

INVENTORY OF FALL PREVENTION INITIATIVES IN THE GTA*

A. FALLS SPECIFIC PROGRAMS

Organization	Program Name	Description	Target Population / Admission Info	Geographic boundary
(Organization Local Health Integration Network)	Contact Information Funding Source; expected duration			
Arthritis Society (CE LHIN)	PACES Contact: Barb Rimmer 705.742.7191 Funding: Internal from MOHLTC; ongoing	Provides general awareness and resources to the general public, health providers, and community-dwelling seniors. Services may include workshops (e.g. pharmacist speaking about the impact of drugs and alcoholism on falls) for the public, health providers. Created an educational booklet in collaboration with the injury prevention group.	Peterborough and Lakefield	None as long as the participant can get to Peterborough or Lakefield.
Community Care East York (TC LHIN)	Fall Prevention Program Contact: Sarah Hilton 416-422-2026, Ext. 235	Offers an interprofessional approach to fall prevention including promotion, education, exercise, nutrition programs, and identification and modification of risk factors. Provides intervention which includes education, fall prevention exercise classes, fall risk assessment, fall investigation, in-home safety assessment & home modification plan, medication review & reconciliation, foot care and communication & promotion. All providers are trained in the Canadian Fall Prevention Curriculum and receive annual refresher training in fall prevention. Staffing includes: wellness manager, integrated wellness coordinators, RPN and adult day program staff	Physician referral is not required. Targeted towards seniors and adults with disabilities who are clients of Community Care East York. There are multiple access points throughout the organization (e.g. day program, seniors' centre, supportive housing program). If you are not a client, call for an intake assessment and you will be directed to the appropriate programs.	Toronto East
Credit Valley (MH LHIN)	The Strong and Steady Fall Prevention Program	Targeted towards people over the age of 65 who are living in the community and are falling. An individualized risk assessment is completed by a geriatrician and the physiotherapist at the start of	Must be medically stable and have the cognitive ability to participate in a group exercise program for 6 weeks. Must be able to	None

* Notes:

- (1) This inventory is primarily an update to the GTA portion of the *Inventory of Fall Prevention Initiatives in Canada – 2005**. Where possible, additional listings have been included for programs which accept referrals from the community; however, this inventory is not intended to be a comprehensive listing of fall prevention programs. Contact your local health providers to find out more about fall prevention programs in your area. Refer to the listing of additional resources at the end of this document.
- (2) If you would like to make any additions or changes to this inventory, please contact info@gtarehabnetwork.ca

*Division of Aging and Seniors. (2005). *Inventory of Fall Prevention Initiatives in Canada – 2005*. Retrieved March 17, 2009 from http://www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/pro/injury-blessure/fall_prevention_initiatives/fall_prevention_initiatives_e.pdf

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Credit Valley (MH LHIN) (cont.)	Contact: Lydia Baksh 905.813.1100, Ext. 6015 Funding: MOHLTC	determine appropriateness for the program and identify individualized risks (e.g. medications). Patients who meet the criteria listed are provided with a 6 week group exercise class and education on prevention and on community resources to support continuing exercises. An environmental risk assessment is completed by the OT; home safety visits may be booked if necessary. Follow up visits with the physiotherapist or geriatrician may be arranged if necessary.	walk 25m with or without a walking aid. Must be able to arrange transportation to the program.	
Halton Healthcare Services (MH LHIN)	Geriatric Outpatient Service – Strong and Steady Falls Prevention Program Contact: Jennifer Roberts 905.338.4367 Funding: MOHLTC	The Strong and Steady Falls Prevention program offers individualized assessment for risk factor identification related to falls prevention, comprehensive medical review by a geriatrician and nurse practitioner. The physiotherapist utilizes specific assessment tools to identify current functional level and balance abilities (Berg Balance Scale, Timed Up and Go, muscle strength testing, etc.). This assessment takes approximately 2-2.5 hours in the clinic. Based on the assessment, appropriate clients are identified for admission to the circuit program. The circuit program includes exercise and education twice a week for 6 weeks with a 3-6 month follow up post-discharge from the program. The identified risk factors (e.g. vision, medication review, importance of exercise, socialization, community referrals for ongoing programming,) are also addressed within the education component of the circuit program. Referrals are made to CCAC, if appropriate, for home safety assessments.	Community-dwelling seniors.	None known
Halton Region Health Department (MH LHIN)	Home Visiting Program for Older Adults at High Risk of Falling Contact: Kathy Miller 905.825.6000, Ext. 7113	Offers a home visiting program for older adults at risk of falling across Halton. The program involves 1-2 home visits by a public health nurse to provide a comprehensive health assessment, health promotion, education and referral. The majority of clients are taught the Home Support Exercise Program. Education is also provided in the community to seniors and caregivers regarding falls prevention, safe use of alcohol and medications. Halton Region Health Department works with coalitions and liaises with the Mississauga Halton and Hamilton	Community-dwelling seniors aged 65+ who have 3 or more risk factors for falls. Accept self referrals and physician referrals.	All of Halton region

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		Niagara Haldimand Brant LHINs regarding falls prevention resources and programming.		
Halton Region Health Department (MH LHIN)	Take a Stand! Prevent a Fall! Stay Independent! Contact: Kathy Miller 905.825.6000, Ext. 7113	Injury prevention projects led by Halton Regional Health. Offers various programs and services involving community education for seniors, caregivers, and health providers in all municipalities. Education includes communication campaigns, presentations, media campaigns, advocacy and collaboration with other partners. Topics covered include: falls prevention and safe medication and alcohol use for seniors.	General public, seniors, caregivers, health providers in Halton region	All of Halton region
Markham Stouffville Hospital (C LHIN)	Markham Stouffville Falls Clinic Contact: Kris Marks 905472.7387 Funding: Hospital	Runs one morning a week. Patient receives multidisciplinary assessment/intervention, including the nurse (60 minutes), physiotherapist (60 minutes), and geriatrician (30 minutes). Recommendations are made for aides, medication is reviewed, and physiotherapy intervention is provided if needed. Patients are referred to CCAC for home safety assessment or to Geriatric Outreach Clinic (Unionville Home Society) for further follow up. Maximum capacity: 2 patients per week.	Physician referral required. Targeted towards community-dwelling seniors, 60 years+, who are independently living with an MMSE score of >23. Patients residing in nursing homes or patients who have a known diagnosis for falls (e.g. Parkinsons, MS) are ineligible.	All of York Region, or at least patients with a physician in the York region
Ontario Injury Prevention Resource Centre (Online)	Canadian Falls Prevention Curriculum E-Learning Course Website: http://www.oninjuryresources.ca/cfpc/ Funding: Population Health Fund	Offers a 2 day training program. The CFPC E-Learning course provides those working with older adults the knowledge and skills needed to apply an evidence-based approach to the prevention of falls and fall-related injuries. Participants learn how to design, implement and evaluate a falls prevention program tailored to their work or community setting. The course uses multimedia presentations, interactive activities and a collaborative environment for journaling and forum discussions. A facilitator moderates discussion forums and provides feedback on the many practical application exercises. The course is available internationally in English through Distance Education at the University of Victoria, as	People working with older adults	None. Available online

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	of the Public Health Agency of Canada	well as in French through the Saint-Jean Campus of the Francophone University of the University of Alberta in Edmonton.		
Peel Coalition for Injury Prevention (CW LHIN)	Remembering When Contact: Joan Batenburg 905.452.7580, Ext. 215	Interactive fall and fire prevention program put on at senior safety events in Peel, including fitness demonstrations and wellness displays.	Seniors	Peel region.
Peel Health (CW LHIN)	Falls Prevention for Seniors Contact: Kathy Kitka 905.791.7800, Ext. 2003 Funding: Regional government and provincial; ongoing	Peel Health works with community agencies that request help with workshops and presentations. Media campaigns are run in June (Seniors' month) and November (Seniors' safety week). Some handouts are available in 5 languages. Peel Health runs a Falls clinics with Public Health Nurse and OT/PT (from CCAC) where possible.	Targeted towards community-dwelling seniors (e.g. retirement homes, but not nursing homes) who are mobile (e.g. walk with aids, but do not require a wheelchair). Education is targeted towards seniors, caregivers and providers.	Anywhere in Peel (Caledon, Brampton, Mississauga)
RNAO (Provincial)	Prevention of Falls and Fall injuries in the older adult Contact: 416.599.1925	Guidelines for nurses to identify fall risk and define intervention. Available online: http://www.rnao.org/Page.asp?PageID=924&ContentID=810	Nurses	Provincial
SmartRisk	Smart moves Contact: 416.977.7350	Toolkit available online http://www.smartrisk.ca/index.php/publications/item/smart_moves_toolkit	Community-dwelling seniors and caregivers	None
South Riverdale Community Health Centre (TC LHIN)	Home Safe Home Road Show: Injury Prevention for Seniors in the community Contact: Elsie Petch	Handouts cover causes of injury and how to prevent injury and also include a facilitator's guide. Video covers training on how to lead a workshop. Available in Cantonese.	Well elderly in the community	Materials are free as long as postage is reimbursed.

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	416.962.9500			
Sunnybrook Health Sciences Centre (TC LHIN)	Falls Screening Clinic and Intervention Program	Patients are screened by the physiotherapist and geriatrician before starting the program. The physiotherapist completes a balance assessment while the geriatrician addresses other medical issues (e.g. medication review, blood pressure). Recommendations and follow up are provided if necessary.	Physician referral required. Targeted towards community-dwelling seniors over the age of 65 years who live at home or in retirement homes. Seniors living in long term care facilities and nursing homes are not eligible. Must have a score of >25 on the MMSE. Must have transportation to/from the program. Must be ambulatory (with or without gait aid).	No geographic catchment as long they are able to get to/from the program.
Sunnybrook Health Sciences Centre (TC LHIN)	Falls Screening Clinic and Intervention Program	FIT provides 3 education sessions which cover home safety, medication management, physical activity and healthy eating. Information on Lifelines is provided.		
(cont.)	Contact: Intake Secretary 416.480.6888 Funding: RGP, MOHLTC; ongoing funding Falls Screening Clinic and Intervention Program	Patients also participate in circuit training exercise sessions (45 minutes, twice a week over six weeks). Patients are provided with home exercise which include balance, how to get up after a fall, etc. If needed, a follow up appointment with the geriatrician is provided; otherwise recommendations are sent back to the patient's family physician for follow up. If more than 4 risk factors are identified (e.g. number of medications, gait aid) after the patient has gone through the program, they may be referred for a home visit by the public health nurse. The program runs Tuesday and Thursday mornings from 9:00-10:30am. Sessions run continuously.		
Toronto Public Health (TC LHIN)	Seniors Injury Prevention Program Contact: Judy Radau 416.338.7600 Funding: MOHLTC and City of Toronto	Offers various educational materials and programs on healthy aging and the contributing factors to falls (e.g. medication management, nutrition, active living, home safety). Educational materials include print and web resources. Resources available on the website: http://www.toronto.ca/health/injuryprevention/seniors65/falls_prevention.htm http://www.toronto.ca/health/injuryprevention/seniors65/make_splash.htm	Seniors	City of Toronto

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Organization	Program Name	Description	Target Population / Admission Info	Geographic boundary
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Toronto Public Health (TC LHIN)	Falls Intervention Team (FIT) Contact: Judy Radau or Pat Thomas 416.338.7600	The Falls Intervention Team (FIT) Project is a partnership between Toronto Public Health and community partners, including North York General Hospital, Sunnybrook Health Sciences Centre, Flemingdon Community Health Centre, University Health Network (Toronto Western Hospital) and City of Toronto Supportive Housing. Physiotherapists at partner organizations provide screening to identify seniors with high falls risk and refer them to Toronto Public Health. Toronto Public Health provides education, individualized risk assessment, 3-5 home visits and exercises (following the Home Support Exercise Program) for seniors.	Community-dwelling seniors with 4+ risk factors for falls.	City of Toronto or based on organizational catchment areas.
Toronto Public Health (TC LHIN)	Funding: MOHLTC and City of Toronto	Contact Toronto Public Health if you are interested in information on future partnerships.		
(cont.)				
Toronto Public Health (TC LHIN)	A Step Ahead – Fall Prevention Training Program for Health and Allied Health Professionals Contact: 416.338.7600 Funding: MOHLTC and City of Toronto	One day course for health providers working with community seniors; including training on Home Support Exercise Program (HSEP). Taught by Nurses certified by the Canadian Centre for Activity and Aging.	Health providers	None
Trillium Health Centre (MH LHIN)	Falls Prevention/ Bone Health Clinic and Exercise/Education Program Contact: 416.521.4090 Funding: MH LHIN	Offers assessment and interventions for falls prevention and management. Assessments are done at Trillium, however, the program is run by Trillium staff at Cawthra Community Centre. Services provided include education, group exercise and individualized risk assessment (via geriatrician assessment, e.g. medication management). Home visits are typically not provided, but outreach services may be recommended.	A physician referral is required. Referrals are accepted for persons 65 years of age or older experiencing at least one of the following: <ul style="list-style-type: none"> Geriatric syndromes e.g. cognitive/functional impairment, or medication management issues Multiple and/or complex medical, 	No specific geographic catchment area as long as transportation can be arranged and a physician referral is made.

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		Staffing available include: geriatrician, physiotherapist, occupational therapist, social worker, nurse practitioner, pharmacist.	functional and psychosocial problems <ul style="list-style-type: none"> Falls or the potential for falls Two or more hospital admissions or frequent emergency room visits within the past year 	
University Health Network (TC LHIN)	Falls Prevention Program Carol Banez 416.603.5800, Ext. 5955	The Falls Prevention Program provides an interdisciplinary approach to falls prevention through (a) comprehensive risk factor assessment and modification; (b) education around risk factors for falling; (c) supervised exercise; and (d) individual counselling. The goal of this program is to enable seniors to decrease their risk for falling through risk factor modification, education, exercise, and individual counseling.	(1) community-dwelling seniors; (2) aged 65+; (3) who have had a fall or are at risk for falls; (4) who are cognitively intact; (5) who are able to participate in the exercise program; (6) who have a referral from a family physician, UHN staff physician or community physician.	GTA
University Health Network (TC LHIN)	Falls Prevention Program Funding: MOHLTC	Team includes: geriatrician, social worker, nurse, pharmacist, physiotherapist, chiroprapist, dietitian, occupational therapist.	Patients from nursing home/LTC will also be accepted provided they are: (1) referred by a family physician; (2) able to come and attend the 3 hour comprehensive assessment; (3) able to complete the balance scale tests; and (4) are cognitively intact.	
(cont.)		On the first visit, clients undergo a 3-hour, comprehensive assessment to identify potential risk factors for falling, which includes tests for balance, strength, mobility and fear of falling. Group sessions are held once a week for 2 ½ hours. Patients are required to return for a 3-month and 6-month follow-up appointments to re-test their balance, strength, mobility and fear of falling. An individualized care plan is developed which may include a referral to the 12-week falls prevention group program. The 12-week group program provides: the following services a) Education on how to reduce the various risk factors for falls; b) A physiotherapist-led exercise class aimed at improving balance and strength; c) Blood pressure and blood sugar monitoring; d) Individual counseling; e) Referrals to other hospital clinics/community resources if necessary.		
		Services are covered by OHIP.		
York Region Health Services	Fall Prevention Program Contact:	Offers written resources in English, Chinese, and Italian. Posters may be setup, but unstaffed.	Community-dwelling seniors	Newmarket, Aurora, King, Vaughan,

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(C LHIN)	Mary Ellen Procher 905.762.1282	No longer provide personal consultation and education by phone or in home, Fall Prevention Clinic (previously run for seniors in community), or monitoring of falls incidences and gaps in service.		Georgina, East Gwillimbury, Whitchurch, Richmond Hill, Markham

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B. GENERAL PROGRAMS

Organization	Program Name	Description	Target Population / Admission Info	Geographic boundary
(Organization Local Health Integration Network)	Contact Information Funding Source; expected duration			
Baycrest (TC LHIN)	Community Assessment and Treatment Team - Community Outreach Team Contact: Isobel Manzer 416.785.2500, Ext. 2395 Funding: MOHLTC	The Community Outreach Team is one of two services offered as part of the Northern Service of the Regional Geriatric Program (RGP) of Metropolitan Toronto. The Community Outreach Team serves the frail elderly who have multiple functional and/or medical disabilities, which limit their independence and/or impose excess burden on their caregivers. Inter-disciplinary assessments are performed in the client's place of residence. A consultation letter, including recommendations, is forwarded to the client's primary care physician. The case manager follows the client until the recommendations have been addressed. If an individual required ongoing supervision which existing resources cannot provide, the Community Outreach Team will facilitate referrals to agencies which provide long term case management (e.g. CCAC, day hospital). Hours of operation: Monday to Friday 8am to 4pm.	Targeted towards community-dwelling seniors. All patients must have discharge plans prior to admission. Patients may have one or more of the following: non-acute multiple and/or complex medical problems; mild to moderate cognitive impairment; recent functional decline. As all patients require geriatric consultation prior to admission, the Geriatrician/Program Coordinator assesses the majority either in the Baycrest Ambulatory Clinic or on a home/institutional visit. The remainder are referred from other geriatricians in a similar variety of settings.	Yonge to Keele and St. Clair to Steeles. If the person lives outside this area, but is able to come to Baycrest they will still be seen by exception, depending on the circumstances
Baycrest (TC LHIN)	Community Assessment and Treatment Team - Day Treatment Centre Contact: For Referral forms 416-785-2500 x 2588 Or Agnes Dzialo for further information 416-	The Saul & Rae Saltzman Day Treatment Centre is part of the Northern Service of the Regional Geriatric Program (RGP) of Metropolitan Toronto. The Day Treatment Centre serves clients who are living in the community who are having difficulty functioning in their homes and the community. The balance of the referrals are for frail elderly clients who have lost functional abilities due to multiple medical problems, and require interventions by a interdisciplinary team. Areas of concern include home safety, caregiver stress, medication	Physician referral required (referral form can be requested from the secretary). Targeted towards community-dwelling frail seniors who are aged 55 and over and able to weight-bear. Client needs to be able to follow through with recommendations or must come with someone who can help with carryover (e.g. family	Yonge to Keele and St. Clair to Steeles.

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Baycrest (TC LHIN) (cont.)	785-2500, Ext. 2586 Community Assessment and Treatment Team - Day Treatment Centre Funding: MOHLTC	management, lack of structured leisure time, swallowing difficulties and falls. The Centre provides assessment, treatment, education and rehabilitation on an outpatient basis with the goal of optimizing the functional abilities of clients and enabling them to remain in the community. Patients attend the Centre 2 days a week, Monday and Wednesday from 1:00-4:00, Tuesday and Thursday from 9:00-12:00. Twelve weeks is the average length of stay. Staff include: family medicine physician, geriatrician, nurse, SLP, TR, PT, OT, SW, dietitian, and dance movement therapist. Pool therapy is available twice a week only in the morning (Tues/Thurs).	member, caregiver). Clients are referred for a variety of medical issues; however, they would have to benefit from a minimum of two disciplines on an ongoing basis to be a candidate for the program (e.g. PT & OT or PT and SLP). Referrals are welcomed from community agencies, physicians, families, hospitals and other health professionals or the patient him/herself. Referrals for seniors residing in long term care facilities are ineligible.	
Baycrest (TC LHIN)	Geriatric Clinic Contact: 416. 785.2500, Ext. 2395 Funding: MOHLTC	Provides assessment by the geriatrician.	Physician referral required.	None known.
Baycrest (TC LHIN)	Baycrest Geriatric Assessment Team Contact: Maureen 416.785.2500, Ext. 2621 Funding: MOHLTC	Provides comprehensive geriatric and functional assessments (including mobility and falls) and consultations as well as access to Baycrest programs and support services where suitable. Team includes certified geriatricians and healthcare professionals.	Physician referral required. Targeted towards community-dwelling seniors.	None known.
Baycrest, NYGH, Yee Hong Centre, Toronto Public Health (TC + C LHIN)	The Power Program Contact: 416.756.6050, Ext. 8030	Developed by Baycrest, North York General Hospital, Yee Hong Centre, Toronto Public Health; Baycrest Geriatric Outpatient. Offers group classes with education, exercise, and nutrition. Classes run for 6 weeks, twice a year.	Community-dwelling seniors with osteoporosis that 1) have not yet received education on osteoporosis; or 2) who have not achieved lifestyle changes that may make a difference to their quality of life.	None as long as inclusion criteria met, go through screening clinic, have medical referral and have transport

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(Organization Local Health Integration Network)	Contact Information Funding Source; expected duration			
Lakeridge Health (CE LHIN)	GAIN (Geriatric Assessment and Intervention Network) Contact: Michelle Acorn 905.623.3331, Ext. 1216 Funding: MOHLTC, CE LHIN	<p>The GAIN Clinic is an urgent/emergent clinic that will incorporate and expands upon the services offered by Lakeridge Health's Specialized Assessment for the Frail Elderly (SAFE) Clinic providing comprehensive assessment for frail seniors living in the community.</p> <p>GAIN is led by a specialized inter-professional geriatric team that includes a Nurse Practitioner, Physiotherapist, Occupational Therapist, Social Worker and Pharmacist with access to a Geriatrician for consultations as required.</p> <p>The GAIN team will work collaboratively with the Geriatric Emergency Management nurse within the Emergency Department and with other professionals within the Emergency Department to identify appropriate clients for GAIN.</p> <p>Although exercise interventions are not provided, patients will be referred to outpatient rehab services as appropriate.</p>	<p>The GAIN Clinic will see high risk seniors (aged 75+ years) in the Emergency Department and will accept referrals from family physicians to assess, treat, and discharge home safely non-acute seniors straight from the Emergency department avoiding a hospital admission. The patients who will be seen are:</p> <ul style="list-style-type: none"> • are living at home or in a retirement residence • are at risk for falling or have fallen • have multiple complex medical, functional and psychosocial problems • can walk with or without a mobility aid indoors (may use a wheelchair to access community) • have recently experienced a health decline or progressive functional decline • are able to arrange transportation for clinic appointments 	Durham region. Community referrals to the GAIN Clinic will be accepted.
South Riverdale Community Health Centre (TC LHIN)	Gentle Tai Chi Contact: 416.461.1925 Funding: Internal from MOHLTC; ongoing funding	Seniors and people with mobility issues (e.g. in wheelchair). No cost to participant. Call to register. Offers regular tai chi classes led by tai chi instructor. Program is coordinated by a health promoter. Classes are held twice a week on an ongoing basis with breaks for holidays. Program is offered in English, Mandarin and Cantonese.	People with limited physical mobility and adults over the age of 55 years.	Priority given to those within service boundaries.
South Riverdale Community Health Centre (TC LHIN)	Seniors' Wellness Program Contact: 416.461.9043 Funding: MOHLTC; ongoing funding	No cost to participant. Call to register. Led by health promoter. Offers educational talks on senior related topics (e.g. safety, security, medical issues), social time. Gentle exercise is part of the program. Meets twice a month. Ongoing.	Adults over the age of 55 years.	Within the service boundaries.

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South Riverdale Community Health Centre (TC LHIN)	Bones for Life Contact: 416.461.1925 Funding: Internal from MOHLTC and Osteoporosis Society; ongoing funding	Provided in partnership with the Osteoporosis Society. No cost to participant. Call to register. Offers a 7 week program in English and Cantonese with education, cooking, and gentle exercises. Led by registered dietitian. Offered throughout the year.	Seniors, people with osteoporosis	None as long as participant can get there.
South Riverdale Community Health Centre (TC LHIN)	Home Safe Home Road Show: Injury Prevention for Seniors in the community Contact: Elsie Petch 416.962.9500	Handouts cover causes of injury and how to prevent injury and also include a facilitator's guide. Video covers training on how to lead a workshop. Available in Cantonese.	Well elderly in the community	Materials are free as long as postage is reimbursed.
St. Joseph's Health Centre (TC LHIN)	Outpatient Elderly Community Health Services Program Contact: Nurse Clinician, 416.530.6770 Funding: MOHLTC	Elderly Community Health Services provides outpatient assessments, health promotion and illness prevention for the elderly patient, with the aim of assisting patients and families to manage the challenges associated with aging. OT and PT services will address falls issues, gait aids, home equipment/modification for those with multiple medical issues. The allied health members make home visits as required to assess a patient's needs. The team includes 4 geriatricians, a nurse clinician, a social worker, physiotherapist, and an occupational therapist.	External referrals must go through St. Joseph's geriatrician first before accessing the ECHS. Must be aged 65 or over, have rehab potential and able to participate. Patients do not need to be medically stable. Patients are typically seen due to frailty, dementia and reduced capacity.	Must reside in the area bordered by: South - Lakeshore West - Mill Road/ Etobicoke Creek East - Ossington/ Bathurst North - Eglinton Ave. West
St. Joseph's Health Centre (TC LHIN)	Outpatient Rehabilitation – Physiotherapy Funding: MOHLTC	Neuro patients referred here with falls-related issues will be provided with fall-related education, individualized risk assessment and exercise intervention. Care is provided to outpatients upon referral from a physician, or as part of a clinical program.	All patients must be referred by their physician, surgeon or specialist.	HWY 401 to Lakeshore, and Bathurst Street to Etobicoke Creek.

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(Organization Local Health Integration Network)	Contact Information Funding Source; expected duration			
Sunnybrook Health Sciences Centre (TC LHIN)	Geriatric Day Hospital Contact: Intake Secretary, 416.480.6888 Funding: RGP, MOHLTC; ongoing funding	<p>The primary difference between the day hospital and the falls intervention program is that patients admitted to the day hospital have access to more variety of services, otherwise the same fall prevention program is provided.</p> <p>Patients are screened by the physiotherapist and geriatrician before starting the program. The physiotherapist completes a balance assessment while the geriatrician addresses other medical issues (e.g. medication review, blood pressure). Recommendations and follow up are provided if necessary.</p> <p>FIT provides 3 education sessions which cover home safety, medication management, physical activity and healthy eating. Information on Lifelines is provided.</p> <p>Patients also participate in circuit training exercise sessions (45 minutes, twice a week over six weeks). Patients are provided with home exercise which include balance, how to get up after a fall, etc. If needed, a follow up appointment with the geriatrician is provided; otherwise recommendations are sent back to the patient's family physician for follow up.</p> <p>If more than 4 risk factors are identified (e.g. number of medications, gait aid) after the patient has gone through the program, they may be referred for a home visit by the public health nurse.</p> <p>The program runs Tuesday and Thursday mornings from 9:00-10:30am. Sessions run continuously.</p>	<p>Physician referral required.</p> <p>Targeted towards community-dwelling seniors aged 65 and over with more complex conditions. May be from home or retirement homes. Seniors living in long term care facilities and nursing homes are not eligible.</p> <p>May accept seniors with a score of <24 on the MMSE within reason. Must be ambulatory (with or without gait aid).</p>	<p>No geographic catchment as long they are able to get to/from the program.</p>
Toronto Rehab (TC LHIN)	Geriatric Medicine Clinic Contact: Virginia Legaspi 416.597.3422 Funding: MOHLTC	<p>The Geriatric Medicine Clinic is designed to complement other in or outpatient programs at Toronto Rehab. The purpose of the clinic is to provide an effective way of assisting elderly individuals with a variety of physical illnesses to maximize their health, independent functioning, and quality of life. Each patient seen in the clinic has an in-depth and comprehensive assessment by a specialist in geriatrics. Other members of the multidisciplinary geriatric team may also assess the patient and provide recommendations to optimize function and quality of life.</p> <p>The Geriatric Medical Clinic conducts specialized medical</p>	<p>Physician referral required.</p> <p>Elderly individuals who are experiencing: deterioration of memory or cognition, multiple physical disabilities, mobility problems, falls or decreased physical function, bowel or bladder difficulties, challenges coping with multiple chronic illnesses or multiple medications, inadequate family or community supports, possible abuse or neglect, alcoholism, poor nutrition or weight loss.</p>	<p>Contact the clinic for more information.</p>

INVENTORY OF FALL PREVENTION INITIATIVES IN THE GTA[†]

B. GENERAL PROGRAMS

Organization	Program Name	Description	Target Population / Admission Info	Geographic boundary
(Organization Local Health Integration Network)	Contact Information Funding Source; expected duration			
Toronto Rehab (TC LHIN)	Geriatric Medicine Clinic	assessments tailored to seniors, provides consultation to the patient's caregivers and physician, assesses the patient's support network, links the patient and family to support services and identifies patients who may benefit from inpatient assessment, rehabilitation or outreach programs.		
(cont.)				
Toronto Rehab (TC LHIN)	Geriatric Rehabilitation Day Hospital Contact: Karlee Lin 416.597.3422, Ext. 3038 Funding: MOHLTC	The Geriatric Day Hospital at Toronto Rehab is an outpatient interprofessional rehabilitation service. Clients admitted to the Geriatric Day Hospital attend two half days a week. Therapy is offered in one-to-one sessions. There are some small group therapeutic activities. Each client receives an individual schedule of appointments. The average duration of service is 3 to 4 months.	For community-dwelling seniors aged 65+. Must be medically stable with rehab potential, with functional decline associated with any or all of the following: falls (with or without injury), general physical deconditioning, cardiac, respiratory, stroke and/or other neurological conditions. Weight bearing is required; mild-mod cognitive impairment is acceptable; must be able to actively participate in 3-4 hrs of therapy 2x/wk	Central Toronto
Unionville Home Society (C LHIN)	Geriatric Outreach Team Contact: Ruth Pie 905.201.5577 Funding: MOHLTC; funding ends 2011 with potential for renewal	Multiple geriatric outreach teams operate throughout C LHIN. This is the only community based team. Geriatric assessment is completed in the person's home (can be home or retirement residence); note that while treatment and exercise are not provided, if required referrals are made as appropriate. All providers are trained in all aspects of the assessment.	Targeted towards community-dwelling seniors aged 60+ living in at home or in a retirement home. Generally they are frail elderly that are typically referred due to recurrent falls, medication issues, poor nutrition, memory impairment, difficulty with day to day living, social isolation, multiple medical problems, or environmental challenges	West of Hwy 404, East of York/Durham line, North border is Davis Drive, South border is Steeles Ave.

C. ADDITIONAL RESOURCES

This inventory is primarily an update to the GTA portion of the *Inventory of Fall Prevention Initiatives in Canada – 2005*[‡]. Where possible, additional programs have been included; however, this inventory is not intended to be a comprehensive listing of fall prevention programs.

Contact your local health provider to find out more about fall prevention programs in your area.

Ontario Association of Community Care Access Centres	Website: www.310CCAC.ca Phone: 416.310.CCAC (416.310.2222)
Durham Public Health	Durham Health Connection Line: 905-666-6241 Toll Free: 1.800.841.2729
Halton Public Health	Phone: Dial 311 or 905.825.6000 Toll Free: 1.866.442.5866 (1.866.4HALTON) TTY: 905.827.9833 Email: accesshalton@halton.ca
Peel Public Health	Phone: 905.791.7800 Toll Free: 1.888.919.7800 Email: info@peelregion.ca
Toronto Public Health	Phone within Toronto city limits: 311 Phone outside city limits: 416.392.CITY (2489) TTY customers (416.338.0TTY (0889) Email: 311@toronto.ca
York Public Health	Phone: For central and northern York Region: 905.895.1231 Toll Free: 1.877.464.YORK (9675) York Health Connection: 1.800.361.5653

[‡] Division of Aging and Seniors. (2005). *Inventory of Fall Prevention Initiatives in Canada – 2005*. Retrieved March 17, 2009 from http://www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/pro/injury-blessure/fall_prevention_initiatives/fall_prevention_initiatives_e.pdf