Spring 2016

PGAP® News

News and updates from the PGAP, an evidence-based treatment program targeting psychosocial barriers to recovery and rehabilitation for clients suffering from debilitating health or mental health conditions.

In this Newsletter

In this issue of the PGAPWorks Newsletter, we describe some of our recent research activities, our ongoing research projects, the emergence of interest in the PGAP across the globe, and we also present a case study. A major development for our Centre has been our relocation to Australia. I have recently left McGill University, where I have been on faculty for the past decade, to take on the position of Director of Recover, Injury Research Centre at the University of Queensland. The move to the University of Queensland will provide exciting opportunities to further develop PGAP services in Australia. We hope to work closely with insurers and rehabilitation service providers to make PGAP an important part of the repertoire of services that are offered to individuals with debilitating health and mental health conditions living in Australia.

While our relocation will permit us to offer more training workshops in Australia, it will unfortunately also affect the availability of training workshops in North America. At this time, we still plan to hold at least two PGAP training workshops in North America each year. Workshops currently scheduled for the coming year include Canada, South Africa and Australia.

In order to facilitate cross-border access to PGAP materials, as of July 2016, all PGAP videos will be available for download from the site: www.PGAPWorks.com. More information on changes to the www.PGAPWorks.com website are provided in a later section of the Newsletter.

Research Activities

In recent years, we have conducted a number of studies examining how perceptions of injustice negatively influence individuals' recovery potential following injury. This research has shown that individuals who appraise their injury, or the consequences of their injury, as an 'injustice', are more likely to develop chronic pain and disability, and are less likely to recover from the emotional consequences of their injury. Readers who are interested in learning more about the relation between perceived injustice and problematic recovery are invited to examine a series of papers published in the latest issue of the journal *Psychological Injury and Law*. The issue contains a series of papers examining how perceived injustice can trigger a cascade of psychological and physiological processes that ultimately compromise an individual's recovery potential. One of the papers in the special issue (Sullivan et al., 2016) shows that perceived injustice can also impact negatively on the recovery potential of individuals with debilitating mental health conditions that are not associated with injury. The same paper shows that participation in the PGAP can be effective in yielding meaningful reductions in perceptions of injustice associated with depression.

Ongoing Research Projects

Working in collaboration with the Centre for Rehabilitation and Health, we have been able to gather data on over 600 individuals with debilitating health or mental health conditions who have participated in the PGAP. The study sample contains individuals representing a wide range of health and mental health diagnoses such as Chronic Pain, Major Depressive Disorder, Bipolar Disorder, PTSD, and Phobia. These data will permit us to address a number of very important questions such as the role of psychosocial risk factors in disability associated with mental health conditions, the effectiveness of PGAP in reducing disability associated with mental health conditions, and characteristics of individuals most likely to respond positively to participation in the PGAP. The results of this program of research will assist in clinical decision-making about the most appropriate avenues of intervention for individuals that vary according to their psychosocial risk profiles. The results of this program of research are also intended to guide future enhancements to the PGAP. We also are excited that Kootenay Health Services in British Columbia have become a research collaborator with our Centre.

We have recently received funding from the Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST) to conduct a clinical trial examining the effectiveness of the PGAP for injured workers suffering from pain and depression. We are seeking PGAP-trained clinicians (residing in Quebec) who might be interested in acting as the PGAP providers for the clinical trial. As PGAP providers for the clinical trial, you would be treating injured clients who are currently receiving salary indemnity benefits from the Commission de la santé et de la sécurité du travail (CSST). You would also receive supervision from one of our clinical coordinators. You would also be working collaboratively with a physiotherapist who is also involved in the care of your client. As a PGAP provider for the clinical trial, you would be remunerated for your clinical

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services. If you are interested in providing PGAP services for this clinical trial, please contact our Centre: info@pgapworks.com and we will provide you with more information about the study.

PGAP Crossing Borders

The first Progressive Goal Attainment Program (PGAP) training workshop was offered in Halifax, Nova Scotia in 2004. The workshop was attended by 70 clinicians, mostly occupational therapists and physical therapists. Since the PGAP was a relatively unknown intervention at the time, clinicians attended primarily out of curiosity. Although the PGAP was an intervention built on evidence-based principles, the first clinical trial supporting the effectiveness of the PGAP would only appear in the literature two years later.

In order to increase insurers' awareness of the program, we offered orientation sessions to insurer representatives across Canada. As insurers became more aware of the PGAP, the number of referrals began to increase, as did the demand for PGAP services. Over the past 12 years, approximately 3000 clinicians have been trained in Canada. The number of disciplines represented as PGAP providers has also expanded beyond occupational and physical therapy to include kinesiology, occupational health nursing, vocational rehabilitation counseling, chiropractic, social work, psychology and medicine.

The PGAP has also expanded beyond Canadian borders. PGAP training workshops have been held in the United States, Ireland, France, Sweden, South Africa, and New Zealand.

This newsletter profiles the implementation and evolution of PGAP services in Canada, the United States and South Africa. These profiles are intended to be illustrative as opposed to exhaustive.

Canada

In Canada, the PGAP is offered within one of two service delivery formats: as part of a range of rehabilitation interventions offered by multi-service rehabilitation clinics or as a stand-alone intervention delivered by independent rehabilitation providers. Here we will focus on a model of service delivery where PGAP is offered as a stand-alone intervention.

In 2007, the Centre for Rehabilitation and Health (CRH) was established in Toronto, Ontario by Tamra Ellis. CRH initially set out to establish a provincial network of PGAP trained providers. This network has now expanded to a national level. Currently, CRH coordinates the activities of approximately 200 PGAP trained providers across Canada. CRH provides insurers with a central referral number through which they can access PGAP services anywhere in the country.

CRH recognized the importance of fidelity to protocol in clinical service provision. Even when trained in a standardized intervention such as the PGAP, some clinicians might drift from protocol, at times to such a degree that the service provided no longer resembles the standardized protocol. Inevitably, drift from protocol tends to be associated with poorer treatment outcomes.

In order to ensure fidelity to the PGAP protocol, CRH instituted a supervised quality control process. All PGAP providers delivering PGAP services through CRH are assigned a clinical supervisor. The clinical supervisor is involved from the time of referral and works with the PGAP provider on a session-to-session basis to ensure fidelity in the delivery of the essential techniques of the PGAP and to maximize the probability that treatment goals will be achieved.

An innovative aspect of the PGAP service delivery model used by CRH is the involvement of all relevant stakeholders from the moment that a referral is initiated. Following initial contact with the referred client, the employer and the insurer are engaged in discussions about the potential structure and content of a graduated return to work plan, the availability of modified work and any work restrictions that might need to be considered. Once this is established, and the client's progress in PGAP is sufficient to reasonably expect a successful transition to a graduated return to work, the attending physician is sent a letter outlining the plan to assist his/her patient back to work after PGAP. A date for the commencement of a graduated return to work trial is set well before the end of PGAP. These initial discussions among central stakeholders foster a shared philosophy in the goals of treatment and ensure that return-to-work remains a primary objective of treatment. The combination of efforts to maximize fidelity to protocol and engaging the participation of multiple stakeholders has contributed in large measure to the impressive clinical outcomes that have been generated by CRH. Many insurers who have been using CRH for several years report outcomes exceeding 80% successful return to work, and impressive ROI on their rehabilitation expenditures with CRH.

Over the past decade, the PGAP has evolved from an intervention aimed at targeting pain-related psychosocial risk factors to an intervention aimed at targeting disability-relevant risk factors for a wide range of debilitating health and mental health conditions. These changes in the PGAP have had an impact on the type of clients that are referred for PGAP services. A decade ago, clients with pain conditions would have formed the majority of cases referred for PGAP services. Increasingly, clients referred for PGAP services are individuals who are work-disabled due to a mental health condition.

Over the past 5 years, mental health referrals to CRH have increased by 300%. The most frequent mental health diagnoses of referrals to CRH in 2014 included major depression, anxiety, PTSD, phobia, panic disorder and adjustment disorder. Referrals for individuals with primary medical conditions still make up a substantive proportion of referrals including low back pain, whiplash, fibromyalgia, arthritis and cancer survivors. Regardless of the individual's health or mental health condition, the objective of treatment is the same, namely to promote re-integration into important life role activities and foster resumption of occupational activities.

Although the PGAP was originally developed as an intervention for individuals who were recently work-disabled, mounting evidence revealed that the PGAP was also effective in yielding positive return-to-work outcomes in individuals who had been work-disabled for a very long time. The effectiveness of the PGAP even for individuals who have been work-disabled for several years has also had an impact on referral patterns. In 2014, 10% of referrals to CRH had been work disabled for 5 years or more. Even with clients with very extended duration of work disability, CRH was still able to achieve successful work re-integration and claim closure in over 60% of extended chronicity cases.

In Canada, the metric used by insurers to gauge effectiveness of an intervention is the Return on Investment indicator or ROI. When a client becomes work-disabled, an insurer must set aside financial resources that will be allocated to cover disability-related costs of the client. The amount that is set aside is typically determined by precedent as a function of characteristics of the individual and the disabling condition. A ROI is the amount of money that can be 'released' or 'saved' as a result of a treatment that has reduced the cost associated with the disability claim. Many multidisciplinary rehabilitation programs yield ROIs in the range of 10% to 15%. This can be interpreted as the insurer being to 'release' or 'save' $10 to $15 for every dollar invested in treatment. The ROIs associated with receiving PGAP through CRH have ranged from $29 to $45, more than three-fold the impact of services provided through multidisciplinary rehabilitation clinics.

"We started using PGAP almost 5 years ago and we started to see immediate results. The ROI results achieved on files where we used PGAP exceeded our targets by more than 30%. We used PGAP on both physical and mental health claims where reactivation was key to returning the employee back to work. PGAP was a win-win solution for the employee, the employer and the carrier."

- Angela Borges, Past Regional Manager, Health and Absence Management, Standard Life

In the coming years, CRH plans to increase and expand its services within and across provinces. Representatives of CRH are present at many PGAP training workshops. Newly trained PGAP providers are thus given the opportunity to learn more about the network of PGAP providers that offer services through CRH and how CRH can assist them in incorporating PGAP as a central component of their clinical practice.

For more information about CRH, please contact: admin@centreforrehab.com

The United States

LifeTEAM currently coordinates the largest network of PGAP trained providers in the United States. LifeTEAM was established in 2011 by Dr. Darrell Bruga in Southern California. Dr. Bruga is a chiropractic clinician and rehabilitation professional whose background had been in functional restoration interventions for individuals with debilitating pain conditions. Through his clinical practice, Dr. Bruga was familiar with the challenges clinicians faced when providing medical and physical medicine treatment to individuals with psychosocial risk profiles. After attending a PGAP training workshop in 2010, he was convinced that rehabilitation outcomes could be improved if PGAP was offered to clients who presented with a psychosocial risk profile. In the same year, Dr. Bruga launched LifeTEAM with the goal of establishing a national network of PGAP trained providers and rehabilitation professionals.

PGAP is one of several interventions offered by LifeTEAM, which has now evolved into a multiservice network specializing in the treatment of individuals at risk for delayed recovery. Between 2010 and 2014, Dr, Bruga collaborated with University Centre for Research on Pain and Disability to offer PGAP training workshops in several regions of the United States. At the present time, LifeTEAM has PGAP trained providers in 46 states. LifeTEAM offers telephonically delivered PGAP in states or regions where the face-to-face intervention cannot be offered.

To date, LifeTEAM has been focusing on the use of PGAP for work-disabled individuals suffering from debilitating musculoskeletal conditions. The treatment team will typically consist of a PGAP trained provider, a physical therapist and a case coordinator. Similar to CRH, LifeTEAM uses a supervised quality control process. PGAP providers with LifeTEAM are assigned a clinical supervisor, who works closely with the PGAP provider to ensure fidelity to protocol and maintain focus on return-to-work objectives.

Referral and clinical practice patterns are notoriously difficult to change. As such, LifeTEAM faced a number of hurdles in its efforts to persuade insurers (and self-insured organizations) to consider innovative approaches to risk detection and risk-targeted intervention. In 2014, Kaiser Permanente agreed to a pilot project of PGAP using the services of LifeTEAM. Kaiser Permanente is the largest managed care hospital system in the US. Through this pilot project, LifeTEAM was not only responsible for providing timely and efficient clinical services, but also had to engage in educational efforts with physicians and case managers to familiarize them with the objectives of the PGAP and the type of

"…there is a new crop of innovators beginning to emerge… LifeTEAM Health is also narrowly focused; They do "disability prevention" based on identifying and addressing psychosocial risk factors - perhaps THE key factor in long-term, seemingly-intractable disability. With providers around the country, they can and do bring a much-needed service to an industry that has yet to fully appreciate the importance of psychosocial issues."

- Joe Paduda, Managed Care Matters

"My patients are very happy with the program. Many of these employees felt like they were dropped or cut-off after their 90-day modified work period. The program has helped people stay motivated to return to work by being supported with an activity coach and at the same time the program has helped them improve their functional capacity."

- J Norton, MD Kaiser Permanente Physician

"Ms. S's overall function and activity has improved, and more importantly has helped her overcome her depression and lack of self-worth from the injury."

- M. Goldstein, D.O.
Kaiser Permanente Physician

"I had a patient (a Kaiser RN) who completed your program visit with me this week; she specifically wanted me to relay that the program was significantly helpful in a the way she perceived her pain, help her transition now into a permanent work position (working) and improve her outlook as she was very depressed prior to the program."

- H.H. Kim, MD, MPH,
Kaiser Permanente Physician

One of our program participants wrote on the survey:

"The program felt very whole person all the way through. I felt very supported. My coaches kept me psyched up that I was doing well and could return to work. It was unfortunate that I did not participate in the program earlier."

client most appropriate for referral to PGAP. The pilot project generated sufficiently positive results that Kaiser Permanente chose to extend the pilot for an additional year.

In addition to Kaiser Permanente, LifeTEAM is currently involved in ongoing pilots with Costco Wholesale, Prudential Insurance, American Airlines, and California's State Compensation Insurance Fund. Early results suggest that return-to-work outcomes have been improved by the addition of PGAP. These organizations have offered numerous testimonials highlighting their positive reactions to the outcomes of PGAP, even noting the high level of treatment satisfaction reported by their clients.

In 2016, LifeTEAM begins offering services to three of the largest workers' compensation carriers in the U.S. LifeTEAM has also partnered with MedRisk; a large network of rehabilitation service providers with 45,000 contracted centers across the U.S. MedRisk receives over 100,000 referrals to their network on an annual basis and is a major service provider for clients of workers' compensation boards in the U.S. The MedRisk/LifeTEAM partnership represents the largest integration of psychosocial intervention with physical medicine currently available in the US.

In the coming years, LifeTEAM plans to continue in its efforts to introduce PGAP to insurers and other stakeholders involved in the management of disabling health and mental conditions. The positive outcomes they have been able to generate through pilot projects have played a key role in establishing a place for PGAP in the repertoire of services made available to individuals who are work-disabled due to a debilitating health or mental health condition.

For more information about PGAP services offered through LifeTEAM, please contact Dr. Bruga at dbruga@lifeteamhealth.com

South Africa

In 2011, two PGAP workshops were held in South Africa as part of a broader pain education programme. 131 health care professionals attended the workshops in Johannesburg and Cape Town. Those attending were mostly physiotherapists, occupational therapists, occupational health nurses and other rehabilitation professionals. From that group, 45 clinicians asked to be included on a referral network, of which ten became available to referrers and funders. A team was formed to assist providers in getting started and to identify codes for reimbursement. Initially, PGAP was envisaged as being situated within the private sector and that most providers would be billing for their services within the medical aid system. This is largely how it has remained with stand-alone interventions offered by independent rehabilitation professionals.

At the time of the original workshops an orientation session was arranged with insurer representatives in Cape Town. The meeting raised awareness of the strengths of the programme with disability funders and has led to increased calls for more accredited providers.

Despite the challenges, there is a groundswell of enthusiasm for PGAP with increasing calls for further training and expansion of services. As a result plans are underway for the second phase of training and implementation. A training workshop has been set for Johannesburg on October 7 & 8, 2016. Stakeholders are being invited to become involved from the outset. In addition, existing providers and funders are being approached in order to identify a key individual who can act as a team leader and take the programme into the future. In this way it is hoped that the outcomes of restoring individuals to their valued roles will be realised.

A PGAP Case Study

We invite clinicians to submit interesting case studies of clients who have participated in the PGAP. This following case study was submitted by ***Marie Duscina, who is a PGAP trained Occupational Therapist*** operating in Manitoba, Canada.

The case study illustrates some of the elements of the PGAP in the treatment of a client with co-morbid pain and depression. The case study describes the client's participation in PGAP as she deals with significant family stresses. Details of the actual case have been changed in order to protect the anonymity of the client.

Case Summary

Penny D. was a 49 yr. old health care worker who was off from her work due to Major Depressive Disorder and substance abuse; she had lost her professional license to practice. She had a history of one suicide attempt with an overdose of narcotics and benzodiazepines two years prior. In addition to her symptoms of depression, Ms. D. also suffered from pain in her left wrist as a result of injuries sustained in a MVA, several years previous. She also suffered from abdominal pain for which she used Tylenol 3's to treat.

Ms. D. was referred to a mental health ambulatory care service by the emergency department of the hospital due to her depressive symptoms. She was referred to PGAP as part of her treatment in ambulatory care, with the hope that she could return to some form of employment. She had one unsuccessful attempt at return to work approximately one year earlier, where she lasted one week. Given this failed attempt, Ms. D.'s husband did not feel that Ms. D. should explore work again, and believed she should be receiving CPP disability benefits instead.

Initial screening revealed that Ms. D. was a suitable candidate for PGAP. With respect to her symptom profile, she indicated moderate levels of physical pain in her abdominal region that she described as throbbing/cramping/gnawing and affective pain that was punishing-cruel and left her feeling exhausted and fearful about the future. Additionally, Ms. D. also endorsed moderate levels of depressive symptoms (16 on the PHQ9) and fatigue (4/10). In terms of psychosocial risk factors, Ms. D. had moderate range of scores on catastrophizing (5/10), perceived injustice (4/10), and self-reported limitations (5/10). Fear was rated in the low range (2/10).

In reviewing Ms. D's activity log, it revealed a sedentary lifestyle. Much of her time was spent on social networking sites or watching television. Her sleep/wake times varied. Ms. D.'s life roles as a health care worker, wife, mother and friend had been disrupted in that she was no longer at work, had decreased her contact with her friend group, had decreased her shared activities with her spouse, took on less household chores and expressed frustration that her adult children did not want to see her as frequently as she wanted to see them.

In the second week of PGAP, Ms. D. was introduced to activity planning and the walking program. She had expressed an

interest in getting back her professional license and spoke of the meaning work had for her: it was the place where she derived the most satisfaction and sense of worth. It was discussed that starting to engage in activities that could eventually approximate the energy and cognitive demands of work would help her to see for herself how ready she would be for work and what kind of supports, if any, would be required.

Ms. D. began a 30-minute walking program. She also began scheduling household tasks such as cleaning out closets and cooking as well as leisure activities such as attending a party. Over the subsequent three weeks, it became evident on reviewing Ms. D's activity log that she often over-scheduled herself and took on too many large tasks e.g. cleaning out the garage, starting a volunteer job at a book store and helping to plan for a family reunion. She found herself doing little for days after and felt defeated. In conversation, Ms. D. revealed that this pattern of over-extending herself to please others happened at her workplace as well as in her relationships with others, including her family. This often left her feeling taken advantage of and angry.

By mid-term evaluation, there appeared to be a definite change in Ms. D's presentation. She reported feeling more depressed. In conversation, Ms. D. revealed that her husband refused to pick up her antidepressant medication from the pharmacy and she had been without her medications for several days. In reviewing her log book, Ms. D. pointed out that she was unaware of the amount of time she spent on social networking sites. She revealed that she found she was able to receive much support regarding her recovery via strangers; support she wished for but did not get at home. She expressed feeling resentful about this. Mid-term evaluation revealed an increase in catastrophizing (8/10), depressive symptoms in the severe range (22 on the PHQ9), high range of self-reported limitations (7/10), and high range of perceived injustice (9/10). Fear remained at (2/10).

With re-introduction of her medications, Ms. D. also started some short-term family therapy sessions. PGAP was simultaneously resumed and the Thought Reaction Record was introduced. Ms. D. reported that reviewing the Activity Log was like "looking in the mirror" at herself. She was able to see her own unhealthy boundaries and the physical and emotional costs.

During her time in PGAP, Ms. D. made the decision to end her marriage; this decision was amicable for both parties. (They had been separated in the past for over a year.) The remaining PGAP sessions focused on faulty thinking patterns that led to negative mood and decreased or over-activity.

At the time of final evaluation, Ms. D.'s symptom profile (pain-depression-fatigue) showed clinically significant improvement. All symptom scores were in the low range (Pain score of 8, Fatigue score of 2/10, and Depression score of 4). She also showed clinically significant reductions in her scores on psychosocial risk factors including perceived disability (2/10), catastrophizing (3/10) and perceptions of unfairness (3/10). Fear was reduced to 1/10.

Through techniques learned in PGAP, Ms. D. indicated greater confidence in dealing with stresses in her personal life as well as those that might occur in the work place. At the time of termination, Ms. D. was actively engaged with her professional association about regaining her license and had obtained supporting documentation from her health care team. In addition, she had initiated conversation with her former employer who was happy to potentially have her return to work. Ms. D. and her husband were in the process of readying their home for sale.

Of significant note, Ms. D. continued to have unresolved physical health issues and associated pain that required ongoing investigations; however, she no longer appeared preoccupied by this. She expressed appreciation for PGAP and that she planned to continue to use the Activities Planned/ Activities Completed format as she moved forward as a way for her to help maintain her gains i.e. to have a mirror reflect back to her how she was actually doing in her daily life.

Clinician's Reflections

As one of my earlier professional experiences with PGAP, I was and still am amazed at the journey Ms. D. had during the program. I am reminded about the power of the building of a trusting relationship and having a genuine curiosity of my clients' lived experiences… what it must be like to walk in their shoes. I am also reminded that perceived injustices do not only occur at the worksite for some of our clients and how important it is to learn about their support systems when you are learning about their stories that brought them to PGAP.

The recovery journey for Ms. D. was not a one of graduated improvements from initial, mid-term to final evaluations. She had times where she arrived late or did not bring her workbook; she feared that she would be rejected by this writer. She was reminded of her goal of return to work and what would be expected work behaviours. She was able to resume and complete PGAP.

Since Ms. D., I have found this mid-term decline to occur with a number of my clients. This has been the perfect time for me to introduce cognitive strategies with positive outcomes. My team has been very enthusiastic about the gains many of my PGAP clients have made. The format for PGAP has been a perfect fit for our ambulatory care service in a teaching hospital. There is power in meaningful activity and challenging one's own faulty assumptions. As one of my most recent clients told me, *"Whenever I start getting down about my life stresses, I re-read my workbook. It reminds me how far I have come and what I did to overcome the challenges and what I need to do now."* The workbook is a visual representation of their recovery journey; they can see the work THEY did. By the final session, clients can see that they no longer "need" me and that they have the ultimate control over how they will proceed in life DESPITE ongoing health issues.

The 'What is PGAP' Video

Last Spring, we placed a video on the www.PGAPworks.com website that briefly describes that structure, content and objectives of the PGAP. As explained, the intended use of this video was to familiarize physicians, insurers and other referral sources with how PGAP might be an appropriate intervention for clients who present with psychosocial risk profiles.

It has come to our attention that some clinicians have provided their prospective clients with password access to the video. This has been problematic because clients are not the intended audience for the video. Consequently, when a client views the video, the viewing raises more questions than it answers. Clients then contact our Centre

for additional explanation. Our Centre is not involved in service provision and we are hesitant to become involved in any way in providing clients with treatment-related information. Please ensure, as a PGAP Provider you are making the appropriate engagement video available to your client for viewing prior to or at the first session.

We strongly recommend that PGAP providers share the password access to the 'What is PGAP' video only with physicians, insurers or other referral agents.

Things To Be Excited About!

New video available in July 2016: English

In 2012, we added to the repertoire of PGAP Information Videos, a Trauma-Mental Health video appropriate for military. It was received with great reviews and comments. It had been created with the input of individuals who were military veterans from Canada and the USA. Individuals working with these populations were also consulted and we took their feedback into consideration. Although the Trauma-Mental Health was received positively, the content of the video was military-specific and the material not well suited to a civilian population. In response to the demand for a PGAP Information Video addressing trauma reactions in the civilian world, we will be launching a new Trauma video in July 2016. Once available, the Trauma video will be listed on the online ordering form.

As of July 2016, orders for PGAP materials and workshop fees will be processed online. Faxes will no longer be accepted for payment. Hospitals and other government agencies may request an invoice for payment by cheque. Cheques from other entities will be accepted if accompanied with the order form for materials and/or workshops. Post-dated cheques will not accepted.

As we near the roll out of the online ordering process, we take the time to remind PGAP Providers and others purchasing products or workshops, that in adherence to the Payment Card Industry (PCI) Data Security Standard, the University Centre for Research on Pain and Disability (a division of PDP Program Inc.) strictly prohibits the transmission of unencrypted cardholder information via EMAIL. If you need to communicate payment card information with the Centre, please use our online form, available in July 2016. Email correspondence or attachments containing payment card information will not be delivered to the recipient due to network security restrictions.

Upcoming Training Workshops in 2016

April 2016
Tumwater, Washington

"Navigating Complex Cases in the PGAP"

Please note, this session is reserved for L&I invited and approved PGAP Providers. For more information contact : info@PGAPworks.com

October 7 & 8, 2016
Johannesburg, South Africa

Contact: debbie@trainpainacademy.co.za

Registration opens for the following PGAP Workshops at end of April.

Please contact: info@PGAPworks.com

October 28 & 29, 2016
Brisbane, Australia

November 4 & 5, 2016
Toronto, Ontario

Training Workshops in 2017

January 13 & 14, 2017
Vancouver, British Columbia

Please contact: info@PGAPworks.com

Did you know we provide small workshops on related topics to PGAP? Below are samples of titles previously presented:

1) Adverse Pain Outcomes: Assessment, Mechanisms and Treatment.
2) Techniques for Managing Perceptions of Injustice During an IME.
3) Psychosocial Determinants of Problematic Recovery following Musculoskeletal Injury.
4) Perceptions of Injustice in Debilitating Injury Cases.
5) An Approach to Maximizing Activity Involvement and Return to Work Potential following Debilitating Injury.
6) Pain-related Psychosocial Risk Factors: Assessment and Intervention in Primary Care.
7) Managing Persistent Pain and Disability: Best Practices.
8) Mental Health Consequences of Injury: Who is at Risk and What Can be Done About it.

To inquire about corporate training for your business, please contact us at: info@PGAPworks.com

Please check our website for further information.

http://www.PGAPworks.com

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