

A tale of two clinics.....

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**It was the best of times, it was
the worst of times, it was the
age of wisdom, it was the age of
foolishness.....**

Charles Dickens
A Tale of two cities

The two clinics.....

- Royal Melbourne Hospital (RMH), Royal Park Campus, Falls and Balance clinic
- Ballarat Health Services (BHS) Gait and Balance clinic

RMH vs BHS

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| <ul style="list-style-type: none">• 1 afternoon per week, plus 2 hours for a PT, OT and nurse in am• Capacity for 4 new clients per week• Variable waitlist | <ul style="list-style-type: none">• 1 morning per week• Capacity for 3-5 new clients per week• Variable waitlist |
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RMH vs BHS

- 2 x 0.1 Geriatrician
- 0.1 Registrar
- 0.2 Gr 4 Physio
- 0.1 Gr 2 Physio
- 0.1 Gr 1 Physio
- 0.2 Gr 2 OT
- 0.2 Nurse (FOF, visual test)
- 0.1 Podiatrist
- 0.1 Psychologist
- 0.1 Geriatrician
- 0.1 Physio Gr 2-3
- 0.1 Nurse (BPPV testing)
- Links with OT

RMH

- Triaged by Direct Access Unit and booked for medical assessment
- Initial Assessment
 - Medical assessment (1 – 1.5 hour)
 - Detailed summary letter sent to GP/referrer
 - 2 weeks later AH assessment (2 hours) & case conference
 - Summary of main risk factors, recommendations and planned actions sent to patient and GP
- 6 week review (1 hour)
 - Medical and AH to ensure follow-through, progress
- 6 month review (1.5 – 2 hours) & Case conference
 - Reassess most measures, progress. Discharge if OK, more intervention if required

BHS

- Triaged by Falls clinic team to be Ax by Geriatrician, Physio or nurse, depending on referral. Some Ax by all at first visit e.g. from long distance away, obviously complicated.
- First assessment lasts 1 – 2.5 hours, followed by case conference
- Detailed summary letter sent to GP (dictated by physio or doctor)
- May return for more assessment by remaining team members (differing time intervals)
- Review if and when required e.g. after Ix, medical changes, repositioning for BPPV. No standard review timeframe

Different structures

Same clientele??

Minimum Data set: Comparison of clinics (RMH vs BHS)

- 14 Falls clinics submitted data for sample of clients over 6 month period in 2003
- Total of 526 clients
 - RMH 50 clients
 - BHS 45 clients

Demographics

	Total n=526	RMH n=50	BHS n=45
% female	73	76	69
Age (SD)	77 (10)	78 (8)	69 (15)
% 65+	89	98	62
% LLC	3	0	4
%HLC	0.4	1	0
% Cog Imp	18	20	20

Referral source (%)

	Total	RMH	BHS
GP	59	64	71
Community	10		19
ACAS	8	8	
Outpatients		12	
Other			7

Reasons for Referral (%)

	Total	RMH	BHS
Falls	75	82	56
Gait	21	48	38
Dizziness	18	22	31

Falls

	Total	RMH	BHS
% Fallers	79	80	67
Multifallers	62	64	56
Injurious fallers	54	54	39

Outcome measures

	Total	RMH	BHS
TUGT (sec)	19.2	22.5	17.1
Step test	7.2	5.9	9.5
MFES	7.6	3.9	5.1
# meds	5.9	3.9	5.1

Thoughts on differences..

- BHS clients younger, less falls, more physically able, but more dizziness
- Difference may reflect limited public neurology/ENT services in Ballarat
- Ballarat became a default “dizzy clinic” or for people with unusual gait patterns

Recommendations	Total	RMH	BHS
Medical referral	10	4	4
Investigations/Rx	31	18	34
Group exercise	26	2	36
Comm Health etc	40	68	29
HEP	47	56	17
Vestib repositioning	6	2	13
Vestib exs	14	2	29
Home visit	46	26	9
Clin Psych referral	6	18	2
Footwear change	17	30	2

Thoughts.....

- Consultant more likely to order Ix in Ballarat
 - ??clients have has less Ix prior to referral
 - ??more diagnosis required
 - At RMH, consultant more likely to recommend GP orders Ix and provides follow up and not directly order the Ix
- Differences in vestib Rx reflects difference in referrals

Thoughts.....

- Group exercise program used more in Ballarat, Community therapy used more in MH
 - At BHS, Gp ex program directly linked with falls clinic and targeted for those clients, limited availability in comm therapy programs
 - At MH, no process for direct referral to Gp program, so via Comm Therapy, which has pretty good availability
 - Limited use of HEP in Ballarat ??perception that it is of limited value with no follow-up/review

Thoughts.....

- Low percentage of home visits from BHS
 - Probably reflects lack of OT
 - ?? Do Dr or PT adequately screen at clinic visit
 - ??some due to difference in clientele, who may not require HV
 - ??difficulty due to distance

Thoughts.....

- Footwear changes
 - High % at MH probably reflects presence of podiatrist with time and skill to provide appropriate advice
 - Very low % at BHS
 - ?? Inadequate screening
 - ??Perception that compliance will be poor

Thoughts....

- Fear of falling identified as risk factor in
 - 31% total
 - 38% MH
 - 22% BHS clients
- Psychology referral in
 - 6% total
 - 18% MH
 - 2% BHS cases
- ?? Under-utilisation
- ?? Low availability of Rx services stops staff referring in most clinics, esp BHS
- ?? Perception that FOF will reduce with other strategies

Advantages & Disadvantages

- BHS is more efficient and cost-effective
 - No systematic review, so outcomes are not known & likely that things get missed
 - Less comprehensive assessment, risk factors likely to be underidentified
 - Relies upon experienced and competent physio, able to screen for multiple factors and write comprehensive letter
 - All clients discussed at case conference
 - Most clients end up seeing Geriatrician, but may be after therapy commences/finished

Advantages & Disadvantages

- RMH is more comprehensive, monitors progress and measures outcomes
- ?? If results in substantially improved outcomes compared with smaller clinics
- Develops falls specialists in multiple professions
- Provides more training and education for rotating staff, visiting clinicians

Core roles for Falls clinics

- Multidisciplinary Ax, diagnosis, management and review for people with falls/mobility issues
- Primary and secondary prevention strategies aimed at maintaining and improving the client's mobility and reducing falls risk
- Reduce carer burden
- Education & training for clients, carers and H professionals regarding best practice
- Referral onto other services
- An environment where research & education can be developed

"Falls and Mobility Clinics" DHS 2000

Additional Roles for falls clinics

- “Some falls and mobility clinics may...undertake activities which build on the core functions of the clinic...some additional roles may be provided on a statewide basis by only one or two ...clinics..e.g.
 - Conduct falls & mobility-related research
 - Develop an educational program that addresses the management of falls and mobility problems more broadly than at the individual client level e.g. seminars, development of educational & resource material

“Falls and Mobility Clinics” DHS 2000