board policy. Once enrolled in RECOVER, participants were also given the opportunity to voluntarily withdraw themselves from continued participation at any time. Injured employees who voluntarily chose not to participate after the employer offered them access to the pilot were sub-categorized into the ‘RECOVER Non-participant’ evaluation group (n=45).

The final reference group consisted of the RECOVER physiotherapy providers. This group included service providers from 16 community physiotherapy clinics that agreed to participate in the pilot program. Clinic locations were spread throughout FH and WSBC’s
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Service Delivery Location (SDLs). Six clinics were located in the Fraser North (Burnaby WSBC SDL), 4 clinics were located in the Fraser South (Surrey SDL), and 6 clinics were located in the Fraser East (Abbotsford SDL) region. Prior to RECOVER roll out, the student worked with the physiotherapy providers during his practicum placement to increase their levels of familiarity and compliance with the pilot program’s features and guidelines (Appendix F). By doing so, it was anticipated that the therapists would establish more positive, collaborative working relationships with members of Workplace Health’s disability management team and WSBC.

Design

This mixed method evaluation on the RECOVER expansion was part of the overall evaluation for this workplace-driven early intervention program. Further analysis of RECOVER should be performed so conclusions about the effectiveness of the pilot could be confirmed. After discussions with the Research Ethics Board (REB) of the University of Northern British Columbia, it was determined that REB approval was not required as this was an internal program evaluation. Furthermore, all data for this project was stripped of personal identifiers prior to the start of pilot evaluation.

Data was obtained from two sources. Quantitative information was extracted from the Workplace Health Incident Tracking and Evaluation (WHITE) system, the internal computer database system at FH, to identify the total number of employer referrals made and the rate of worker acceptance for participation in the pilot. To measure employee and provider satisfaction scores, the primary researcher (UNBC graduate student) developed three qualitative-response surveys that were respectively distributed to the RECOVER
participants, non-participants, and physiotherapy providers. Representatives from FH’s Workplace Health department were assigned the responsibility of providing employees with a copy of the appropriate survey to complete. For pilot participants, employees were provided a copy of the RECOVER Participant Satisfaction Survey to complete after they had been discharged from participating in the pilot program. For workers who chose not to participate in the pilot, the RECOVER Non-Participant Satisfaction Survey was sent to the employees shortly after they had declined the employer’s offer to RECOVER services. Completion of the surveys was voluntary, and all employees were given a pre-stamped, pre-addressed envelope that they could return their completed surveys in. For the physiotherapy providers, the primary researcher contacted and distributed the RECOVER Provider Satisfaction Survey to each of the 16 participating clinics four months after pilot roll out. Treatment providers were given a timeline of two weeks to return their completed surveys to the primary researcher for inclusion in this evaluation.

Measures

Rate of Participation was defined in terms of any FH employee who experienced an acute, work-related musculoskeletal injury; and who complied with all injury reporting procedures and timelines; and was offered voluntary referral to RECOVER and chose to participate in the pilot (participants) versus those eligible employees who met the above-mentioned criteria, and were offered a referral to RECOVER and voluntarily chose not to participate in the pilot (non-participants). Referral and acceptance rates were quantitatively tracked in WHITE. This database was also able to extract socio-demographic indicators such as an employee’s age, occupational group, employment status, and the WSBC SDL office
that their file was assigned to. Collection of data commenced as of the pilot’s roll out date of October 19, 2009.

The RECOVER Participant Satisfaction Survey (Appendix B) is a qualitative instrument that the primary researcher (UNBC graduate student) developed to assess an injured employee’s perceived level of satisfaction with elements of the RECOVER pilot project. The employer sent the employee the survey after discharge from participation in the pilot and asked them to voluntarily provide feedback on their experiences. Questions were rated on a 5 point Likert scale that ranged from 1 (strongly disagree) to 5 (strongly agree). Participants were also given an opportunity to provide recommendations on how they felt the pilot could be improved upon. Instrument items were categorized into five components that evaluated the employee’s overall level of satisfaction with the pilot program. The first component consisted of four items related to their satisfaction with key features of RECOVER. This included an employee’s ability to begin receiving services from a physiotherapist prior to WSBC claim adjudication, prior to seeing their attending physician, and at no personal cost. The second component consisted of two items related to the participant’s level of satisfaction with the amount of communication they received from FH and WSBC during their absence and transition back to the workplace. Six items were included for the third component of this survey. These questions were related to the participant’s satisfaction with the quality of service they received from their RECOVER provider. Items included: advice from the physiotherapist on symptom management for their musculoskeletal injury and what they should do to prevent re-injury, discussions regarding the benefits associated with recovering from their injury while at work, and the therapist’s level of knowledge about the employee’s job demands. The fourth survey component
consistent of three items which asked about the participant's personal experiences during their transition back to the workplace. Items included: identifying whether the employee stayed at work or gradually returned back to work during their time in the pilot, whether the employee felt that participating in RECOVER facilitated with their transition back, and whether there was perceived managerial support during their transitional process. The final component asked participants to identify which pilot feature that they thought had the greatest impact in assisting them with staying at or returning back to work, and provided them with an opportunity to provide additional feedback on how the pilot could be improved upon.

The RECOVER Non-Participant Satisfaction Survey (Appendix C) is a qualitative instrument that the primary researcher (UNBC graduate student) developed to investigate why eligible employees did not choose to participate in the RECOVER pilot after they were offered a referral to program services. Questions were rated on a 5 point Likert scale that ranged from 1 (strongly disagree) to 5 (strongly agree) or through the use of check boxes that the employee would select if the statement applied. Instrument items were categorized into four components. The first component consisted of two items that were related to the employee’s reasons for non-participation and to determine if the employee would reconsider participating in RECOVER services if they re-injured themselves at a later date. The second component consisted of two items related to the participant’s satisfaction with the amount of communication they received from FH and WSBC during their absence and transition back to the workplace. The third component consisted of two items which asked about the participant’s personal experiences during their transition back to the workplace. Items included: identifying whether the employee had stayed at work or gradually returned back to
work following their work-related incident and whether there was perceived managerial support during their process of transitioning back. The final survey component offered non-participants an opportunity to be contacted by the primary researcher to provide additional information on why they chose not to participate in the pilot.

The RECOVER Provider Satisfaction Survey (Appendix D) is a qualitative instrument that the primary researcher (UNBC graduate student) developed to assess the service providers’ overall impressions with their clinic’s participation in the RECOVER pilot expansion. Providers were sent the survey four months after the pilot expansion date and were asked to voluntarily provide feedback on their experiences. Questions were rated on a 5 point Likert scale that ranged from 1 (strongly disagree) to 5 (strongly agree) or through the use of boxes that the physiotherapist would check if the statement applied. Providers were also provided an opportunity to provide recommendations on how they felt the pilot could be improved upon. Instrument items that were measured included: the RECOVER provider’s knowledge of their roles and service expectations, their level of understanding and compliance to the pilot’s processes and guidelines, and their perceptions of the development of a collaborative working relationship with Workplace Health personnel. Items would also determine if physiotherapists consistently shared information regarding symptom management, preventing re-injury, stay-at-work initiatives, and/or graduated return-to-work planning with RECOVER participants during their time in the pilot program.
Treatment of Data

Quantitative values for voluntary rate of participation in the RECOVER pilot were collected from FH’s WHITE database. Data that was collected included the total number of referrals made by the employer to eligible employees between October 19, 2009 – February 26 2010, and the rate of employee acceptance and decline of services during that time. Separate one way ANOVAS were then used to determine if the dependent, demographic variables ($x =$ age, occupational group, employment status, WSBC SDL) were correlated with the explanatory variable ($y =$ decision to participate) and its two possible outcomes (RECOVER Participant or Non-participant). Recognizing that multiple ANOVAs increase Type I error, the p-value was set at $p < 0.01$ to minimize this effect. Having an alpha level of .01 made the criterion more stringent and only the lowest 1% of the distribution was rejected. The dependent variables were then further broken down into smaller sub-categories to determine if these sub-variables were correlated with the values observed in the employees’ acceptance or decline rates. To analyze any differences observed between the groups, Tukey 99% simultaneous confidence intervals were used on all paired comparisons.

For items in the qualitative RECOVER Participant and Non-Participant Satisfaction Surveys, a mean Likert value of 3.5 out of 5 (70%) was set to indicate a high level of agreement with the item statement. Welch’s t-test is a adaption of Student’s t-test intended for use when two population variances are assumed to be different (the two sample sizes may or may not be equal) and hence must be estimated separately. Three separate Welch’s t-test were performed on pilot participants and non-participants to determine if there were any differences observed between the two groups in terms of their satisfaction with the amount of communication they received from FH and from WSBC during their absence and return
back to the workplace, and in their perceived level of managerial support during their transition back to the workplace.

In terms of the qualitative RECOVER Provider Satisfaction Survey, a mean Likert value of 3.5 out of 5 (70%) was also qualitatively set to indicate a high level of agreement with the item statement. For situations where clinics returned more than one provider survey, an average score was obtained for each survey item. These values were considered to be a representation of the clinic's overall response for each of the statements. Average values were then included with the data received from all other clinics to collectively determine overall mean RECOVER Provider satisfaction ratings.

Chapter 4: Analysis

Preliminary Analysis

Prior to commencing this project report, a preliminary analysis was conducted to determine if there would be adequate MSI claims available for data collection. Values observed in a quasi-experimental design analysis on the PEARs Plus pilot indicated that a population of (n=92) injured workers in the Abbotsford SDL reference group, (n=93) workers in the Burnaby SDL, and (n=104) individuals in the Surrey SDL reference group made up the study’s overall sample size (Dawson, 2009). Because RECOVER was using the same three SDLs in its comparative analyses, it was expected that there would be a similar number of reported musculoskeletal injury claims available for data collection. FH had originally offered 132 injured workers a referral to RECOVER services. However, it was later deemed that five of the referred employees did not meet the pilot's eligibility criteria and were not appropriate candidates for inclusion in this study. As such, data collection and
analyses on rates of referral and acceptance were only performed on a remaining sample size of 127 eligible FH employees. For preliminary analysis of the qualitative satisfaction surveys, mean Likert values were obtained for each of the survey items on the RECOVER participant, non-participant, and service provider questionnaires prior to comparing the applicable data. A mean Likert value of 3.5 out of 5 (70%) was set to indicate a high level of agreement (satisfaction) with the item statement. Survey items that were left blank were not included in any of the comparative analyses.

Primary Analysis

Rate of Participation

During the data collection period, October 19, 2009 – February 26, 2010, a total of 127 appropriate RECOVER referrals were made to eligible Fraser Health employees. Of that number, 82 employees (64.6%) voluntarily accepted the employer’s referral and agreed to participate in the pilot and 45 employees (35.4%) voluntarily declined the referral and did not participate. This supports the student’s original hypothesis that there would be a voluntary pilot acceptance rate of more than 60% for all eligible employees offered access to RECOVER services.

For analysis on participation rates in the RECOVER pilot, separate one-way ANOVAs were used to determine if the means for the dependent demographic variables (x = age, occupational group, employment status, WSBC SDL) were correlated with the explanatory variable (y = decision to participate) and its two possible outcomes (RECOVER Participant or Non-participant). The dependent variable, employee age, was then further separated into five sub-categories: 35 years and over, 36 – 40 years, 41 – 45 years, 46 – 50
years, and 51 years and older. Occupation was sub-categorized into four groups: patient care and handling, food and nutrition, administration, and other; Employment status was sub-categorized into three groups: full-time; part-time; and casual; and finally WSBC SDL office was sub-categorized into three groups: Abbotsford, Burnaby, and Surrey.

The first ANOVA on employee age found no significant difference (p=0.141) between those eligible employees who accepted the employer's referral and those eligible employees who declined it, R-Sq (adj) = 15.6%, F (-22.614 - 7.814) = 2.66, with p<0.01. When comparing the variable's sub-categories, the 35 and under group (n=33), had 25 eligible employees from that sub-category group's population (75.8%) accept the employer's offer and 8 eligible employees (24.2%) decline the offer. The 36-40 age group (n=19) had 13 eligible employees from that sub-category group's population (68.4%) accept the employer's offer and 6 eligible employees (31.6%) decline the offer. The 41-45 age group (n=13) had 7 eligible employees from that sub-category group's population (53.8%) accept the employer's offer and 6 eligible employees (46.2%) decline the offer. The 45-50 age group (n=18) had 10 eligible employees from that sub-category group's population (55.6%) accept the employer's offer and 8 eligible employees (44.4%) decline the offer. The final age group, 55 years and older (n=44), had 27 eligible employees from that sub-category group's population (61.4%) accept the employer's offer and 17 eligible employees (38.6%) decline the offer (Table 1).

The second ANOVA on employee occupation group found no significant difference (p=0.626) between those eligible employees who accepted the employer's referral and those eligible who declined it, R-Sq (adj) = 0.00%, F (-76.08 - 57.58) = 0.26, with p<0.01. When comparing the variable's sub-categories, the patient care and handling group (n=102), had
70 eligible employees from that sub-category group’s population (68.6%) accept the employer’s offer and 32 eligible employees (31.4%) decline it. The food and nutrition group (n=5) had 2 eligible employees from that sub-category group’s population (40.0%) accept the employer’s offer and 3 eligible employees (60.0%) decline it. The administration group (n=3) had 1 eligible employee from that sub-category group’s population (33.3%) accept the employer’s offer and 2 eligible employees (66.7%) decline it. The final occupational group, “other” (n=17), had 9 eligible employees from that sub-category group’s population (52.9%) accept the employer’s offer and 8 eligible employees (47.1%) decline the employer’s offer of RECOVER services (Table 1).

The third ANOVA on employment status found no significant difference (p=0.423) between those eligible employees who accepted the employer’s referral and those eligible employees who declined it, R-Sq (adj) = 0.00%, F (-75.98 - 51.32) = 0.80, with p<0.01. When comparing the variable’s sub-categories, the full-time worker group (n=80), had 49 eligible employees from that sub-category group’s population (61.2%) accept the employer’s offer and 31 eligible employees (38.8%) decline the offer. The part-time worker group (n=31) had 21 eligible employees from that sub-category group’s population (67.7%) accept the employer’s offer and 10 eligible employees (32.3%) decline the offer. The final employee status group, casual workers (n=16), had 12 eligible employees from that sub-category group’s population (75.0%) accept the employer’s offer and 4 eligible employees (25%) decline the offer (Table 1).

The final ANOVA on WSBC SDL office also found no significant difference (p=0.309) between those eligible employees who accepted the employer’s referral and those eligible employees who declined it, R-Sq (adj) = 6.66%, F (-61.08 - 36.42) = 1.36, with
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p<0.01. When comparing the variable’s sub-categories, the Abbotsford SDL group (n=43), had 36 eligible employees from that sub-category group’s population (83.7%) accept the employer’s offer and 7 eligible employees (16.3%) decline the offer. The Burnaby SDL group (n=62) had 29 eligible employees from that sub-category group’s population (46.8%) accept the employer’s offer and 33 eligible employees (53.2%) decline the offer. The final WSBC SDL group, Surrey (n=22), had 17 eligible employees from that sub-category group’s population (77.3%) accept the employer’s offer and 5 eligible employees (22.7%) decline the offer (Table 1). Findings from the ANOVAs supported the student’s original research hypothesis, which stated that there would be no significant demographic differences observed between employees who accepted participation in RECOVER those who declined services.

Rate of Satisfaction

Participants

There was a very low response rate as only 3 out of 82 employees (3.66%) voluntarily returned the RECOVER Participant Satisfaction Survey back to the primary researcher (UNBC graduate student) for evaluation during the data collection timeline of October 19, 2009 – February 26, 2010. For survey items, an average Likert value of 3.5 out of 5 (70%) was predetermined to indicate a high level of agreement (satisfaction) with the item statement. The mean qualitative satisfaction values obtained for each of the applicable survey items indicated that overall, participants were highly satisfied with all but two features of their experiences with RECOVER (Table 2). These items were related to the amount of communication they received from the employer during their absence and
transition back to work ($\mu=67\%$) and the amount of communication they received from the insurer, WSBC, during their absence and transition back to work ($\mu=67\%$). As such, these findings did not support the student’s original hypothesis which stated that participants would be highly satisfied with all aspects of their experiences partaking in the RECOVER pilot.

Non-participants

There was a very low response rate as only 8 out of 45 employees (17.78\%) voluntarily returned the RECOVER Non-participant Satisfaction Survey back to the graduate student for evaluation. Mean values observed in Table 3 indicate that non-participants were highly satisfied with the amount of communication they received from the employer during their absence and transition back to work ($\mu=85.7\%$) and the amount of communication they received from the insurer, WSBC, during their absence and transition back to work ($\mu=77.5\%$). Findings also indicated that non-participants highly agreed with the statement that they would reconsider participation in RECOVER, if they were to experience another acute, work-related musculoskeletal injury in the future ($\mu=82.5\%$). The most cited reason which influenced the non-participants’ decision to decline the employer’s referral to treatment was that employees did not feel that they required services from a RECOVER physiotherapist (five responses). The least cited reason was that the non-participant was unable to attend a RECOVER physiotherapy clinic, due to the geographic proximity of the nearest clinic in Chilliwack (employee lived in Hope).
A Comparison of the Groups

Mean values for the RECOVER participant and non-participant groups were compared in terms of their level of satisfaction with the amount of communication they received from FH during their absence and transition back to work; the amount of communication they received from WSBC during their absence and transition back to work; and their perceived level of managerial support they felt they received while participating in a “stay-at work” program at FH. Three separate Welch’s t-test were performed to determine if there were any significant differences observed between the two groups, in terms of the above mentioned survey items. Welch’s t-test was used as the two population variances were assumed to be different, and hence must be estimated separately.

For level of satisfaction with the amount of communication eligible injured employees received from FH during their absence and transition back to work, there was found to be no significant difference between the participant and non-participant groups ($T=0.66, p=0.66, 95\% CI (-1.738 - 2.822)$). In addition, for level of satisfaction with the amount of communication eligible injured employees received from WSBC during their absence and transition back to work, there also was no significant difference between the participant and non-participant groups ($T=1.09, p=0.326, 95\% CI (-1.295 - 3.2)$). No difference was observed between the perceived levels of managerial support that participants and non-participant groups felt they received while participating in a “stay-at work” program at FH. This was because mean values for both groups were found to be exactly the same ($\mu=100\%$).
RECOVER Providers

Fifteen of the sixteen pilot physiotherapy clinics (93.8%) voluntarily returned the RECOVER Provider Satisfaction Survey back to the graduate student for evaluation during a two week data collection timeframe. For provider survey items, an average Likert value of 3.5 out of 5 (70%) was predetermined to indicate a high level of agreement (satisfaction) with the item statement. Mean values observed indicated that service providers collectively agreed that they had a good understanding of their roles and service expectations, and of RECOVER’s pilot processes and guidelines (Table 4). Physiotherapists also felt they had developed collaborative working relationships with Workplace Health personnel since the pilot rolled out. Survey responses also showed that therapists consistently provided RECOVER participants with information regarding symptom management, the prevention of re-injury, stay-at-work initiatives, and/or graduated return-to-work planning during the individual’s time in the pilot program. Upon closer examination however, it was noted that as a group the therapists in the Surrey SDL did not highly agree with one survey item. This item was related to the usefulness of materials (i.e.: JDAs, RTW guidelines, etc) that FH provided to them to assist the therapists in making decisions about the worker’s RTW (μ=63.4%). The Burnaby SDL service provider group also did not collectively agree that their clinics had established better working relationship with FH personnel as a result of the RECOVER pilot (μ=63.4%).
RECOVER as an Early Intervention Model

Chapter 5: Discussion

Discussion

Current literature has demonstrated the there is much value associated with providing early intervention opportunities immediately or shortly after acute, musculoskeletal injuries are reported. Appropriate management of these injuries should focus on providing supportive resources such as physiotherapy in conjunction with modified work or transitional duties programs (Badii et al., 2006; Cooper et al., 1996; Davis et al., 2004; Dawson, 2009; Franche et al., 2005, 2007; Harder & Scott 2005; Loisel et al., 1994, 1997; Staal et al, 2005; Tate et al., 1999). The purpose of this study was to determine the effectiveness of the RECOVER pilot in its expanded roll out state. The RECOVER model was built off its predecessor, PEARS Plus, which was a collaborative FH early intervention initiative that focused on minimizing bureaucratic barriers, decreasing delays to receipt of treatment, establishing immediate and ongoing contact with the employee, and developing opportunities for the injured workers to stay at work or gradually transition back to their regular duties. Respectively, there were three reference groups that were included for purposes of this project. These groups consisted of RECOVER pilot participants, non-participants, and physiotherapy service providers. For pilot participants and non-participants, a total of 132 individuals received a RECOVER referral from their employer. All individuals were employees of FH Authority and were actively working within the hospital or community delivering healthcare services when their injury occurred. Of this sample group, 5 employees did not meet the program’s eligibility criteria and were excluded from participation in the RECOVER pilot. For the remaining 127 eligible employees, 82 individuals accepted the employer’s offer and agreed to voluntarily participate in the pilot,
whereas 45 individuals declined the employer’s offer and did not agree to participate. A study objective was to determine if there were any demographic differences between these two groups and their decision to participate or not in terms of their age, occupational group, employment status, and WSBC SDL handling their file. For the RECOVER physiotherapy service provider group, a total of 16 clinics agreed to participate in the pilot project. Representatives from the clinics included the clinic manager, the office manager, and the dedicated physiotherapist(s) who assessed and treated all the RECOVER referrals made to the clinic. Data for this project report was collected over a timeline of October 19, 2009 – February 26, 2010, and was either obtained quantitatively through FH’s WHITE computer database or qualitatively through responses given in survey instruments. Minitab was used to analyze the data, and to determine if there were any significant differences observed between the RECOVER participant and non-participant groups when comparing data.

Research Hypotheses

There were four primary research hypotheses outlined in this project. The first hypothesis was that there would be a voluntary acceptance rate of more than 60% for all eligible employees referred to RECOVER services. The student further hypothesized that there would be no significant demographic differences observed between RECOVER participant groups and non-participant groups with regards to their age, occupational group, employment status, and WSBC SLD office managing their file. The student’s second research hypothesis was that as a group, pilot participants would collectively provide high satisfaction ratings with all elements of the RECOVER pilot program. High satisfaction ratings would be determined by an average Likert response of more than 70% for each of the applicable RECOVER Participant Satisfaction Survey items. These survey items include the
participant’s perceived level of satisfaction with key features of the pilot program, the amount of communication they received from FH and WSBC during their absence and transition back to work, the quality of service they received from their RECOVER physiotherapist, and their personal experiences and perceived level of managerial support during their stay-at-work or graduated return-to-work process. For the student’s third research hypothesis, mean values from the pilot participants’ and non-participants’ survey responses were compared in terms of the two group’s satisfaction with the amount of communication they received from FH during their absence and transition back to work, the amount of communication they received from WSBC during their absence and transition back to work, and their perceived level of managerial support during their transition back to work. The student hypothesized that pilot participants would give higher overall mean satisfaction values for the above three survey items, than pilot non-participants. The student’s final research hypothesis was that findings from the RECOVER Provider Survey would support the assumption that RECOVER physiotherapy clinics were very consistent in providing pilot participants with information regarding the prevention of recurrent injuries, symptom management, and the value of participating in stay-at-work or graduated return-to-work programs. It was further hypothesized that qualitative survey findings would provide high levels of agreement (satisfaction) with the providers’ knowledge of their expected roles and service obligations, their level of compliance to the pilot’s processes and guidelines, and the providers’ perceptions of the development of more collaborative working relationships with FH’s Workplace Health personnel.
Rate of Participation Findings

During the data collection period of October 19, 2009 – February 26, 2010, a total of 127 appropriate RECOVER referrals were made to eligible Fraser Health employees. Of that number, 82 employees (64.6%) voluntarily accepted the employer’s referral and agreed to participate in the RECOVER pilot. For the 45 eligible employees (35.4%) who voluntarily declined the employer’s referral and did not agree to participate in the pilot, data from the qualitative RECOVER Non-Participation Survey (from those who responded) indicated that the reason which most influenced the workers’ decision to decline the employer’s referral was that they did not feel they required services from a RECOVER physiotherapist at that time. Survey findings also showed however, that many non-participants strongly agreed that they would reconsider participating in the RECOVER pilot, if they were to experience another acute, work-related musculoskeletal injury in the future (µ=82.5%). These findings therefore support the first part of the student’s research hypothesis, which stated that there would be a voluntary acceptance rate of more than 60% for all eligible employees referred to RECOVER services. Additional analyses performed on project findings supported the second part of this research hypothesis, which stated that there would be no significant demographic differences between RECOVER participants and non-participants, with regards to the employees’ age, occupational group, employment status, and WSBC SLD office managing their file.

Upon closer inspection of the employees’ demographics, when the total number of appropriate referrals made by the employer in terms of employee age was examined (n=127), injured workers who were 51 years and older received the greatest number of employer offers to participate in RECOVER (n=44); whereas those individuals who were
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between 41-45 years old received the fewest number of referrals (n=13). This group with the most number of referrals however, was not found to be the sub-category group with the highest pilot acceptance rates. The sub-category group that had the highest rate of accepted pilot referrals was injured workers aged 35 years or younger. The 35 and under group (n=33), had 25 eligible employees from that sub-category’s population (75.8%) accept the employer’s offer and 8 eligible employees (24.2%) decline the offer. This rate of acceptance indicated that 35 years or younger group were the most receptive towards early treatment interventions and opportunities that could help them recover from their workplace musculoskeletal injury. Additional research should be performed to identify if injured workers 35 years old or younger would continue to proactively seek out timely physiotherapy services on their own, if they were not appropriate candidates for a RECOVER referral (i.e.: injury at home). The group of individuals that had the lowest rate of accepted pilot referrals was the 41-45 year olds. The 41-45 year old sub-category group (n=13) had 7 eligible employees from that group’s population (53.8%) accept the employer’s offer and 6 eligible employees (46.2%) decline it. A possible reason for this sub-category group’s low acceptance rate may be in part due to the fact that this same group of individuals also received the fewest number of overall employer referrals.

When examining the total number of appropriate offers made by the employer in terms of the employees’ occupation (n=127), the patient care and handling sub-category group received the most number of employer referrals (n=102). This finding was consistent with current literature which reports that in 2002, nursing aides and orderlies had the highest absenteeism rates related to injury and illness when they were compared against other full-time occupational groups in the Canadian workforce. The occupational group that was found
to have the second highest absenteeism rates was full-time registered nurses (Canadian Labour and Business Centre, 2003). The patient care and handling sub-category group also had the highest rate of acceptance for voluntary participation in the RECOVER pilot. This group had 70 eligible employees from its sub-population (68.6%) accept the employer’s referral and 32 eligible employees (31.4%) decline the offer. The administration worker sub-category group had the lowest employee acceptance rate, as there was only one eligible employee from its sub-population (33.3%) who accepted the employer’s referral. This low acceptance rate may be in part due to the fact that this sub-category group also received the fewest number of appropriate employer referrals to participate in RECOVER services (n=3).

It was interesting to observe that although full-time workers were offered the most number of employer referrals to RECOVER (n=80), they had the lowest acceptance rate for pilot participation. This sub-category group had 49 eligible employees from its population group (61.2%) accept the employer’s referral and 31 eligible employees (38.8%) decline the offer. Further investigation should be performed to determine if there are other extraneous variables that may have influenced the eligible, full-time workers’ decisions not to accept the employer’s offer of timely services from a RECOVER physiotherapist. Conversely, the employment status sub-category group that had the highest rate of voluntary acceptance was the part-time worker group (n=31). This group had 21 eligible employees from its sub-category group’s population accept the employer’s referral and 10 eligible employees (32.3%) decline the offer. Findings also showed that the casual worker sub-category group (n=16), had the fewest number of total appropriate referrals made by the employer (n=127).

In terms of the employees’ WSBC SDL, the sub-category group that had the highest pilot acceptance rate was the Abbotsford SDL. Of the 43 appropriate referrals made by the
employer to this group, 36 eligible employees (83.7%) accepted the offer and agreed to
voluntarily participate in the pilot. This finding was expected as employees in the FH East
(Abbotsford SDL) region should have already been familiar with RECOVER’s predecessor,
PEARS Plus, and the benefits associated with participating in an early intervention program.
Another reason that could have explained this high pilot acceptance rate was that Workplace
Health personnel in FH East have the most experience referring injured workers for early
intervention services (i.e.: first through PEARS Plus, then through RECOVER). This
increased level of familiarity with the pilot’s key features could have resulted in the
development of better communicative scripts that encouraged injured workers to voluntarily
accept the employer’s referral and participate in RECOVER. Conversely, although eligible
workers in the Burnaby SDL received the most number of RECOVER referrals from FH
(n=62), this sub-category group also displayed the lowest rate of voluntary pilot acceptance.
Only 29 eligible employees from that sub-category group’s population (46.8%) accepted the
employer’s offer of timely access to RECOVER services. This finding was somewhat
surprising as prior to roll out of the PEARS Plus pilot in the FH East region, the PEARS
early intervention model was temporarily trialed out of an acute care hospital in the FH
North region. It was anticipated that employees that worked in the North (Burnaby SDL)
may have remembered the PEARS model and the values associated with receiving timely
physiotherapy services. Data also showed that the sub-category group of employees who
received the fewest number of appropriate referrals from the employer during the period of
October 19, 2009 – February 26, 2010, all worked in the FH South (Surrey SDL) region
(n=22).
Rate of Satisfaction Findings

Participants and Non-participants

The second research hypothesis regarding high levels of participant satisfaction with all features of the RECOVER pilot was not supported, as the participation group collectively did not strongly agree (μ > 70%) with all of the items on the RECOVER Participant Satisfaction Survey. The two items that the participants did not provide high mean values for were related to the amount of communication the injured workers received from FH (μ = 66.7%) and the amount of communication they received from WSBC (μ = 66.7%) during their absence and transition back to work. Conversely, the non-participant group collectively reported high satisfaction values with the amount of communication they received from FH (μ = 85.7%) and the amount of communication they received from WSBC (μ = 77.5%) during their absence and transition back to work. It is recommended that future studies clarify the variable, “amount of communication” as it was possible that one individual may have perceived the amount of communication they received from FH and WSBC as being too much, whereas another individual may have perceived the same amount as not being enough. When separate Welch’s t-tests were run, findings indicated that there were no significant differences observed between the participants’ and non-participants’ mean satisfaction ratings with regards to the amount of communication they received from both FH and WSBC during their time away from work. Therefore, based on these findings the student also had to reject the third research hypothesis which stated that pilot participants would provide higher overall mean satisfaction values on the survey items than the non-participants would. It is recommended that future studies be performed on larger sample sizes to help improve the credibility observed in this study’s findings. To help improve
communication levels, FH should make every possible effort to establish early contact with the injured workers. Discussions with the workers should focus on providing appropriate disability management services and keeping them connected to the workplace through recovery-at-work initiatives. Dyck (2000), notes that for employers to be most successful, these workplace interventions should ideally occur within the first 30 days following onset of the employees’ absences.

For the remaining satisfaction survey items, RECOVER participants collectively reported that they had high levels of agreement (satisfaction) with: the key features of the pilot program, the quality of service they received from their RECOVER physiotherapist, and their personal experiences and perceived managerial support during their stay-at-work or graduated return-to-work processes. Mean satisfaction values for RECOVER’s key features included the employee’s ability to begin receiving services from a physiotherapist prior to WSBC claim adjudication (μ=73.4%), prior to seeing their attending physician (μ=73.4%), and at no personal cost (μ=80%) immediately after the employer had offered them a pilot referral. Furthermore, participants reported that they would participate in RECOVER again if they were to injure themselves at a later date (μ=80%), and would also recommend participation in the pilot to their co-workers if they were to experience a workplace injury (μ=73.4%). These findings were supported by Hackett et al., (1993); Pinnington et al. (2004); and Robert & Stevens (1997) who note that individuals value direct referrals to physiotherapy mainly for the convenience and reassurance it provides. These variables could then in turn later help to contribute to an individual’s overall level of satisfaction with the way that they perceive their recovery is progressing.
For evaluation on the quality of service RECOVER physiotherapists provided to pilot participants, it was discovered that collectively, the participant group provided high satisfaction values with regards to the quality of services they received. The participants collectively reported that over the course of their treatment, therapists regularly provided them with useful advice on symptom management (μ=86.7%), the prevention of re-injury (μ=73.4%), and participating in a stay-at or graduated return to work program (μ=80%).

RECOVER participants also reported that they felt the therapists had a good understanding of the type of work they did (μ=80%). As evidenced in the findings, physiotherapists play a big role in an injured worker's recovery process. Service providers should work with employees to help desensitize any perceived feelings of helplessness and/or difficulties coping with their sudden removal from the workplace (Harder, 2003). Research has shown that the provision of early referrals to appropriate treatment interventions could help to produce favorable employee occupational outcomes. Benefits are associated with an injured worker's improved ability to physically function post-injury, self-manage their reported pain levels, and increase their perceptions of self-efficacy and control over their injury (Bekkering et al., 2005; Cooper et al., 1996; Schonstein et al., 2003; Shaw et al., 2006; Sinclair et al., 1997; Tate et al., 1999). Workers could also greatly reduce their risks of experiencing significant physical, emotional, and financial losses, prolonged disability, and chronic pain (Cooper et al., 1996; Franche et al., 2007).

In terms of the pilot participants' satisfaction with the perceived level of managerial support they received during their stay at work program, employees collectively gave a very high agreement rating with the applicable survey item statement (μ=100%). This identical rating was also evidenced in the non-participant pilot group's response when asked the same
question. As such, the primary researcher (UNBC graduate student) was unable to perform a Welch’s t-test on this comparative analysis as mean values for both groups were found to be exactly the same. This inability to compare values also contributed to the student’s failure to accept the third research hypothesis. This hypothesis stated that pilot participants would give higher overall mean satisfaction values than non-participants, in terms of perceived managerial support during their transition back to work. A benefit of these findings was it appeared some FH managers were consistent in providing workplace support during an employee’s stay at work process, regardless of if they were participating in the pilot or not. Consistency in managerial support could therefore also help to promote a workplace culture which conveys the message that there are benefits associated with remaining connected to their work while recovering from a soft-tissue musculoskeletal injury.

RECOVER Providers

Collectively as a group, service providers strongly agreed ($\mu>70\%$) with all of the items listed in the RECOVER Provider Satisfaction Survey. This was evidenced through the physiotherapists’ reported understanding of how RECOVER referral processes differ from a regular WSBC referral ($\mu=90.2\%$); their understanding of their roles and service expectations ($\mu=89.4\%$); their sense of more open lines of communication ($\mu=86.2\%$) and better working relationships ($\mu=82.6\%$) with FH; and whether they found the provision of occupational resources (i.e.: Job Demands Analyses) to be helpful when making decisions concerning return to work planning ($\mu=76\%$) (Table 4). Some clinics were not able to report on these survey item statements as they were yet to receive a RECOVER referral, when data for the project was evaluated. Although collectively these findings could provide support to
the student's final research hypothesis, the same cannot be said if the providers’ mean satisfaction values were examined on a regional basis.

When looking at mean regional values, the providers in the FH South region (Surrey WSBC SDL) did not collectively strongly agree that the provision of occupational resources was helpful (μ=63.4%). Furthermore, the FH North group (Burnaby WSBC SDL) was not in strong agreement that they had established better working relationships with FH after pilot roll-out (μ=63.4%). A reason that may have contributed to this low satisfaction rating was that some clinics in the FH North group mentioned that as of pilot evaluation date, they hadn’t received a RECOVER referral and were unable to report on that statement. It was interesting to observe that the FH East region (Abbotsford WSBC SDL) provided most of the highest mean satisfaction values. These findings however, were expected as service providers in the FH East regional group should have already been familiar with the pilot’s service expectations and process guidelines. This was because prior to RECOVER expansion, the clinics in the FH East region had previously been the intervention group for the recently piloted PEARs Plus study.

A primary driver for successful early intervention programs is the collaborative reassurance and support, and consistent messaging that injured workers receive from stakeholders during their recovery process. As such, physiotherapists should redirect the focus of their treatment plans to that of a more collaborative, occupationally-based one. Furthermore, providers are encouraged to proactively communicate with employers to gather information about the requirements and duties of their patient’s jobs, and to impart the employer with advice and recommendations when assisting with their patient’s return back to the workplace. The message that the injured workers receive should be consistent
and aligned with keeping them attached to the workplace (Badii et al., 2006; Davis et al., 2004; Dawson, 2009; Franche et al., 2005, 2007; Frank et al., 1998; Harder & Scott, 2005), and their treatment should consist of low-intensity, work-specific interventions that take ideally place on-site at the employee’s worksite (Franche et al., 2005; Schonstein et al., 2003; Staal et al., 2005). By doing so, physiotherapists could play a role in setting the worker’s and employer’s expectations about recovery and return to work readiness right from the start.

Limitations and Recommendations

There were numerous limitations associated with the methodology used in this study. The two most prominent were related to project timelines and the methods used for data collection. The timeframe that the primary researcher (UNBC graduate student) was able to collect data for inclusion in this project report was limited by UNBC semester dates and delays associated with the actual roll-out date of the RECOVER pilot. Because pilot expansion occurred later than originally anticipated, there was only less than five months of data available to be collected for analysis. This did not allow the student to evaluate and report on any long term effects of the RECOVER pilot. Furthermore, because this project used a mixed methods evaluation which included quantitative counts and qualitative satisfaction measurements, it is recommended that future experimental design studies be performed to provide more scientific backing to the success of RECOVER in its expanded state. Variables that could be used for these evaluations include Claims Costs, Disability Duration, and Durability of Return to Work.
For Rate of Participation, a limitation for data analysis was sample size. A factor which may have contributed to this was that due to other pressing issues that were concurrently occurring at FH shortly after RECOVER had rolled out, numerous Workplace Health personnel were temporarily removed from their regular duties (which included providing referrals to RECOVER) to assist with these matters. Therefore, it is possible that there could have been larger sample sizes for pilot referral and acceptance rates had these other pressing issues not occurred. These larger reference groups could have also enhanced the credibility of the comparative analyses between the two participant groups with respect to the injured employees’ demographic characteristics.

Data for satisfaction ratings was limited by a very low response rate for pilot participants (3.66%) and non-participants (17.78%). A factor that contributed to this was the method by which the qualitative surveys were administered to the participants and non-participants. Employees were mailed the applicable survey with a pre-paid, pre-addressed envelope, and were asked to return their completed surveys back for pilot evaluation. Because the process of completing and returning of the surveys was entirely voluntary, very few individuals complied with the request. This resulted in a limited source of materials to collect data from. Having a larger sample size to analyze would have enhanced the credibility of the project’s comparative analyses between the two RECOVER participation groups. When comparing the participant and non-participant groups in terms of mean satisfaction values for corresponding survey items (i.e.: level of communication and managerial support), it should be identified that all of the workers’ claims were managed by different regional FH facilities and corresponding WSBC SDL offices. Although each of these organizations were to adhere to standardized RECOVER policies and practices,
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regional and/or individual differences on how claims were handled may have impacted survey responses. These differences made it difficult to distinguish if the mean satisfaction values observed in each of the participation groups were influenced by the actual features of the RECOVER pilot, or by the characteristics of the individuals who were managing their claims. It is recommended that continued performance reviews of this model be conducted across various FH regions and corresponding WSBC offices. Additional methods of data collection could include brief follow-up interviews with the referred employees after they have returned back to work. This follow-up could help clarify survey item responses and provide further support that a participant’s satisfaction with RECOVER is indicative of the key features of the early intervention model, and not from the regional/individual differences in claims management.

Because of the large number of providers that were included in this pilot expansion, some employees had to choose their RECOVER physiotherapist from a list of multiple clinics all located in the same geographic area. Through follow-up surveys with the clinics, it was found that providing injured employees with a choice of clinics to attend resulted in some providers reporting that they were yet to receive a RECOVER referral, four months after pilot roll-out. Because of this, some clinics were unable to provide responses to certain survey items (and one clinic failed to return to entire survey altogether) when data was later collected and analyzed. It is recommended that if RECOVER is to continue after its pilot completion date, the overall number of providers offering RECOVER services be reduced. This would result in an increased number of referrals made to the remaining participating clinics, thereby further increasing the clinic’s level of familiarity with the RECOVER’s processes and guidelines. A reduction in the
number of clinics would also assist in the establishment of closer and more collaborative relationships between FH and the physiotherapy service providers when working together to assist in an injured employee’s transition back to the workplace.

Summary

This project report was based on an initial assessment of the RECOVER pilot in its expanded state. The pilot, formerly known as PEARs Plus in the FH East region (Abbotsford WSB SDL), combined elements of early intervention, timely access to physiotherapy services, recovery in the workplace, and collaboration amongst the employer, insurer, and physiotherapy providers. As of four months after pilot expansion, findings demonstrated that RECOVER was a beneficial way of delivering early intervention services to injured employees who experienced an acute, work-related musculoskeletal injury. This was observed quantitatively through a high rate of voluntary pilot acceptance and qualitatively through high rates of mean RECOVER participant and service provider satisfaction values. Findings from this project review will also contribute towards the final overall evaluation of RECOVER, which will occur after pilot completion date of October 18, 2010. It is imperative that this additional analysis of RECOVER be performed so conclusions about the effectiveness of the pilot could be made. If results from this final evaluation are positive, it may support WSBC in making future changes to their Board policy and practices. By doing so, WSBC could then incorporate and provide an early intervention model similar to RECOVER to all other employer groups throughout British Columbia.
The aim of RECOVER was to minimize bureaucratic barriers and delays associated with the timely receipt of physiotherapy services. This was established through collaborative efforts and improved relationship building between all stakeholders involved in the injured worker’s recovery process. The belief was that if provided with the appropriate resources, prompt claim adjudication, and employer support and re-engagement, individuals would likely recover from their injuries and return to work sooner. The immediate offer and employee acceptance of early treatment interventions could also assist with improving functional status and decreasing injury duration for workers with an acute, soft-tissue injury (Badii et al., 2006; Bekkering et al., 2005; Cooper et al., 1996; Davis et al., 2004; Dawson, 2009; Franche et al., 2005, 2007; Harder & Scott, 2005; Kosney et al., 2006; Loisel et al., 1994, 1997; Shaw et al., 2006; Sinclair et al., 1997; Staal et al., 2005; Tate et al., 1999).

Furthermore, as seen in this project’s results, factors such as high levels of managerial support and the provision of stay at work and transitional work opportunities could greatly contribute to an early intervention model’s success. Keeping injured employees connected to the workplace could provide them with a more supportive environment that encourages recovery and decreases some of the managerial uncertainty and mistrust which is commonly seen in lengthy claim decisions (Harder & Scott, 2005). It is recommended that future experimental studies that measure workplace costs and the long term effects associated with participating in the RECOVER pilot be performed to provide more scientific backing that supports the pilot’s success in its newly expanded state. Variables that should be included for evaluation include Claims Costs, Disability Duration, and Durability of Return to Work.
Bibliography


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Appendix A: Eligibility Criteria for the RECOVER Pilot

Inclusion Criteria

Participants will include any Fraser Health employee who;

- Has experienced a likely work-related* musculoskeletal injury (MSI) resulting from a specific identifiable incident resulting in a sudden onset of symptoms, and
- Has reported his/her injury to FH and WorkSafeBC within 7 days, and
- Has no history of related symptoms or injury within a three-month period prior to the current report of and,
- Arrives for treatment within 7 days of the reported incident.

* All work-related or likely work-related MSIs will be related to a specific or identifiable incident as described during an intake interview to the program. The decision to refer an employee to RECOVER will be determined by the FH CMA during intake and is independent of the WSBC claims entitlement process.

Criteria for Continuing Eligibility

- Arrive for treatment within 7 calendar days of being offered the RECOVER program.
- Sees Attending Physician within 5 business days from initial visit.

Exclusion Criteria

- Employees who appear to have a pathology of a non-MSI origin.
- Employees who are reporting no specific incident/ have gradual onset of symptoms or activity related soft tissue injuries.
- Employees who do not report their injury within 7 calendar days.
- Employees who do not begin physiotherapy treatment within 7 calendar days.
- Employees who do not seek medical attention within 5 calendar days of first treatment with the physiotherapist.
Withdrawal Criteria

Participants will be withdrawn from the Program following:

- Withdrawal of consent to participate, or

- The participant’s lack of satisfactory progress, despite regular and appropriate interventions, as determined by WorkSafeBC or FH, or

- The participant’s lack of attendance, or a lack of compliance with recommendations put forth by the program staff.
Appendix B: RECOVER Participant Satisfaction Survey

Thank you for participating in RECOVER!

We would greatly value your feedback. Please help us better meet the needs of your fellow co-workers by sharing your experiences as a RECOVER Program participant. Once you have completed the survey, use the enclosed pre-addressed and pre-stamped envelope to mail back your responses. Please note that your anonymity and confidentiality will be maintained throughout this collection process.

Please return Survey by: ____________________________

Please provide us with some background information:

Date survey completed: ______  Clinic attended: ______  Workplace Health Representative: ______

- My age falls within the following range:

35 years or younger: ______  36 – 40: ______  41 – 45: ______  46 – 50: ______  51 or older: ______

- My work primarily involves:

Patient Care & Handling: ______  Food & Nutrition: ______  Administration: ______

Other: _________________________

- I have had a workplace-related injury before: Yes: ______  No: ______

- I have used physiotherapy services for a work-related injury before.

Yes: ______  No: ______

Please rate your response to the following questions on a scale of 1 to 5; with 1 meaning Strongly Disagree, 2 meaning Disagree, 3 meaning Neutral/No Opinion, 4 meaning Agree and 5 meaning Strongly Agree.

My decision to participate in the RECOVER Program was influenced by:

1) Being able to see a RECOVER physiotherapist prior to WSBC claims adjudication.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

49
RECOVER as an Early Intervention Model

2) Being able to see a RECOVER physiotherapist prior to seeing my family doctor.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

3) Being able to see a RECOVER physiotherapist at no personal cost.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

4) Other: ____________________________

Level of communication:

5) I was satisfied with the amount of communication I received from my Workplace Health team (Fraser Health CMA and/or DMC) during my absence and return back to work.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

6) I was satisfied with the amount of communication I received from WorkSafeBC during my absence and return back to work.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Personal experiences with the RECOVER Program:

7) I have a better understanding of how I could self-manage my injury.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>
RECOVER as an Early Intervention Model

8) I have a better understanding of what I could do to prevent re-injury at work.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

9) I have a better understanding of the benefits associated with participating in a Stay-at-Work or Gradual Return-to-Work Program.

<table>
<thead>
<tr>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

10) I felt that my RECOVER Program physiotherapist had a good understanding of the type of work I do.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

11) I would participate in the RECOVER Program again.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

12) I would recommend the RECOVER Program to my co-workers.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

My Return-to-Work experiences with the RECOVER Program:

13) As a result of the RECOVER Program, I participated in a: (circle whatever applies)

a) Stay-at-Work Program  b) Gradual Return-to-Work Program  c) I have not returned to work yet

14) (only answer if you circled option (a) for the above question)
i) I felt the RECOVER Program helped me safely Stay-at-Work.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
ii) I felt that my manager was supportive and involved with me Staying-at-Work.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15) *(only answer if you circled option (b) for Question 13)*

i) I felt the RECOVER Program helped me safely and Gradually Return-to-Work.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ii) I felt that my manager was supportive and involved with my Gradual Return-to-Work.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Summary:**

16) Considering all aspects of the RECOVER Program, please list the top 3 things that you think had the biggest impact in helping you safely Stay-at or Gradually Return-to-Work?

1) 

2) 

3) 

17) Please share with us any suggestions on how we could improve the RECOVER Program:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Optional:

18) I would like to be contacted to discuss my ratings and comments:

Yes: ___ No: ___

(if you responded ‘Yes’ please provide us with your name and contact information)

Name (please print): _________________________
Phone: _________________________
E-mail: _________________________

Thank-you again for your participation in RECOVER and
for your feedback!

Please use enclosed envelope and return completed surveys to:

Workplace Health
Eagle Ridge Hospital
475 Guildford Way
Port Moody, BC V3H 3W9
Appendix C: RECOVER Non-Participant Satisfaction Survey

We would greatly value your feedback on why you chose not to participate in the RECOVER Program. Your responses could help us improve Program services to better meet the needs of your fellow co-workers. Once you have completed the survey, use the enclosed pre-addressed and pre-stamped envelope to mail back your responses. Please note that your anonymity and confidentiality will be maintained throughout this collection process.

Please return Survey by: ______________________

<table>
<thead>
<tr>
<th>Please provide us with some background information:</th>
<th>Date survey completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• My age falls within the following range:</td>
<td></td>
</tr>
<tr>
<td>35 years or younger: _____ 36 - 40: _____ 41 - 45: _____ 46 - 50: _____ 51 or older: _____</td>
<td></td>
</tr>
<tr>
<td>• My work primarily involves:</td>
<td></td>
</tr>
<tr>
<td>Patient Care &amp; Handling: _____ Food &amp; Nutrition: _____ Administration: _____ Other: ____________________</td>
<td></td>
</tr>
<tr>
<td>• I have had a workplace-related injury before: Yes: _____ No: _____</td>
<td></td>
</tr>
<tr>
<td>• I have used physiotherapy services for a work-related injury before.</td>
<td>Yes: _____ No: _____</td>
</tr>
</tbody>
</table>

Reasons for Non-Participation

1) I chose not to participate in the RECOVER Program because (check all that apply):

____ I was unable to meet Program timelines (specify): ________________________________

____ I was unable to attend a RECOVER physiotherapy clinic (specify):

______________________________

____ I did not feel that I needed services from a RECOVER Physiotherapist at this time.

____ I chose to receive alternate services from my own treatment provider(s) (specify):

______________________________

____ Other (specify): ________________________________
RECOVER as an Early Intervention Model

Please rate your response to the following questions on a scale of 1 to 5; with 1 meaning Strongly Disagree, 2 meaning Disagree, 3 meaning Neutral/No Opinion, 4 meaning Agree and 5 meaning Strongly Agree.

2) I would consider participating in the RECOVER Program if I re-injured myself at a later date.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Level of communication:

3) I was satisfied with the amount of communication I received from Workplace Health (Fraser Health’s CMA and/or DMC) during my absence and return back to work.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

4) I was satisfied with the amount of communication I received from WorkSafeBC during my absence and return back to work.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

My Return-to-Work experience:

5) I participated in a: (circle whatever applies)

a) Stay-at-Work Program  b) Gradual Return-to-Work Program  c) I have not returned to work yet

6) (only answer if you circled option (a) for the above question)

iii) I felt that my manager was supportive and involved with me Staying-at-Work.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>
RECOVER as an Early Intervention Model

7) (only answer if you circled option (b) for Question 5)
   iii) I felt that my manager was supportive and involved with my Gradual Return-to-
       Work.

   | Strongly Agree | 5 |
   | Strongly Disagree | 1 |
   | 2 | 3 | 4 |

Optional:

1) I would like to be contacted to discuss my ratings and comments:
   Yes: ___ No: ___

(if you responded ‘Yes’ please provide us with your name and contact information)

Name (please print): ______________________
Phone: ______________________
E-mail: ______________________

Thank-you again for your participation in RECOVER and
for your feedback!

Please use enclosed envelope and return completed surveys to:

Workplace Health
Eagle Ridge Hospital
475 Guildford Way
Port Moody, BC V3H 3W9
Appendix D: RECOVER Provider Satisfaction Survey

Thank you for participating in RECOVER!

Your feedback is important and greatly appreciated. Please help us better meet the needs of our employees by sharing with us your thoughts about the RECOVER Program. Once you have completed the survey, use the enclosed pre-addressed and pre-stamped envelope to mail back your responses. Please note that your anonymity and confidentiality will be maintained throughout this collection process.

Please return Survey by: _______________________

Date survey completed: ________________________

Clinic name: _________________________________

Please rate your response to the following questions on a scale of 1 to 5; with 1 meaning Strongly Disagree, 2 meaning Disagree, 3 meaning Neutral/No Opinion, 4 meaning Agree and 5 meaning Strongly Agree.

1) I feel that I have a good understanding of my role and expectations in the RECOVER Program.

   Strongly Disagree 1 2 3 4 5 Strongly Agree

2) I feel that I have a good understanding of how RECOVER Program processes differ from a regular WSBC referral.

   Strongly Disagree 1 2 3 4 5 Strongly Agree

3) I found the portable USB device, with Fraser Health JDAs on it, to be helpful when making decisions about my clients’ safe and early return to work.

   Strongly Disagree 1 2 3 4 5 Strongly Agree
4) I feel that because of the RECOVER Program, the clinic has a better working relationship with Fraser Health’s Workplace Health personnel.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

5) I feel that because of the RECOVER Program, the clinic has more open lines of communication with Fraser Health’s Workplace Health personnel.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

6) The clinic regularly provided RECOVER participants with information on: (check all items that apply):

- Symptom management
- Preventing re-injury at work
- Safe work practices (i.e.: safe lifting procedures, ergonomic advice, etc.)
- The value of Stay-at-Work Programs
- The value of Graduated Return-to-Work Programs
- Maintaining fitness levels after Program discharge (i.e.: continuing with their reconditioning exercises at home)
- Other (specify): __________________________

7) Do you have any suggestions on how we can improve the RECOVER Program?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Thank-you again for your participation in the RECOVER pilot Program

and for your feedback!
RECOVER as an Early Intervention Model

Please use enclosed envelope and return completed surveys to:

Workplace Health
Eagle Ridge Hospital
475 Guildford Way
Port Moody, BC V3H 3W9
**Appendix E: Descriptive Data**

Table 1

Mean Demographic Values Observed for Rate of Participation*.

<table>
<thead>
<tr>
<th>N=127</th>
<th>Accepted</th>
<th>% n</th>
<th>% N</th>
<th>Declined</th>
<th>% n</th>
<th>% N</th>
</tr>
</thead>
<tbody>
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<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 35</td>
<td>25</td>
<td>75.8</td>
<td>19.7</td>
<td>8</td>
<td>24.2</td>
<td>6.3</td>
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<tr>
<td>(n=33)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-40</td>
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<tr>
<td>(n=19)</td>
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<td></td>
<td></td>
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<td>41-45</td>
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<td>53.8</td>
<td>5.5</td>
<td>6</td>
<td>46.2</td>
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<tr>
<td>(n=13)</td>
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<td>46-50</td>
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<td>7.9</td>
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<tr>
<td>51 &lt;</td>
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<td>21.3</td>
<td>17</td>
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<td>Food &amp; Nut</td>
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<td>40</td>
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<td>10</td>
<td>32.3</td>
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<td>Casual</td>
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<td>22.8</td>
<td>33</td>
<td>53.2</td>
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<td>5</td>
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</table>
### Table 2
Mean Satisfaction Values for RECOVER Pilot Participants*.

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Q. 1</th>
<th>Q. 2</th>
<th>Q. 3</th>
<th>Q. 5</th>
<th>Q. 6</th>
<th>Q. 7</th>
<th>Q. 8</th>
<th>Q. 9</th>
<th>Q. 10</th>
<th>Q. 11</th>
<th>Q. 12</th>
<th>Q. 14ii</th>
</tr>
</thead>
<tbody>
<tr>
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<td>3.67</td>
<td>3.33</td>
<td>3.33</td>
<td>4.33</td>
<td>3.67</td>
<td>4</td>
<td>4</td>
<td>3.67</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>% average</td>
<td>73</td>
<td>73</td>
<td>80</td>
<td>67</td>
<td>67</td>
<td>87</td>
<td>73</td>
<td>80</td>
<td>73</td>
<td>80</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>High rating</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

*Refer to Appendix B: RECOVER Participant Satisfaction Survey

### Table 3
Mean Satisfaction Values for RECOVER Pilot Non-Participants*.

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Q. 2</th>
<th>Q. 3</th>
<th>Q. 4</th>
<th>Q. 6i</th>
</tr>
</thead>
<tbody>
<tr>
<td>μ score</td>
<td>4.125</td>
<td>4.29</td>
<td>3.875</td>
<td>5</td>
</tr>
<tr>
<td>% average</td>
<td>82.5</td>
<td>85.7</td>
<td>77.5</td>
<td>100</td>
</tr>
<tr>
<td>High rating</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

*Refer to Appendix C: RECOVER Non-Participant Satisfaction Survey

### Table 4
Mean Satisfaction Values for RECOVER Pilot Service Providers*.

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Q. 1</th>
<th>Q. 2</th>
<th>Q. 3</th>
<th>Q. 4</th>
<th>Q. 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>μ score</td>
<td>4.62</td>
<td>4.67</td>
<td>4.28</td>
<td>4.78</td>
<td>4.83</td>
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<tr>
<td>μ score</td>
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<td>4.57</td>
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<td>4.77</td>
<td>4.9</td>
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<tr>
<td>μ score</td>
<td>4.17</td>
<td>4.33</td>
<td>3.6</td>
<td>3.17</td>
<td>3.5</td>
</tr>
<tr>
<td>μ score</td>
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<td>4.51</td>
<td>3.8</td>
<td>4.13</td>
<td>4.31</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% average</td>
<td>89</td>
<td>90</td>
<td>76</td>
<td>83</td>
<td>86</td>
</tr>
<tr>
<td>High rating</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

*Refer to Appendix D: RECOVER Provider Satisfaction Survey
Appendix F: Practicum Placement Report

Using the RECOVER Pilot as a Workplace-Initiated Early Intervention Program

Student: Steve Nasu

Disability Management 795

Academic Supervisor: Dr. Henry Harder
Practicum Co-Supervisors: Dr. Renée-Louise Franche, Karlene Dawson
Program Chair: Dr. R. Luke W. Harris
Date: December 4, 2009
Overview

A description of the student’s experiences assisting with the expansion of the employee-centered RECOVER pilot program. RECOVER was rolled out across all Fraser Health acute care hospitals, health care agencies, residential care facilities, and related WorkSafeBC Service Delivery Locations (SDLs). RECOVER is a workplace driven early-intervention program that was built off the findings and recommendations resulting from the PEARS Plus pilot program. Learning objectives for this practicum are to gain a better understanding of how an early-intervention program’s processes and procedures are developed; and to determine the effectiveness of RECOVER in its expanded roll out state. The latter objective will be determined by looking at the success of the Program in terms of its Voice of the Customer (Fraser Health employees that participate in RECOVER) and its Voice of the Business (Community based physiotherapy providers). Placement for this practicum will also extend into the student’s Disability Management Project course, which the student will take and report on during the Winter (January) 2010 semester.

The RECOVER Program

RECOVER (Rehabilitation and Early Connection to Occupation and Vocation for Effective Recovery) is a one-year pilot program that is based on a tripartite agreement between Fraser Health, WorkSafeBC, and community-based physiotherapy providers. The Program provides eligible Fraser Health employees who have sustained an acute, work-related musculoskeletal injury immediate access to physiotherapy services (at no personal cost), with the goal of regaining the functional levels needed to stay at or return-to-work in a safe and timely manner. Process development for RECOVER was influenced by
recommendations and lessons learned that resulted from an analysis and report of the earlier piloted PEARs Plus program. The RECOVER expansion will be piloted from October 19, 2009 to October 18, 2010. Initial findings that result from the expansion will be evaluated and reported on at a later date for the student's combined Disability Management Project course.

PEARs (Prevention and Early, Active Return to Work Safely) Plus is a workplace-initiated early intervention program that was piloted under a collaborative effort between Fraser Health and WorkSafeBC. The program was trialed between May 1, 2007 and April 30, 2008 in the ‘East’ Fraser Health region (Abbotsford SDL) and relied on the physiotherapy services of external treatment providers. Findings from the pilot showed that the provision of physiotherapy services within one week of their workplace injury resulted in significant cost savings and a reduction in the injured employee’s short term disability duration (RECOVER Project Team, 2009). To further determine the effectiveness of PEARs Plus, the pilot’s name was changed to RECOVER and early intervention program was rolled out across all of Fraser Health and its related SDLs.

Placement Location

The practicum placement took place within the Workplace Health department at various Fraser Health acute care hospitals (Langley Memorial Hospital and Eagle Ridge Hospital). As BC’s largest and fastest growing health region, Fraser Health operates as a network of integrated health care services that all work together to meet needs of its residents. Fraser Health currently employs over 23,000 health care professionals and 2,200 doctors; with an additional 10,000 employees working out of various contracted health care agencies (http://www.fraserhealth.ca/).
Workplace Health is a department that operates throughout Fraser Health. Its area based teams are committed to providing various services that protect and promote the health and well-being of all Fraser Health employees. Such services include assistance with occupational health and safety issues, ergonomic workplace assessments and the provision of disability management resources.

Length of Practicum Placement

The student’s placement for the RECOVER expansion originally commenced in May 2009 and is currently ongoing. Due to issues associated with delays in the RECOVER pilot roll out date, the student had to postpone his originally planned practicum start date of May 4, 2009 to September 8, 2009. For purposes of UNBC’s Disability Management 795 course, the student will mostly report on his personal experiences and the roles and duties assigned during the practicum timeframe of September 8, 2009 to December 4, 2009. Duties that occurred between May to September will also be discussed in this report, if they played a significant role in contributing to the actual RECOVER pilot roll out date of October 19, 2009.

Practicum Role

Prior to the RECOVER roll out date of October 19, 2009, the student assisted Workplace Health’s RECOVER Pilot Expansion Team in the formation of new and the revision of existing PEARs Plus processes and procedures; attended and contributed to various stakeholder planning meetings; created various marketing materials to raise workplace and provider awareness of the RECOVER program, and developed measurement
and evaluation tools that will provide qualitative feedback from injured Fraser Health employees and RECOVER pilot service providers.

After October 19, the student switched roles and he was designated as one of the primary contact persons for the RECOVER pilot program. More specifically, the student was the point person for the pilot’s *Voice of the Customer* and the *Voice of the Business*. Duties included fielding RECOVER questions from various stakeholder groups, clarifying program procedures and expectations with Fraser Health employees, managers and RECOVER service providers, following up with the program physiotherapists, and providing the clinics with information and resources pertaining to stay-at-work and/or timely return-to-work opportunities within Fraser Health. More details of the specific duties performed throughout the course of the student’s practicum will be described in the latter contents of this practicum report.

**Learning Objectives**

The purpose of the practicum was to support the notion that workplace-initiated early intervention programs improve rates of recovery for injured employees and contributes to more positive, collaborative working relationships between workplaces and external rehabilitative service providers.

The student had two goals for this practicum placement. The first goal was to gain a better comprehension of how early intervention programs are developed in the workplace. In terms of learning objectives, the student was interested in participating in all the processes that the RECOVER Pilot Expansion Team would have to follow when they are implementing and rolling out an early intervention program, such as RECOVER, throughout
RECOVER as an Early Intervention Model

their organization. The student gained experience in this area and was able to meet this learning objective by contributing firsthand to some of the pilot’s final processes and appendices that were included in the Memorandum of Agreement (MOA) between Fraser Health, WorkSafeBC and the external service providers. Much of the experience and knowledge gained from this practicum placement occurred when the student attended meetings with various RECOVER stakeholder groups.

The student attended numerous process development and planning meetings with both Workplace Health’s RECOVER Pilot Expansion Team and members of WorkSafeBC’s Health Care Services Department. Unfortunately, all but one meeting took place prior to the student’s official practicum start date of September 8, 2009. Meetings were held early on in the year to ensure that the pilot would stay on track for the newly proposed roll out date of Fall 2009. All meetings and teleconferences with the Workplace Health Expansion Team occurred prior to the practicum start date. These events occurred on: September 2, August 31, July 21, June 29, June 19, May 19, March 24, and March 19, 2009. Meetings and teleconferences (prior to practicum start date) that took place with both Workplace Health and WorkSafeBC representation occurred on: August 4, July 23, June 15, and May 6, 2009. Only one meeting took place after the practicum start date. This meeting occurred on September 22, 2009, and it involved both Workplace Health and WorkSafeBC. Additional discussions between various members of the RECOVER stakeholder groups and updates on the pilot’s progression also took place less formally through the regular use of internet email communication.

The second goal was to establish materials that would increase the effectiveness of the RECOVER pilot in an expanded roll out state. Success for RECOVER was to be defined
in terms of its Voice of the Customer, or responses from Fraser Health employees that participated in the pilot; and its Voice of the Business, or subjective reports from external physiotherapists who provided services for the RECOVER pilot program.

In terms of the pilot’s Voice of the Customer, the student had two specific learning objectives. These objectives were to develop ways that could increase employee participation rates and satisfaction rates for the recently expanded RECOVER pilot. More detail on the above-mentioned learning objectives will be described throughout the later pages of this practicum report. In terms of the pilot’s Voice of the Business, the student’s learning objective was to work with RECOVER physiotherapists to increase their levels of satisfaction and compliance with the pilot program’s features and guidelines. The student was also interested in seeing if the external service providers had established positive working relationships with members of Workplace Health’s Disability Management team. Initial findings that result from these learning objectives will be discussed in greater detail when the student completes his combined UNBC Disability Management Project course in the January 2010 (Winter) semester.

Voice of the Customer:

Rate of Participation

For purposes of this practicum, Rate of Participation was defined in terms of any Fraser Health employee who experienced an acute, work-related musculoskeletal injury; and who complied with all injury reporting procedures and timelines; and was offered voluntary access to RECOVER and chose to participate in the pilot (Participants)-versus-those employees who met the above-mentioned criteria, and were offered access to RECOVER
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and voluntarily chose not to participate in the pilot (Non-Participants). A further study objective for this practicum was to see if there were any identifiable demographic differences noted between RECOVER Participants and Non-Participants in terms of their: age, occupational group, employment status, and WorkSafeBC SDL.

The student hypothesized that there would be a voluntary pilot participation rate of more than 60% for all eligible employees that were offered access to RECOVER services. The student also hypothesized that there would be no significant demographic differences observed between RECOVER Participant groups and Non-Participant groups. These hypotheses will be supported/not supported at a later date when the student reports on initial pilot findings in his Disability Management Project course.

To help increase participation rates, the student was assigned the task of coming up with strategies that could increase stakeholder awareness about the features and benefits associated with participating in the RECOVER pilot. Unfortunately the majority of duties performed for this learning objective occurred prior to the practicum start date of September 8, 2009, as completed materials needed to be approved and ready for distribution prior to the official pilot roll out date. Duties performed however, will still be briefly discussed, as the student believes that these materials helped contribute to the pilot roll out date, and thus the student's practicum start date.

Through brainstorming sessions and discussions that took place at team planning meetings, an identified way that the student could increase awareness about the pilot, and thus participation rates, was through the development of various marketing materials. These marketing materials would provide the stakeholder groups with a brief overview of the
RECOVER as an Early Intervention Model

recently expanded RECOVER pilot program. The student developed four different brochures for RECOVER, each containing information and highlighting the benefits that were specifically targeted towards its intended audience. These brochures were targeted towards Fraser Health employees and management groups, the employee’s family physicians, and the RECOVER physiotherapy providers.

The student also updated Workplace Health Disability Management Consultants on a monthly basis about the progress that was being made towards roll out expansion. He also developed informative scripts that Consultants could use when they were updating their managers about the RECOVER pilot expansion at their on-site regional management meetings.

To monitor Rate of Participation, Workplace Health’s Program Leader for Research and Evaluation created a tracking system in Fraser Health’s WHITE.net database. This tracking system also has the ability to capture the total number of referrals made to RECOVER and reasons for employee participation or non-participation in the pilot. To further investigate why eligible employees did not choose to participate in the RECOVER pilot after they were offered program services, the student developed a RECOVER Non-Participant Survey during the course of his practicum. Non-Participants were asked to complete this survey and to provide information for their reasons for non-participation. The survey also asked employees to identify pilot features that could be improved upon, and if improvements were made, would they reconsider participating in RECOVER if they injured themselves at a later date. The Non-Participant Survey was included in the RECOVER Pilot Program’s MOA between Fraser Health, WorkSafeBC, and the external service providers.
Rate of Satisfaction

Rate of Satisfaction was defined twofold in terms of the employees’ overall level of satisfaction with key features of RECOVER and in terms of the employee’s satisfaction with the amount of perceived workplace support they received during their transition back into the workplace.

To help increase satisfaction rates, the student worked with the RECOVER Pilot Expansion Team and built off the recommendations and lessons learned that resulted from the PEARS Plus pilot. One recommendation was to increase employee awareness about the key features of RECOVER. The key features that the student highlighted included the injured employee’s ability to receive treatment from a RECOVER physiotherapist (at no personal cost) prior to a decision being made on their WorkSafeBC claim and prior to them seeing their family physician. By removing the delays to treatment that are oftentimes associated with these two factors, it is anticipated that the Participant’s overall satisfaction rating for RECOVER pilot features would be result in relatively high scores.

Another feature was related to the perceived quality of care and return-to-work assistance that Participants received from their RECOVER service providers. As part of their service expectations, physiotherapists are required to provide Workplace Health with actionable recommendations and timelines surrounding the employee’s readiness and ability to return-to-work. To assist physiotherapists with making these decisions, the student ensured that RECOVER clinics were provided with additional resources; such as, information related to the employee’s pre-injury position and Fraser Health’s early and safe return-to-work policies. With these resources, it was anticipated that the physiotherapists
would be able to better tailor their treatment plans around helping employees reach the functional requirements needed to return to their job. Service providers were also strongly encouraged to provide Participants with education on symptom management techniques, the use of proper body mechanics, and ways that they could prevent the likelihood of re-injury in the future.

The student hypothesized that there would be high Rates of Satisfaction with elements of the RECOVER pilot program (average Likert response rating of more than 70%). This includes high levels of satisfaction associated with key features of the pilot program and the Participant's personal experiences during their stay-at-work or graduated return-to-work process. For the second part of this hypothesis, specific variables that will be followed include the Participant's satisfaction rating with the timeliness and amount of communication they received from Workplace Health and WorkSafeBC personnel, and the level of perceived managerial support they felt during their transition back into their workplace. To obtain data for Rate of Satisfaction, the student developed a RECOVER Participant Survey. This survey will be sent to pilot Participants by Workplace Health personnel upon receipt of the employee's Physiotherapy Discharge Report from RECOVER. Findings that result from the Participant Survey will be discussed in detail at a later date for part of the requirements for the student's Disability Management Project course. The final version of the RECOVER Participant Survey was completed and submitted for inclusion in the RECOVER Pilot Program’s MOA on October 6, 2009.
Voice of the Business

Voice of the Business was defined in terms of the service providers’ overall impressions with their clinic’s participation in the RECOVER pilot expansion. This includes the physiotherapists’ impressions of their expected roles and service requirements and their impressions regarding the working relationships they established with Workplace Health’s Disability Management team.

A total of 16 community physiotherapy providers spread throughout Fraser Health were selected for clinic participation in the RECOVER pilot program. Throughout the course of the student’s practicum, the student met with the various service providers at their clinics to discuss RECOVER pilot guidelines and service expectations with them. The student also provided the clinics with a RECOVER orientation package that included an informative brochure that was specifically targeted towards physiotherapists, the clinic’s regional Workplace Health contact list, and a portable computer USB device. The USB device was loaded up with files containing valuable pieces of information and access to resources that could help physiotherapists make decisions regarding their client’s safe and early return back to their pre-injury position. The first clinic visit occurred on August 10, 2009. The final clinic visit occurred on December 2, 2009. Periodic follow-up meetings with the clinics will also be arranged at a later date to ensure that clinics are still complying with RECOVER pilot guidelines and to collect data for the student’s combined Disability Management Project course.

The student hypothesized that service providers would have relatively high impressions of the RECOVER pilot. This would be demonstrated in the form of the clinics
consistently fulfilling their expected service obligations and through their perceptions of positive and collaborative working relationships with Workplace Health personnel. To measure the success of the pilot’s *Voice of the Business*, the student developed a RECOVER Provider Survey. This survey was also included in the MOA between Fraser Health, WorkSafeBC, and the RECOVER service providers. Variables that will be followed include the physiotherapist’s knowledge of their roles and service expectations, their level of compliance to the pilot program’s processes and guidelines, and their collaborative efforts in working with Workplace Health. Findings from this survey will be discussed in detail at a later date when the student completes his combined Disability Management Project course in the Winter 2010 semester.

**Problems**

The student encountered two problems during the course of his practicum placement. The first problem was with respect to clinic selection. One of the recommendations that resulted from the PEARs Plus pilot was to decrease the number of physiotherapy providers that offered RECOVER services. This would result in an increase in the number of referrals made to the participating clinics, and thus an increase in the clinic’s level of familiarity with the RECOVER pilot’s processes and guidelines. Reducing the number of service providers would also enable Workplace Health’s Disability Management team to develop closer and more collaborative working relationships with the clinics and would increase

At the start of student’s practicum 11 clinics were selected for participation in the RECOVER pilot expansion, with only two clinics being located in the “East” Fraser Health (Abbotsford) SDL region. However, because contracts for the earlier trialed PEARs Plus
pilot were issued for two years, an additional four physiotherapy clinics in the “East” were included into the list of participating clinics. Furthermore, because WorkSafeBC had to announce details about the RECOVER roll out on their website for a one-week period, one more provider from the “South” Fraser Health region (Surrey) SDL was added to the list after the clinic protested WorkSafeBC’s Notice of Intent and was awarded with inclusion into the RECOVER pilot expansion.

The second problem involved major delays associated with the actual start date of the RECOVER pilot expansion (and thus the student’s practicum placement start date). Most delays were related to issues surrounding the concurrent roll out of Fraser Health’s WHITE.net computer database and WorkSafeBC’s new Claims Management System (CMS) throughout their organizations. These competing projects oftentimes prevented the RECOVER Pilot Expansion Team from moving forward and meeting all of their targeted deadline dates. Furthermore, because of all the delays the student was unable to pursue all of his learning objectives by the end of the May 2009 semester. By the start of the September 2009 semester however, more progress was being made in process development for RECOVER and the student was able to “officially” resume his placement in the Disability Management Practicum course.
References
