MONASH University

Centre of Research Excellence in Patient Safety

State Government Victoria Department of Health & Human Services

Key ingredients for successful falls prevention programs—did we get it right?

RESPOND

Respond to the first fall to prevent the second

Rebecca Morris
PhD candidate

Key ingredients

Timeliness

Intensity

Patient-centredness

Participation

Data sources

- Clinician case notes for intervention participants (total=223, Vic=114, WA=109).
- Participant-completed calendars detailing attendance at healthcare appointments (total = 440, intervention=223, control=217).
- Audio-recordings of RESPOND clinician-participant intervention contacts (random sample of 44 from total of 926)
- Semi-structured individual interviews with RESPOND clinicians (n=6). 3 in Vic and 3 in WA.
- Focus groups with RESPOND participants (n=41over 6 groups). 3 groups in Vic and 3 in WA

Timeliness

Recruitment to home visit PROTOCOL: ≤14 days

Timeliness

Recruitment to home visit PROTOCOL: ≤14 days

Median days from recruitment to home visit = **17 days**

Delivered as planned = **40.8%**

Recruitment to home visit within 30 days = **77.1 %**

Timeliness: time to home visit

- **RESPOND clinician feedback**

- ***"It was often very difficult to get in within that 2 weeks. Mainly because of the complex nature of that age group. So at times perhaps all of the health issues weren't immediately understood when they were seen in ED so sometimes that would mean re-presentations or it would mean later on they'd end up being admitted to rehab or staying on in the hospital. Sometimes it was just hard to get in to see them or they'd gone to stay with family."***

- Clinician 1, Vic

Timeliness

Home visit to first follow-up call PROTOCOL: ≤14 days

Timeliness

Home visit to first follow-up call PROTOCOL: ≤14 days

Median days from home visit to first phone call = **14 days**

Delivered as planned = **67.4%**

Timeliness: time to first coaching call

RESPOND clinician feedback

"That was, again, not always something that we had control over, and I think that's where the kind of... the nature of human beings came in and played into that opportunity to meet that protocol requirement. You know we had people who would get sick again or who would go back into hospital. We had people who, you know, "yeah, yeah, I'll be here on Thursday next week" and they weren't, you know, and you did your best to try and call them and you just... there was no way".

- Clinician 2, Vic

Timeliness: time to first coaching call

RESPOND clinician feedback

"I think you need to catch them definitely within a fortnight because any rapport building you've done if you wait any longer it's gone, and always... there's always something. There's either something that they've decided to work on and you can touch base on that, and even if it involves, which it often does, the GP, and even if they haven't had time to get there at least it's still on the agenda and you... you know, you're touching base. And any longer than that you've lost the rapport, they've forgotten about it, so I think you've got to get them while it's... it's fresh in their minds. So the first call within two weeks is perfect".

- Clinician 4, WA

Timeliness

First to second follow-up call PROTOCOL: ≤ 3 months/91days

Timeliness

First to second follow-up call PROTOCOL: ≤ 3 months/91days

Median days from first to second phone call = **21 days**

Delivered as planned = **98.1%**

Timeliness: time first to second coaching call

RESPOND clinician feedback

"I definitely would have had no problem with the second being within 3 months".

Clinician 1 Vic

"Yeah, hugely doable. That's fine".

Clinician 3, Vic

Intensity

10 hours over 6 months

Dosage of intervention PROTOCOL: 10 hours over 6 months

Intensity

10 hours over 6 months

Dosage of intervention PROTOCOL: 10 hours over 6 months

Median hours of intervention provided = 2.55 hours

Delivered as planned = 0 **%**

Intensity: 10 hours of intervention over 6 months

RESPOND clinician feedback

"I would say that the dosage of 10 hour average per intervention participant over the course of six months was higher than necessary. People didn't need an average of 10 hours, and what I found from my experience was the people who had some of the best, like most positive experiences from the program, who gained a lot from the program, who got some great outcomes, and who made some great changes to their lifestyle probably got about four to five phone calls and would have probably averaged about two and a half to three hours of chat and they didn't need more than that".

- Clinician 2, Vic

Intensity: 10 hours of intervention over 6 months

RESPOND clinician feedback

"Certainly the protocol of averaging 10 hours with every client when that was raised it became obvious that we weren't getting anywhere near that, so that's been a real challenge. And sometimes, you know, you just can't talk for the sake of talking with people, and people are busy".

- Clinician 4, WA

Intensity

≈ **45 mins**

PROTOCOL: each intervention contact to last approx 45 mins

Intensity

≈ **45 mins**

PROTOCOL: each intervention contact to last approx 45 mins

Median duration of each intervention contact = 20 minutes

Delivered as planned = 11.3%

Intensity: each contact to last approx. 45 mins

RESPOND clinician feedback

"The ones who work full-time tend to have shorter calls on the whole, but that's not only them. You've got the really active 72-year-olds who are just so busy doing three and four or five things today and every day that they're just far too busy to actually talk to you. "I'm doing fine. I'm doing this. I'm doing that. I'm doing that." So, it's not just workers, but the workers definitely were shorter calls at all times".

Clinician 3, Vic

Intensity

Intensity

Median number of intervention contacts over 6 months = 7

Intensity: number and frequency of calls

RESPOND clinician feedback

"In terms of frequency I think you need to stay in touch with them every two or three weeks otherwise they forget and it becomes strange to talk about something that you have discussed at the last phone call. So I think it's to keep them on track but then you run the risk also that you become and sometimes I do feel like that, a bit like as a person that pesters them with the calls. But that varies from person to person. Most of the time I would say that my clients find it encouraging, find the encouragement that they receive from me is good. I think for the majority every two to three weeks is good".

Clinician 5, WA

Patient-centredness

"The quality of a clinical decision, or its patient-centeredness, is the extent to which it reflects the considered needs, values, and expressed preferences of a well-informed patient and is thus implemented. Shared decision making is a critical feature of patient-centered communication".

(Levit et al, 2013)

Patient-centredness

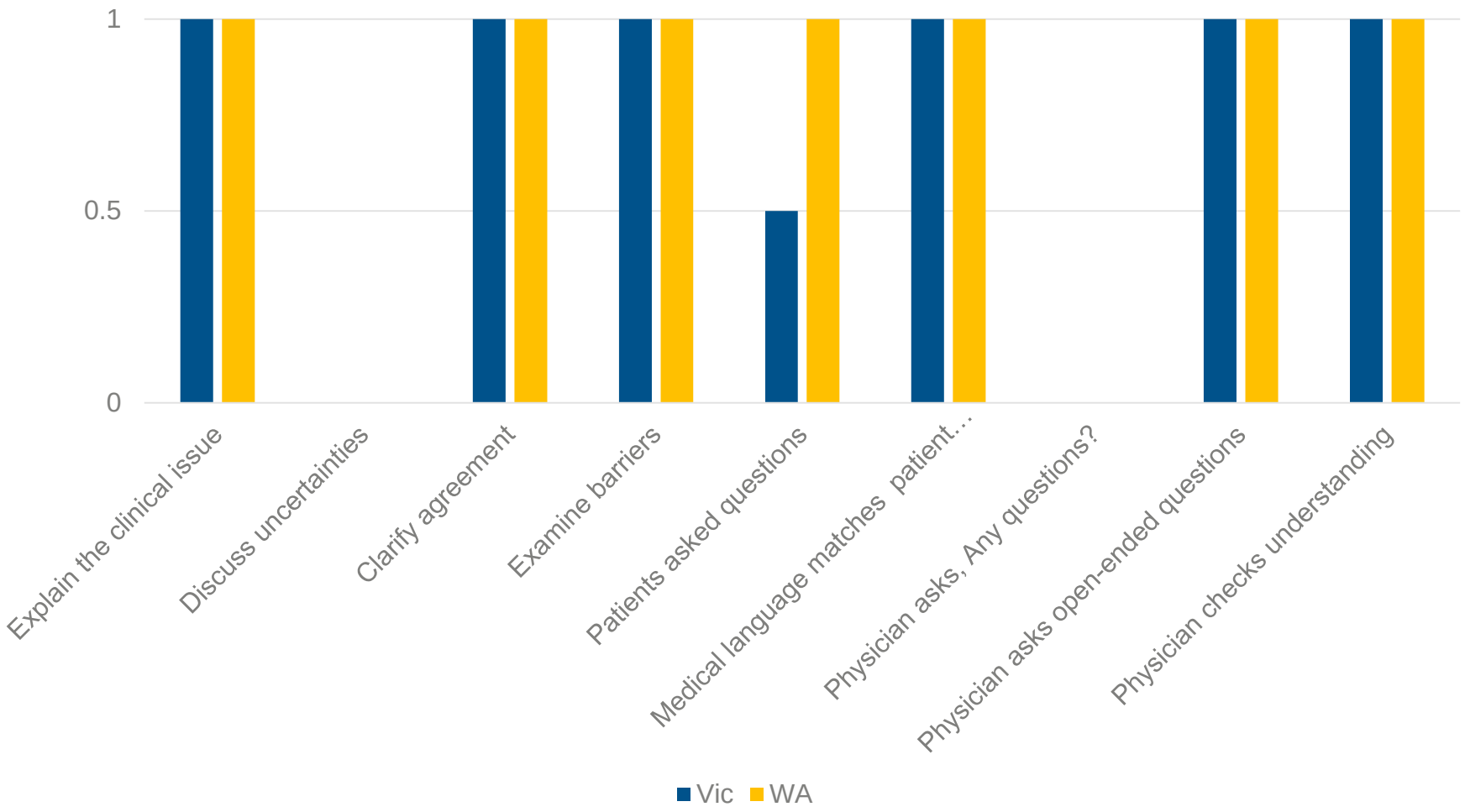
Rochester Participatory Decision-Making Scale (RPAD)

- Reliable, valid, and easy-to-code objective measure of participatory decision making.
- Total of 926 audio-recordings of RESPOND clinician-participant intervention contacts.
- Preliminary results (n=44) random selection.
- Vic = 19: 1 HV, 18 TC
- WA = 25: 9 HV, 16 TC

Patient-centredness

- Scale consist of 9 questions
- Score 0, 0.5 or 1 (item 6 scored -0.5, 0.5 or 1)
- Median score of:
- **Vic: 6/ 9**
- **WA: 7/9**

RPAD results (median score per item)



Patient-centredness

Participant feedback

"If practitioners told me that that was the best thing for me to do, I would go along with it, but I think I would know what I needed most".

Focus group 2, Vic

"The girl that I was speaking to asked me originally, What would you like to do? What exercise do you like? What would you like to have a go at?" What's something that you might be interested in?" So I told her. So then she went off and found these different things around the area for me, so it was all very much about what I wanted. But she would be throwing in suggestions, and I'm sure if I hadn't been very forthcoming, I'm sure she would have put things out for me to try".

Focus group 4, WA

"I don't react well when people tell me what to do".

Focus group 6, WA

Participation

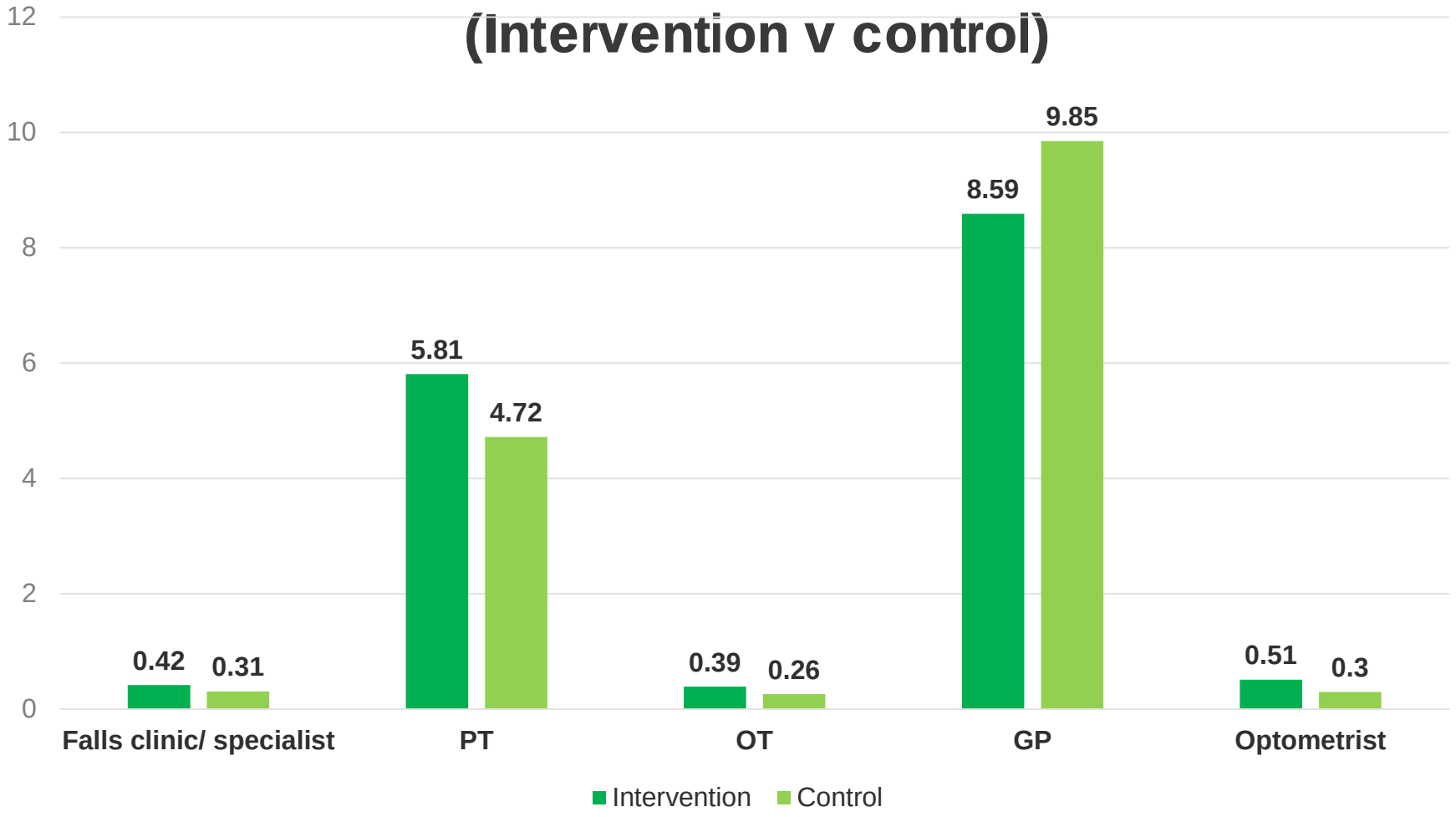
Attendance at appointments with specific health care providers:

- Falls specialist/ falls clinic – comprehensive falls Ax
- Physiotherapist (PT) – strength and balance program
- Occupational therapist (OT) – home environment assessment
- General practitioner (GP) – vitamin D test/ DXA scan
- Optometrist – test vision

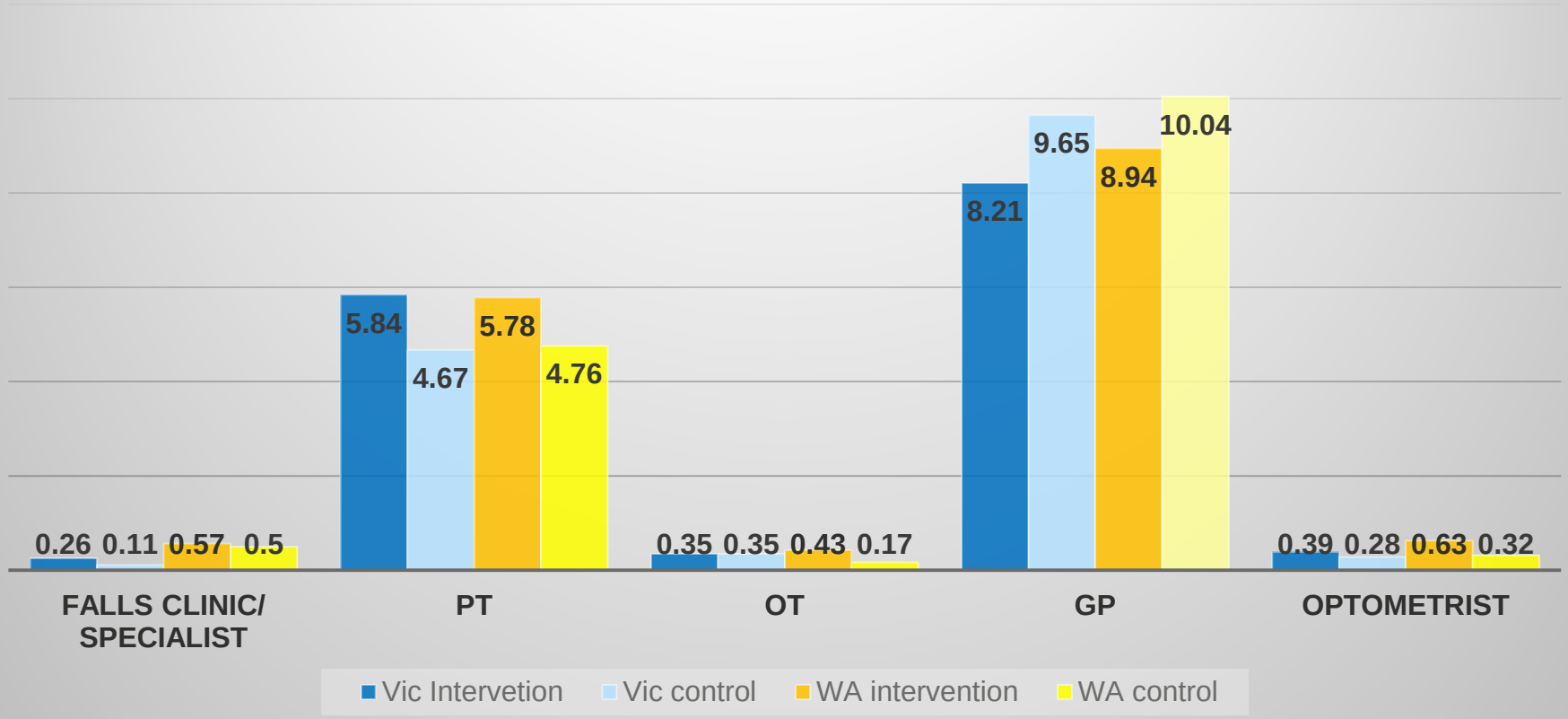
- Evidence-based management strategies to address 4 falls risk factors.

- RESPOND clinicians provided education and community linkage for these strategies.

Rate of attendance at healthcare appointments per person-year (Intervention v control)



Rate of attendance at healthcare appointments per person-year (Vic v WA)



RESPOND

Respond to the first fall to prevent the second

Did we get it right?

- RESPOND supports and builds on the existing literature regarding the key ingredients for successful fall prevention programs.
- Complex health and social issues increase challenge of providing timely and intense dosage of intervention.
- RESPOND was delivered in a patient-centred manner. This is valued by participants.
- RESPOND was delivered in a timely manner and with sufficiently intense dosage to increase participation in falls prevention activities compared with usual care.
- RESPOND achieved an increase in rate of attendance at community health services, with a lower dose than planned – efficient use of resources!

“I think it was well and truly worthwhile, and I’m so glad I said yes. I did learn a lot and the people that I had contact with, like everybody has said, were very caring, very knowledgeable and just really helped in those first few weeks when you’re at home and you’re sort of thinking “oh my god, what have I done here?”. I found that very reassuring. I was very impressed”.

Focus group 6 ,WA