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

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Abstract

The aim of this study was to identify common themes and differences in structure and function of Falls Clinics in Australia, to provide a framework for planning future activity. A paper-based survey was circulated to 20 identified Falls Clinic services throughout Australia in late 2000. Fifteen responses (75%) were received, although two of the 15 Clinics were not operating at the time of the survey, and so their responses were not included. Nine of the Clinics had commenced operation since 1998. Staffing commonly included a physiotherapist, geriatrician, and an occupational therapist, with the comprehensive multidisciplinary assessment process taking an average of 130 minutes. Although standard assessment tools were used by more than half of the Clinics, there were no universally applied assessment tools. Waiting lists for initial assessments ranged up to 16 weeks (average 6 weeks). Most Clinics instituted a number of management options themselves, but also used a range of existing community services to provide some of the planned interventions. Limited formal evaluation of the effectiveness of Clinics was reported. Recommended future activity included increasing staff levels and operating times for Clinics to more adequately meet identified need, increased networking and data sharing between Clinics, and a greater emphasis on research and staff training.

We conclude that the recent increase in the number of Falls Clinics around Australia has occurred in a relatively unstructured manner, with many differences in staffing, operation and evaluation. There is a need for improved communication and standardisation of core procedures and assessment tools to facilitate best practice in all Clinics, and to provide a framework for a systematic evaluation of the effectiveness of Falls Clinics in Australia.

Introduction

The estimated direct cost associated with falls among older people in Australia is $406million annually (Mathers and Penm, 1999). The majority of costs are associated with the most serious falls, for example, those requiring hospitalisation (Rizzo et al, 1996). These falls constitute only about 20% of all falls among older people (Tinetti et al, 1995). In addition to the direct costs associated with the more severe falls, the magnitude of the problem is compounded by the effects of minor injuries, loss of confidence, loss of independence, and reduced quality of life (Tinetti et al, 1994a).

An analysis of recent data from the Australian Institute of Health and Welfare indicates that one key indicator of the magnitude of the problem of falling in Australia - the rate of hospitalisations related to falls - has remained relatively stable throughout the 1990s (Hill et al, 2000). However, the proportion of the Australian population in the "at risk" ages (greater than 65 years) is predicted to increase from 11.0% to 16.7% between 2001 and

2021 (Australian Bureau of Statistics, 2000). Therefore, case numbers seeking management for serious injuries after a fall are likely to escalate, even if rates for falls and falls injuries remain stable. Effective falls prevention and falls injury minimisation initiatives are urgently needed.

Falls prevention should incorporate a broad spectrum of activity, and there is increasing evidence that different falls prevention interventions are required for different levels of risk (Hill et al, 1999; Speechley and Tinetti, 1991). For older people with no or minimal falls risk, health promotion approaches to falls prevention such as exercise (tai chi, group exercise programs) (Wolf et al, 1996; Lord et al, 1995) may be most useful. There should also be strategic education programs highlighting circumstances, consequences, and strategies to minimise risk of falls among healthy older people. Importantly, education programs need to consider ways to maximise identification with the health promotion message for the target group (Commonwealth Department of Health and Aged Care, 2001; Braun, 1998).

For older people with increased falls risk, screening at the level of the general practitioner or other health practitioner needs to effectively identify presence of key risk factors, and provide a framework for a range of management options. For many older people, this level of assessment and management should adequately address the more readily identifiable and remediable falls risk factors. However, for older people with a complex interaction of falls risk factors, or those who have ongoing problems of increased falls risk for which the cause/s remain unclear, a targeted falls prevention program following comprehensive assessment is likely to be most effective (Gillespie et al, 2000). The latter may include inpatient or outpatient programs, and may occur in a community, hospital, or residential aged care setting (Hill et al, 2000a). The specialist Falls Clinic provides one avenue for addressing the needs of this high falls risk group of older people.

There is no widely accepted definition of a Falls Clinic in the research literature. The Victorian Department of Human Services (Department of Human Services, 2001a, p 7) has defined Falls Clinics as "....specialist multidisciplinary services, which focus on the assessment and management of clients with falls, mobility and balance problems. Clinics commonly provide time limited, specialist intervention to the client and advice and referral to mainstream services for ongoing management. They provide education and training to clients, to carers and to health professionals."

This definition provides a useful framework. For the purposes of this paper, three key criteria of a Falls Clinic were adopted:

- the primary aim of the service was to reduce falls, falls injuries, and associated problems;
- assessments were multidisciplinary (ie, two or more disciplines involved); and
- assessment and management plans were needs based and tailored to provide an individually targeted program.

Several different models of Falls Clinics have been reported in the research literature, however almost all report only initial assessment findings, or at most, a pre- and post-design with respect to effectiveness of interventions. In an American Falls Clinic with a medical team incorporating a geriatrician, neurologist, cardiologist, and a physiatrist, Wolf Klein et al (1988) reported a 12 month follow-up of 36 patients who had all fallen at least once within the 12 months prior to the Clinic assessment. A range of previously undiagnosed medical problems potentially contributing to increased falls risk was identified. Individualised management plans were instituted, including physiotherapy and occupational therapy if indicated by the assessment findings. Review of patients at 12 months indicated that 77% had experienced no further falls, and 17% continued to fall, although less frequently than prior to the Clinic management program.

A six-month review of older people (mean age 77 years) attending an Australian multidisciplinary Falls Clinic staffed by geriatricians, physiotherapists, an occupational therapist, and nurse, has been reported. It identified a reduction in the proportion of patients experiencing one or more falls from 82% to 49% during a six month follow-up, and the proportion of multiple fallers reducing from 51% to 29% (Hill, 1998).

Similar results were reported by Tideiksaar (1996) in a Clinic team of a clinical gerontologist and a geriatrician, with referral to other professionals such as neurologists, physiatrists, orthopedists, podiatrists, physical and occupational therapists, nurses and social workers if required. Eighty eight percent of patients reported one or more falls in the 6 months prior to assessment. Following the implementation of the intervention program, half reported no further falls during a three-year follow-up, and those who continued to fall did so less frequently on average. All of these studies have used a pre-post study design, and relied on self-report of falls at follow-up.

Close and colleagues (1999) conducted the only published randomised controlled trial to evaluate an intervention that met the criteria defined above for a Falls Clinic. Their approach included a medical and an occupational therapy core assessment as a basis for determining an individual faller's management plan. Other health professionals were involved if considered necessary. Older people who presented to an Emergency Department following a fall were randomised to the comprehensive assessment and management program, or to a control group. The intervention group achieved significantly fewer falls in the follow-up period.

An unpublished project report from Western Domiciliary Care in Adelaide involved evaluation of a pilot program for older patients referred to Western Domiciliary Care with one or more risk factors for falls (Sutherland et al, 1997). Patients were randomised to usual care (with the domiciliary team) or a Falls Clinic program. All patients in the Falls Clinic intervention were assessed by a geriatrician and a physiotherapist, with screening to identify need for referral to other health practitioners. A unique aspect of this program was that all Falls Clinic patients underwent an exercise program conducted by the Clinic team. The intervention group achieved significant improvements on a range of falls risk factors, and a (non-significant) reduction in falls and falls injuries. Although promising, these results need to be interpreted cautiously due to the small sample size, and some methodological problems with data loss. There have been no randomised controlled trials evaluating Falls Clinics that incorporate more than two staff in the core assessment.

The first specialist multidisciplinary Falls Clinic in Australia was established in 1988 at the then Mount Royal Hospital (now Melbourne Extended Care and Rehabilitation Service, MECRS), in conjunction with the then National Research Institute of Gerontology and Geriatric Medicine (now the National Ageing Research Institute, NARI) (Hill et al, 1994). Since that time, and particularly in the late 1990's, a number of other Falls Clinics have developed across Australia. While there has been some informal communication between established and new clinics which has resulted in similarities in structure and models of service delivery, there also appear a number of differences between Clinics. The aim of this project was to review the structure and function of Falls Clinics in Australia, to serve as a framework for further collaboration, research and service enhancement in Falls Clinics.

Method

Sample

A paper based survey was sent to all identified Falls Clinics in Australia. Sources for identifying the existing clinics included discussion with the Victorian Department of Human Services, who have funded Clinics in Victoria in recent years, as well as an extensive database of falls prevention programs in Australia (Department of Human Services, 2001b; Healthy Ageing Quality Ageing website), and a stocktake of falls prevention activity in Australia (Hill et al, 2000b; DHAC website).

Twenty services were identified as meeting the eligibility criteria, and surveys were distributed. Over a period of four weeks, 13 completed surveys were returned. In addition to the completed surveys received, one other clinic in NSW responded that it had ceased operation as a stand-alone Clinic because of low numbers of referrals, and a clinic in Queensland reported that it was undergoing refurbishment, and was not currently operational. Therefore, in total there were responses from 15 of the 20 clinics (75% response rate). The results from the 13 Clinics completing full surveys are summarised below.

Survey design

The survey was developed to explore issues associated with all aspects of operation of Falls Clinics. Survey questions included:

- date of Clinic commencement;
- frequency and duration of each Clinic session, and waiting list for service;
- referral sources;
- Clinic staffing;
- assessment and reassessment procedures;

- intervention strategies implemented within the scope of Clinic operations;
- information provided for clients;
- outcomes and evaluation of Clinics;
- funding for Clinic operations; and
- recommendations for improved service delivery and operation.

Statistical analyses

Frequencies of responses to each question were analysed. A small number of responses involved parametric data, and in these instances, means and standard deviations have been reported.

Results

Nine of the clinics completing the survey were from Victoria, two from South Australia, and one each from New South Wales and Tasmania. Nine Clinics (69%) had commenced operation since 1998. Nine of the clinics operated weekly, two fortnightly, one monthly, and one as required (in response to referrals). All clinics operated at most for only one four hour session per week, and saw an average of eight new referrals per month (range 3 to 12).

Initial assessments were on average 2 hours and 10 minutes duration (range 30 minutes to 230 minutes). In view of the length of initial assessment procedures, seven Clinics (54%) spread their initial assessment over two or more sessions.

Over two thirds of Clinics (69%) received the majority of their referrals from general practitioners, although other common sources of referrals were other health practitioners, and medical specialists. Most Clinics indicated they received a small proportion of referrals from the client themselves, or the client's carer.

All Clinics except two indicated they had a waiting list. The average waiting list duration was six weeks (SD=4.3; range 0-16 weeks). Only five of the 13 Clinics had a waiting time less than the one month benchmark set in the guidelines for Falls Clinics developed for the Department of Human Services, Victoria (2001a).

The staffing mix of Clinics varied considerably, although physiotherapists, geriatricians and occupational therapists were the most common core staff members of Clinics (Figure 1), and almost half of the Clinics included nursing staff. Podiatrists, psychologists and dieticians were also listed as core staff in a small proportion of Clinics. About half the Clinics had secretarial staff, and only one clinic reported having dedicated staff for data entry and analysis.

Five Clinics (38%) conducted all of their core assessments at the Clinic. The remaining eight Clinics conducted at least part of their assessment for **all** clients in the client's home, in most cases this being the occupational therapy home hazard assessment. One Clinic also had a pharmacy staff member conduct assessments in the client's home.

Clinics were asked to provide details of the main assessment procedures used. There was considerable diversity in the assessment procedures reported. Table 1 lists the tests of balance, gait, fear of falling, activity, and home assessment used. While over half the clinics used some common tests (Functional Reach, Step Test, Clinical Test of Sensory Integration of Balance, Timed Up and Go, gait velocity and stride length, and the Modified Falls Efficacy Scale), there was no single test or combination of tests used universally.

Clinics varied considerably in the type of interventions they delivered directly, relative to the interventions they referred on to other agencies to provide. Gait aid modification, home exercises and home hazard assessments and modification were the most common interventions conducted directly by Clinics (Figure 2). Injury minimisation strategies (such as hip protectors and personal alarms) were implemented by 10 (77%) Clinics, and medication modifications by eight (62%) Clinics. Where Clinics did not have the capacity to directly deliver these interventions, referral was made to appropriate local agencies (eg Community Health Centre, rehabilitation provider).

Most Clinics (85%) routinely provided clients with some form of written material as part of the assessment and management program. Most commonly, this was a home exercise program (85%), although existing brochures

(54%) and specifically developed information brochures (62%) were also commonly used. Only six Clinics (46%) provided clients with an individualised letter outlining the treatment plan.

Two Clinics (15%) did not review or reassess clients at all following the implementation of the management plan. The remaining Clinics varied in terms of the frequency and timing of review assessments. The majority of these had a short term review between 6 and 12 weeks from the initial assessment. Seven Clinics (46%) had a six month review, which would be more likely to identify changes in outcome measures. One of these Clinics used a phone review rather than a face to face assessment at follow-up. A number of Clinics also indicated that they adopted client specific time-frames for review, in addition to the standard review times. Only eight of the Clinics reported re-attendance rates for follow-up reviews, and these were on average 77% (SD=15).

Six Clinics (46%) reported undertaking some form of evaluation of the effectiveness of their Clinic. Two have produced a report on their outcomes, three have presented data at conferences, however none have reported outcomes in a journal publication. The six month review data for one Clinic formed part of a PhD thesis (Hill, 1998), and one Clinic had presented its outcomes in a quality assurance presentation.

Only five Clinics indicated they received dedicated funding for the operation of their Clinic, and that this covered all costs associated with running the Clinics in their present format. These five Clinics were all within Victoria. Several other Victorian Clinics, as well as all Clinics in other states indicated they received some indirect funding (through a State Department of Health, or community based programs) or no specific funding (their costs were absorbed by the host agency). Nine of the Clinics did not charge clients for the assessment process, while the remaining four Clinics charged a fee for each attendance, ranging from $5 to $10 per session.

Clinics were asked to list the activities or services they would add to their existing service if funding were available. Most common responses related to:

- increased diversity of professional staff involved in assessment and management,
- improved education opportunities for clients,
- improved ongoing training for staff,
- increased operating times for the Clinics in order to reduce waiting lists and provide service to a greater number of "at risk" older people,
- a greater emphasis on research, education and training for staff involved in falls prevention activity, and
- improved communication and networking between Clinics.

Survey respondents were also asked whether they would be interested in participating in a national Falls Clinic network. All survey respondents indicated they were in favour of a network, with recommendations for format varying from meetings once or twice yearly, to email networks and meetings attached to National Conferences such as the Australian Association of Gerontology Conference.

Discussion

Over the past three years there has been a rapid growth in the number of specialist multidisciplinary Falls Clinics in Australia, most notably in Victoria, where dedicated funding for a number of Clinics has been provided. There is increasing research evidence about the effectiveness of a range of single and multiple interventions in reducing falls among older people (Campbell et al, 1997; Campbell et al, 1999; Close et al, 1999; Cumming et al, 1999; Robertson et al, 2001 a & b; Tinetti et al, 1994b; Wolf et al, 1996). However, there have been no randomised controlled trials investigating the model most commonly adopted in Australian Falls Clinics, which includes a geriatrician, physiotherapist, and an occupational therapist as core staff members involved in each new assessment.

Given the resource intensive approach adopted by most of these Clinics, there remains a clear need to identify both the effectiveness of the Clinics through well designed randomised controlled trials, as well as a health economic evaluation of the Clinic process relative to current practice. Additionally, Falls Clinics should not be the first intervention for an older person who is falling, or at risk of falling. Instead, local assessment and management procedures by the general practitioner, and other health professionals may be sufficient to adequately manage the individual's falls risk factors. However, for those clients who continue to be at moderate

to high risk despite these interventions, or for whom the cause of falling and increased falls risk remains unclear, a Falls Clinic assessment and management program may be indicated. Investigation of the type of patient most likely to benefit from a Falls Clinic assessment and management program would be valuable, in order to target this resource intensive approach to those with greatest capacity to benefit from the process.

Although many Clinics included core staffing of geriatrician, physiotherapist and occupational therapist, there was considerable variation in the mix of other staffing for Clinics. Nursing staff and secretarial staff were also available in approximately half of the Clinics. Decisions need to be made within a Clinic team as to specific staffing to meet local needs, and important considerations include available links with other important clinical groups in falls prevention, such as podiatrists, dieticians, clinical psychologists and pharmacists. To date there appears to be no consensus about the role of these disciplines as part of a core service, or to be closely linked through a referral service.

While there has been some informal communication between Clinics, particularly between established Clinics and newly developing Clinics about assessment and procedures, there has been no formal avenue for long term networking and collaboration. Many Clinics surveyed identified this as a desirable development. Potential benefits of networking and collaboration between Clinics include standardisation of core assessment procedures, sharing of resources (such as brochures, videos, etc) and sharing of data to enable collaboration on research initiatives and evaluation. Also of potential benefit are opportunities for collaborative workforce training initiatives, and developing an effective reference and lobby group for those involved in planning and implementing state and national falls prevention initiatives.

A major concern with the existing Clinics is the limited duration of their operation, resulting in very limited reach of the services and the lengthy waiting lists in many of the Clinics. Relative to specialist Clinics for other common health problems associated with ageing, such as Memory Clinics and Continence Clinics, there remain surprisingly few Falls Clinics nationally, especially outside of Victoria.

The guidelines for Falls Clinics developed for the Victorian Department of Human Services (2001a) have established a benchmark that waiting lists be maintained at less than one month. A triage system to screen referrals and identify alternative management programs other than a Falls Clinic assessment is used by several Clinics, and in one of these well established Clinics there is no waiting list. A review of the utility of this system for more widespread use, or exploring other strategies to reduce the magnitude of waiting lists is required, so that the limited resources in existing Clinics are readily available to those identified in most need. However, the combined capacity of all 13 existing Clinics who responded to the survey was estimated at 104 new clients per month, or 1248 new clients per year nationally. Given the high and increasing number of older people at moderate to high risk of falls living in the community, there appears a need for a larger number of Clinics, including outside of capital cities, and for increased capacity for some existing Clinics to service more clients.

Currently, most Clinics provide a comprehensive assessment process, and then provide a limited range of interventions directly, more often referring the client to other agencies for a range of targeted interventions. Medical interventions such as medication modifications and further investigations are usually recommended to the client's general practitioner, who retains responsibility for primary medical management. Those activities, which require a greater degree of therapist involvement such as supervised exercise programs or home assessments for clients outside a local area are those most commonly, referred to other agencies. One Clinic provides a supervised exercise program for all patients referred to the Clinic. In Victoria, a number of the Clinics responding to the survey were funded by the Department of Human Services, however none of these provided a supervised therapy program as part of their routine management, instead referring to local out-patient rehabilitation providers for this service. The benefits of having Clinics directly provide the full range of management options needs to be considered within the broader context of appropriate services available within the local community.

Another need identified in the survey of Falls Clinics, and also identified in a recent national stocktake of falls prevention programs in Australia (Hill et al, 2000b), was increased opportunities for workforce training in falls prevention. Falls Clinics, particularly those associated with academic and research institutions are an obvious provider of workforce training in falls prevention. Innovative approaches to workforce training for the community, residential aged care, and hospital settings, and other methods of translating the available research and clinical evidence into routine practice need to be developed, implemented and evaluated. The potential role of outreach for Clinic staff with specialist assessment and management skills has yet to be fully explored.

Increasing the capacity of the aged care workforce to implement falls prevention programs with at risk older people is an important strategy to which Falls Clinic staff can successfully contribute.

Existing Clinics have a major emphasis on service delivery, and in many cases limited or no capacity for long term follow-up and evaluation of outcomes of the service being provided. It may not be necessary for all Clinics to develop specialist data management and interpretation skills, or to directly employ staff who can support these activities. Instead, it may be more cost effective for a small number of Clinics to be funded to undertake a more focused evaluation and research role. However, standardisation and pooling of data between Clinics would provide a strong basis for informed decision making to ensure that service delivery adequately and effectively meets consumer needs.

Conclusion

While the recent expansion of Falls Clinics in Australia is encouraging, this has barely scratched the surface in meeting the need for specialist assessment and management for older people at moderate to high risk of falls and falls-related injury. There is a need for greater communication between Clinics, and some standardisation of core assessment procedures and data collection. An emphasis on research that investigates effectiveness and cost benefits associated with Falls Clinic interventions is needed. Better overall planning and integration of falls prevention services, including Falls Clinics, is likely to reduce the unacceptably high rates of falls and falls-related injuries among older Australians.

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Melbourne Extended Care and Rehabilitation Service, Parkville, Vic
Murrindindi Community Health Service, Eildon, Vic
Peninsula Health Care Network, Mt Eliza, Vic
Repatriation General Hospital, Daw Park, Adelaide, SA
Southcare Mobility Clinic, Miranda, NSW
St Georges Hospital, Kew, Vic
Sunbury Community Health Centre, Sunbury, Vic
Western Domiciliary Care, Adelaide, SA
Falls Clinic, St Joseph's Hospital, Auburn, NSW*
University of Queensland Falls Clinic, Brisbane, Qld*
The Clinics marked with asterisks reported that they were not operational at the time of the survey.

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Figure 1. Core staffing for Clinics

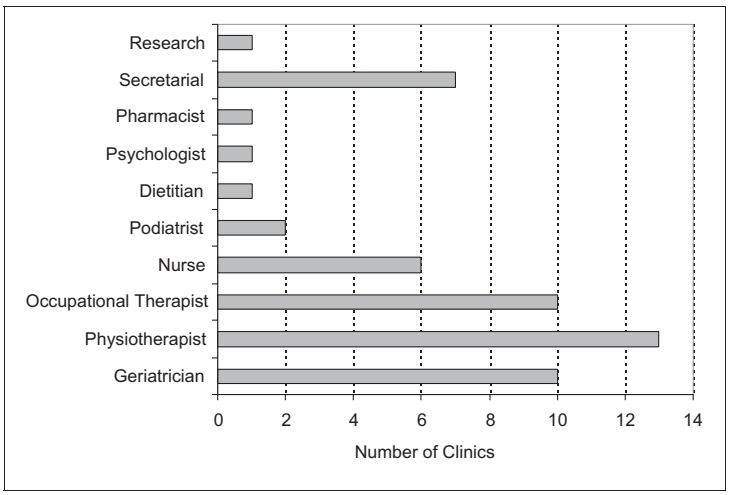

Table 1. A selection of the assessment procedures being used by Falls Clinics

Assessment procedure / tool	Clinic 1	Clinic 2	Clinic 3	Clinic 4	Clinic 5	Clinic 6	Clinic 7
Balance:							
• Clinical Test of Sensory Integration of Balance	✔	✔	-	-	-	-	✔
• Step Test	✔	✔	-	-	-	-	✔
• Functional Reach	✔	✔	-	-	-	-	✔
• Berg Balance Scale	-	-	-	-	-	-	-
• Tinetti POMA (balance component)	-	-	✔	-	-	✔	-
• Timed Up and Go	-	✔	-	✔	-	✔	✔
• Other	✔	✔	-	✔	✔	-	✔
Gait:							
• Velocity	✔	✔	✔	-	-	✔	✔
• Stride length	✔	✔	-	-	-	✔	✔
• Double support phase duration	✔	✔	-	-	-	-	✔
• Tinetti POMA (gait component)	-	✔	✔	-	-	✔	-
• SAFE screening assessment	-	-	-	-	✔	-	-
Muscle strength							
• Dynamometer	✔	✔	-	-	-	-	✔
Fear of falling:							
• Direct questioning	-	-	✔	-	✔	-	-
• Falls Efficacy Scale	-	-	-	-	-	-	-
• Modified Falls Efficacy Scale	✔	✔	-	-	-	-	✔
Activity / function / PADL / DADL / IADL							
• Human Activity Profile	✔	✔	-	-	-	-	✔
• SF-12 / SF-36	-	-	-	-	-	✔	-
• Frenchay	-	✔	-	-	-	-	✔
• Other	-	-	-	-	✔	-	-
Nutrition							
• ANSI	-	-	✔	-	-	-	-
• BMI	-	-	-	✔	-	-	-
• Other	-	-	-	-	-	-	-
Home assessment							
• Westmead home assessment	-	-	-	-	-	-	-
• Other	✔	✔	✔	✔	✔	✔	✔

POMA=Problem Oriented Mobility Assessment

PADL=Personal Activities of Daily Living

DADL=Domestic Activities of Daily Living

IADL=Instrumental Activities of Daily Living

ANSI=Australian Nutrtion Screening Instrument

BMI=Body Mass Index

Table 1. A selection of the assessment procedures being used by Falls Clinics cont.

Assessment procedure/tool	Clinic 8	Clinic 9	Clinic 10	Clinic 11	Clinic12	Clinic 13
Balance:						
• Clinical Test of Sensory Integration of Balance	✔	✔	✔	-	-	✔
• Step Test	✔	✔	✔	-	-	✔
• Functional Reach	✔	✔	✔	-	-	✔
• Berg Balance Scale	-	-	-	-	✔	-
• Tinetti POMA (balance component)	-	-	-	-	-	✔
• Timed Up and Go	✔	✔	✔	✔	-	✔
• Other	✔	-	✔	✔	✔	✔
Gait:						
• Velocity	✔	✔	✔	-	✔	✔
• Stride length	✔	-	✔	-	-	✔
• Double support phase duration	-	-	✔	-	-	-
• Tinetti POMA (gait component)	-	-	-	-	-	✔
• SAFE screening assessment	-	✔	-	✔	-	✔
Muscle strength						
• Dynamometer	✔	✔	✔	-	-	-
Fear of falling:						
• Direct questioning	-	-	-	✔	-	-
• Falls Efficacy Scale	-	-	-	-	-	✔
• Modified Falls Efficacy Scale	✔	✔	✔	-	-	✔
Activity / function / PADL / DADL / IADL						
• Human Activity Profile	-	-	✔	-	-	✔
• SF-12 / SF-36	✔	-	-	-	-	-
• Frenchay	-	-	-	-	-	-
• Other	-	✔	✔	✔	-	-
Nutrition						
• ANSI	-	-	-	-	-	-
• BMI	-	-	-	-	-	-
• Other	-	✔	-	✔	-	-
Home assessment						
• Westmead home assessment	✔	-	-	-	-	✔
• other	-	✔	✔	✔	-	-

Figure 2. Most common interventions implemented directly by the Clinic team.