W8: Implementation of pelvic floor muscle training programs in health services: challenges and strategies

Workshop Chair: Helena Frawley, Australia
03 September 2019 10:00 - 11:00

Start	End	Topic	Speakers
10:00	10:05	Introduction	Helena Frawley
10:05	10:15	Introduction to topic: - Implementation: leakage of evidence-into-practice throughout the healthcare system. Barriers and enablers to implementation of PFMT - A vignette describing an everyday clinical scenario of a patient referred to PFMT for POP/UI	Helena Frawley
10:15	10:25	The Behaviour Change Wheel (BCW) as it applies to PFMT intervention. Understanding the levels that impact on implementation of evidence into practice at different levels of the health service.	E Jean C Hay-Smith Sarah Dean
10:25	10:40	Group-based activity: Identification of barriers, and how to incorporate behaviour change techniques in delivery of interventions to facilitate uptake of new practice and services.	Helena Frawley E Jean C Hay-Smith Sarah Dean
10:40	11:00	Group feedback of barriers they identified and strategies for facilitation. Discussion of how to implement strategies in local health services.	Helena Frawley E Jean C Hay-Smith Sarah Dean

Aims of Workshop

This workshop will address the barriers and enablers to implementation of pelvic floor muscle training (PFMT) in health services, using a vignette that reflects a typical clinical scenario. While evidence for PFMT as an effective treatment for urinary incontinence and pelvic organ prolapse is strong, and international recommendations endorse this intervention as first-line treatment, availability of the service is variable and uptake and adherence is poor. The reasons are complex and relate to several levels within the health service: the treatment itself, the patient, the clinician, the social and the organisational context. This interactive workshop will provide strategies for participants to implement in their workplace to address the barriers and enablers to effective implementation of PFMT, so that evidence can be translated into practice.

Learning Objectives

Appreciation of the complexity and challenges of implementation of PFMT into a health service, and an understanding of why it is not always successful.

Target Audience

Urogynaecology, Conservative Management. All clinical disciplines and those interested in research translation.

Advanced/Basic

Intermediate

Suggested Learning before Workshop Attendance

- Damschroder, L. J., D. C. Aron, et al. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implementation Science 4: 50 DOI: 50 10.1186/1748-5908-4-50
- Dumoulin, C., J. Hay-Smith, et al. (2015). "2014 consensus statement on improving pelvic floor muscle training adherence: International Continence Society 2011 State-of-the-Science Seminar." Neurourology and Urodynamics 34(7): 600-605.
- Lamin E, et al (2016), Pelvic Floor Muscle Training: Underutilization in the USA, Current Urology Reports, 17(2): DOI: 10.1007/s11934-015-0572-0
- Frawley, H., P. Chiarelli, et al. (2014). Uptake of antepartum continence screening and pelvic floor muscle exercise instruction by maternity care providers: an implementation project. Neurourology and Urodynamics 33(6): 976-977.
- Greenhalgh, T. (2014). How to Read a Paper: The Basics of Evidence-based Medicine. Ch15: Getting evidence into practice.
- Grimshaw, J. M., M. P. Eccles, et al. (2012). "Knowledge translation of research findings." Implement Sci 7: 50.
- Grol, R., M. Wensing, et al., Eds. (2013). Improving patient care: the implementation of change in health care. Oxford, Wiley Blackwell.

- Michie, S., M. M. van Stralen, et al. (2011). "The behaviour change wheel: A new method for characterising and designing behaviour change interventions." Implementation Science 6(1).
- Salmon, V.E, Hay-Smith, E.J.C, Jarvie, R., Dean, S., Terry, R., Frawley, H., Oborn, E., Bayliss, S.E, Bick, D., Davenport, C., MacArthur, C. & Pearson, M. and on behalf of the APPEAL study group. "Implementing pelvic floor muscle exercises in women's childbearing years: A Critical Interpretive Synthesis of individual, professional, and service issues" (under review)
- Salmon V E, Hay-Smith J, Jarvie R, Dean S, Oborn E, Bayliss S E, Bick D, Davenport C, Ismail K M, MacArthur C, Pearson, "Opportunities, challenges and concerns for implementing pelvic floor muscle assessment and training during childbearing years: a critical interpretive synthesis", ICS 2017 abstract, Best in Category Prize – Health Services Delivery
- Salmon V E, Hay-Smith J, Jarvie R, Dean S, Oborn E, Bayliss S E, Bick D, Davenport C, Ismail K M, MacArthur C, Pearson, and on behalf of the APPEAL study, "Opportunities, challenges and concerns for the implementation and uptake of pelvic floor muscle assessment and exercises during the childbearing years: protocol for a critical interpretive synthesis", Systematic Reviews (2017) 6:18. DOI 10.1186/s13643-017-0420-z
- Willis CD et al. (2016). "Sustaining organizational culture change in health systems", Journal of Health Organization and Management, Vol. 30 Iss 1 pp. 2 – 30 DOI: org/10.1108/JHOM-07-2014-0117.

Presentations

Helena Frawley, Physiotherapist, Australia

Introduction: Implementation: leakage of evidence-into-practice throughout the healthcare system

Implementation of evidence-into-practice into a healthcare system – with fidelity to the research – is challenging, and these challenges are faced by many evidence-based interventions. Health services delivery of evidence-based PFMT is not immune to these challenges. While PFMT is recommended as the first-line intervention for women with urinary incontinence (UI) or pelvic organ prolapse (POP) (Dumoulin 2016), actual practice does not reflect these good intentions in many jurisdictions (Lamin 2016, Ismail 2009, Chiarelli 1997). There is a known evidence-into-practice gap of up to 17 years (Morris 2011) for new interventions, and the incorporation of evidence into policy, in order to change a healthcare system, may be an even larger gap. Even when there is an intent to implement evidence, attrition or 'leakage' of adherence to the recommendations occurs along the pipeline of research into practice (Glasziou 2005). This attrition has been documented in many aspects of healthcare (Mickan 2011), however there are no reports of why and how this attrition occurs in the implementation of PFMT. Lack of attention to the attrition which occurs at each of the stages of change (aware, agree, adopt, adhere) is a lost opportunity for patient benefit. Findings from these other areas of healthcare will be used to inform our discussions of why and how the 'leakage' is occurring in the health system for PFMT, and why there may be unique aspects related to PFMT. Studies are emerging which consider the broader aspects which impact on implementation and uptake of PFMT in the childbearing year (Salmon 2017), however a complete synthesis of factors relevant to other populations affected by pelvic floor dysfunction is lacking. Indeed, recent research suggests local uptake of evidence is less informed by the traditional linear pipeline of 'evidence–guidelines–practice' and more by locally contextual issues such as budget, capacity and political influence (Atkins 2017).

Barriers and enablers to implementation of PFMT: This topic will explore examples of barriers and enablers in a health service that may impact on successful implementation.

A vignette describing an everyday clinical scenario of a patient referred to PFMT for POP/UI

The following vignette will be presented and strategies to maximise evidence-based practice in this scenario, and how this could be managed differently explored:

Family doctor / surgeon referred patient to physiotherapist / continence professional for POP/UI, said she could give PFMT a try. After being on a waiting list for 4 months, the patient attended an initial visit. Because of clinical load and waiting list, the therapist offered the patient a program of 4 visits. Patient cancelled 2nd visit but managed to attend 3rd visit. Patient was dissatisfied, she reported she was not improved and did not want to attend again. The therapist referred the patient back to the referring doctor. The case was labelled as patient had 'failed' PFMT, and the patient proceeded to surgery.

The Behaviour Change Wheel (BCW) (Michie et al 2011) as it applies to PFMT
Sarah Dean, Psychologist, UK and Jean Hay-Smith, Rehabilitation Academic, New Zealand

This topic explores the three 'levels' of the BCW and how they apply to implementation of PFMT. First, at the centre, the sources of behaviour which are capability, opportunity and motivation (COM-B). Second, the middle level, the implementation functions (such as enabling, persuading, training, education – see Hay-Smith et al 2015) we might use to facilitate behaviour change. Third, the outer level, the policy categories (e.g. service provision, guidelines), which we acknowledge yet rarely overtly consider as 'clinical' sources of influence on behaviour. Drawing on previous and current research trials of the panel each of these levels is illustrated with respect to their influence on awareness, agreement, adopting, and adhering to PFMT. Workshop participants will then apply this learning to the vignette (see below).

Group based activity: With reference to the vignette, this session will involve a practical activity to be done in groups per table. Participants will brainstorm the aspects they perceive to be barriers and enablers in a health service which impact on implementation of evidence-based recommendations, using the BCW as a framework for understanding where these barriers and facilitator lie. Each group will choose items from the policy level and brainstorm ways to support awareness, agreement, accessibility, adoption and adherence of evidence-based recommendations.

Group feedback: Each table / break-out group will feedback to the whole group, the barriers and facilitators they thought were at play in the vignette, with reference to their own particular health service. This may involve multiple perspectives, reflecting the diverse geographical, cultural and health services contexts represented by individual group members. If time allows, discussion will explore how other members of the healthcare team may support implementation of evidence-based PFMT for women with pelvic floor dysfunction at different life-stages, and how a multi-disciplinary approach may be facilitated.

References:

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- Chiarelli, P. and E. Campbell (1997). "Incontinence during pregnancy. Prevalence and opportunities for continence promotion." Australian and New Zealand Journal of Obstetrics and Gynaecology 37(1): 66-73.
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- Morris Z, Wooding S, Grant J (2011). The answer is 17 years, what is the question: understanding time lags in translational research. J R Soc Med 2011: 104: 510–520. DOI 10.1258/jrsm.2011.110180