

West End Integrated Falls Prevention Program

Assessment

Intervention

Education

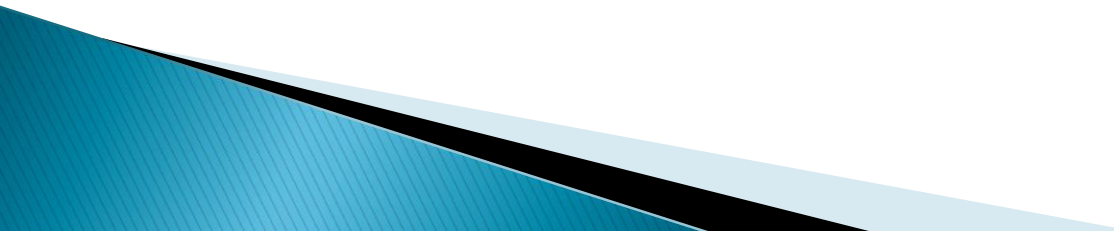
Advocacy

Helping Seniors Reduce Their Risk of Falls

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A unique partnership

- ▶ In 2007 locally recognized need for a coordinated fall prevention service in Ottawa
 - ▶ Interested parties met and worked together to submit an application to the Champlain LHIN for Aging at Home funding
 - ▶ Lead partners ...
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Partnerships



Queensway Carleton
Hospital



A logical combination

- ▶ West End of Ottawa has high growth in senior population

65-85+	2008	2014	2020	2030
Ottawa West	43,936	54337 (23% ↑)	67748 (54%↑)	109942 (150%↑)

- ▶ Queensway Carleton Hospital:
 - High ALC pressures demonstrate need for prevention in this demographic
- ▶ PineCrest Queensway Community Health Centre:
 - ideally positioned to offer an out patient program for prevention

First Steps

- ▶ Consultant hired to devise a program design based on best practice principles
- ▶ Completed extensive literature review of research done in the UK, Australia, USA and Canada
- ▶ Key informant interviews with local agencies – community support services, public health, Regional Geriatric Program, Osteoporosis Canada



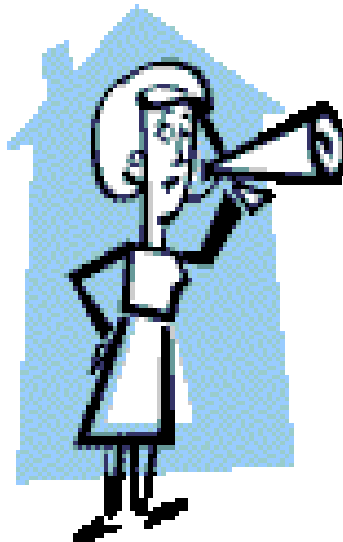
Key Findings

- ➡ 1 in 3 seniors ≥ 65 yrs fall once each year, increasing to 1 in 2 ≥ 80 yrs
- ➡ Falls account for 85% of all injury-related hospitalizations for seniors
- ➡ Hip fractures account for 38% of fall-related hospitalizations
- ➡ 40% of admissions to long term care facilities are directly related to falls
- ➡ Estimated costs of fall related injuries in Canada in a 1 year period...

...\$6.2 BN annually (Smartrisk, 2009)

The Message

- ▶ Falls are *not* an inevitable part of aging!
- ▶ Many falls are predictable and preventable
- ▶ We are all prone to falling, but the consequences are much greater for seniors

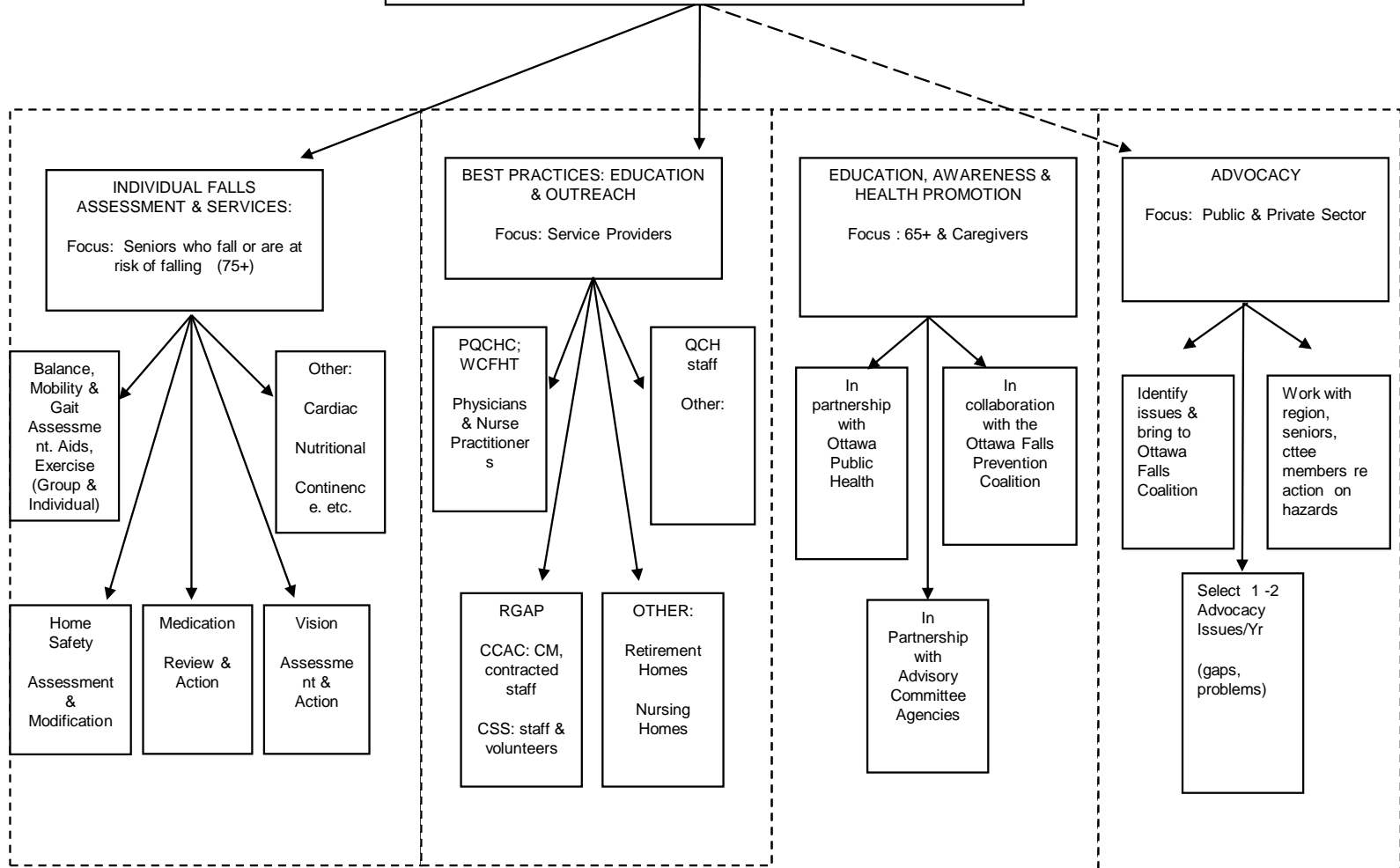


Spread the word!

West End Integrated Falls Program

- ▶ Program model based on best practice findings from around the world – Australia, UK, BC particularly.
- ▶ Program model incorporates all of the major components necessary for a successful approach to fall prevention:
 - Individual assessment & intervention
 - Provision of education to seniors/caregivers
 - Best practice education & outreach to service providers
 - Advocacy on issues relating to fall prevention

WEST END INTEGRATED FALLS PREVENTION PROGRAM MODEL



This Program operates in partnership with: Pinecrest-Queensway Community Health Centre; Queensway Carleton Hospital; Champlain Community Care Access Centre; Ottawa Public Health; Regional Geriatric Assessment Program; The Old Forge; Western Ottawa Community Resource Centre; Centre de services Guigues; West Carleton Family Health Team; Osteoporosis Canada

The Team

- ▶ 0.5 FTE interdisciplinary team of healthcare professionals including:
 - Program Coordinator
 - Occupational Therapist
 - Nurse Practitioner
 - Physiotherapist
 - Rehabilitation Assistant
 - Geriatrician – consult
 - Volunteers



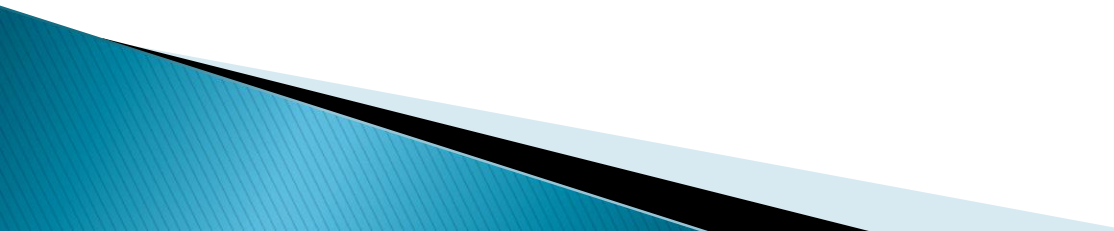
Individual Falls Risk Assessment & Services




Who refers?


The program accepts referrals from all sources

Top referrers:

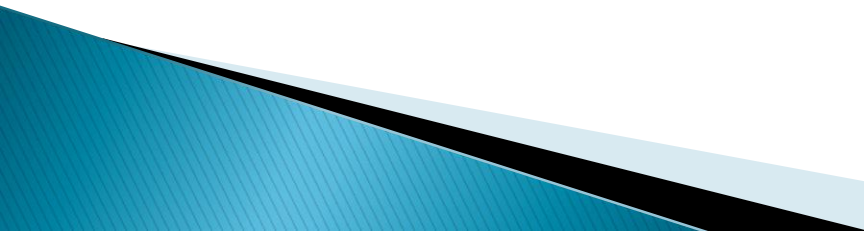
- ▶ Family physicians 29%
 - ▶ GEM nurses 21%
 - ▶ Hospital rehab staff 16%
 - ▶ Self/Family 13%
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Assessment & Intervention (Individuals)

- A member of the team visits the client in their home
 - Comprehensive falls risk screening completed using assessment tool developed in-house
 - Recommendations and action plan provided to address factors contributing to falls
 - Discipline specific interventions as appropriate, for up to 12 weeks
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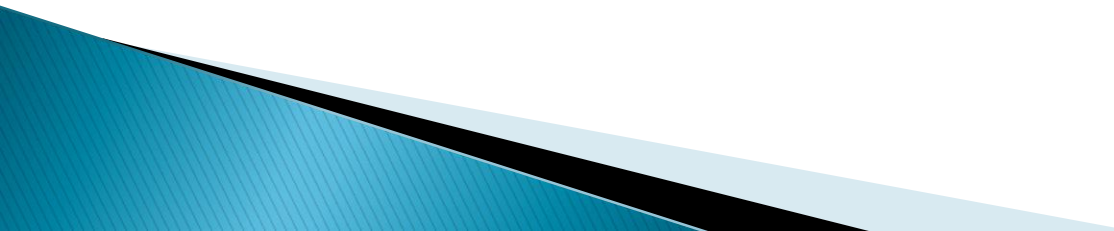
- Exercise program – Otago (progressive balance/exercise program)
 - Review/modification of medications
 - Treatment of contributing health concerns in conjunction with family physician
 - Home safety/environmental modifications
 - Acquisition of assistive devices & training in use
 - 1:1 education & resources to address risks
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Assessment & Intervention (Mobile Clinic)

- Successful service piloted in BC
 - Improves access to falls education, screening, and intervention by taking service to the seniors
 - Clinics were set up at seniors' centres, churches, community centres and seniors' housing complexes
 - Ideal for rural areas
 - Multidisciplinary team involvement
 - Opportunities for partnerships to staff clinics
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Mobile Clinic

Participants have the opportunity to sit one-on-one with various health professionals for 15-minute sessions – various aspects of the participants' fall risk status will be assessed and interventions discussed:

- Postural BP
 - Vision screening
 - Falls history
 - Medication review
 - Physiological Profile Assessment
 - Personalized activity program
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Mobile Clinic

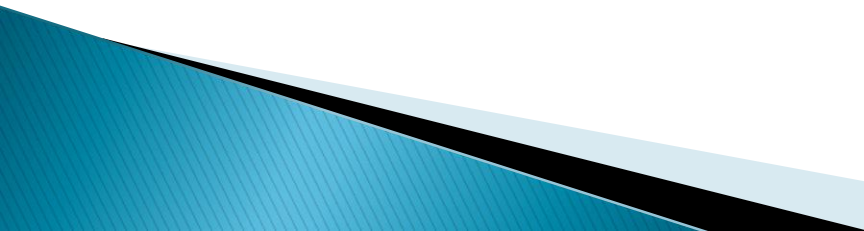
A written report with information from each station and recommendations to reduce falls is provided after the clinic to the client and their family physician, with consent.

The family physician is an important member of the team, although not directly involved in the clinic.

Part 2: Best Practices Education & Outreach



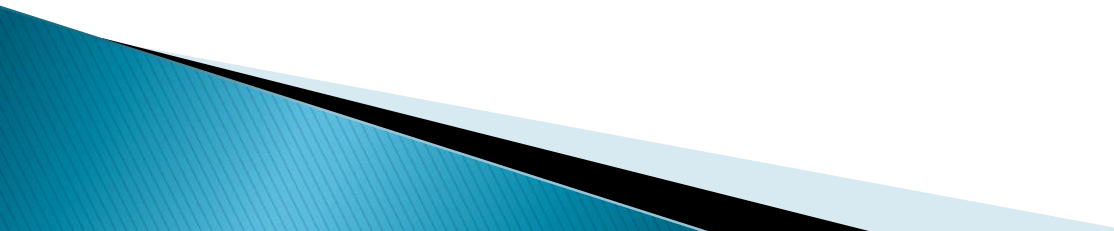
Sharing the Research Knowledge

- ▶ Falls prevention must be incorporated into everyday practice
 - ▶ Partner with Ottawa Public Health and RGP for education sessions
 - ▶ Current target populations:
 - Primary care physicians and nurse practitioners
 - CCAC case managers
 - Community Support Service Agencies
 - Hospital-based healthcare professionals
 - Retirement home staff
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Part 3: Education, Awareness & Health Promotion



Community Health Promotion

- ▶ Partnering with Ottawa Public Health to provide education sessions to seniors and caregivers.
 - ▶ Taking education to seniors by targeting day programs, diner's clubs & caregiver support groups.
 - ▶ Seeking to utilize local media to promote education regarding falls prevention in the wider community.
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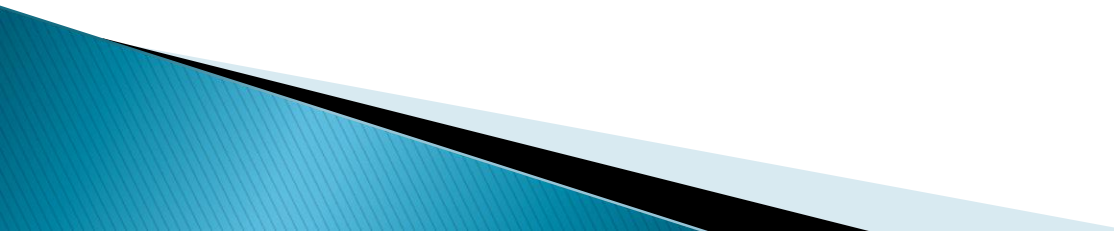
Part 4: Advocacy



Community Health Approach

- ▶ Identify issues & bring them to Ottawa Falls Prevention Coalition.
- ▶ Focus on issues to address gaps in services to seniors at risk of falling and on fall safety issues in general:
 - ✓ *Exercise options for frail seniors in the community.*
 - ✓ *Transportation options for seniors unable to drive.*
 - ✓ *Financial barriers to accessing transportation & exercise options.*

The numbers! (Jan – Dec 2010)

- ▶ 176 referrals received for in-home services
 - ▶ 160 referrals accepted for in-home services
 - ▶ 40 declined service
 - ▶ 96 assessed in-home
 - ▶ 73 assessed at mobile clinic
 - ▶ 24 awaiting assessment on 01st January 2011
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The numbers! (Jan - Dec 2010)

▶ AGE:

- ▶ 65 – 74 years: 14.6%
- ▶ 75 – 84 years: 50.3%
- ▶ 85 years and older: 35.1%


▶ GENDER:

- ▶ Male: 24.1%
- ▶ Female: 75.9%

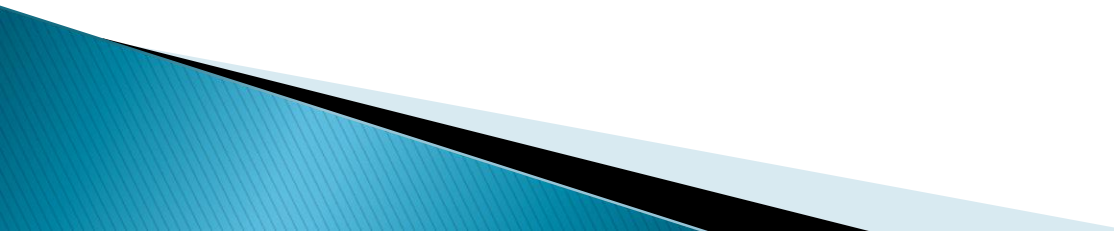
Queensway Carleton Hospital Impact

- ▶ Reduction in Falls for 75-84 age group
- ▶ Reduction in serious injury, hips, forearm and pelvis
- ▶ Reduction in admissions: 51 fewer admissions for Falls to QCH in 2010-11
- ▶ Reduction in Fractured Hips:
 - 263 in 2008-09
 - 183 in 2010-11
 - 80 fewer patients with fractured hips @ \$27,000 per case (2001 costing) = **\$2,160,000 saved**

Client feedback

- ▶ We live right here, so it was convenient.
 - ▶ It was time well spent and very thorough.
 - ▶ I prefer to see the six professionals during one visit, rather than having six appointments.
 - ▶ The personal touch was really nice.
 - ▶ It made me reflect on how I could be more careful.
 - ▶ I learned a lot about balance.
 - ▶ I certainly will tweak some areas of my home and be more aware of my surroundings.
 - ▶ Hadn't thought about falls. Don't want to think about age. But guess we have to!
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Client feedback

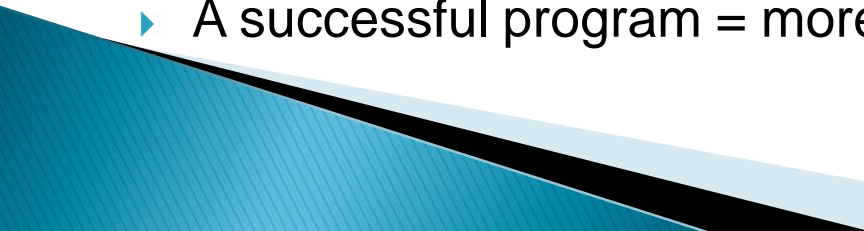
- ▶ 100% of clients satisfied/very satisfied with the program
 - ▶ 70% reported learning new information regarding falls prevention
 - ▶ 60% reported making changes to the home environment
 - ▶ 91% reported feeling just as confident/more confident in ability to rise from the floor after a fall
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Benefits and Challenges

Benefits

- ▶ Enhanced partnership between hospital and CHC
- ▶ Demonstrates LHIN success in promoting integration
- ▶ Knowledge transfer between partners through staffing and education
- ▶ Hospital staff good referral source for prevention of falls and higher demand on acute care system

Challenges

- ▶ Staffing: difficulty recruiting Nurse Practitioner
 - ▶ One partner is unionized, one is non-unionized
 - ▶ Fixed funding levels and legislative need to balance budgets against unionized rise in wages
 - ▶ A successful program = more referrals = resources fixed = wait list
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Next Steps



- Funding sought to collaborate with a local multicultural seniors group to provide the Stand Up! program
- Targeted marketing campaign to retirement homes to offer:
 - ✓ *Health promotion education sessions to residents*
 - ✓ *Staff training*
 - ✓ *Mobile clinics*
 - ✓ *1:1 intervention for residents*
 - ✓ *Gauge interest in the provision of Stand-Up! program training to benefit residents and seniors in the wider community.*

Project Partners

- ▶ Pinecrest-Queensway Community Health Centre
- ▶ Queensway Carleton Hospital
- ▶ Western Ottawa Community Resource Centre
- ▶ Regional Geriatric Program of Eastern Ontario
- ▶ Champlain Community Care Access Centre
- ▶ Centre de Services Guigues
- ▶ West Carleton Family Health Team
- ▶ Ottawa Public Health
- ▶ The Olde Forge
- ▶ Osteoporosis Canada



Any questions?

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