

Falls Prevention in Primary Care Assessment to Intervention

Project Report

March, 2017



This report was prepared by the project evaluation assistant, Alyssa Bedard. Many thanks to the people who led this project and provided support and guidance in preparing this report, especially:

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Falls Prevention in Primary Care

Assessment to Intervention

Executive Summary

Introduction

“Falls Prevention in Primary Care - Assessment to Intervention” is a project that assessed whether a standardized fall risk screen and assessment tool can help Family Health Teams in the North East Local Health Integration Network (LHIN) identify older adults who are at risk for falls and help refer them to falls prevention resources in the community.

Background

Falls are a significant public health issue for older adults in Canada, resulting in hospitalization and economic burden. The proportion of the population age 65 and older is projected to increase in Northeastern Ontario, meaning more people will be at risk for falls. Multifactorial risk assessments and interventions are shown to be effective for reducing falls among older adults. However, primary care providers in Northeastern Ontario have not historically assessed older adults for falls risk, and the interventions to address risk factors can be limited in rural and northern communities. This project aimed to test the feasibility of implementing a tool in the Northeast to assess falls risk and refer at-risk individuals to appropriate interventions. It was supported by an award from Improving & Driving Excellence Across Sectors (IDEAS).

Methods

The work in primary care began in October 2013 with this phase officially beginning in November 2015. The project working group used evidence-based strategies and adapted a comprehensive falls prevention algorithm from the Centers for Disease Control and Prevention (CDC) (United States) and Stopping Elderly Accidents, Deaths & Injuries (STEADI) to implement a screening and assessment tool using electronic medical record (EMR) and tablet technology. The tool was tested using a series of Plan Do Study Act (PDSA) cycles, based on the principle of continuous quality improvement. Six Family Health Teams piloted the project (Great Northern, Temagami, Powassan, Espanola, City of Lakes, and East End). The project was evaluated using EMR data, participant surveys and focus groups.

A Look at the Fall Risk Screen and Assessment Tool

The fall risk screen and assessment tool involves a screen, a multifactorial risk assessment, and referral to community programs or resources. The screen consists of a set of 12 questions, answered either by the patient in the waiting room using a tablet, or with the provider during the appointment. Based on the results of the fall risk screen, the patient is assigned a score which may flag them as “high risk”. The tool recommend to providers that a multifactorial risk assessment be completed for high risk patients.

The provider may complete this assessment immediately or at a later date. Based on the results from the multifactorial risk assessment, the provider can refer patients to appropriate resources and follow up.

Results

EMR data revealed that 501 patients were screened during the project pilot, 31% of patients screened were identified as high risk, and 19% of these high risk patients received a multifactorial risk assessment. Survey feedback from providers showed that the fall risk screen was easy to integrate into their workflow but that the multifactorial risk assessment was more difficult. All providers referred their patients to community resources; however fewer tracked the number of patients referred and whether or not patients followed through on the referral. This tool was thought to have increased interprofessional collaboration at some of the FHTs. The resources provided were considered useful, and offering links to enable follow-up and effective referrals were important components identified.

Discussion

Overall, implementing the fall risk screen and assessment tool was considered feasible and effective for identifying older adults at risk for falls and referring them to community resources, as well as improving collaboration in primary care. The fact that the multifactorial risk assessment was more difficult to complete may explain why only 19% of high risk patients received it. Next steps include gaining more feedback to continue to improve the process, spread the learning, expand the exercise classes and work with providers to increase completion of multifactorial assessments. This work includes integrating the nutrition assessment tool, S.C.R.E.E.N., Seniors in the Community Risk Evaluation for Eating and Nutrition. As well, an increased focus on medication management is underway.

Introduction

“Falls Prevention in Primary Care - Assessment to Intervention” is an innovative project aimed at reducing falls among older adults from a primary care perspective. The initiative was started by a small working group in October 2013, with the current project beginning in November 2015. Since then, it has expanded across the North East LHIN and has involved meaningful collaboration from many partners.

The project tested whether a standardized best practice fall risk screen and assessment tool could be incorporated into the workflow of primary care providers to assess fall risk among senior patients. It also tested whether this tool could help refer at-risk older adults to appropriate falls prevention resources in the community based on identified risks. This report gives an overview of the project to date.

Background

Falls as a Public Health Issue

Falls represent a significant public health issue for Canadian older adults. Between 20% and 30% of Canadians age 65 and older experience one fall each year, and falling remains the leading cause of injury-related hospitalization for older adults. As such, falls present a significant personal, family, and economic burden, costing Canadians \$2 billion per year.¹

In the North East LHIN, the proportion of the population age 65 and over is projected to increase from 19% to 30% by 2036.² For example, in both Great Northern Family Health Team and Temagami Family Health Team, 22% of patients belong to the 65 and over age group.

Need for Assessment and Intervention in Primary Care

Research indicates that a multifactorial risk assessment paired with multifactorial interventions addressing the risk factors for falls among older adults can reduce the incidence of falls. Historically, however, primary care providers in the North East have not systematically assessed falls risk among older adults and linked them to community-based interventions. Additionally, interventions to address risk factors for falls are limited, especially in rural northern communities. Therefore, this project aimed to answer the questions:

- Can a standardized best practice falls risk screen and assessment tool be incorporated into the daily workflow of a Family Health Team, including the use of a tablet by the patient, to screen for fall risk among all patients 65+?
- Will the “at-risk” patient receive a multifactorial assessment for falls and be referred for preventative interventions, including a prescription for physical activity?

Funding

The project was funded by a \$25,000 award from Improving & Driving Excellence Across Sectors (IDEAS), a province-wide initiative offered through the University of Toronto, the Ministry of Health and Long-Term Care and Health Quality Ontario. IDEAS aims to enhance Ontario's health system performance by increasing quality improvement, leadership and change management capacity across all health care sectors.³ The IDEAS award was used to support project spread and sustainability.

Methods

The project aimed to use evidence-based strategies and incorporate the principles of continuous quality improvement.

Collaboration

Collaboration was a key enabler in this project. Collaborative practice is beneficial for patients and health care providers, and that it helps increase efficiency and effectiveness of the health care system.^{4,5} Structured information systems and shared electronic medical records (EMR) are facilitators to collaborative practice and quality patient care.^{4,5,6}

A partnership was formed in Northeastern Ontario to explore the feasibility of addressing falls among older adults from a primary care perspective. This partnership was initiated by the executive directors of two Family Health Teams (FHTs), and involved collaboration with a regional coordinator, Stay on Your Feet (SOYF), North East LHIN, a public health promoter from the Timiskaming Public Health Unit, a Quality Improvement Decision Support Specialist, an evaluation assistant and an older adult peer volunteer. This core group led and collaborated on the various phases of the project.

With respect to leveraging existing collaborative partnerships, the network of Northeast executive directors of the Family Health Teams have had a long standing and trusting working relationship. The ability to partner at such a level greatly contributed to the spread and sustainability of this project. The initiation of the NE LHIN regional falls prevention strategy in April 2014 allowed for an enhanced focus and resourcing of this initiative. Without these relationships and structures, more time would have been required to network and gain credibility to move a project of this magnitude forward.

Supporting Evidence

Evidence on effective fall risk assessment and intervention was appraised in the American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons.⁷ This document helped guide the project, and the recommendations presented state that:

- A strategy to reduce the risk of falls should include a multifactorial assessment of known fall risk factors and management of the risk factors identified.
- Direct interventions customized to the identified risk factors, coupled with an appropriate exercise program should follow the multifactorial fall risk assessment.
- Interventions should be implemented by the team conducting the fall risk assessment.

Adaptation of CDC/STEADI Algorithm

The work of the comprehensive falls prevention program developed in the United States by the Centers for Disease Control and Prevention (CDC) and Stopping Elderly Accidents, Deaths & Injuries (STEADI) was a very useful resource for the initiative. The program included a simple yes or no self-risk assessment to be completed by the patient and an algorithm for the clinician to follow, along with other tools and resources. The CDC and gave permission to adapt and integrate their program to meet project needs.

PDSA Test for Change

A series of PDSA cycles were used throughout the phases of the project to test for continuous quality improvement. The PDSA cycle consists of four parts:

1. Plan: Identify objectives, predictions, how the cycle will be carried out, and how data will be collected.
2. Do: Carry out the plan, document observations and record data.
3. Study: Analyse data, compare results to predictions, and summarize what was learned.
4. Act: What changes are to be made? What will the next cycle involve?

The working group regularly reviewed project goals, tests and results and adapted the phases accordingly.

Family Health Team Involvement

The Family Health Teams who piloted the assessment and intervention process were:

- Great Northern Family Health Team, New Liskeard
- Temagami Family Health Team, Temagami
- Powassan Family Health Team, Powassan
- Espanola Family Health Team, Espanola
- City of Lakes Family Health Team, Sudbury
- East End Family Health Team, Timmins

Evaluation

Data was collected from the EMR of each team involved to evaluate use of the screening tool. The data collected included: number of patients screened for fall risk, number of patients with high risk scores, and number of patients who received a multifactorial assessment.

A 12 question survey was conducted among FHT staff to assess the feasibility of integrating the screening tool and multifactorial assessment process into their practice. Following the survey, a focus group was conducted to gain more in-depth perspectives.

Interviews with patients are planned as the intervention spreads to other sites.

Project Timeline

This work began in October 2013 and has continued to evolve incorporating learning from each phase. The project timeline can be found in Appendix A.

A Look at the Fall Risk Screen and Assessment Tool

The fall risk screen and assessment tool involves the following:

- 1) Fall Risk Screen
- 2) Multifactorial Risk Assessment
- 3) Referral to Community Programs and provisions of resources

1) Fall Risk Screen

Patients 65 years of age and older are asked to complete the falls risk screen once a year. The screen can be completed in two different ways. Health care providers can ask the screen questions to patients during their appointment, using an Encounter Assistant built into their EMR system. The EMR has a reminder set to flag patients 65+ so nobody is missed. Alternatively, patients can answer the same risk screen questions while in the waiting room using a tablet. The questionnaire completed on the tablet populates the provider's EMR, so patient responses are accessible during the appointment.

The fall risk screen consists of twelve items, based on the Staying Independent Checklist, scored as indicated below if the answer is "yes":

Screening Questions

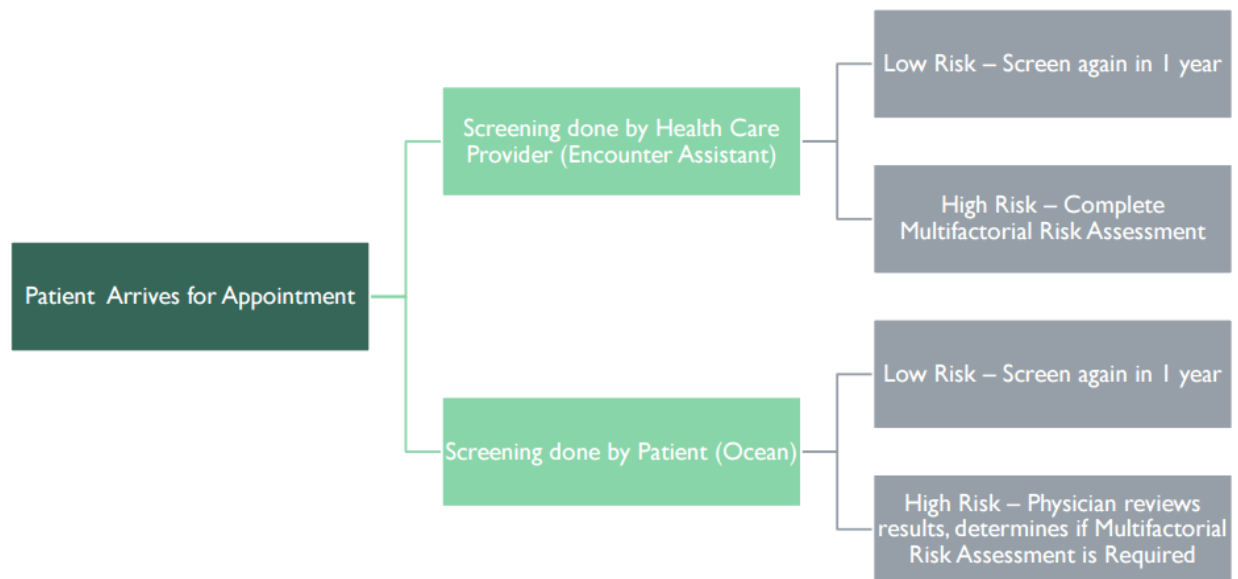
1. I have fallen in the past six months (2)
2. I use or have been advised to use a cane or walker to get around safely (2)
3. Sometimes I feel unsteady when I am walking (1)
4. I steady myself by holding onto furniture when walking at home (1)
5. I am worried about falling (1)
6. I need to push with my hands to stand up from a chair (1)
7. I have some trouble stepping up onto a curb (1)
8. I often have to rush to the bathroom (1)
9. I have lost some feeling in my feet (1)
10. I take medicines that sometimes make me feel light-headed or more tired than usual (1)
11. I take medicine to help me sleep or improve my mood (1)
12. I often feel sad or depressed (1)

A patient is considered at high risk for falling in either of the following cases:

- a) They receive a score of 4 or higher on the twelve items, **or**
- b) On the provider-facilitated screen, they answer "yes" to any of the "Quick Screen Questions", which are **items 1, 3, and 5**:
 - I have fallen in the past six months
 - Sometimes I feel unsteady when I am walking
 - I am worried about falling

Additional screening is done after the fall risk screen questions. It includes evaluating if a patient's gait is normal, whether the patient uses walking aids, and their history of falls.

The fall risk screening process is outlined by the following chart:



2) Multifactorial Risk Assessment

Based on the results of the fall risk screen and additional screening, the Encounter Assistant will recommend completing a multifactorial risk assessment for patients flagged as “high risk”. The provider can open the new Encounter Assistant and perform the multifactorial risk assessment immediately, or they can select from the following options:

- Based on clinical judgement, multifactorial assessment is not required
- Patient to call and schedule at later time
- Send message to reception to book follow up with MD
- Send message to reception to book follow up with NP

The multifactorial risk assessment consists of 3 sections:

1. History
 - History of Falls
 - Review of medical conditions
 - Pharmacy
 - Vision
 - Risk Factors (smoking, alcohol intake)
 - Footwear
 - Behaviours Risks
 - Environmental hazards (currently not included)

2. Assessment
 - Pain, gait, balance and mobility problems
 - Hypotension
3. Plan

See **Appendix C** for the multifactorial risk assessment questions.

3) Referral to Community Resources

Based on the results from the multifactorial risk assessment, patients are referred to community resources to help reduce the chance of occurrence or recurrence of falls. The Stay on Your Feet (SOYF) regional strategy in partnership with the five public health units in the region develop and distribute falls prevention resources.

Some examples of free older adult focused physical activity opportunities available in many northeastern communities include:

- STAND UP! 12 week group classes, offered for free to older adults in the community, incorporating education and physical activity.
- “From Soup to Tomatoes”, an OTN facilitated chair-based exercise program, accessible online and hosted by a local volunteer in one community.
- 48 week NE LHIN funded older adult community exercise classes.
- Six-week foam rolling class hosted once a week for pain management; offered in Temagami, New Liskeard to date with an instructional home video.

Other instructional resources include:

- Stay on Your Feet handouts
- “Prescription for a Healthy Independent Life” checklist developed by Stay on Your Feet (see **Appendix D**)

It is important to note that all patients 65 years and older are encouraged to participate in a community older adult exercise program, regardless of their falls risk score.

Results

EMR Results

Data pulled from the six Family Health Teams' EMR showed the following results:

- **501** patients were screened for fall risk as of October 4th, 2016
- **157** patients (or **31%** of all patients screened) resulted in a high risk score
 - This value ranged across FHTs from 13% to 47%
- **30** patients (or **19%** of high risk patients) received the multifactorial risk assessment (see **Survey Results** and **Focus Group Results** sections for explanation of low uptake) in the timeframe of the pilot.

Survey Results

Survey responses were received from 10 staff members from the 6 Family Health Teams involved in the pilot.

Integration

- All 6 FHTs found the fall risk screen easy to integrate into their regular workflow.
- Respondents from 3 of the 6 FHTs found that the multifactorial risk assessment was **not** easy to integrate.
 - Issues with the multifactorial risk assessment were that it required extra resources, took too long, or was not possible to complete on the same day of visit.

Referrals

- All 6 FHTs referred patients to community resources, such as an exercise class.
- 3 of 6 FHTs tracked the number of patients referred to an exercise class.
- 2 of 6 FHTs tracked if patients followed through on the referral.
 - Tracking was done through exercise classes offered in-house and by calling patients.

Collaboration

- 4 of 10 respondents said collaboration within their FHT has increased because of this process,
- 3 of 10 think collaboration has remained the same, and
- 3 of 10 are not sure if collaboration has changed.

Resources

Of the resources provided to the FHTs during the pilot,

- 7 of 10 respondents used the paper handouts,
- 5 of 10 used the electronic links, and
- 3 of 10 used the prescription pads.

Other Significant Findings

- There is general consensus that having current links to providers offering exercise classes supported follow up and effective referrals.
- Despite the multifactorial assessment being difficult to complete due to extra time and resources required, providers saw value in completing it.
- Providers found that this process helped them educate the older adult population about falls prevention and identify patients who are at high risk.
- A challenge identified was having exercise classes in all communities to recommend to people in the area.

Focus Group Results

The focus group involved Family Health Team staff from the 6 Family Health Teams involved in the pilot. Information on the following topics emerged.

Screening Process and Tool

Staff found the screening process quick and easy, and found the tool useful for identifying older adults at risk. The tablet was useful for linking to patients' files regardless of the providers' technical knowledge. Most patients liked that the screening was being done and were willing to be screened.

Some older adults had difficulty using the tablet technology, having the clinician do the screening seemed to save time and be more efficient. On occasion it was difficult for front reception staff to flag the patients who needed to be screened, and in a few instances with busy reception areas, patients were missed. A few patients may have been falsely identified as at risk when, in reality, they were very stable and had experienced a careless trip. Relying on the providers' clinical judgement was necessary.

Multifactorial Risk Assessment Process and Tool

The multifactorial risk assessment was seen to be useful for identifying patients with certain issues that may contribute to their fall risk (i.e. hypotension, medications) who may otherwise have been missed. There was mixed feedback on the willingness of older adults to come back for an assessment when flagged as 'at-risk' during the screening.

The multifactorial risk assessment was very time consuming to complete, and therefore not many multifactorial risk assessments were completed. As a result, there was little information about the patient experience and whether follow-up was done by physicians. There was consensus around the need to streamline the multifactorial risk assessment process.

Community Falls Prevention Resources

This project helped identify older adults who could benefit from falls prevention programs. FHT staff found it important to have Stay on Your Feet resources available (e.g. STAND UP! groups, waiting room TV monitors), and having a list of local exercise classes available. They liked the prescription pad and thought that an electronic copy of the assessment was good for office use while a paper copy is good to

give the patient to take home. Some patients were referred to a mental health worker when feelings of sadness or depression were identified.

Discussion

Summary

Prior to using the fall risk screen and assessment tool, providers were uncertain about the feasibility of the process, the benefit to the patients, and the extra work it might entail. However, implementing the fall risk screen and assessment tool was generally considered to be feasible and effective for identifying older adult patients who are at risk for falls and referring them to community resources. The multifactorial risk assessment was more difficult to complete and this may explain why only 19% of high risk patients received it. The fall risk screen and assessment tool helped to improve collaboration in primary care. With the implementation of these tools, there has been excitement and feedback leading to true quality improvement and innovation. The assessment and referral process is an effective model that is easily incorporated into the EMR. This model could be used to screen for other health risks.

Enablers and Challenges

Enablers and challenges were encountered during the project, and include:

- **Enablers:**
 - \$25,000 IDEAS Award
 - Passionate people working on common goal
 - Technology, skills sets, capacity to have fun
 - Stay on Your Feet, regional falls prevention strategy
- **Challenges:**
 - Limited resources and vision (initially)
 - Clinician engagement due to limited time
 - Lack of staff availability to complete the multifactorial risk assessment

Recommendations

Strategies for improving the fall risk screen and assessment process were uncovered through the survey and focus group, based on the learning of FHT staff involved in the project. The following recommendations were shared:

- Start small and work within the capacity of the team.
- Distribute the workload among the team and use the full scope of professional practice.
- Streamline the multifactorial risk assessment process to allow more high risk patients to be screened.
- It is important to have buy-in from the whole team to give them ownership of the process and allow them to feel that what they are doing is relevant and important. Identifying champions of

this approach and highlighting their work will help to drive home the importance of this assessment.

- Use an electronic copy of the assessment for office use and a paper copy for the patient so they have something to take away with them.
- Develop tailored fact sheets for each FHT that can be printed and given to patients for their personal use.
- Implement a STAND UP! graduate course to support older adults' exercise progress.
- Work together, learn from each other and keep moving things forward.

Next Steps

- Interview patients to gain their feedback.
- Use the evaluation findings on the pilot to improve the process, based on PDSA cycles of improvement.
- Spread learning to other primary care organizations (Family Health Teams, nurse practitioner-led clinics, community health centres and others).
- Expand "From Soup to Tomatoes" in other communities in the Northeast as referral option.
- Expand work with Osteoporosis Canada.
- Incorporate SCREEN (Seniors in the Community Risk Evaluation for Eating and Nutrition), a nutrition screening tool.
- Identify and provide best practice resources to support the multifactorial risk assessment

References

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Stay on Your Feet

www.nelhin.on.ca/stayonyourfeet

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Appendix A: Project Timeline

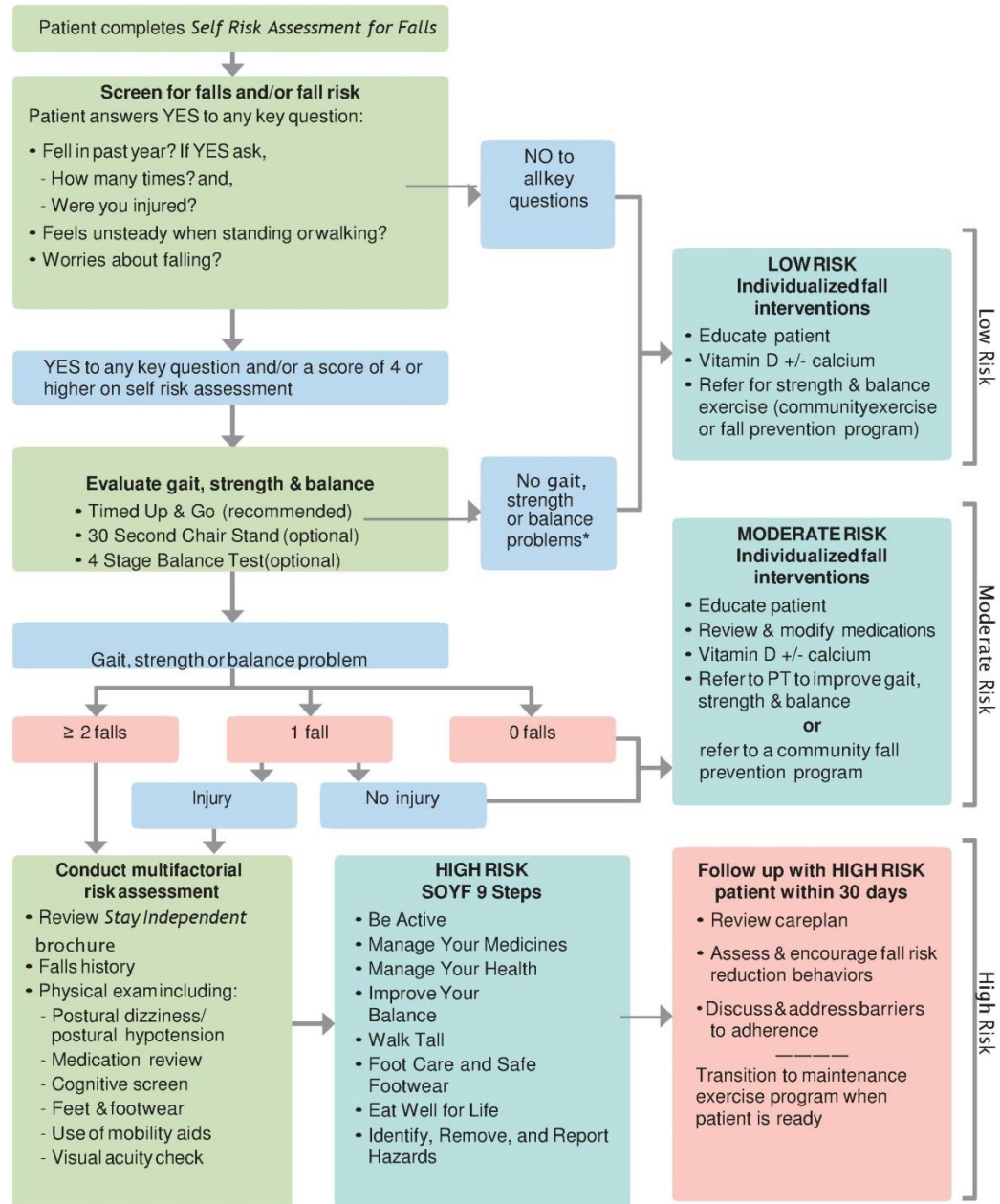
This timeline shows the project progression and phases:

October 2013	<p>Timiskaming Health Unit asked Great Northern and Temagami FHTs to present at a community falls forum. It was identified that, within the respective teams, there was no focus on falls prevention. Application was made by the Great Northern FHT Executive Director to IDEAS 5 day program to apply a quality approach to a project based on falls prevention in primary care.</p> <p>Phase 1: In-office risk assessment The application was accepted and the project scope consisted of a small pilot test in one physician's office using a paper based risk assessment tool. Opportunities for system improvement were identified.</p>
December 2013	<p>Phase 2: Mailed risk assessment The second test included a risk assessment tool, mailed to 248 patients. Responses were received from 182 patients, with 60 identified as having 4 or more risks. However, there were still few referral options, particularly for physical activity, and the mail out approach was time consuming and costly.</p>
April 2014	<p>The NE LHIN initiated a regional fall prevention strategy, Stay On Your Feet (SOYF), in which primary care is involved.</p>
June 2015	<p>Phase 3: Peer-led model of "From Soup to Tomatoes" The third test was to explore the ease of implementation of "From Soup to Tomatoes", an armchair-based exercise program, in a small rural community using a peer-led model. It was offered in June 2015 to select patients with good success.</p> <p>Phase 4: Falls Prevention Screening Pilot The Regional Coordinator and Chair of Stay on Your Feet presented at a Northeast Family Health Team Executive Director Conference where the SOYF strategy was explained. At that meeting, four other FHTs, along with a Telus representative and a FHT QIDSS agreed to work on moving forward with an electronic version of falls risk assessment in the EMR, with embedded links to community prevention programs such as SOYF.</p>
October 2015	<p>The peer-led model of "From Soup to Tomatoes" was expanded and open to the public, with great success.</p>
November 2015	<p>2015 IDEAS Alumni Achievement Award Funding Proposal approved with \$25,000 provided in support of spreading the project.</p>
March 2016	<p>Over the next 9 months the working group worked on developing EMR functionality that allowed primary care to screen older adults for falls risk. The project received funding from IDEAS to support the teams in developing this EMR functionality. In March 2016, 6 Family Health Teams started piloting the</p>

	falls risk screen in assessment.
May 2016	The working group presented this project at the national fall prevention conference “Watch Your Step – Applying Integrated Approaches”, in Calgary, Alberta on May 16 and 17 th .
June 2016	Phase 5: Expansion A follow-up presentation was delivered with respect to the falls work undertaken at the Northeast Executive Director Conference. An additional fourteen teams expressed interest in implementing the risk assessment and interventions within their team. Additionally, a nurse practitioner-led clinic expressed interest.
August 2016	The “From Soup to Tomatoes” implementation guide was developed to share with partners.
October 2016	The working group presented the project on October 19 th at IDEAS. A storyboard highlighting the project was also featured on October 27 th at the conference “It takes a community... to prevent a fall” hosted by the North East LHIN and the Stay on Your Feet Regional Network.
March 2017	Presentation at AFHTO workshop.
Future...	Future work for the project will involve working to promote the project and engage more Family Health Teams in the Northeast. Other work includes integrating with Osteoporosis Canada’s EMR tools, incorporating SCREEN nutrition screening tool for older adults, and introducing the assessment to nurse practitioner clinic teams and other early adopters in primary care.

Appendix B: CDC Algorithm

Algorithm for Fall Risk Assessment & Interventions



*For these patients, consider additional risk assessment (e.g., medication review, cognitive screen, syncope)



Centers for Disease
Control and
Prevention National
Center for Injury
Prevention and Control

STEADI Stopping Elderly
Accidents, Deaths & Injuries

Adapted with permission, Feb 2016

Appendix C: Multifactorial Risk Assessment Questions

HISTORY:

History of Falls:

Number of falls in the past year:

☐ Falls with injury

☐ Patient concerned about falling

Walking Aids:

Urinary Incontinence:

☐ Acute or fluctuating medical conditions (hypotension, hypo/hyperglycemia, syncope, seizures)

☐ Chronic medical conditions (osteoporosis, urinary incontinence, cardiovascular disease)

Impaired Vision:

☐ Cataracts requiring surgery

☐ Bifocals or progressives

☐ Exam >1 year ago

Behaviour Risks:

☐ Sleep changes

☐ Decreased interest

☐ Mood changes

☐ Psychomotor changes

☐ Psychosomatic complaints

☐ Suicidal thoughts

☐ Appetite or weight loss

☐ Memory or cognition issues observed

Pharmacy:

Number of Current Medications based on profile: 0

☐ Polypharmacy (6+)

☐ Psychoactive medications (including sedative hypnotics, anxiolytics, antidepressants)

☐ Prescriptions associated with falls

Footwear:

- ☐ Normal
- ☐ Poor Footware
- ☐ Arthritis
- ☐ Pain
- ☐ Bunions
- ☐ Deformities
- ☐ Ulcers
- ☐ Sensory loss
- ☐ Other

Fracture Risk:

Last BMD:

- ☐ Prior fractures
- ☐ Parental hip fractures
- ☐ Arthritis
- ☐ Glucocorticoid use
- ☐ Current Smoker
- ☐ Regular Drinker
- ☐ High risk for low BMD, future fractures, and falls

ASSESSMENT:**Evaluation of Gait, Balance, and Strength**[TUG Information Sheet](#)

Timed Up and Go:

>14 seconds correlates with high risk for falls

>30 seconds correlates with more dependence in ADLs, query need for assistive devices

<20 seconds correlates with independence with ADLs

- ☐ Reduced muscle strength/deconditioned
- ☐ Decreased upper body strength
- ☐ Unable to rise independently from a chair without the use of arm rests or assistance
- ☐ Pain related mobility
- ☐ Unable to retrieve an item off the floor
- ☐ Decreased lower extremity strength

Postural Hypotension:

BP:

Pulse:

Standing BP:

Sitting BP:

Lying BP:

- ☐ Symptomatic
- ☐ Dizziness without postural hypotension

Section 3: PLAN

PLAN:

- ☐ Vitamin D +/- Calcium
- ☐ Review & modify medications
- ☐ Assess and encourage fall risk reduction behaviours
- ☐ Provided patient with falls prevention materials
- ☐ Referred patient to community exercise program
- ☐ Referred patient for CCAC Homecare
- ☐ Referred patient to physio

Comments: _____

SOYF Handouts:




[SOYF Balance](#) _____
[SOYF Be Active](#) _____
[SOYF Eat Well](#) _____
[SOYF Eyesight](#) _____
[SOYF Fact Sheet Medication Safety](#) _____
[SOYF Footcare](#) _____
[SOYF Hazards](#) _____
[SOYF Health](#) _____
[SOYF Medicines](#) _____
[SOYF Staying Independent Checklist](#) _____
[SOYF Walk Tall](#) _____
[SOYF What To Do If You Fall Fact Sheet](#) _____

Finish

Useful Link:

[Preventing Falls Guide](#) _____
[RGPEO webpage for Fall Algorithm and Tools](#) _____
[Fall Algorithm](#) _____
[Timed Up and GO test](#) _____
[Senior's Falls Can Be Prevented brochure](#) _____

Appendix D: “Prescription for a Healthy Independent Life” Checklist



PRESCRIPTION FOR A HEALTHY INDEPENDENT LIFE

Be Active

- ☐ Join a balance focused class such as Stand Up or Tai Chi
- ☐ Work on strength and balance with exercises at home
- ☐ Aim for at least 30 minutes of activity/day

Manage Your Medicines/Health

- ☐ Have medications reviewed by a pharmacist
- ☐ Avoid medications that cause dizziness or drowsiness
- ☐ Take managing health conditions seriously such as ☐ diabetes, ☐ high blood pressure, ☐ depression, ☐ osteoporosis, ☐ other _____

Improve Your Balance/Walk Tall

- ☐ Be active to strengthen your muscles
- ☐ Be properly fit for a walking aid by a physiotherapist or occupational therapist

Foot Care and Safe Footwear

- ☐ Choose proper footwear
- ☐ Visit a foot care provider/personal support worker (cut nails, deal with corns)
- ☐ Do foot exercises to maintain circulation

Check Eyesight and Hearing

- ☐ Make an appointment to have vision tested
- ☐ Make an appointment to have hearing tested

Eat Well for Life

- ☐ Eat regular, balanced meals including foods rich in calcium and Vitamin D to keep bones strong
- ☐ Drink water often
- ☐ Take a regular Vitamin D supplement
- ☐ Make an appointment with a Registered Dietitian

Identify and Remove Hazards

- ☐ Use the Independent Living Guide to identify and modify hazards in your home

Comments: _____

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