Translating clinical research findings into everyday practice

Associate Professor Vasi Naganathan
Sydney Medical School
Consultant Geriatrician,
Centre for Education and Research on Ageing
Concord Hospital, Sydney, Australia

Multicomponent Intervention to Prevent Delirium in Hospitalised Older Patients.

Inouye et al. NEJM 1999; 340:669-676.

- Controlled clinical trial (n = 852)
- Significant reductions in number (15% vs 9%) and duration of episodes of delirium in hospitalised older patients
- No significant effect on the severity of delirium or on recurrence rates

- Cognitive impairment
  - Orienting communication, including orientation board
  - Therapeutic activities program
- Immobilisation
  - Early mobilisation
  - Minimise restraints: lines, IDC, physical restraints

- Psychoactive medications
- Sleep deprivation

- Restrict psychoactive medications
- Non-pharm approach to manage sleep & anxiety
- Noise-reduction strategies
- Allow uninterrupted sleep periods

• Vision impairment	• Provision of aids
• Hearing impairment	• Provision of amplifying equipment, repair aids • Instruct staff in communication methods
• Dehydration	• Early recognition and volume repletion

Search advanced

- Welcome
- Older Adults/Caregivers
- For Clinicians
- HELP Conference
- The HELP Program
- The HELP Model of Care
- HELP Goals
- HELP Background
- Geriatric Team
- Core Interventions
- Volunteer Staff
- Starting a Program
- Key References
- Building Local Support
- Challenges
- Testimonials
- HELP News

Is Your Hospital in Need of HELP?

The hospital should be a place where older people can go to recover from their illnesses.

Yet, more than two million older Americans this year will develop delirium and functional decline during their inpatient care. These complications will result in increased morbidity and mortality, prolonged hospital stays, increased provider liability, a greater likelihood of needing long-term care and billions of dollars in excess health care costs. This scenario is not inevitable.

HELP is on the way

This section of the website provides general information about the background, goals, and implementation of the Hospital Elder Life Program. It also provides information about our dissemination activities to assist other institutions in implementing HELP. In an effort to make HELP more widely available, the HELP materials are now available without charge. Any institution can have access to the HELP manuals, tools and resources. Copyright restrictions must still be observed. All uses of this material should acknowledge: The Hospital Elder Life Program (© 2000, Hospital Elder Life Program, LLC). To access these materials, click the Sign In / Register link and create an account.

Notice - Sharon K. Inouye M.D., the Hospital Elder Life Program, Yale University School of Medicine, and the Institute for Aging Research, Hebrew SeniorLife assume no responsibility for any injury or damage resulting from the use of this website or its contents. All use of this website and its contents is at the risk of the user.

Hospital Elder Life Program (HELP)

- Year 2000: description of the HELP Program
- Hospital wide program
- Functional decline as well (not just cognition)
- Same 6 risk factors
- Geriatric nurse specialist/Elder life specialists/trained volunteers
- Widened enrollment criteria to 800 patients/year from 300/year
- Interdisciplinary experts consultations
- community advisory board,
  - consisting of representatives from 14 community agencies serving older people (e.g senior housing, Adult day care, area agency on aging, volunteer agencies, cooperative ministries, etc.) meets twice yearly to provide input for the program and strategies to better meet the needs of the older

Hospital Elder Life Program (HELP)

- Adherence rate 89%
- Elder Life Specialists review documentation on completion of interventions by volunteers or other staff and reasons for nonadherence are evaluated. Any changes in adherence are reviewed. Recommendations to improve adherence are implemented and tracked
- The Program Director meets individually with each staff member to review their satisfaction and effectiveness in their role
- staff members undergo paired standardization and reliability checks for all program screening, enrollment, and intervention procedures
- Similar for Volunteers
- Patient-family survey

Hospital Elder Life Program (HELP)- data

- 1716 admissions – 8% decline in MMSE $\geq$ 2, 14% decline ADL $\geq$ 2
- Median length of stay, mortality
- Historical data on MMSE and ADL as well as control arm of trial
- Costs
- $3000 to set up program, $1500 to maintain
- 200-250 patients – 1.0 FTE Elder Life specialist, 0.5 Specialist nurse, 0.2 Geriatrician, 21 volunteers (one shift per week for a year)
- saving approximately $800 per enrolled person in the hospital setting and reducing the costs of long-term care as well

- **benefits to Yale New Haven Hospital** – gaining recognition as a national center of excellence in acute geriatric care, providing cost-effective care, improving quality of patient care for the older population, enhancing patient and family satisfaction with hospital care, increasing public relations and community outreach, and providing an interdisciplinary educational site and resource for geriatric care.

HELP- Dissemination and training materials

- For replications sites
- a funded dissemination team (a full-time nurse practitioner, 10% time for the geriatrician who developed the program, and 25% time for a dissemination project director)

- Organizational and Procedure Manual
- Training videotapes and manuals for the volunteers
- tracking software program for adherence and outcomes data
- an interactive website with support staff to answer questions
- Online discussion forum
- Annual conference

HELP- Dissemination of the Hospital Elder Life Program: Implementation, Adaptation, and Successes – JAGS 2006

- Survey of 13 of 17 sites, 11 300 patients enrolled
- Data on hospital characteristics, personnel across sites, procedures and adaptations
- Outcomes tracked across hospitals – use of restraints, delirium, MMSE
- Advantages and successes

HELP- Translating Research into Clinical Practice: Making Change Happen– Bradley EH et al, JAGS 2004

Table 3. Common Challenges and Strategies for Translating Evidence-Based Programs into Practice, Experiences in the Dissemination of Hospital Elder Life Program

Challenge in New Program Implementation	Strategies for Addressing Challenges
Gain internal support for the program.	Identify key constituents and their respective requirements and goals. Develop and target individualized messages to appeal to goals of each constituent.
Ensure effective clinician leadership.	Identify clinical leader(s) with credibility within hospital, high personal commitment to program, linkages to organization's administrative structure, and knowledgeable about the organizational culture. Retain clinical leaders through adequate funding of their time and budget flexibility to invest needed resources during implementation.
Integrate with existing geriatric programs.	Articulate the relative advantage of the program. Manage sharing of resources with existing programs. Emphasize how the program complements, rather than competes with, existing geriatric programs.
Balance program fidelity with hospital-specific circumstances.	Emphasize that the proven benefits of the program are based on implementing the program as designed originally, including all parts of the intervention. Minimize necessary adaptations.
Document and publicize positive outcomes.	Gather and summarize site-specific data. Use language that is relevant and credible to senior administrative, financial, and clinical staff. Present data on program outcomes regularly to those with budget authority.
Maintain momentum while changing practice and shifting organizational culture.	Manage expectations so hospital staff recognize that implementation may require more than 1 year. Plan for staff turnover during implementation.

HELP- Sustaining Clinical Programs During Difficult Economic Times: JAGS 2011

- By 2011 - 100 Hospital in US and 7 other countries
- Survey of 19 hospitals, 62 interviews

- Interact Meaningfully with Decision Makers- High quality presentations, brief but data that matters, informal contacts, newsletters, local media – gain attention of decision makers

- Documenting Successes in Metrics that Resonate with Decision-Makers- Determine the best data to collect by considering the priorities of decision-makers, collect data that will show how much work has been done in terms of patient care (e.g., number of patients served, number of interventions completed), finances, patient satisfaction, and staff satisfaction,

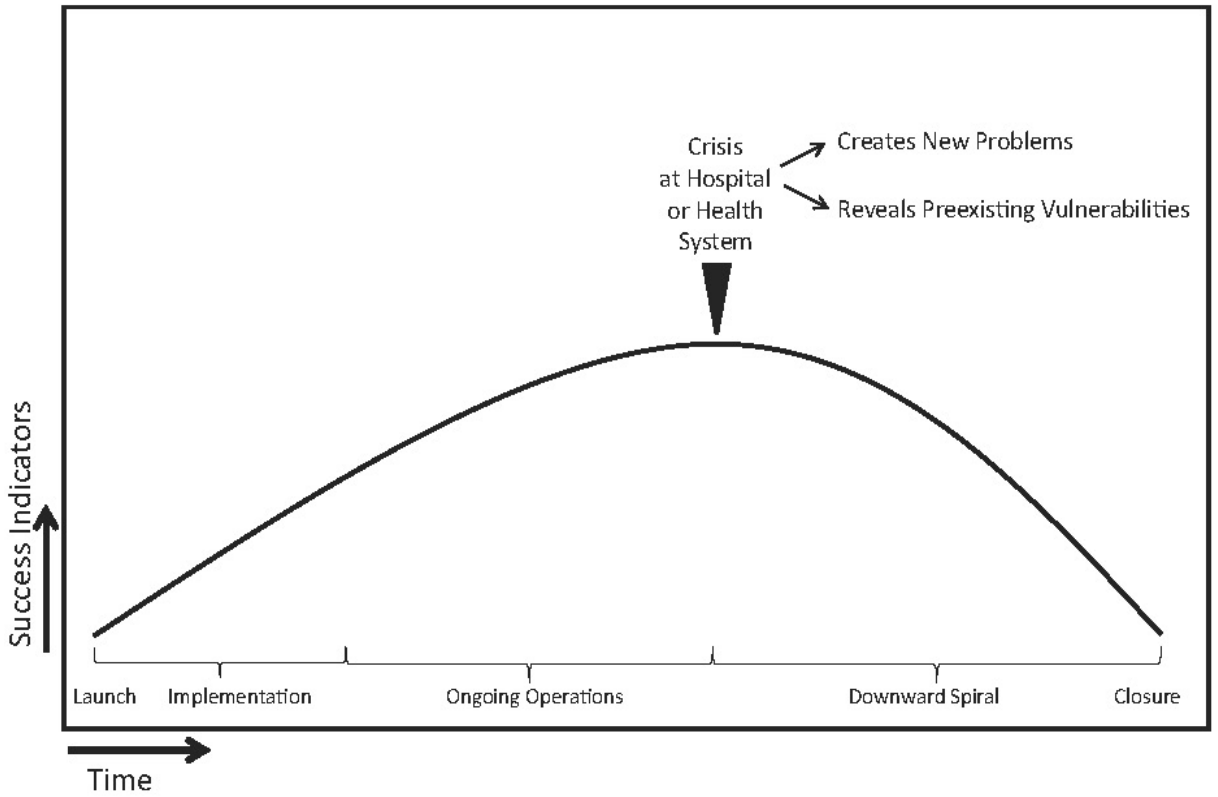
Supplement paid staff hours for data collection , Use patient and family surveys to gather more personal stories about the way the program has touched patient and family lives, State in clear words on any reports how the program fits the hospital or health system's mission or strategic plan

HELP- Sustaining Clinical Programs During Difficult Economic Times: JAGS 2011

- Garner support from influential staff - Identify the needs of staff and physicians who will interact with the program to ensure their buy-in and help generate positive word-of-mouth about the program
- Develop materials that support staff education needs while showcasing the program (e.g., training for new hires or continuing education modules)
- Consider the feasibility of conducting related projects that assist staff and physicians even if they are outside the scope of the original program (e.g., patient support programs that address nurses' concerns)

Learning from the Closure of Clinical Programs: A case series from HELP- JAGS 2013

- 2013 now in > 200 sites
- Interviews of 14 people from 6 former HELP sites



Pattern of Events Leading to Closure of HELP Sites

Problems Created by Crisis

- Funding Deficits Were Used to Justify Decision
- Restructuring Led to Loss of Champion
- New Administrators Prioritized Finances
- New Administrators Believed HELP Can Be Replicated at a Lower Cost
- New Program Structure Undermined Operations

Vulnerabilities Revealed by the Crisis

- Programs Did Not Have Sufficient Champion Support
- Staff Were Not Connecting to Broader Hospital Staff or Publicizing Programs Effectively
- Programs Were Not Collecting Data with Financial Relevance
- Programs Had Difficulty Demonstrating Clinical Effect

Australian Government

Australian Institute of Health and Welfare

Hospitalisations due to falls by older people, Australia 2009–10

Clare Bradley

Flinders UNIVERSITY

(http://fallsnetwork.neura.edu.au/search.htm)
Search
(http://fallsnetwork.neura.edu.au/search.htm) (http://fallsnetwork.neura.edu.au/search.htm)

The Falls Prevention Network

- ## Events

  Southern NSW LHD NSW Falls Prevention Network Rural Forum

  Thursday 24th October, 10 am – 3 pm

  Coachhouse Marina Resort, Batemans Bay

  Presentation PDFs (http://fallsnetwork.neura.edu.au/events/index.php#past)

  Professor Marcia Ory Presentation on *Fall Prevention initiatives in the United States*

Prevention of Falls and Harm from Falls among Older People

2011–2015

NSW GOVERNMENT | Health

NATIONAL FALLS PREVENTION FOR OLDER PEOPLE PLAN: 2004 ONWARDS

July 2005

Clinical Care Standards
Clinical Communications
Credentialling for Health Professionals
Falls Prevention
- Falls Prevention For Community Care
- Falls Prevention For Hospitals
- Falls Prevention For Residential Aged Care Facilities

Health Service Standards and Accreditation
Healthcare Associated Infection
Improving the Management of Cognitive Impairment
Information Strategy
Medical Practice Variation
Medication Safety
Mental Health
National Standards and Accreditation
Open Disclosure
Patient and Consumer Centred Care
Patient Identification
Patient Safety in Primary Health Care
Recognition and Response to Clinical Deterioration

Falls Prevention

Falls are one of the largest causes of harm in health care and are a national safety and quality priority. The Australian Commission on Safety and Quality in Health Care (the Commission) assists health services to reduce the number of falls, and the resulting patient harm, through a number of national initiatives.

Falls Prevention Guidelines

Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals, Residential Aged Care Facilities and Community Care 2009 was developed to reduce the number of falls experienced by older people in care and the harm endured from them. The guidelines provide a consistent national basis for falls prevention.

The guidelines and support materials are available to purchase in hard copies from the Queensland Government Bookshop. You can contact the Bookshop on 13 13 04, or email service@sds.qld.gov.au. As with all of the Commission's publications, we encourage reproduction of the guidelines for training and education purposes provided that ownership is acknowledged and it is not for profit.

The guidelines are designed to inform clinical practice and assist hospitals, residential aged care facilities and community care providers develop and implement practices that reduce the falls experienced by those receiving care and the harm sustained from falls.

The guidelines are in three documents, each one separately addressing a care setting: hospital, residential aged and community.

Each guideline has a smaller version called a guidebook which is designed for front line health professionals. The guidebooks provide the essential information needed when providing care for older people at risk of falling.

There is an implementation guide for hospitals and residential aged care facilities. The guide is designed to assist implementation and provides a tested methodology and practical tips.

There are fact sheets which provide the core messages from the guidelines for health professionals and others providing care to older people at risk of falling. There are also fact sheets designed for patients and residents.

Click on the care setting of interest to you for access to the guidelines, guidebooks and other support materials:

- Hospitals
- Residential Aged Care Facilities
- Community Care

Latest Falls Prevention Research and Practice

The Falls Prevention Guidelines are due to be reviewed in 2013-2014. Keeping the Falls Prevention Guidelines up to date is important. The Commission provides:

Search

Related Links
- National Safety and Quality Health Service Standards
- Falls Prevention for Community Care
- Falls Prevention for Hospitals
- Falls Prevention for Residential Aged Care Facilities
- Falls Prevention Research and Practice

Falls Clinics in Australia: a survey of current practice, and recommendations for future development

KEITH HILL, ROBYN SMITH, AND JENNY SCHWARZ

Keith Hill is Senior Research Fellow at the National Ageing Research Institute (NARI) and co-director of the Falls and Balance Clinic at Melbourne Extended Care and Rehabilitation Service (MECRS). Robyn Smith is currently director of the Public Health Division at NARI. Jenny Schwarz is co-director of the Falls and Balance Clinic at MECRS.

Stepping on Program as an example

Why Successful in influencing policy?

- matters to Government and Health system
- strong evidence base and cost-effective (cheap)
- “CHAMPIONS”
- engagement with government (they come up with the plan!)
- Clinical Excellence Commission/Australian Commission on Safety and Quality
- Decades of work
- Data..data….data
- Community engagement – Community based programs
- Falls coordinators
- KPIs