Translating Research Into Practice

An example of a falls intervention programme

Angelique Chan
Executive Director, Centre for Ageing Research and Education
Associate Professor, Health Services and Systems Research, Duke-NUS Medical School

"Every 32 minutes, an elderly person turns up at a public hospital emergency department because of an injury from a fall. Each month, about 100 seniors find themselves in hospital staying a week of more because of such injuries."

--published on Strait Times July 3, 2015

Falls are a particular hazard among the elderly population.

- In a previous MOH-funded randomised controlled trial, we examined the effectiveness of the Steps to Avoid Falls in the Elderly (SAFE) programme.

ACRM
AMERICAN CONGRESS OF REHABILITATION MEDICINE

Archives of Physical Medicine and Rehabilitation
journal homepage: www.archives-pmr.org
Archives of Physical Medicine and Rehabilitation 2017;98:1086-96

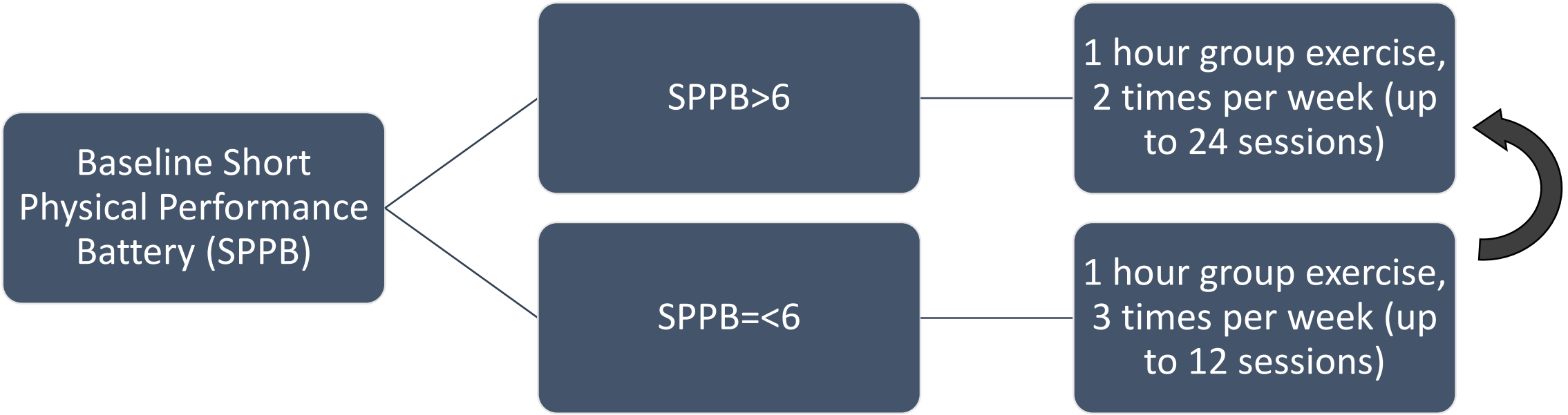
ORIGINAL RESEARCH

Randomized Controlled Trial of Screening, Risk Modification, and Physical Therapy to Prevent Falls Among the Elderly Recently Discharged From the Emergency Department to the Community: The Steps to Avoid Falls in the Elderly Study

David B. Matchar, MD,[a,b] Pamela W. Duncan, PhD, PT,[c] Christopher T. Lien, MBBS, MPA,[d] Marcus Eng Hock Ong, MBBS, MPH,[a,e] Mina Lee, MASc,[f] Fei Gao, PhD,[a,g] Rita Sim, BSc,[a] Kirsten Eom, MPH[a]

SAFE intervention

SAFE intervention is a broad range of exercises designed to be adaptable to a wide spectrum of physical function. The focus is on strength and balance – elements that are closely related to falls.



The intervention group had fewer individuals with injurious falls. Multivariate analyses indicated a strong interaction effect between the intervention and presence of 2 or more major comorbidities

Table 2 Number (%) of participants in each group and relative risk (95% CI) of falling or incurring injurious falls over 9 months between groups

Group	Control (n = 177)	Intervention (n = 177)	Relative Risk Between Groups
Fallers	67 (37.8)	54 (30.5)	.72 (.46–1.12)
Injurious fallers	40 (22.6)	25 (14.1)	.56 (.32–.98)

NOTE. Values are n (%) or relative risk (95% CI).
Abbreviation: CI, confidence interval.

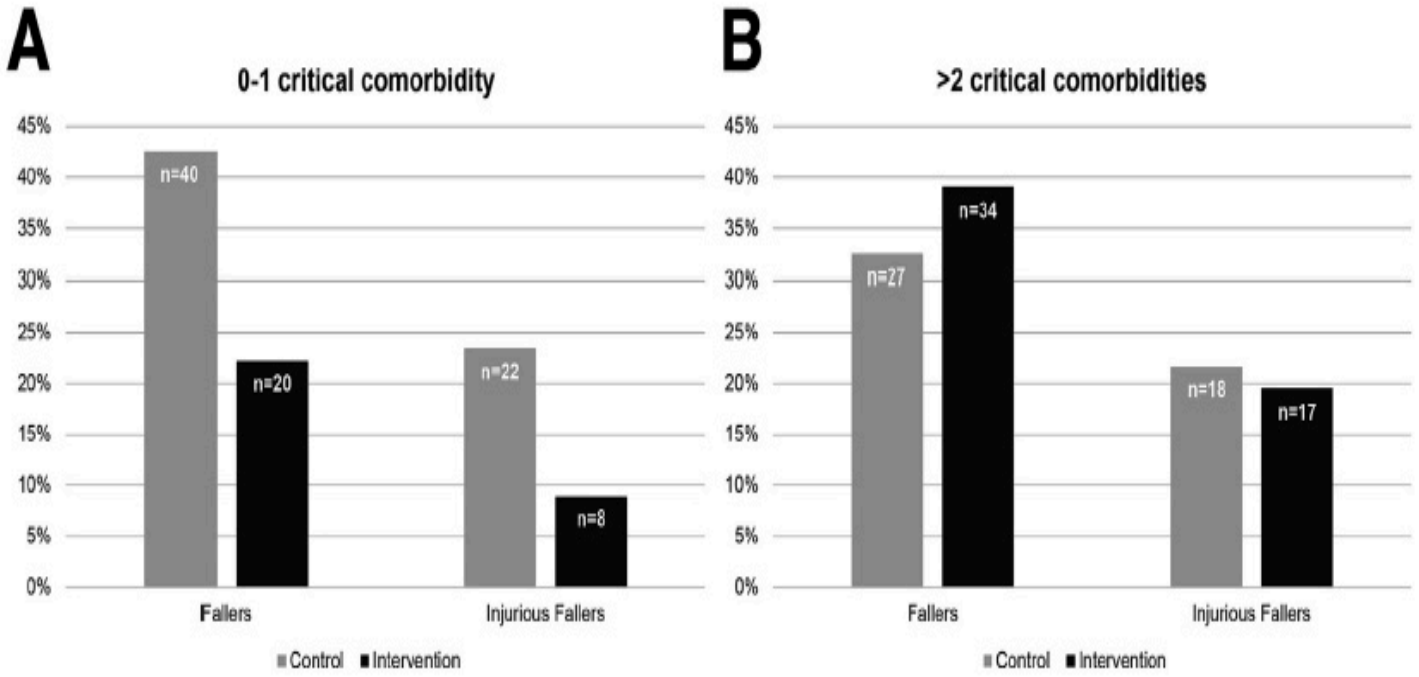


Fig 3 Proportions of fallers and of injurious fallers in 2 groups stratified by the number of critical comorbidities.

From RCT to implementation in the community

Steps to Avoid Falls in the Elderly - Translating Research into Practice (SAFE TRIP)

- Ministry of Health, Singapore - National Innovation Challenge on Active and Confident Ageing Healthy Ageing Innovation Grant 2018
- Started fieldwork in August 2018.

Overall aim:

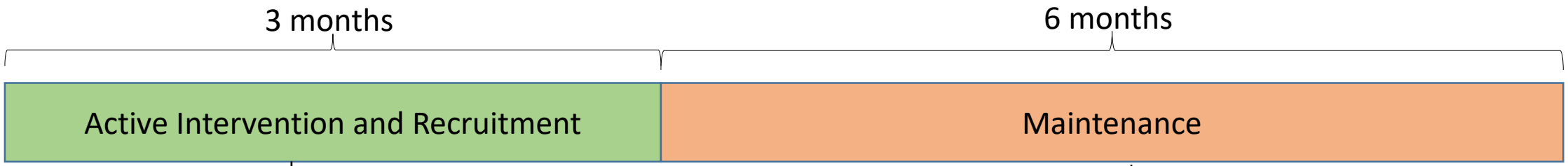
- To identify **innovative** strategies for implementing SAFE programme in the community in a way that maintain **high fidelity** and **optimising acceptability** and **cost.**
- To develop a **toolkit** for implementing a proven programme of falls prevention that will allow **broad dissemination** of the SAFE programme across Singapore

Target participants

Inclusion criteria for participation at all sites are:

- ✓ Age 60 >= years
- ✓ Singapore citizen or Permanent Resident
- ✓ Had a fall in the last one year
- ✓ Short Physical Performance Battery (SPPB)>=6
- ✓ Has not more than 1 major comorbidity (Heart attack, heart failure, cerebrovascular disease & cancer)
- ✓ Abbreviated Mental State (AMT)>=6

Methodology: Intervention



Intervention

(i) Education sessions on importance and benefit of exercise
(ii) Education sessions on SAFE programme
(iii) SAFE exercise programme, twice a week for an hour each

Participants will be encouraged to

(i) participate in an evidence-based fall exercise intervention by other agencies in the community (i.e. Tai Chi);
(ii) continue to exercise at home using a simplified exercise programme provided by SAFE TRIP study;
(iii) encourage participants to incorporate balance and strength activities into their everyday routine and/or
(iv) continue exercising with a peer-led/ volunteer-led group exercise programme using a simplified exercise protocol

Centre for Ageing Research & Education

Current status

- Community
  - Marine Parade: Recruited 56 participants
  - Beach Road and Bukit Panjang recruitment starts October 2018.
- Rehabilitation Centres
  - Recruitment starts in October 2018.
- Home-based
  - Development of gamification

DukeNUS Medical School

Part 1: Community

- To determine whether SAFE can be established in existing location with high concentration of eligible individuals
- N=160

Part 2: Rehabilitation Centres

- To understand the requirements for a successful implementation of the SAFE in locations that already provide rehabilitation to older adults
- N=40

Part 3: Home-based

- To develop 3 innovative approaches: (i) video conferencing; (ii) gamification and (iii) self-guided exercise program and to pilot these approaches
- N=120

Caring for Persons with Dementia: Towards a Sustainable Community Based Dementia Care System

8 February 2018

Objectives

- To understand the met and unmet needs of cognitively impaired persons (CIPs) and their caregivers in Whampoa community
- To evaluate a pilot model of dementia care, Hua Mei Dementia Care Services (HMDCS)
- To develop a conceptual model of a Dementia Friendly Community

Methodology

- Qualitative interviews with community stakeholders, e.g., police, hawkers)
- Survey interview on caregiver needs
- Evaluation of an intervention of a dementia care service provided by Tsao Foundation
- Aims:
  - To reduce care recipient memory and behavioural problems
  - To decrease caregiver burden
  - Establish whether programme is cost effective compared to usual care

Importance of community engagement

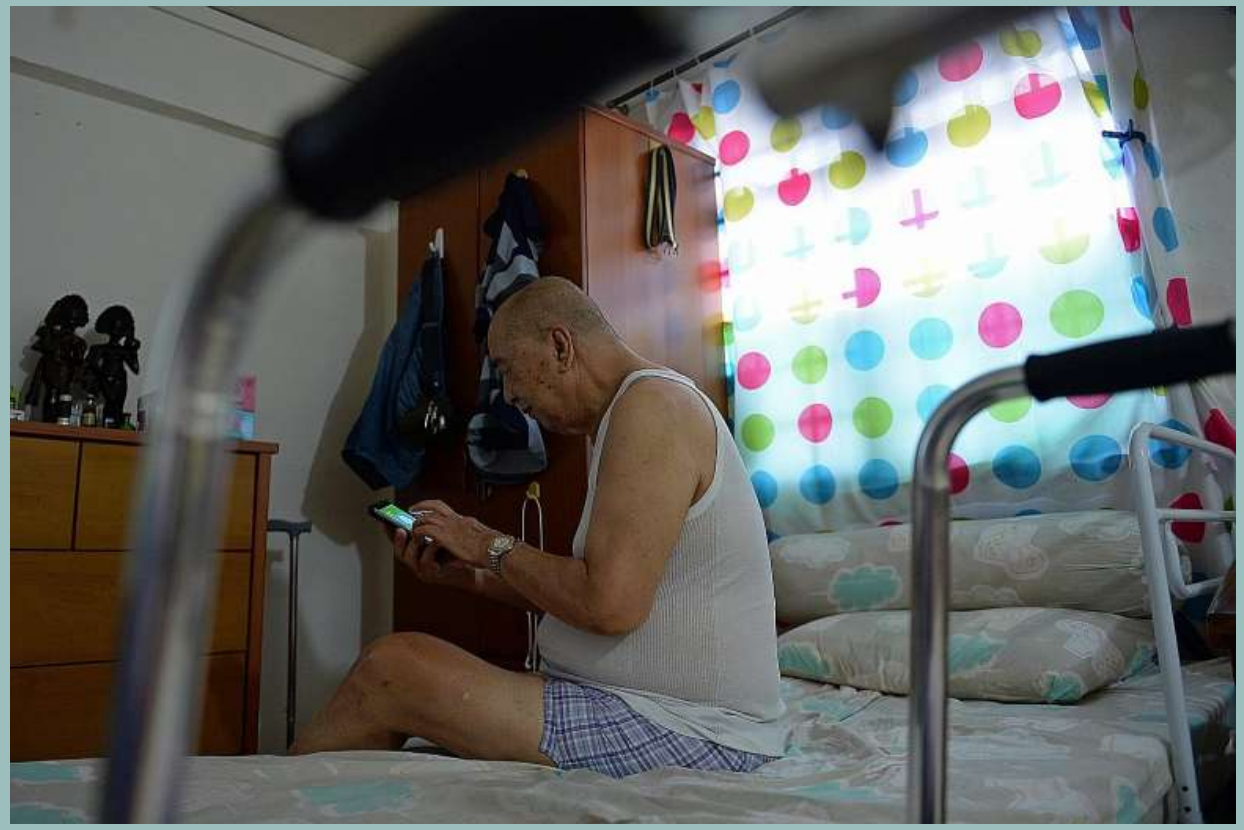
- Both research and translation projects involve close collaboration with community partners

- Community engagement is crucial to the success of research in the community, and translation of research into practice

Citation Guidelines

- To cite the presentation slides, please use the following:

  Source: Chan, A. (2018). *Translating Research into Practice – An Example of a Falls Intervention Programme,* Oral Presentation presented at the 2018 International Alliance of Research Universities (IARU) Ageing, Longevity and Health Scientific and Graduate Student Conference, Singapore. Retrieved from *(URL).*



"THE HOME ISN'T A HOSPITAL"

Translating older patients' perspectives into better community care research and intervention design

Ad Maulod, Lu Si Yinn
Centre for Ageing Research & Education, Duke-NUS Medical School

OLDER RESIDENTS IN CHINATOWN, SINGAPORE

In Singapore, majority of patients who were identified as at high-risk for readmission tend to be poor elderly living alone in public rental flats

- Complex care needs
- Dependent on financial assistance
- Little to no social support in case of need

(Source: Chin Swee Community Survey, 2016)


SINGAPORE

The lonely people of Chin Swee Road

Last month, a 51-year-old homeless man was found dead at a Chin Swee Road HDB staircase landing. CHAI HUNG YIN (chaihyn@sph.com.sg) and SEOW YUN RONG (seowyr@sph.com.sg) visit the area to learn more about the homeless there

Chai Hung Yin | Seow Yun Rong
Dec 27, 2015 06:00 am

9 Shares

It was Christmas Eve, and the Chin Swee Road HDB estate was abuzz with activity.

People shuffled in and out of the estate, children laughed at the playground while the adults sat at a nearby coffee shop.

In 2016, a **Communities of Care (CoC)** model was developed to integrate health and social care to address the medical and social needs of high-risk older clients in public rental housing

In the Community of Care model, nurses are embedded in the community as Patient Navigators

GOAL

Help patients **navigate** healthcare system and **coordinate** care transition through entire care continuum

Roles of PNs (3Cs)

- **C**linical Assessment
- **C**are Coordination
- **C**are Navigation

Post-discharge follow up
(2 visits + tele support)

→ **Right-site & minimise re-admission**

→ **Prevent/delay progression of condition**

→ **Keep patients in community**

Monitor patients' health and refer them to appropriate care transition programmes in the community

TRANSLATING PATIENTS' PERSPECTIVES TO RESEARCH/ INTERVENTION DESIGN

Objective of Research:

- Explore the role of patient navigation as a tool in healthcare delivery for vulnerable elderly communities
- Identify components of patient satisfaction to delivery and outcomes of integrated care
    i. Describe and analyze patient navigator (PN) activities as experienced by patients during home-visits (from patients' point of view)
    ii. Assessing impacts of PN's activities through client satisfaction of care received
- Capture other outcomes of integrated care delivery that are important to the patient and frontline staff but tend to be overlooked by administrator

Methodology

- Qualitative research conducted over 6 months between August 2017 to January 2018 → total of **45 homes**
- "Go-Along" interviews with PNs (n=9)
- In-depth interviews with patients (n=22) recruited through PN referrals as well as PNs

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#1 NEGATIVE PERCEPTION TOWARDS HELP/ CARE IN ELDERLY POOR COMMUNITIES

DEEP-ROOTED STRUCTURAL AND PERSONAL CIRCUMSTANCES: DISTRUST IN PROVIDERS AND HEALTH SYSTEM

Patients who were dissatisfied with the service expressed the following:

1. **They are a burden**

"I just don't want to burden nurses to take care of me. I feel like they are here because it's their job…why else would you come and visit?"

2. **They are doing just fine**

"Whatever doctor say, I do. I can eat. I got a job. What is there to help me? No need to ask me what I need, if I don't feel comfortable, I can see doctor myself."

3. **They do not have a choice**

"Whether the nurses come or don't come [to my house], my life still goes on…can't be they come and I "show face" and tell them to go away.

"If nurses want to come and check, let them check. I don't have a choice?

4. **The people caring for them are just doing their job**

"Nurses don't have a choice, they see me because supervisors ask them to come."

"I watch how nurses behave in hospitals, they can't act immediately on a problem because they don't want to shoulder the blame if something wrong happens to me. How can I trust them with my health, when they are not actually the one making the decisions?"

5. **Those people are going to leave anyway**

"They come, ask me questions, take my blood pressure, check my medication and they disappear for quite long. I don't even know if they are coming again, and then suddenly, they appear."

#2 FOR AN INTERVENTION TO BE EFFECTIVE IN MODIFYING HEALTH BEHAVIORS, CLIENTS NEED TO KNOW WHY THEY ARE ENROLLED AND HOW IT WOULD BENEFIT THEM

AWARENESS OF PURPOSE/BENEFITS OF H2H MAY INCREASE LIKELIHOOD OF COOPERATION

Do you know why nurses visit you at home?

50% of the participants did not know the purpose of home visits even though they welcome PNs into their homes

- H2H is a research survey
- Not sick enough to warrant home visits
- Nurses are just saying 'hello'
- H2H is a befriending service
- Nurses appear at the door, so just let them in
- No reason to reject good intentions

Trust to do no harm → Trust to bring benefits

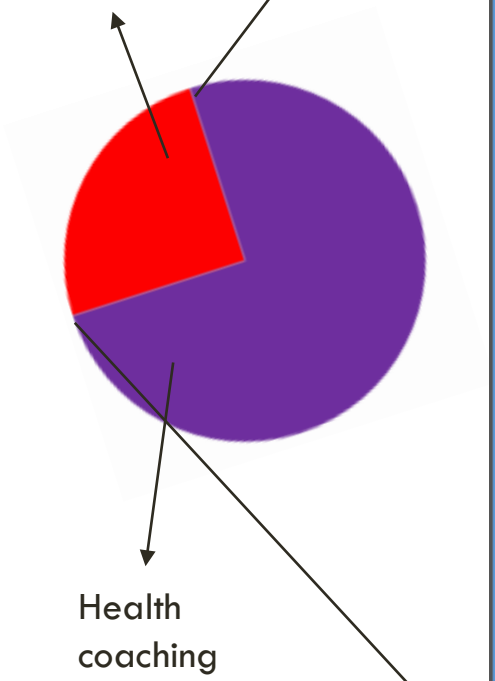
- Generally, patients feel safe with PNs and trust that PNs have good intentions but may not understand how it will benefit them
- Patients who are more cooperative trust and understand the benefits of home visits

Importance of familiarity

- Patients who were more cooperative recognized PNs as those they had interacted with (screener) while they were admitted in the hospital

#3 WHAT PATIENTS REMEMBER ABOUT A HEALTH SERVICE REVEAL CRUCIAL INTERVENTION COMPONENTS

PATIENTS WERE MORE LIKELY TO RECALL *HEALTH COACHING* ASPECTS COMPARED TO *CLINICAL ASSESSMENT*



A

Self-Management Support

Medication management
Appointment reminders
Nutritional advice
Post-surgery care
Information about symptoms
Assessing severity of risk
Falls prevention

E **Connecting patients to resources**

Coordinating care between health and social partners

Assist with follow-up appointments

D **Bridge between clinician and patients**

Update doctors on patients' conditions

Advise recommended care/treatment plan

C **Emotional Support**

Listening ear

Enquiring about well-being

Affirmation
Coping with anxieties

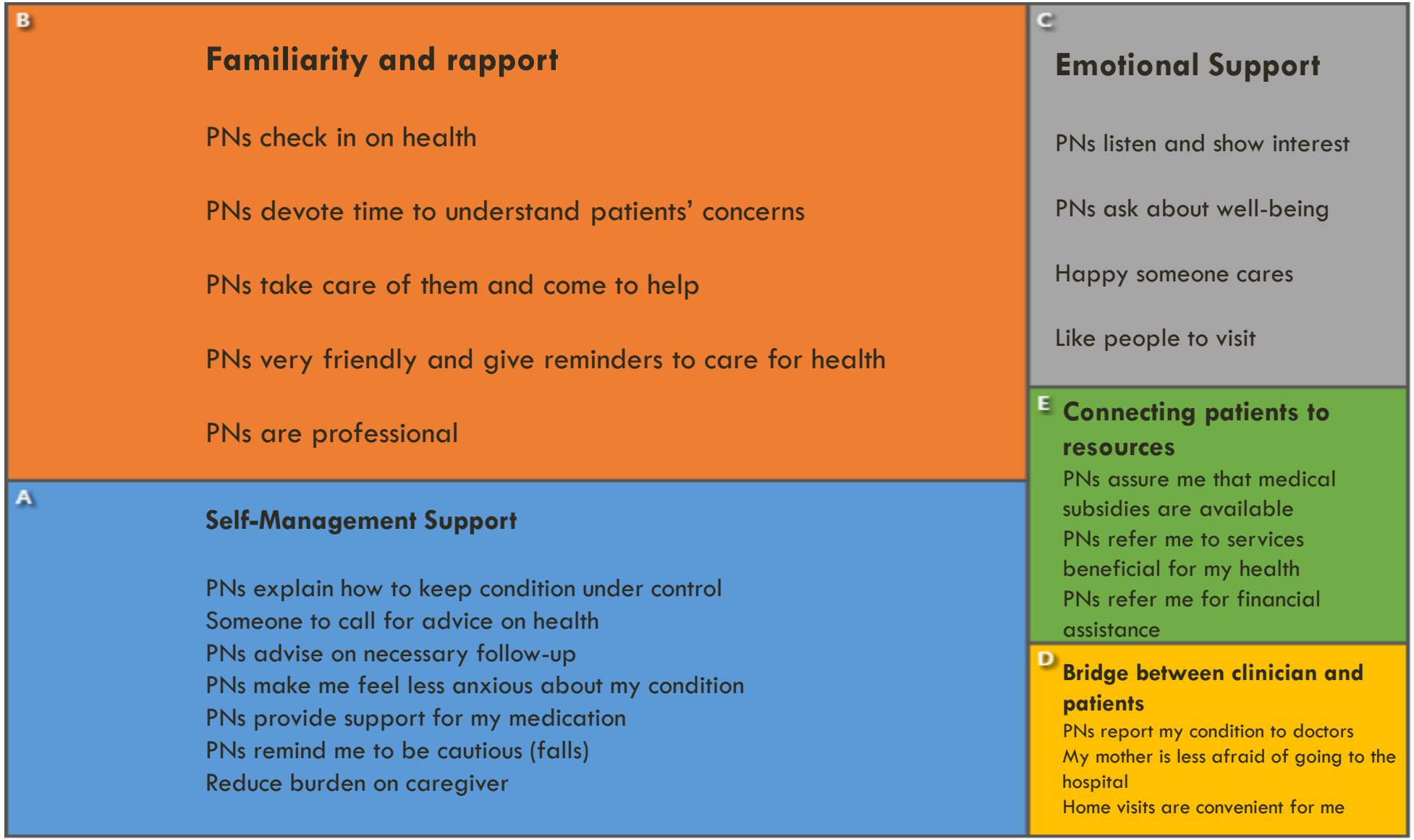
B **Familiarity and rapport**

Being available

Follow-up calls

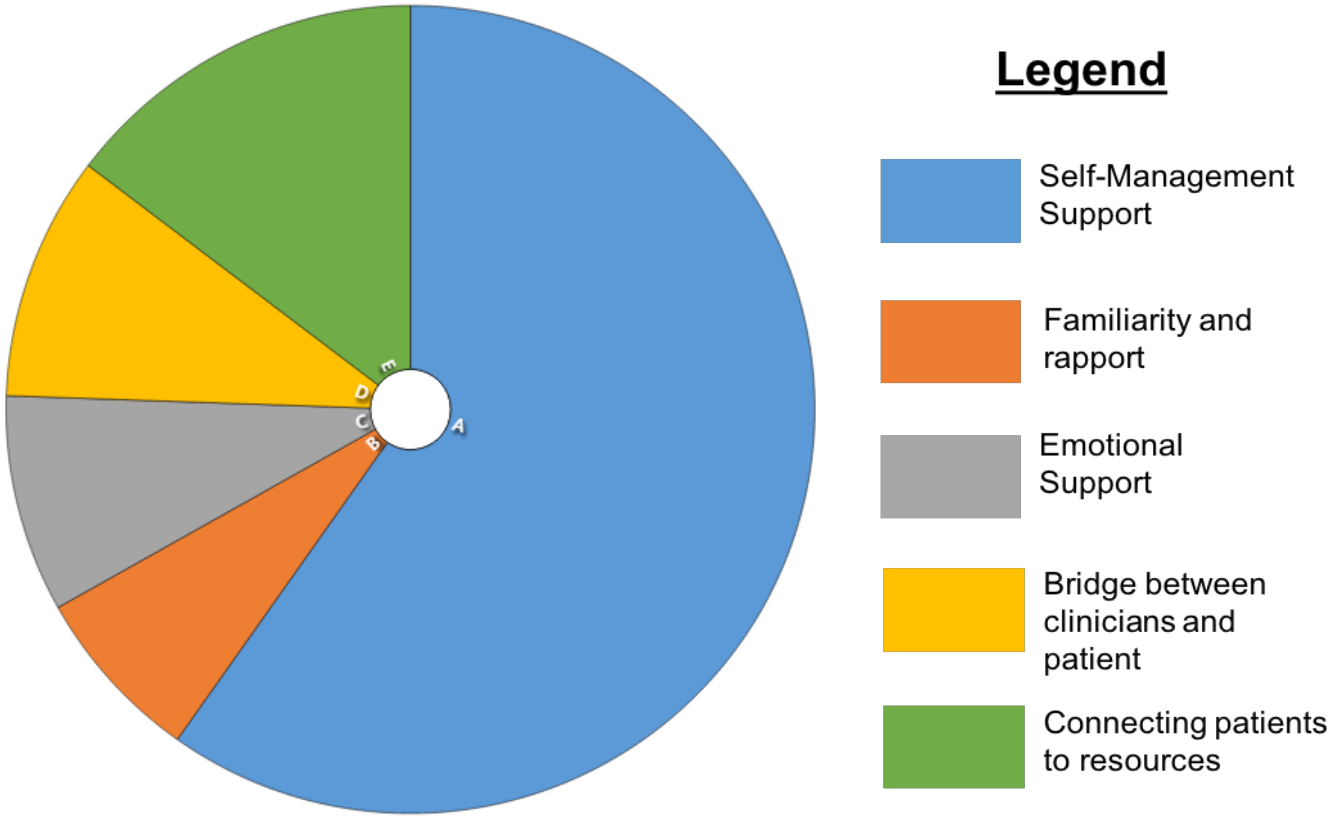
Trust

POSITIVE EXPERIENCES CAME FROM GENUINE INTERACTIONS WITH PNS



UNDERSTANDING OLDER PATIENTS' SATISFACTION WITH COMMUNITY CARE

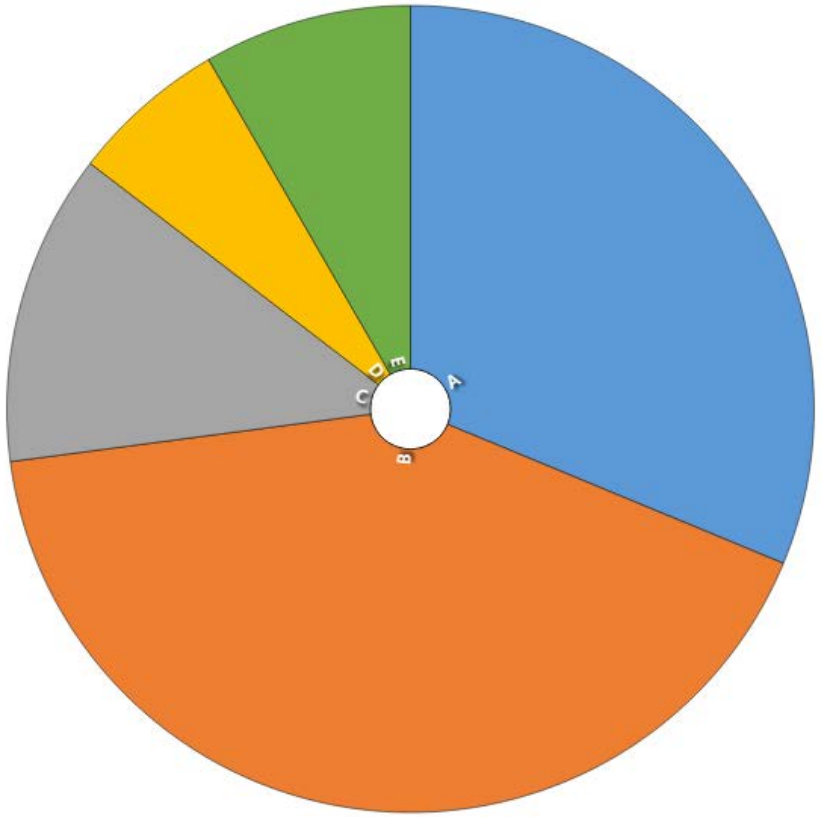
PNs health coaching intervention



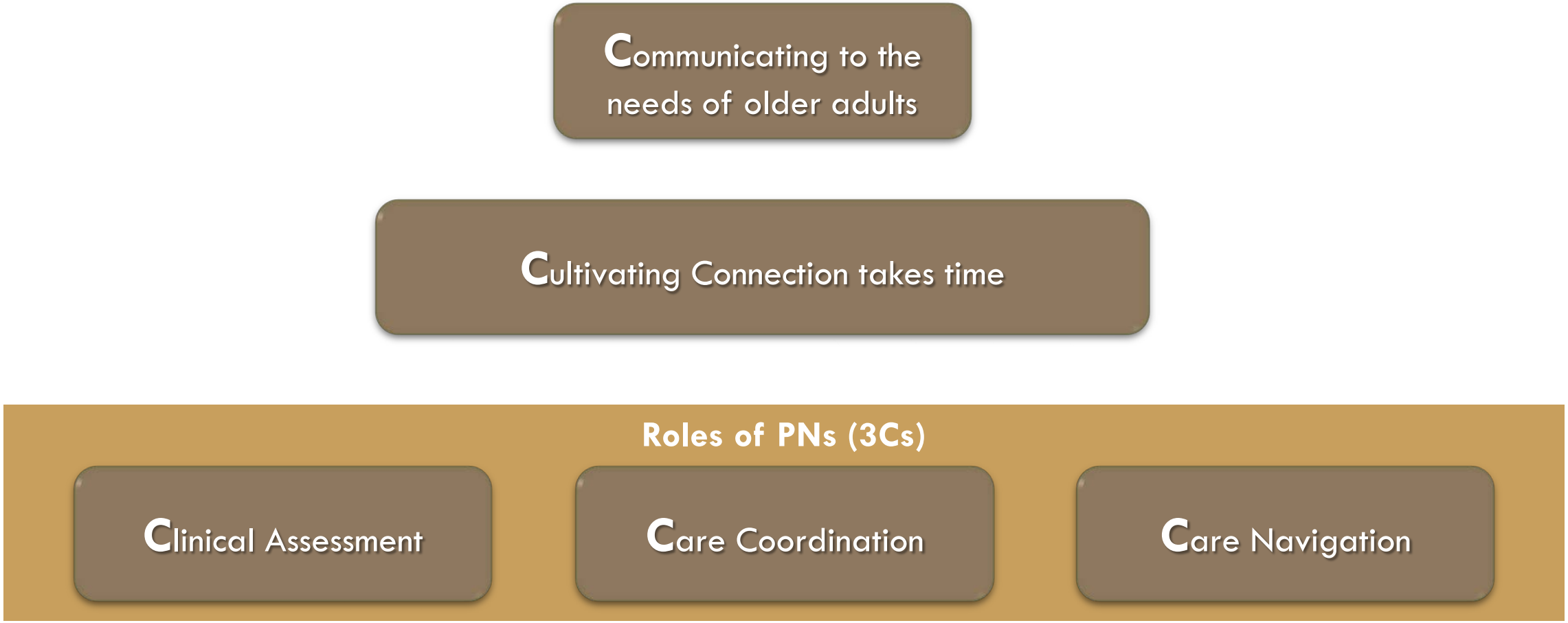
Legend

- Self-Management Support
- Familiarity and rapport
- Emotional Support
- Bridge between clinicians and patient
- Connecting patients to resources

Areas of patients' satisfaction



PATIENT NAVIGATION IN CHINATOWN:
PYRAMID OF CARE



TAILORING CARE STRATEGIES FOR SOCIALLY DISADVANTAGED OLDER ADULTS

- Community care needs to take into account different patient activation levels/ resource capacities in recommended care plans
  - Patient capacities are not necessarily tied to their medical conditions, but other individual, social and economic resources that shape people's capabilities
- Rapport building is important and takes time
  - Establishing a relationship of trust increases elder clients' sense of ownership towards managing their health and well-being
  - Benefits of the programme has to be consistently communicated
- A "virtual" or "community" ward is first and foremost, a person's home
  - Care providers are guests—accord the same respect towards entering someone's home
- Dignity and affirmation of the individual as a whole person instead of "patient" (self-worth, autonomy, efficacy)

KEY TAKEAWAYS FROM USER EXPERIENCE

Affirmation of the individual as a whole person instead of "patient" (self-worth, autonomy, efficacy)

Benefits of the programme has to be consistently communicated

Care expectations have to be properly managed

Deciding with patients on the appropriate course of action

Efforts towards adherence are impeded by continual lack of reliable social support and poor living conditions

Financial barriers to care remain an issue

Great relationships take time to build and develop

ACKNOWLEDGEMENTS

This research would not have been possible without the support of the following individuals and organization:

- H2H study participants for trusting us with their feedback and life stories
- Patient Navigators and Sisters from Office of Integrated Care (OIC), SGH for their support in the recruitment of participants, facilitating home visits and data-sharing
- Assoc. Prof Lee Kheng Hock and Dr Low Lian Leng (Dept of Family Medicine and Continuing Care), SGH for the generosity in welcoming us to the integrated care network and opportunities for collaboration
- Assoc. Prof Angelique Chan, (Centre for Ageing Research & Education) for the provision of intellectual and resource support

CITATION GUIDELINES

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Source: Maulod, A & Lu, SY. (2018). *"The Home Isn't A Hospital" Translating Older Patients' Perspectives into Better Community Care Research and Intervention Design,* Oral Presentation presented at the 2018 International Alliance of Research Universities (IARU) Ageing, Longevity and Health Scientific and Graduate Student Conference, Singapore. Retrieved from *(URL)*.