

Appendix J

Project Description Update

**National Center for Injury Prevention and Control
Division of Unintentional Injury Prevention
Home, Recreation, and Transportation Branch
Home and Recreation Team**

Title

Testing health messages in STEADI older adult fall prevention materials among caregivers

Protocol Summary

Each year, one in every three adults ages 65 or older falls and 2 million are treated in emergency departments for fall-related injuries. The risk of falling increases with each decade of life. The long-term consequences of fall injuries, such as hip fractures and traumatic brain injuries (TBI), can impact the health and independence of older adults. Thankfully, falls are not an inevitable part of aging. In fact, many falls can be prevented. Everyone can take actions to protect the older adults they care about.

CDC's Injury Center created the STEADI Tool Kit for health care providers who see older adults in their practice who are at risk of falling or who may have fallen in the past. The STEADI Tool Kit gives health care providers the information and tools they need to assess and address their older patients' fall risk.

In addition to health care providers who provide medical care in a formal setting (e.g., physician's office), many older adults also receive care from either formal or informal caregivers in a home or community setting. These caregivers also have a role to play in preventing falls in the older adults for whom they care. The purpose of this project is to conduct formative evaluation focus groups with caregivers who provide care for older adults in a home setting to determine how best to expand the STEADI Tool Kit messages and materials to meet their needs. Results from these focus groups will be used for the development and placement of the messaging and materials targeted at caregivers who provide care to older adults.

CDC Investigators' Role/Funding Sources

Name and Title: Erin Parker, Health Scientist

Degree: Ph.D. in Sociology

Roles and Responsibilities: Development of the project design and protocol, data analysis, final review

Name and Title: Judy Stevens, Epidemiologist

Degree: Ph.D. in Epidemiology

Roles and Responsibilities: Development of the project design and protocol, final review

Name and Title: Robin Lee, Home and Recreation Team Lead

Degree: Ph.D. in Epidemiology

Roles and Responsibilities: Development of the project design and protocol, final review

Name and Title: Margaret Kaniewski, Public Health Advisor, Home and Recreation Team

Degree: MPH

Roles and Responsibilities: Project Officer

Funding source for this project is:

Award Title: Dissemination of the STEADI Toolkit
Award Institution: Weber Shandwick (CMGRP, Inc)
Contract#:Contract 200-2007-20025, Task Order 0004

Focus group activities will be conducted through a contract with Weber Shandwick, who will recruit participants, moderate the focus groups, transcribe the data, and provide an initial summary report of findings along with de-identified transcripts.

Objectives

The Division of Unintentional Injury has developed a toolkit called STEADI (Stopping Elderly Accidents, Deaths, & Injuries), to help healthcare providers incorporate fall risk assessment and fall prevention into their clinical practice. We would like to expand the toolkit to include messaging and materials for the caregivers of older adults. To do this, we plan to conduct focus groups that will inform the development of the messages, materials, and material delivery. We plan to use the Health Messaging Testing System (HMTS) for OMB approval for this project.

General Approach

The general approach of this project is a descriptive assessment of formal and informal caregivers' reactions to older adult fall prevention materials. As part of this assessment, we will also assess formal and informal caregivers' knowledge, attitudes, and beliefs regarding older adult falls prevention.

Procedures/Methods

Project Design: Four focus groups will be conducted with up to 11 participants in each group. Two focus groups will be conducted with informal (unpaid) caregivers, and two focus groups will be conducted with formal (paid) caregivers. Participants will participate in the focus groups in-person in either the Baltimore metro area (1 informal and 1 formal caregiver focus group) or the Miami metro area (1 informal and 1 formal caregiver focus group). Focus groups will be moderated by an independent contractor, Weber Shandwick, who will also recruit participants, transcribe the data, and provide an initial summary report of findings. At the conclusion of the project, participants will be given a check for 75 dollars, as a gift for their time and effort.

Project Timeline:

2013

July-Aug Finalize questionnaires

Sep-Dec HMTS review

2014

Jan Recruit and conduct focus groups

Feb Transcribe and analyze

Mar Final report from Weber Shandwick

Apr-Jun Analyze data at CDC and make modifications to messaging materials

Protocol review: This project protocol is eligible for NCIPC determination and qualifies as non-research, since the primary intent is formative evaluation and improvement of existing STEADI program messages and materials for use with caregivers.

Project Population

Both informal and formal caregivers who care for older adults (age 65+) outside of an institutional setting are the population of interest. Caregivers will be recruited from within the greater Baltimore metro area and the greater Miami metro area, locations chosen for proximity to the contractor offices to minimize costs.

Participant inclusion criteria

Participants must be between the ages of 25 and 65 and currently providing care for an adult age 65+ outside of an institutional setting in order to be eligible to participate in this project. Participants must also be able to attend a focus group session in one of the two locations (Baltimore or Miami).

Participant Recruitment

Focus group participants will be recruited via telephone by each of the focus group facilities (see Appendices B and C for the recruiting script/screening tools for informal and formal caregivers). The focus group facilities maintain lists of individuals who have completed a questionnaire about themselves and their interests. In each location, the recruitment process for the informal caregiver group will start by pulling records from their facility database for respondents who have indicated they care for family and friends. For the formal caregiver group, records of individuals whose occupations match the criteria will be pulled.

These lists of individuals will be supplemented with individuals identified through referrals and cold-calling using phone lists from the Baltimore and Miami area. Additionally, for formal caregivers, recruiters may also contact health care agencies directly via telephone and fax to identify potential participants.

During the recruiting call, respondents who agree to participate will be asked to provide their mailing address, so that they can be sent a confirmation letter. They will also be asked to provide their telephone number, so that they can receive a reminder telephone call the day before the scheduled focus groups.

Estimated number of participants

We plan to recruit 11 persons for each of 4 focus groups with the expectation that 9 will show. The approximate total number of participants is 36 (4 9-person focus groups), but could be as many as 44.

Type of Respondent	Form Name	Number of Respondents	Frequency of Response	Average Burden Response (Hours)	Total Burden Hours	Average Hourly Wage Rate	Total Respondent Cost
Informal Caregiver	Discussion Guide (Appendix A)	22	1	2.00	44.00	\$22.01	\$968.44
	Recruiting Script (Appendix B)	100	1	0.2	20.00	\$22.01	\$440.20
Formal Caregiver	Discussion Guide (Appendix D)	22	1	2.00	44.00	\$10.49	\$461.56
	Recruiting Script (Appendix C)	100	1	0.2	20.00	\$10.49	\$209.80
Total		244			128.0		\$2,080.00

Wages based on BLS data for all occupations (used for informal caregivers) and home health aides (used for formal caregivers)

Target respondent characteristics

~75% female (Source: Women and Caregiving: Facts and Figures at

http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=892)

Baltimore target composition: 30% White/70% non-White (based on US Census)

Miami target composition: 80% White/20% non-White (including ~2/3 Hispanic ethnicity) (based on US Census)

Description of risks and benefits to participants

This research involves no more than minimal risk to participants, as the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life.

Consent process

Participants will be asked to sign an informed consent form when they arrive at the focus group (see Appendix D).

Description and justification of incentive

To maximize positive responses to the recruiting calls, participants will be given a financial incentive for the time and effort their participation involves. The incentive serves as a tangible thank you to participants for their time and engagement in the project. The amounts need to be high enough that participants feel like it is worth their time to participate and cannot be so low that participants perceive their time and candid responses are undervalued.

Participants in this project will receive \$75 check given to them upon completion of their participation. This figure is based on the substantial burden this group will incur to participate. For caregivers of older adults, the opportunity cost of lost time is a substantial burden. Informal caregivers provide an average of over 20 hours per week on care, with live-in informal caregivers providing nearly 40 hours of care (National Alliance for Caregiving 2009). This is in addition to any paid job they may have in the formal sector. Participating in a two hour in-person focus group plus transportation time is a large sacrifice for this group. Formal caregivers are also a highly burdened group, as providing care is a highly demanding but low paid job (PHI National 2011).

Recent focus groups with caregivers reported in the literature have used similar incentive rates (\$75 by Kosa, et al. 2011; \$50 plus taxi vouchers for transportation by Boughtwood, et al. 2011; \$50 plus child care services by Gittleman and Pomerantz 2011; and \$50 plus dinner and child care by McKee, et al. 2010). Given that we will not be covering transportation or caregiving costs—which is not practical for older adults who are less mobile and may have more diverse needs than children—\$75 is an appropriate gift for this group.

Data Collection

During the focus groups, a moderator will ask participants a set of questions concerning sources of health information, falls knowledge, attitudes, beliefs, their opinions and perceptions of the STEADI messages and materials, and what changes they would make to STEADI messages to make them more useful for caregivers. The moderator will facilitate the discussion that results from the participants' responses to these questions (see Appendix A for the focus group discussion guide). The discussion will last no more than 2 hours. The focus group discussions will be audio and video recorded for transcription purposes.

Weber Shandwick will handle the logistics of the conference calls and the recording of the group discussions. The recordings will be transcribed and provided to the CDC in hard copy and electronic form, and the principal investigators will use those transcripts for data analysis.

Participation rates:

Care will be taken to maximize positive responses to the recruiting calls and to reduce no-shows or cancellations of those who do agree to participate in the focus groups. To maximize positive responses to the recruiting calls, participants will be given financial remuneration for the time and effort their participation involves.

Additionally, recruiters will use a script that emphasizes the importance of the project (See Appendices B and C for the scripts). To reduce no-shows and cancellations, all participants will receive a confirmation letter and a reminder call before their scheduled group.

Data Management and Analysis

Data analysis:

Analysis will involve an initial review of the transcribed discussions to identify patterns and themes that emerged from the discussions. After this initial review, a code list will be developed, and the transcript for focus group

will be coded using the coding scheme. If additional themes are identified during the course of analysis, all transcripts will be reanalyzed for these additional themes.

Data management:

Recordings from the discussions will be transcribed into Microsoft Word by Weber Shandwick. Any identifying information will be removed from the documents (e.g., first names only will be used). De-identified transcripts will be provided to CDC researchers electronically along with a spreadsheet of focus group attributes (dates and times of groups, number of participants, type of caregivers) and respondent attributes based on the recruitment script (e.g., first name, age, sex, gender, age of older adult for whom they care, relationship to adult, type of caregiver).

The electronic versions of the transcripts will be stored on a secure CDC server. The data will belong to the CDC, and will only be accessed by authorized project personnel. The contact information on participants will be stored at Weber Shandwick to send reminder letters, but will be stored separately from the transcripts. Recordings and transcripts with any identifiable information will be destroyed once de-identified transcripts have been reviewed by CDC.

Dissemination, Notification, and Reporting of Results

Results of these focus groups will be used to inform the development of messages and materials in the STEADI Tool Kit aimed at older adult caregivers. Results will also be used to help with placement and dissemination of such materials. Results may be published in a peer-reviewed journal.

References

1. Centers for Disease Control and Prevention (CDC). STEADI (Stopping Elderly Accidents, Deaths & Injuries) Tool Kit for Health Care Providers. <http://www.cdc.gov/homeandrecreationalafety/Falls/steady/index.html>. Accessed May 2013.
2. National Alliance for Caregiving, American Association of Retired Persons. (2009). Caregiving in the U.S., 2009. http://www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf. Accessed May 2013.
3. Kosa, K. M., Cates, S. C., Adams-King, J., & O'Brien, B. (2011). Improving foodborne illness prevention among transplant recipients. *Health Promotion Practice, 12*(2), 235-243.
4. Boughtwood, D. L., Adams, J., Shanley, C., Santalucia, Y., & Kyriazopoulos, H. (2011). Experiences and perceptions of culturally and linguistically diverse family carers of people with dementia. *American Journal of Alzheimer's Disease and Other Dementias, 26*(4), 290-297.
5. Gittelman, M. A., & Pomerantz, W. J. (2011). The Use of Focus Groups to Mobilize a High-Risk Community in an Effort to Prevent Injuries. *Journal of Prevention & Intervention in the Community, 39*(3), 209-222.
6. McKee, M. D., Maher, S., Deen, D., & Blank, A. E. (2010). Counseling to prevent obesity among preschool children: acceptability of a pilot urban primary care intervention. *The Annals of Family Medicine, 8*(3), 249-255.
7. Paraprofessional Healthcare Institute. (2011). Facts February 2011 Update: Who are direct-care workers? <http://phinational.org/blogs/phi-fact-sheet-who-are-direct-care-workers>. Accessed June 2013.