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September 19, 2011

Re: Integrated Provincial Falls Prevention Project

Stay Up. Keep Up.

This is the premise behind the Integrated Provincial Falls Prevention Project, a collaboration between Ontario's 14 Local Health Integrated Networks (LHINs) and 36 Public Health Units to reduce falls among seniors.

As you are probably well aware, falls are the leading cause of injury and death among seniors. One in three seniors is likely to fall at least once per year – a risk that increases with age, with seniors 85 and older 3.4 times more likely to fall than the general population.

Falls can have a devastating impact on the quality of life for our seniors, affecting their mobility, health and independence. Falls also cost the Ontario health-care system billions of dollars, resulting from avoidable Emergency Department (ED) visits, hospitalizations and all too often, admission to long-term care homes.

And yet, most falls are avoidable, with proper education, awareness, screening, assessment, intervention and prevention. Keeping in mind that we have an aging population, this initiative is even more important and timely. That's why the Integrated Provincial Falls Prevention Framework & Toolkit has been developed.

We know that many organizations are already doing great work to reduce falls among seniors. We also know that there are existing programs already in place. This Framework & Toolkit builds upon that good work, pulling together the best programs, tools, resources and practices to effectively reduce the number and impact of falls, and to increase the quality of life for seniors in an integrated and collaborative manner.

We encourage you to read the Integrated Provincial Falls Prevention Framework & Toolkit and apply it to your work with seniors. The Integrated Provincial Falls Prevention Framework & Toolkit and companion information can be found on Algoma Public Health's website homepage www.algomapublichealth.com until October 24th after which time it will be located in Reports and newsletters section.

We look forward to working with you on this exciting initiative as we help Ontario seniors maintain their quality of life and independence.

Sincerely,

Allan A Northan MD MHSc FRCP(C)
Medical Officer of Health
Algoma Public Health

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Integrated Provincial Falls Prevention Framework & Toolkit – Backgrounder (pamphlet)

STAY UP, KEEP UP!

Falls reduce quality of life for our seniors, impacting their mobility, health and independence.
Fall also cost the Ontario health-care system billions of dollars, resulting in avoidable visits to the Emergency Department, hospitalizations, high Alternate Level of Care rates, and all too often, admission to long-term care homes.
And yet, most falls are avoidable, with proper education, awareness, screening, assessment, intervention and prevention.

THE INTEGRATED PROVINCIAL FALLS PREVENTION PROJECT

In September 2010, falls prevention was identified as a top priority by the Ministry of Health and Long-Term Care (MOHLTC). In response, the *Integrated Provincial Falls Prevention Project* was initiated as a Local Health Integration Network (LHIN)-priority project, in partnership with Ontario's Public Health Units (PHUs).
The *Integrated Provincial Falls Prevention Framework & Toolkit* was developed to improve quality of life for Ontario seniors aged 65 years and over, and to lessen the impact of falls on the health care system by reducing the number and impact of falls.

BUILDING UPON LEADING PRACTICE

We know that many organizations are already doing great work to reduce falls among seniors. That's why we pulled together leading practices, programs and resources to create a coordinated, consistent approach to measure the effectiveness of falls prevention interventions across the province.

METHODOLOGY

As part of our research, we:

- Conducted an in-depth literature review;
- Surveyed other LHINs with existing, successful multi-sector falls prevention initiatives in place;
- Surveyed experts from other health care sectors and organizations;
- Surveyed the 36 Medical Officers of Health in Ontario; and
- Looked at other jurisdictions with effective falls prevention models.

The input we received is reflected in this integrated and multi-faceted *Framework and Toolkit*.

FALL FACTS

Impact on Seniors:
Falls are a leading cause of injury and death among seniors. A fall can lead to a drastic change in a senior's life such as loss if independence, change in living arrangements, change in level of freedom, even death.
One in three seniors over the age of 65 is likely to fall at least once per year and that risk increases with age, with seniors 85 and older 3.4 times more likely to fall than the general population.

Impact on the Health Care System:
Falls are one of the leading causes of injury among seniors, and often result in avoidable Emergency Department visits, hospitalizations and admission to long-term care homes.
Ontario's annual costs for falls in seniors have been estimated at $962 million.

In the fiscal year 2009:

- 50% of injury-related hospitalizations were due to falls;
- >90% of all hip fractures are due to falls;
- ~55 per 1,000 seniors visited the ED due to a fall; and
- ~13 per 1,000 seniors were hospitalized due to a fall.

Prevention:
Falls among seniors can be prevented. Coordinated, community-wide, multi-strategy initiatives have been shown to significantly reduce fall-related injuries in seniors by up to 33%.
A 20 percent reduction in falls among seniors 55 and over can result in 4,000 fewer hospital stays. The mean length-of-stay for a fall-related injury is about 15 days.

RISK FACTORS*	EXAMPLES
Physiological	Impaired vision, muscle weakness
Socio-demographic	Age, gender, live alone, living in poverty
Medical	History of falls, addictions, arthritis, osteoporosis
Pharmacological	Incorrect use of pain medications, sedatives
Environmental (internal/external)	Steep stairs, clutter/ice, snow, improper lighting
Behavioural	Fear of falling, agitation, confusion

**Risks leading to a fall are not singular. The more risks seniors are exposed to, the more likely they are to fall.*

THE PLAN

At the Local Level:
Each LHIN, in partnership with their respective PHU(s), will be requiredto implement a *LHIN-wide Integrated Falls Prevention Program*, with flexibility to ensure local needs are addressed appropriately. Where LHIN-wide programs already exist, the framework can be used to strengthen those particular programs and ensure consistency is achieved where required.

At the Provincial Level:
The framework also calls for the creation of a provincial structure to perform three main functions:

- Inter-LHIN Coordination
- Standardized Provincial Performance Measurement
- Alignment and Collaboration with Provincial and National Organizations and Initiatives

The provincial structure will be responsible for ongoing education and training, as well as support for provincial communication campaigns targeted to seniors, caregivers and professionals across the province. It will establish and monitor performance indicators and align and collaborate with other provincial and national organizations and initiatives on behalf of the 14 LHIN-wide Falls Prevention Programs.

PROVINCIAL PRIORITY ALIGNMENT

The *Integrated Provincial Falls Prevention Project* is one of the priorities under the LHINs' provincial *Access to Care* plan which includes 10 initiatives to measurably improve Ontarians' access to care. This project aligns with government and LHIN priorities to reduce Alternate Level of Care and Emergency

Department wait times, the province's *Excellent Care for All Act* as it relates to quality improvements and public health's Injury Prevention and Health Communities strategies.

NEXT STEPS

The completion of this *Framework & Toolkit* marks the end of Phase I of the *Integrated Provincial Falls Prevention Project.*

As part of Phase II, we will:

- Share the *Integrated Provincial Falls Prevention Framework & Toolkit* with our stakeholders;
- Implement some of the key actions outlined in this report; and
- Consult with stakeholders on an ongoing basis.

The Integrated Provincial Falls Prevention Project is a joint initiative of:
Ontario's 14 Local Health Integration Networks
Ontario's 36 Public Health Units

Integrated Provincial Falls Prevention Framework & Toolkit – Q & A

What is the purpose of this Framework & Toolkit?

Ultimately, the purpose of the *Framework & Toolkit* is to prevent and reduce the impact of falls among seniors.
Preventing falls as well as lessening the impact of falls on seniors enables them to continue to lead healthy lives independently. In addition, preventing falls can result in significant savings for the health care system.
At the local and provincial levels, the *Framework & Toolkit* provides a consistent approach to preventing falls, including effective monitoring of falls prevention progress across Ontario.
In addition, this report provides a collection of current best practice programs, tools and resources to support the Local Health Integration Networks (LHINs), Public Health Units (PHUs) and other organizations in implementing effective local falls prevention interventions.

Isn't this a duplication of many good falls prevention programs that already exist?

We know that many organizations are already doing great work to reduce falls among seniors.
Our goal was to leverage best programs and best practices from the many successful falls prevention projects underway, in order to optimize resources and avoid duplication.
The *Integrated Provincial Falls Prevention Framework & Toolkit* is not a one-size-fits-all; rather it's a collection of a wide range of successful falls prevention practices from across Ontario and other jurisdictions.
We believe this framework will lead to a more coordinated, consistent approach to falls prevention across the province. This integrated approach to intervention will result in falls reductions and greater efficiencies.

How did falls prevention become a provincial priority?

In September 2010, falls prevention was identified as a top priority by the Ministry of Health and Long-Term Care (MOHLTC). In response, the *Integrated Provincial Falls Prevention Project* was initiated as a LHIN priority project a month later, in partnership with public health.
It brings health system partners together to improve the quality of life and wellbeing of seniors through the prevention of falls and fall-related injuries.
This partnership between LHINs and public health is the first of its kind at this level.

How was the Framework & Toolkit developed?

The Integrated Provincial Falls Prevention Mobilization Committee was established to bring together the LHINs, their Health Service Providers, Public Health Units (PHUs) and Primary Care to formulate an *Integrated Provincial Falls Prevention Framework & Toolkit* that will assist all parties in implementing effective falls prevention initiatives across the province.
The Committee, co-led by the LHINs and PHUs, met five times to formulate the *Framework & Toolkit*. Their work included:

- An in-depth literature review;
- Surveys of other LHINs and Public Health Units with existing, successful multi-sector falls prevention initiatives in place;
- Surveys of experts from other health care sectors and organizations;

- Surveys of the 36 Medical Officers of Health in Ontario; and
- Review of other jurisdictions with effective falls prevention models.

The input we received is reflected in this integrated and multi-faceted *Framework and Toolkit*.

Why was it necessary to create this Framework & Toolkit?

Most falls are avoidable, with proper education, awareness, screening, assessment, intervention and prevention.
Falls can have a devastating affect on the quality of life for our seniors, impacting their mobility, health and independence.
Falls cost the Ontario health-care system billions of dollars, resulting from avoidable visits to the Emergency Department, hospitalizations, high Alternate Level of Care rates, and all too often, admission to long-term care homes.

Seniors:
Falls are a leading cause of injury and death among seniors. One in three seniors over the age of 65 is likely to fall at least once per year and that risk increases with age, with seniors 85 and older 3.4 times more likely to fall than the general population.
A fall can lead to a drastic change in a senior's life such as loss if independence, change in living arrangements, change in level of freedom, even death.

Cost to the Health Care System:
Falls are one of the leading causes of injury among seniors, and often result in avoidable Emergency Department visits, hospitalizations and admission to long-term care homes.
Ontario's annual costs for falls in seniors have been estimated at $962 million.
In the fiscal year 2009:

- 50% of injury-related hospitalizations were due to falls;
- >90% of all hip fractures are due to falls;
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Prevention:
Falls among seniors can be prevented. Coordinated, community-wide, multi-strategy initiatives have been shown to significantly reduce fall-related injuries in seniors by up to 33 percent. A 20 percent reduction in falls among seniors 55 and over can result in 4,000 fewer hospital stays. The mean length-of-stay for a fall-related injury is about 15 days.

That's why we've developed the *Integrated Provincial Falls Prevention Framework & Toolkit*, to serve as a valuable guide for Ontario's LHINs, PHUs, Community Care Access Centres, hospitals, long-term care homes and other stakeholders committed to helping our senior citizens stay healthy, happy, mobile and independent.

What are organizations supposed to do with this Framework & Toolkit?

At the Local Level:

Each LHIN, in partnership with their respective PHU(s), will be required to implement a LHIN-wide Integrated Falls Prevention Program, with flexibility to ensure local needs are addressed appropriately. Where LHIN-wide programs already exist, the framework can be used to strengthen those particular programs using the most current best practice models and ensure consistency is achieved where required.

At the Provincial Level:
The framework also calls for the creation of a provincial structure to perform three main functions:

- Inter-LHIN Coordination
- Standardized Provincial Performance Measurement
- Alignment and Collaboration with Provincial and National Organizations and Initiatives

How does this align with provincial priorities?

The Integrated Provincial Falls Prevention Project is one of the priorities under the LHINs' provincial *Access to Care* plan which includes 10 initiatives to measurably improve Ontarians' access to care. This project aligns with government and LHIN priorities of reducing alternate level of care in hospitals and emergency department wait times, the province's *Excellent Care for All Act* as it relates to improvements in quality and public health's Injury Prevention and Healthy Communities strategies. There is perfect alignment as it relates to this priority.

What's next?

The completion of this *Framework & Toolkit* marks the end of Phase I of the Integrated Provincial Falls Prevention Project.
Phase II focuses on releasing the *Framework & Toolkit* to stakeholders across the province as well as implementing some of the key actions outlined in this report.
There will be ongoing extensive stakeholder consultation. As well, an event is being planned for November for stakeholders to discuss implementation strategies and next steps.

For more information, please call:

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LHINCollaborative

Integrated Provincial Falls Prevention

Framework & Toolkit

July 2011

Ontario
Local Health Integration Network

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*The **LHIN Collaborative (LHINC)** is an advisory structure formed to work at a provincial level to engage with and strengthen relationships among health service providers, their associations and the LHINs collectively on system-wide health issues related to the LHINs' mandate.*

EXECUTIVE SUMMARY

Falling can have a significant impact on seniors, their families and the health care system. Falls can result in a major life change for seniors including loss of independence, change in living arrangements and even death. For the Ontario health care system, the impact of falls is on taxpayers with a cost of millions of dollars every year.

In September 2010, falls prevention was identified as one of the key pan-Local Health Integration Network (LHIN) priorities at the quarterly Stocktake* meeting held by the Ministry of Health and Long-Term Care (MOHLTC) and LHINs. The Integrated Provincial Falls Prevention Project was later ratified as a priority project by every LHIN CEO at the LHIN CEO retreat in October 2010. As a result, a multi-sector provincial working group that was co-led by the LHINs and public health was convened. This working group developed a framework for falls prevention at the local and provincial levels (see Figure E1 below) to ensure a consistent approach to preventing falls across the province. To leverage current leading practices, the toolkit portion of this report collates existing successful programs, tools and resources that can be used by falls prevention administrators across the continuum of care. The completion of this framework and toolkit marks the end of Phase I of the Integrated Provincial Falls Prevention Project. Phase II will focus on releasing this framework and toolkit to stakeholders across the province as well as on implementing some of the key actions outlined in this report. In identifying implementation strategies and next steps, an extensive stakeholder consultation process is being planned.

Falls Prevention Framework

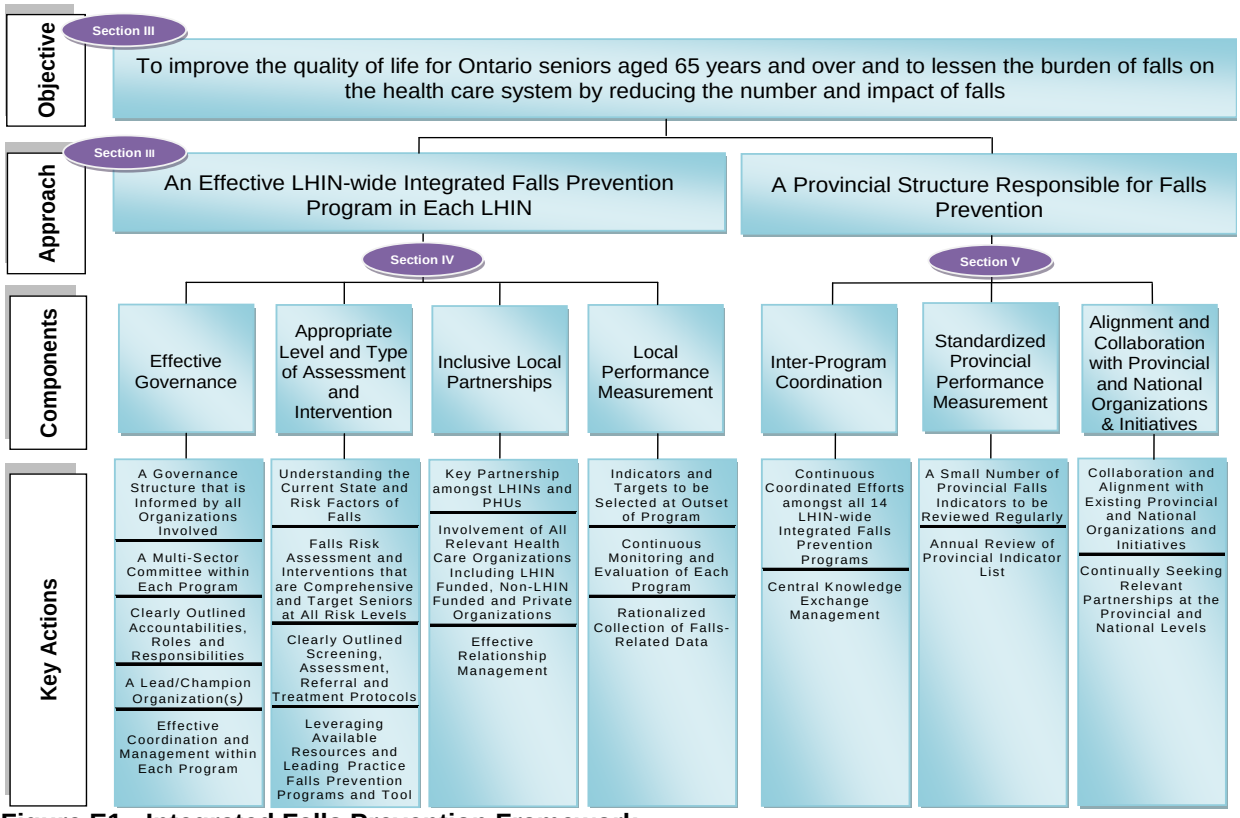


Figure E1: Integrated Falls Prevention Framework

Note: This figure is provided in a larger, more readable format within the body of the report.

* MOHLTC-LHIN Stocktake meetings are held on a quarterly basis to review performance on ED/ALC indicators agreed upon by both parties.

Objective

The main objective, as outlined in Figure E1 above, is to *"improve the quality of life for Ontario seniors aged 65 years and over and lessen the burden of falls on the health care system by reducing the number and impact of falls".* With the increase in the population demographic that is 65 years of age and older, it is important that quality of life outcomes are achieved. Preventing falls as well as lessening the impact of falls would contribute to ensuring seniors lead healthy lives independently. In addition, preventing falls can result in significant savings for the health care system. This objective was formulated in a way so that it resonates with many different sectors and organizations, which will support effective collaboration and integration.

Approaches and Components

To achieve the main objective, the following two approaches which are further described below are recommended (see Figure E1):

1) An effective LHIN-wide Integrated Falls Prevention Program in each LHIN; and
2) A provincial structure responsible for falls prevention

The first approach, an effective LHIN-wide Integrated Falls Prevention Program in each LHIN, as well as a component of the second approach, provincial performance measurement, are required; and therefore **must** be implemented. These are described further in their relevant sections below.

1) **An Effective LHIN-wide Integrated Falls Prevention Program in Each LHIN**

A LHIN-wide Integrated Falls Prevention Program **must** be implemented in each LHIN catchment area. Although some consistency is required, there is a great deal of flexibility with respect to the approaches used in implementing each LHIN-wide Integrated Falls Prevention Program and the complexity of each program to ensure local needs are addressed appropriately. To facilitate the LHINs, public health units (PHUs) and their partners in implementing effective LHIN-wide Integrated Falls Prevention Programs, the framework outlines four components that should be addressed by each program. Where programs exist, this framework and toolkit can be used to strengthen them and ensure consistency is achieved where required.

The four key components of an effective LHIN-wide Integrated Falls Prevention Program in each LHIN and the key actions within each of these components are outlined in Figure E1 and briefly described below.

a. Effective Governance

With multiple local parties involved in each LHIN-wide Integrated Falls Prevention Program, it is important to have a clear and effective governance structure in place. Since a governance structure would typically outline accountabilities, key roles and responsibilities of each participating organization, those organizations should be involved in the development of such a structure. An integral part of the governance structure would be the formation of a multi-sector committee. This allows all relevant organizations and sectors that are currently involved in the field of falls prevention or who have an interest in preventing falls in seniors to have input into the overall program. The exact structure and meeting frequency of the committee would vary, depending on the local needs and realities of each LHIN geographic area and the complexity of the program. In implementing each LHIN-wide Integrated Falls Prevention Program, a champion organization(s) would also be important as part of the overall governance structure. This organization(s) would act as a role model for the other organizations involved and may play a key role in implementation. This organization(s) would have a passion for the subject as well as experience in preventing falls in seniors. With many

parties involved, effective coordination and management of the program is required to attain efficiency and continuity.

b. Appropriate Level and Type of Assessment and Intervention

To ensure the appropriate level and type of assessment and intervention are achieved, pertinent risk factors for falls and existing falls prevention initiatives should be identified and well understood by each LHIN-wide Integrated Falls Prevention Program. Once the needs and gaps within the LHIN catchment area are identified, each LHIN-wide Integrated Falls Prevention Program can then plan to ensure that assessments conducted and interventions offered as part of the program (if any) are comprehensive and target all risk levels to the greatest extent possible. Assessments and interventions currently being offered within participating organizations should be leveraged by each LHIN-wide Integrated Falls Prevention Program before any new ones are created. An important component of the program is to clearly outline the screening, assessment, referral and treatment protocols for all program administrators to ensure consistency. Since there are many leading practices, resources and tools readily available to administrators, each LHIN-wide Integrated Falls Prevention Program should be able to identify such resources and leverage them appropriately.

c. Inclusive Local Partnerships

Falls prevention is an issue of importance to a number of organizations and sectors. As such, it is important that those interested in preventing falls in seniors partner and collaborate to leverage their experiences and resources. The LHINs and PHUs would play a key role through partnering and collaborating at the local and provincial levels. Many other sectors and organizations whether LHIN-funded, public non-LHIN funded or private, also have critical roles to play. To harness and maintain the required partnerships, effective relationship management is required.

d. Local Performance Measurement

At the local level, each LHIN-wide Integrated Falls Prevention Program should select indicators (in addition to the provincial indicators described later) at the outset of the program for regular review. Each LHIN-wide Integrated Falls Prevention Program would have the flexibility in measuring its effectiveness depending on local needs, complexity of the program and how the program is administered. It is recommended that each LHIN-wide Integrated Falls Prevention Program leverage current data collection methods and data sources before investigating new ones.

2) A Provincial Structure Responsible for Falls Prevention

This second approach to achieving the main objective suggests that a provincial structure is required to perform three main functions as described below. The provincial structure may involve a number of existing or newly created entities. The LHINs and PHUs would play a key leadership role within this structure.

a. Inter-Program Coordination

The provincial structure would facilitate and coordinate activities that are relevant to the 14 LHIN-wide Integrated Falls Prevention Programs. Such activities may include education or training events that would be valuable to all program administrators as well as supporting provincial communication campaigns targeted to seniors, caregivers and professionals across the province. The provincial structure would also manage knowledge exchange across the 14 LHIN-wide Integrated Falls Prevention Programs. This may be achieved through use of a web-based resource that allows information sharing and through planning and implementing knowledge exchange events for all 14 LHIN-wide Integrated Falls Prevention Programs. Through such knowledge exchange forums, the 14 LHIN-wide Integrated Falls Prevention Programs can share their experiences and learn from one another as well as continue to leverage leading practices.

b. Standardized Provincial Performance Measurement

To measure the effectiveness of falls prevention efforts across the province, a number of consistent performance indicators **must** be monitored for each LHIN-wide Integrated Falls Prevention Program. This framework outlines three indicators that will be monitored at a provincial level by the provincial structure on a regular basis. These indicators are ones that do not require additional data collection processes to be developed by the 14 LHIN-wide Integrated Falls Prevention Programs. Rather, they can be extracted from existing databases by the provincial structure. The indicators are:

- Falls-related admissions to hospitals from emergency department (ED) per 100,000 seniors aged 65 years and older;
- Number of falls-related ED visits per 100,000 seniors aged 65 years and older; and
- Repeat ED visits for falls in the past 12 months at the beginning of the rolling 12-month period per 100,000 seniors aged 65 years and older.

c. Alignment and Collaboration with Provincial and National Organizations and Initiatives

There are a number of provincial and national organizations and initiatives whose work may have an impact on falls in seniors such as Residents First and the Ontario Osteoporosis Strategy to name a few. The 14 LHIN-wide Integrated Falls Prevention Programs should align and in some cases collaborate with these organizations and initiatives to avoid overlap and maximize resources. To avoid duplication of effort, the provincial structure would align and collaborate with those organizations and initiatives on behalf of the 14 LHIN-wide Integrated Falls Prevention Programs. With time, new provincial organizations or initiatives may emerge; and therefore, the provincial structure will need to continually seek relevant partnerships with these new and emerging organizations and initiatives.

Falls Prevention Toolkit

This part of the report outlines a select number of falls prevention tools under the categories listed below. A brief description, the author, the year, the main audience and access method is provided for each tool.

- Best Practice Guidelines
- Implementation Guides
- Falls Prevention Toolkits
- Existing LHIN-wide and/or Multi-sector Falls Prevention Programs
- Leading Falls Prevention Interventions
- Web-Based Resources
- Falls Prevention Guides Targeted to Seniors

Section I: Introduction

A. Impact of Falls In Ontario

Marie Oberle is a 92-year-old woman who lived alone and had maintained an independent active and social life until she experienced a second fall. Marie's first fall was outdoors and occurred suddenly while she was standing due to weakness in her legs caused by heart problems and arthritis. At that time, Marie experienced facial injuries, but was able to continue living at home independently. Unfortunately, Marie developed a fear of falling and became less active to avoid falling again. As time passed, Marie became frailer and began to wall walk in her home to get from one place to the other. In 2009, Marie's daughter Marguerite found her mother flat on the bedroom floor and was forced to call an ambulance to take her mother to the hospital. After a 10-day hospital stay, the family was shocked with the news that their mother will be unable to live independently in her own home moving forward. From that day forth, Marie's family became involved in Marie's care in different ways. Arrangements were made immediately for Marie to live in a retirement residence, an option accepted but not preferred, by Marie. Marie's home had to be sold and Marie's life became quite different. Marie is now unable to do some of the things that she loved like hosting parties and cooking for her family and friends. She requires a driver to go out to the hairdresser and other places. With early intervention and the right supports and services for Marie and her family, Marie's story could have had a different ending where Marie would have been able to sustain her independence for a longer time while living in her own home.

Falls* are prevalent amongst people over the age of 65 (seniors) and can significantly change a senior's life. It is estimated that one in three seniors are likely to fall at least once per year [World Health Organization (WHO), 2007]. This is especially alarming since seniors are the fastest growing population, with an increase of 12% from 2001 to 2006 (Ministry of Finance, 2006). A fall for a senior can mean disability, change in level of function, loss of independence, change in living arrangements or even death. In 2006, almost half of all injury-related deaths amongst seniors in Canada were caused by falls (Butler-Jones, 2010).

Falls are one of the leading causes of preventable injury in Ontario amongst seniors and often lead to avoidable emergency department (ED) visits, hospitalizations, and admissions to long-term care homes. In the fiscal year 2009, falls were responsible for 95.1% of all hip fractures. In that same year, approximately 50% of injury-related hospitalizations in seniors were due to falls while the age-adjusted ED visit rate in Ontario reached approximately 55 ED visits per 1,000 seniors and the hospitalization rate reached approximately 13 per 1,000 seniors (see graphs and data sources in Appendix A).

Unintentional injuries due to falls are the costliest category of injury within the Ontario health care system [Ontario Injury Prevention Resource Centre (OIPRC), 2007]. Ontario's annual costs for falls in seniors have been estimated at $962 million (OIPRC, 2007). Therefore, reductions in the number and rate of falls can have a significant impact on the health care system [Medical Advisory Secretariat (MAS), 2008].

Fortunately, falls can be prevented to increase the quality of life for seniors and to alleviate the burden on the health care system. Many existing programs and strategies have demonstrated the reduction of falls amongst seniors by 20% and more (SMARTRISK, 2006). It is estimated that a 20% reduction in falls among seniors aged 55 years and over could result in 1,000 fewer older adult permanent

*For the purposes of this framework, a fall is defined as an event that results in a person coming to rest inadvertently on the ground or floor or other lower level, with or without injury (RNAO, 2005).

disabilities and 4,000 fewer hospital stays. The direct health care costs avoided would amount to almost $121 million annually (SMARTRISK, 2006). With a mean length of stay for a falls-related injury being approximately 15 days, 4,000 hospital stays can equate to a significant number of hospitals days avoided (Scott, Wagar & Elliott, 2010).

B. Falls Prevention Initiatives in Ontario

Recognizing the importance of preventing falls in seniors, many Ontario Local Health Integration Networks (LHINs), public health units (PHUs) and health service providers (HSPs) are delivering falls prevention initiatives. Currently, six of the 14 LHINs are following/have followed an integrated, multi-sector approach in their falls prevention efforts. Most of the LHINs, including those with a LHIN-wide or multi-sector program, have implemented falls prevention interventions as part of the Aging at Home Strategy.

Although many of these initiatives are demonstrating positive results, their full potential has not yet been realized as they are being implemented in a fragmented, inconsistent manner across the province. There is no generally accepted provincial framework to guide LHINs, HSPs and PHUs in effectively preventing falls in seniors across all settings and across all of Ontario collectively. With the absence of such a framework, coordination and integration amongst health providers and the evaluation of falls prevention efforts are minimal. In addition, there exists variation across the LHINs with respect to falls prevention efforts as well as ED and hospitalization rates due to falls, demonstrating an opportunity to achieve some consistency across the province (see Appendix A).

Case for Action

With the lack of coordination and integration, resources are not optimally utilized, leading practices are not adequately shared and potential duplication or gaps in work can occur, impacting the quality of prevention measures and delivery of care. A provincial falls prevention framework is therefore needed in Ontario to ensure the appropriate level of integration at the LHIN and provincial levels and to ensure a standardized approach to performance measurement. Coordinated, community-wide, multi-strategy initiatives to preventing falls have been shown to significantly reduce falls-related injuries in seniors by between 6% and 33% (McClure et al., 2005). Thus, a coordinated and integrated provincial approach to falls prevention can strengthen current efforts in preventing falls and more effectively reduce falls and the impact of falls on seniors.

C. Overview of Integrated Provincial Falls Prevention Project

In September 2010, falls prevention was identified as one of the key pan-LHIN priorities at the quarterly Stocktake* meeting held by the Ministry of Health and Long-Term Care (MOHLTC) and LHINs. The Provincial Integrated Falls Prevention Project was later ratified as a priority project by every LHIN CEO at the LHIN CEO retreat in October 2010. Given the LHIN Collaborative's (LHINC's) mandate of fostering collaboration among the LHINs and HSPs and engaging relevant stakeholders on system level issues, LHINC was approached to support this Project.

*MOHLTC-LHIN Stocktake Meetings are held on a quarterly basis to review performance on ED/ALC indicators agreed upon by both parties.

A working group, the Integrated Provincial Falls Prevention Mobilization Committee (Mobilization Committee), brought together the LHINs, public health and a number of organizations from different health sectors and organizations to develop the Integrated Falls Prevention Framework and Toolkit (see Appendix B for Mobilization Committee membership).

Since PHUs play a key role in falls and injury prevention, collaboration with PHUs at the provincial level is necessary. The key partnership and collaboration between the LHINs and PHUs in this initiative is demonstrated through the co-chairing of the working group by Dr. Paul Roumeliotis, Chair of the Council of Medical Officers of Health (at the time) and the Medical Officer of Health and CEO of the Eastern Ontario Health Unit; along with Bernie Blais, the CEO of the North Simcoe Muskoka LHIN.

This collaboration between the LHINs and public health at the provincial level is the first of its kind. It is anticipated that this will lead to further collaborations between the two sectors to achieve better health care outcomes.

There are two phases to the Integrated Provincial Falls Prevention Project. The first phase is marked by the completion of this report. Phase II will focus on releasing this report to stakeholders across the province as well as on implementing some of the key actions. In identifying implementation strategies and next steps, an extensive stakeholder consultation process is being planned.

Purpose of This Report

The ultimate goal is to improve the quality of life for seniors by reducing the rate and impact of falls, in turn decreasing the rates of ED visits and hospitalizations through the implementation of this framework. Such a decrease in falls, ED visits, and hospitalizations will likely result in decreases in the alternate level of care (ALC)* rate due to falls. This report provides a framework for falls prevention at the local and provincial levels to ensure a consistent approach to preventing falls. At a provincial level in particular, the framework ensures effective monitoring of falls prevention progress across Ontario. In addition, this report provides a collection of current best practice programs, tools and resources to support the LHINs, PHUs and other organizations in implementing effective local falls prevention interventions. The main audience of the report would therefore be administrators of falls prevention programs and interventions in the aforementioned organizations.

D. Alignment with Provincial Priorities

The work of the LHINs and PHUs with respect to falls prevention must align with the priorities of the MOHLTC and of the Ministry of Health Promotion and Sport (MHPS). For the MOHLTC, the reduction in ED/ALC rates has been a priority for many years. This framework aims to reduce falls and the impact of falls on seniors, which will likely reduce ED visits due to falls and will ultimately reduce the ALC rate.

In addition, the reduction of the impact of falls naturally aligns with the MOHLTC's *Excellent Care for All Act (ECFAA)*, which fosters a culture of continuous quality improvement in health care by requiring health care organizations to undertake certain quality-related activities. Specifically, falls prevention considerations can be found under the domain of Safety in the quality improvement plan framework adopted by the MOHLTC (MOHLTC, 2011). When

* Patients are designated as ALC when they occupy an acute care bed although they are well enough to be in a non-acute setting thereby unnecessarily occupying a needed and limited resource.

reducing falls and the impact of falls on seniors, seniors directly benefit as they experience better health outcomes and a higher quality of life. Also, with fewer falls and the system less burdened, seniors can be more assured that an effective health care system with sufficient capacity is available to serve them when they need it most.

The goal of this project to reduce falls also aligns with the MHPS's Injury Prevention Strategy which aims to reduce the frequency, severity and impact of preventable injury in Ontario overall and in all ages (MHPS, 2007). With integration and inclusive partnerships being an integral part of the Integrated Falls Prevention Framework (see Figure E1), the framework is also consistent with the MHPS' *Healthy Communities* initiative. This initiative envisions "healthy communities working together and Ontarians leading healthy and active lives" (MHPS, 2011a) and provides funding for community partnerships to plan and deliver integrated programs.

E. Methodology

The Mobilization Committee met five times over the course of the project to formulate this Framework and Toolkit. At the initial stages of the project, a high-level document scan of the LHINs was conducted to better understand the types of falls prevention initiatives currently funded and/or monitored by the LHINs. A preliminary literature review was then conducted, from which 48 relevant references were identified. Findings from this review were summarized in "A Preliminary Literature Review on Falls Prevention for the Elderly" (see Appendix C for Summary of Literature Review Findings). The literature review focused on the following four key areas:

- Leading practices in implementing a successful falls prevention program/strategy;
- Greatest risk factors of falls in the elderly;
- Best practice interventions; and
- Performance indicators and metrics used to measure effectiveness of falls interventions.

A key finding from this review was that effective falls prevention programs often involve comprehensive and inclusive partnerships. As such, the six LHINs with comprehensive, multi-sector falls prevention programs were surveyed and interviewed in-depth to identify key success factors in implementing their programs. Additional objectives of the LHIN surveys were to collate leading practices and obtain feedback with regards to the provincial falls prevention framework.

Through surveys and interviews conducted with members of the Mobilization Committee, other sectors' and organizations' viewpoints with regards to their role as part of the integrated falls prevention framework were solicited. The 36 Medical Officers of Health were also surveyed to better understand the current role of PHUs in falls prevention as it pertains to the public health standards as well as their potential role within an integrated provincial falls prevention framework.

Key subject matters experts as well as leaders of key programs and initiatives identified by members of the Mobilization Committee and LHINC Council were consulted (see Appendix D for list of subject matter experts and programs/initiatives consulted). With British Columbia (BC) recognized as a leading province in falls prevention, their falls prevention model was also reviewed at a high level (see Appendix E for BC model). Findings of the research efforts were synthesized and were used by the Mobilization Committee as inputs into the development of the

key actions outlined within this report. This broad, consultative process allowed for the development of a comprehensive, integrated and multi-faceted approach to falls prevention that is reflected in this Framework and Toolkit.

Section II: Overview of the Integrated Falls Prevention Framework

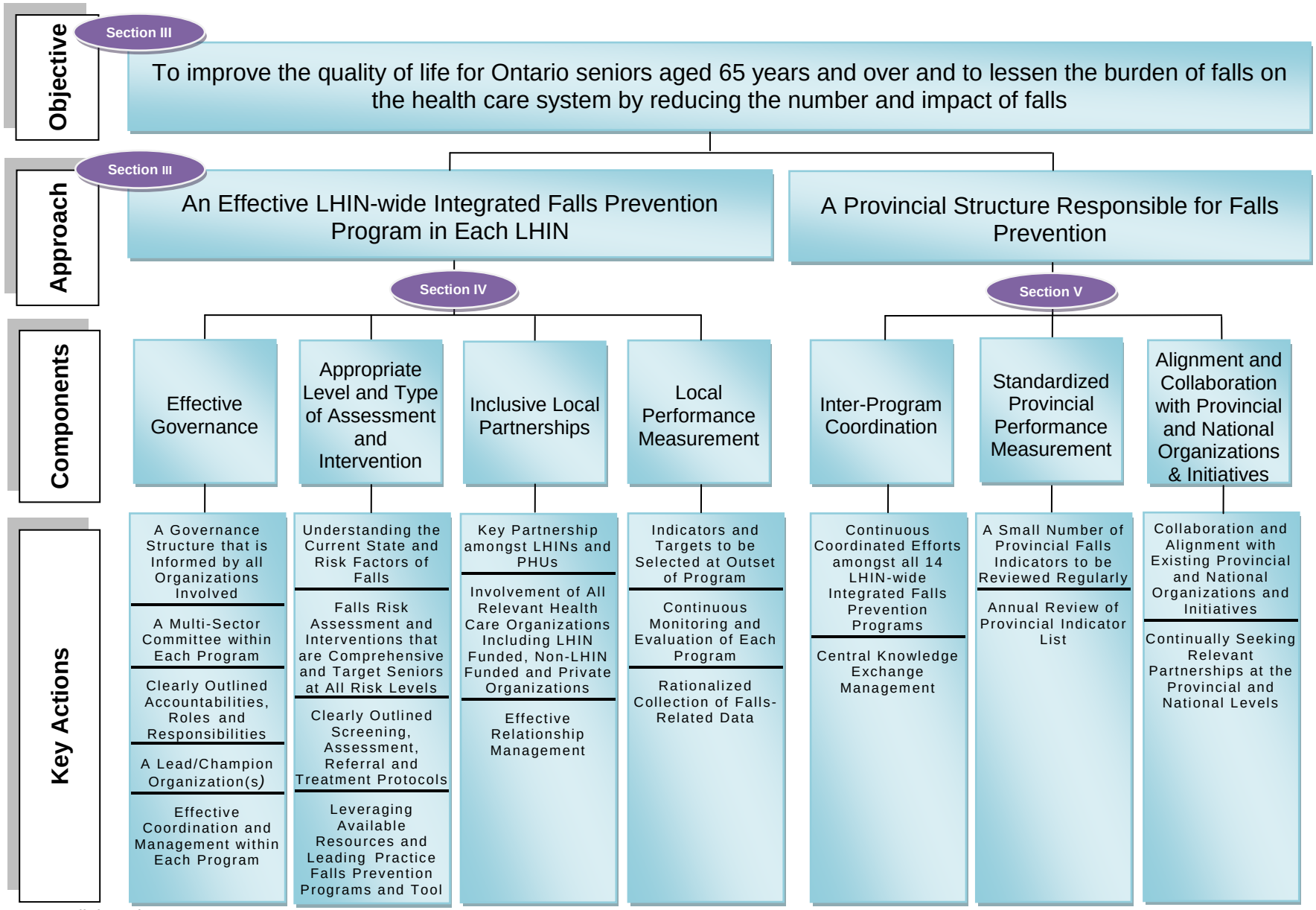
The Integrated Falls Prevention Framework depicted in Figure 1 below outlines the falls prevention objective for Ontario and how that objective can be achieved by the LHINs, PHUs and other organizations (the corresponding section numbers that describe each part of the framework are illustrated in the diagram below). The main objective of the project as described previously is to reduce the number of falls as well as the impact of falls on Ontario seniors aged 65 and over thereby improving their quality of life and reducing the burden of falls on the health care system.

This framework suggests that the main two approaches in achieving this objective are as follows:

1) An effective LHIN-wide Integrated Falls Prevention Program in each LHIN; and
2) A provincial structure responsible for falls prevention.

The framework also illustrates the components of the two approaches. The components necessary to establish each effective LHIN-wide Integrated Falls Prevention Program are: effective governance; local integration and inclusive partnerships; comprehensive and evidence-based assessment and intervention; and local performance measurement. In order to achieve the second approach, there should be inter-program coordination and knowledge exchange, provincial standardized performance measurement as well as alignment of the 14 LHIN-wide Integrated Falls Prevention Programs with provincial and national organizations/initiatives. Each of these components as well as the key actions that fall within them will be described in detail in this report.

Figure 1: Integrated Falls Prevention Framework



Section III: Objective and Approach

A. Objective

To improve the quality of life for Ontario seniors aged 65 years and over and to lessen the burden of falls on the health care system by reducing the number and impact of falls

The framework aims to achieve better outcomes for the 65+ age group through a number of interventions and actions primarily targeted at this specific age group. Reducing falls in this age group is critical since this cohort is growing and prone to falling. The framework also describes preventative efforts at an earlier age so that when seniors reach the age of 65, they are less likely to fall or suffer a falls-related injury.

B. Approach

An Effective LHIN-wide Integrated Falls Prevention Program in Each LHIN

The approach of this framework requires a LHIN-wide Integrated Falls Prevention Program in each LHIN catchment area. The intent of having such a program in each LHIN geographic area is to ensure a more coordinated and collaborative effort among the LHINs, PHUs and other organizations in preventing falls in seniors. This will result in efficiencies within each LHIN catchment area as falls prevention activities are more effectively coordinated. For those LHINs that have a LHIN-wide or multi-sector falls prevention program, this Framework and Toolkit will serve to further strengthen the existing programs. See Table 7 in Section VI for examples of existing key LHIN-wide/multi-sector Programs and related contact information.

Given that the 14 LHINs vary in geography, stakeholder relationships, population demographics and existing falls prevention initiatives, it is anticipated that each LHIN-wide Integrated Falls Prevention Program will be implemented slightly differently to address local needs. Therefore, although this framework outlines areas where consistency should be achieved across the province, it still allows for variability in implementing some of the key actions based on the unique needs of the communities in each of the 14 LHIN catchment areas.

A Provincial Structure Responsible for Falls Prevention

As each LHIN-wide Integrated Falls Prevention Program is being implemented, managing inter-LHIN/PHU interaction, as well as collaborating and aligning with key provincial and national organizations and initiatives can be quite challenging for each of the 14 programs. To collaborate and align at the provincial and national levels, a dedicated provincial structure is needed. In addition, the provincial structure would evaluate performance at a provincial level to inform provincial progress with respect to falls prevention. This provincial structure can be an existing or newly created entity which may involve a number of parties and would operate on behalf of all the LHINs and PHUs.

The provincial structure is vital to ensuring the Ontario falls prevention framework is adhered to and that the 14 LHIN-wide Integrated Falls Prevention Programs have the support they require to implement this report's recommendations. With provincial performance measurement and coordination and alignment occurring at the provincial and national level, system-wide efficiencies can be achieved.

Section IV: Components and Key Actions for an Effective LHIN-wide Integrated Falls Prevention Program in Each LHIN

Within each of the four components of having an effective LHIN-wide Integrated Falls Prevention Program, there are key actions that should be executed by the LHINs, PHUs and their partners. This section outlines and describes the four components and the key actions in detail.

A. Effective Governance

Effective governance is crucial for every program to succeed as it ensures that the necessary accountabilities and relationships are in place. Effective governance enables program goals and objectives to be achieved.

A Governance Structure that is Informed by all Organizations Involved

Before finalizing a governance structure, regardless of how complex or simple, feedback should be solicited from all organizations interested in being involved in the LHIN-wide Integrated Falls Prevention Program. This is especially important to ensure full buy-in and commitment to the shared goal of each LHIN-wide Integrated Falls Prevention Program. Furthermore, such engagement will allow for a better understanding of governance structures that currently exist within or between participating organizations.

A Multi-Sector Committee within Each LHIN-wide Integrated Falls Prevention Program

Falls prevention is a topic of importance for many organizations and health sectors and thus there are many falls prevention initiatives currently underway in Ontario. To ensure a comprehensive and effective approach to falls prevention, all relevant parties should be involved in each LHIN-wide Integrated Falls Prevention Program within the geographical area of a LHIN. The recommended approach, subject to local considerations, is an integrated, multi-sector falls prevention committee (hereafter referred to as the core committee). The sectors and organizations to consider as part of such a committee will be discussed in Section IV.C.

- *Involvement of all relevant local organizations*
- *Involvement of leadership and front line staff*
- *Committee structure and frequency depends on local needs*
- *Commitment from all parties*

Depending on the complexity of each LHIN-wide Integrated Falls Prevention Program, the core committee would vary in structure and meeting frequency. The core committee could range from a well-established, fully operational structure which meets regularly (e.g. monthly) and is heavily involved in the day-to-day operations of the program to a body that brings together a group of representatives from the various relevant sectors and meets much less regularly (e.g. bi-yearly or yearly) to inform key areas of

focus of the program. Regardless, this core committee should recognize existing regional coalitions within the LHIN geographic area and align or collaborate with those existing coalitions. The core committee may be involved in some or all of the following activities depending on its structure and meeting frequency:

- Providing a forum for different sectors to exchange leading practices and experiences
- Organizing LHIN-wide multi-sector events related to falls prevention
- Planning and developing the program, this includes identifying existing interventions/programs within the LHIN catchment area and outlining the additional interventions required to be provided as part of the program
- Ensuring roles and responsibilities of participating organizations are clearly outlined.
- Monitoring the implementation efforts of newly created interventions as part of the program
- Evaluating program effectiveness through the evaluation of the various interventions that make up the program
- Facilitating capacity and readiness assessment of interested organizations to ensure organizations can effectively participate in the program
- Investigating funding opportunities through the various partners

The core committee should include members that are at the executive/management levels as well as members at the front-line level to ensure both perspectives are considered. Also, commitment from all parties involved is critical to achieving the planned outcomes and to ensuring continuity of each LHIN-wide Integrated Falls Prevention Program. See Appendix F for a sample governance structure currently in place in one of the existing LHIN-wide and/or multi-sector falls prevention programs.

Clearly Outlined Accountabilities, Roles and Responsibilities

The roles and responsibilities of the parties outlined in the structure should be clearly documented in as much detail as possible from the outset of each LHIN-wide Integrated Falls Prevention Program. There are many different types of documents that can be used for this purpose; such as a terms of reference, an accountability agreement, partnership agreement, and funding and service agreement (see Appendix G for sample accountability documents) depending on the needs of the program. All representatives need to clearly understand their role as well as their organization's role in the program. The most effective way to ensure that this understanding is present is to have a formal sign-off of the documentation.

A Lead / Champion Organization(s)

A lead/champion organization or organizations should be identified to act as the model for other organizations and to lead some of the implementation efforts for each LHIN-wide Integrated Falls Prevention Program, where applicable. Core components of each LHIN-wide Integrated Falls Prevention Program may be coordinated or delivered by a lead organization(s) within the LHIN catchment area such as a falls prevention clinic, a central referral service or even training and education of staff. Key characteristics of the lead organization(s) would include a demonstrated passion for preventing falls among seniors, experience in falls prevention and capacity to manage some of the core components of a LHIN-wide

Role of the lead organization(s):

- *Delivery of certain initiatives that are part of LHIN-wide Integrated Falls Prevention Program*
- *Leverage current relevant partners*

Integrated Falls Prevention Program. Being in a leadership position, the lead organization(s) would have the responsibility of leveraging its current partnerships relevant to falls prevention by soliciting their partners' support and investigating opportunities for their inclusion into the overall LHIN-wide Integrated Falls Prevention Program. The lead organization(s) would play a critical role and thus should be selected carefully by each LHIN-wide Integrated Falls Prevention Program.

Effective Coordination and Management of Each LHIN-wide Integrated Falls Prevention Program

- *Effective coordination and support of core committee activities*
- *Building relationships amongst participating organizations*
- *Support of newly created interventions*

Activities of each LHIN-wide Integrated Falls Prevention Program require effective coordination and support. Key coordination functions in managing the program include building effective relationships with the parties involved, continually fostering collaboration amongst them and identifying new local collaborations to consider. Much of the success of the program will be based on the strength and effectiveness of relationships amongst the parties involved, which will be discussed further in Section IV.C. In addition, should new interventions be initiated to be part of a LHIN-wide Integrated Falls Prevention Programs, implementation of those interventions will require adequate support as well as consideration of the variation that exists across organizations related to mandate, available resources and implementation expertise. As such, the level of support provided to each participating organization would vary and may even extend to include coaching and mentoring of the staff of the organization in question. Another key activity requiring a coordination effort is the collection of local data to effectively monitor and evaluate each LHIN-wide Integrated Falls Prevention Program.

Each LHIN-wide Integrated Falls Prevention Program could assign a dedicated falls prevention coordinator to conduct the key functions outlined in this section or could distribute the key functions amongst current resources within any of the participating organizations.

Coordination and collaboration amongst the 14 programs will also be required; however this would be the role of the provincial structure described in Section V.

B. Appropriate Level and Type of Assessment and Intervention

At the program level, it is important to ensure that the assessment for falls and interventions to prevent falls are comprehensive in that the majority of seniors aged 65+ would be screened or assessed for the risk of falls and that there are a wide variety of interventions targeting all risk levels provided to seniors to alleviate the risk of falling. Since there are many evidence-based and validated falls prevention practices that have shown great success within Ontario, across Canada and around the world, these should be leveraged when formulating a LHIN-wide Integrated Falls Prevention Program in each LHIN.

This section describes the key actions to ensure the appropriate level and type of assessment and intervention is provided or referred to by each LHIN-wide Integrated Falls Prevention Program.

Understanding the Current State and Risk Factors of Falls

Current State of Falls

Each LHIN-wide Integrated Falls Prevention Program should identify the main causes of falls and common settings where falls occur in its catchment area to help determine the target populations and how to intervene in those target populations.

- *Identification of main causes, common settings, risk factors and trends of falls in seniors residing in the program's catchment area*
- *Risk factors are often multi-factorial and may be challenging to uncover*

While some interventions can be offered to the general public, there may be specific populations that require extra attention. By using the data resources described in Section IV.D, each LHIN-wide Integrated Falls Prevention Program can identify the trends associated with falls as well as where falls occur and what may have caused them.

Risk Factors for Falls

Risks leading to a fall are not singular, rather they are multi-factorial. It is likely that the more risks the senior is exposed to the more likely they are to fall. In addition, it can be difficult to uncover some risk factors and thus it is important to know the various risks to consider and ensure these risks are adequately assessed.

There have been more than 400 falls risk factors documented in the literature to-date (Morris, 2007). These risk factors can be grouped into six categories: physiological, socio-demographic, medical, pharmacological, environmental and behavioural. Rather than trying to address all risk factors at once, each LHIN-wide Integrated Falls Prevention Program should identify and then focus on the most significant and modifiable risk factors within its geographic area first. Figure 2 below provides some examples within each of the risk factor categories. It should be noted that the list below is not a comprehensive one and that these risk factors are not in order of priority or importance, rather they are listed in alphabetical order.

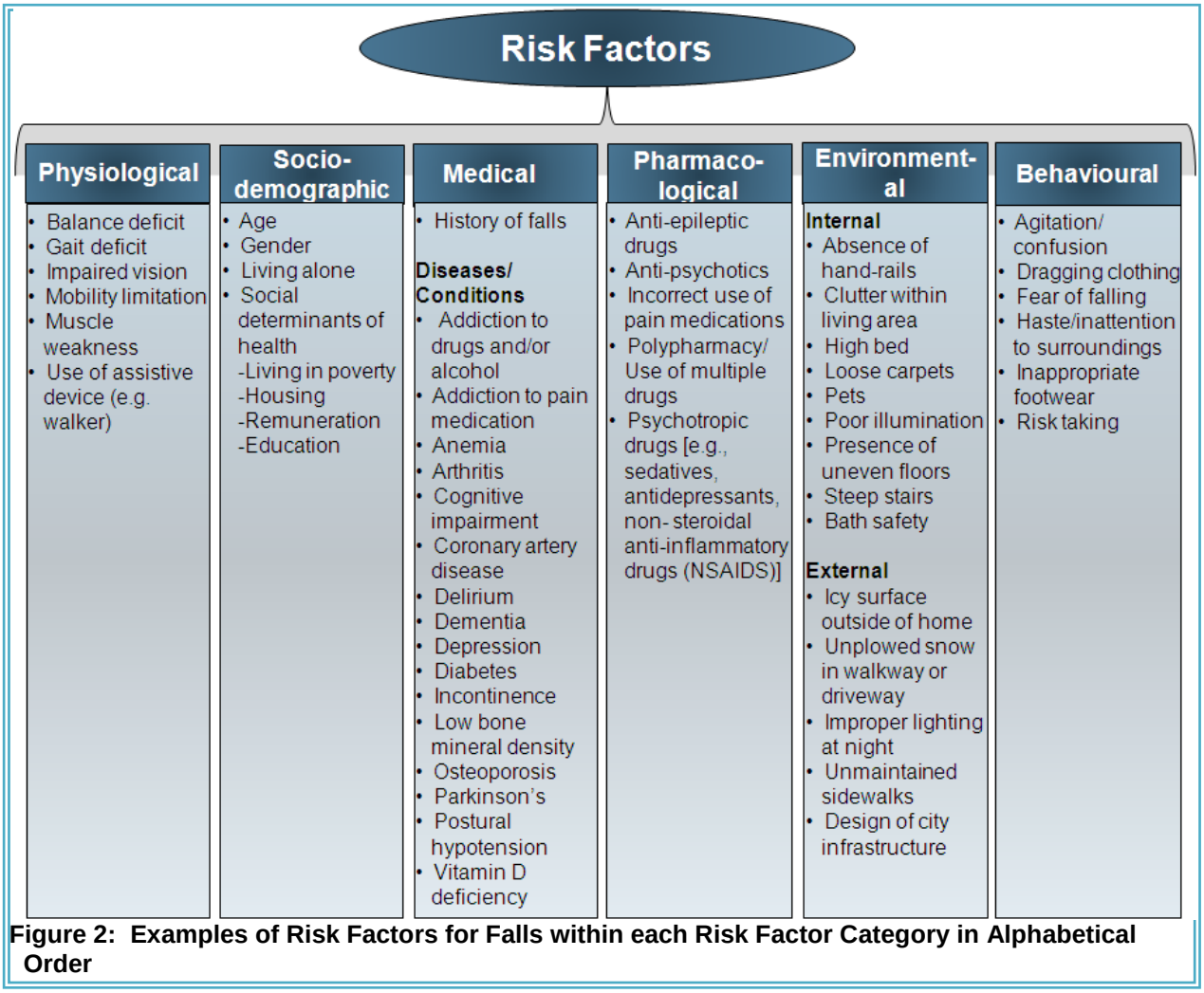


Figure 2: Examples of Risk Factors for Falls within each Risk Factor Category in Alphabetical Order

Falls Risk Assessment and Interventions that are Comprehensive and Target Seniors at All Risk Levels

To effectively reduce the rate and burden of falls in the population, each LHIN-wide Falls Prevention Program should consider seniors at all risk levels when deciding on their intervention strategies. The goal of each LHIN-wide Integrated Falls Prevention Program should be to provide a comprehensive set of interventions that address both individual and environmental risk factors.

The level of assessment and the type of intervention will largely depend on the risk level of the particular senior (see Figure 3). Screening and follow-up is an individual approach to falls prevention. Low risk seniors are likely to never have fallen, would be leading relatively healthy lives and may have a low number of risk factors for falls present. Healthy older adults who are not yet 65 years of age may be targeted with preventative interventions to lessen risk of falling after the age of 65. High risk seniors, on the other hand, are often frail, have fallen before and have a large number of risk factors for falls.

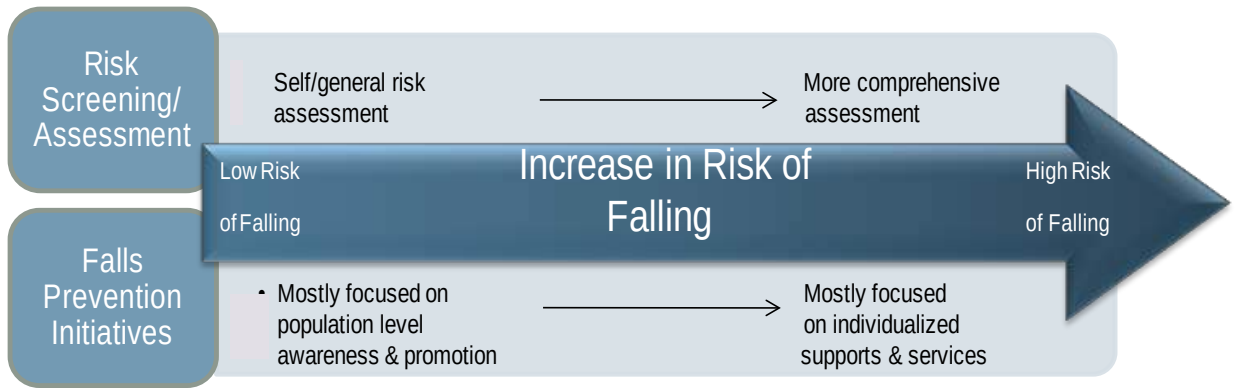


Figure 3: Relationship between Screening/Assessment & Interventions and Risk of Falling

Screening

At an individual level, screening is the first step in determining falls risk and the most appropriate intervention to reduce the risk of falling. Generally, screening can be done by health care providers, caregivers and personnel that regularly interact and deal with seniors. It is also sometimes used as a simple and quick investigation of the need for a more in-depth assessment for falls risk.

Assessment

Assessment can be the first or second step depending on whether screening was conducted or not. Seniors in the low risk category should be offered a simple assessment that may even be a self assessment (see sample in Appendix H), whereas those at the high risk level require a more comprehensive risk assessment (see Figure 3). The more comprehensive assessments are best conducted by a multi-disciplinary health care team including a physician, physiotherapist (PT) or occupational therapist (OT), registered nurse (RN)/registered practical nurse (RPN), pharmacist and other health care professionals as deemed necessary. Comprehensive risk assessments would include all or some of the following: assessment of the home for any environmental hazards; thorough assessment of current medications; a full medical assessment; assessment of gait and balance; assessment of equipment such as walkers and wheelchairs; and assessment of underlying addictions or recreational use of non-prescription drugs and/or alcohol.

- *Screening and assessment is the first step in determining the most appropriate individualized intervention*
- *Falls risk assessments can range from being simple and quick to being more thorough and comprehensive*
- *Falls risk screening and assessment should be provided through as many avenues as possible*
- *Individuals assessing for falls risk can begin the patient tracking process*
- *There are many validated and reliable screening and assessment tools that can be used*

<u>Screening and Assessment Settings</u>

Ultimately, each LHIN-wide Integrated Falls Prevention Program should aim to screen/assess as many seniors aged 65+ as possible within its catchment area to determine any risk for falls. To achieve this goal, the programs should use a variety of methods depending on the care setting and risk

level of seniors. The programs should ensure that many venues for screening/assessing for falls risk in seniors are utilized to maximize the number of seniors being screened/assessed and receiving appropriate interventions.

Assessment can be integrated into the current practice of typical formal caregivers (e.g. family physicians, nurse practitioners, chiropractors) operating independently or as part of a team [e.g. family health team (FHT) or community health centre (CHC)]. For home-based seniors that are community care access centre (CCAC) clients, screening can be performed by personal support workers (PSWs) and assessment for falls would be emphasized as part of the CCAC's overall assessment of clients through the Resident Assessment Instrument for Home Care (RAI-HC) assessment tool. Depending on the underlying issue, CCAC clients may also be referred to an OT, PT, primary care provider, pharmacist and/or community agencies (e.g. Canadian National Institute for the Blind) for further assessment.

Community-dwelling seniors can also be screened for falls risk by atypical or informal caregivers, essentially anyone working with or dealing with seniors. Senior volunteers, individuals working in the ED, emergency medical services (EMS) and community-based programs can all play a role. These personnel should be able to identify the risk of falling and be informed of where to refer seniors when falls risk(s) is identified. These individuals would be a key resource in educating seniors and a means of relaying key messages to them. Specialized falls clinics, whether fixed or mobile can also be established to target those seniors living in the community who have not been assessed for falls by other means.

The settings where screening and assessment for falls risk occur can be the main entry points into a LHIN-wide Integrated Falls Prevention Program. A program algorithm (discussed in Section IV.B) would then determine the next step for the senior depending on setting of assessment and risk of falling.

Screeners and assessors could also play a part in keeping a record of seniors that were screened/assessed as part of the local evaluation of the program. This would facilitate follow-up and enable performance measurement of each LHIN-wide Integrated Falls Prevention Program. Therefore, they should be adequately equipped with the tools and associated processes to facilitate data collection within each LHIN-wide Integrated Falls Prevention Program.

Assessment Tools

There are a number of valid and reliable assessment tools that have been used to assess for falls risk (Scott et al, 2007). An example of a popular simple assessment tool that assesses for gait and balance deficit and may be easily integrated into the current practice of many health care providers is the Timed Up and Go (TUG) tool (available as part of the Geriatrics Inter-professional and Inter-organizational Collaboration Toolkit outlined in Table 6, Section VI). Although this tool can work for the general population, each LHIN-wide Integrated Falls Prevention Program should consider the populations with special needs and ensure the appropriate tool is used to screen for falls in these populations. Other tools include the Morse Fall Scale and the Berg Balance Scale (see Appendix I for a list of validated screening/assessment tools).

Interventions

Interventions are any services provided that are used to prevent and alleviate falls and the negative impact of falls on seniors e.g. exercises to improve muscle strength. There may be interventions already in place that would have been developed prior to and without the direct involvement of a LHIN-wide Integrated Falls Prevention Program. It is essential for each LHIN-wide Integrated Falls Prevention Program to be aware of all those different falls prevention interventions offered within the LHIN geography by the relevant organizations and to ensure effective engagement of the organizations that manage those services. Each LHIN-wide Integrated Falls Prevention Program should collect an inventory of falls prevention interventions provided by all applicable HSPs as best as possible. Although this may not necessarily provide a full picture of every falls prevention activity, at least this gives a good starting point. The gaps will be addressed through engaging the relevant organizations as discussed in Section IV.C.

- *Program to be versed in and be able to refer to all falls prevention interventions offered by partner organizations*
- *Interventions to range from population level promotion and education all the way to individualized clinical intervention*
- *Falls prevention interventions can be provided in many settings*
- *Program should be accessible to as many seniors as possible*
- *Seniors should be effectively engaged to ensure uptake of interventions*

The interventions provided or referred to as part of a LHIN-wide Integrated Falls Prevention Program should be comprehensive and range from health promotion/preventative measures to clinical interventions. Health promotion/preventative measures would be mainly targeted to healthy and low risk seniors who may not be necessarily 65 years and older. These measures would promote healthy lifestyles and address the social determinants of health [conditions in which people are born, grow, live, work and age shaped by the distribution of money, power and resources (WHO, 2011)] to prevent falls from occurring in the first place and ensure that when individuals reach the age of 65 years old, their risk of falling are significantly reduced. Such measures can be implemented in collaboration with community partners including municipalities as described in Section IV.C. Often, these measures include population-based communication campaigns focusing on promoting seniors' independence with effective messaging. On the other end of the spectrum, seniors at moderate or high risk of falling and those who have fallen previously would require environmental modifications and/or individualized clinical intervention that require more support to help decrease the number and impact of falls.

To ensure comprehensiveness of interventions, the BEEEACH model can be applied. The BEEEACH model outlines all the types of interventions that can be provided to seniors at all risk levels for falls. Each of the categories outlined by the BEEEACH model can be applied differently to seniors with different levels of falls risk. This model is described below.

<u>The BEEEACH Model</u>

There are many interventions that can be used to prevent falls in seniors. These can be categorized in six different categories: **E**ducation, Provision of **E**quipment, Changing the **E**nvironment, **A**ctivity, **C**lothing & Footwear and **H**ealth Management. These categories were extracted from the **BEEEACH** model. This model is evidence-based and was developed by the Canadian Falls Prevention Curriculum (CFPC) and has been used by best practice programs

across the country (Safer Healthcare Now, 2010). It suggests that any falls prevention initiative needs to result in **B**ehavior change (the inner square in Figure 4) not only in seniors, but also in health care providers, city planners, policy makers, care givers and anyone working with or has an impact on falls in seniors. This model addresses the fact that preventing falls and the impact of falls on seniors is not only a medical or clinical issue but extends to city planning and policy making, etc.

Multi-factorial interventions have been shown to reduce the rate of falls (Gillespie et al, 2009). As such, each LHIN-wide Integrated Falls Prevention Program should address some or all of the categories that are listed in the BEEEACH model to ensure interventions offered are multi-factorial. Although a LHIN-wide Integrated Falls Prevention Program may first focus on the behavioural change of seniors, families, caregivers and health care providers, it should keep in mind and eventually engage with the broader perspective to impact the behavioural change. An example of this would be to advocate for building codes of buildings where seniors reside to be built in a way that reduces falls risk (e.g. non-steep stairs, grab bars, etc.). The BEEEACH model categories are described below.

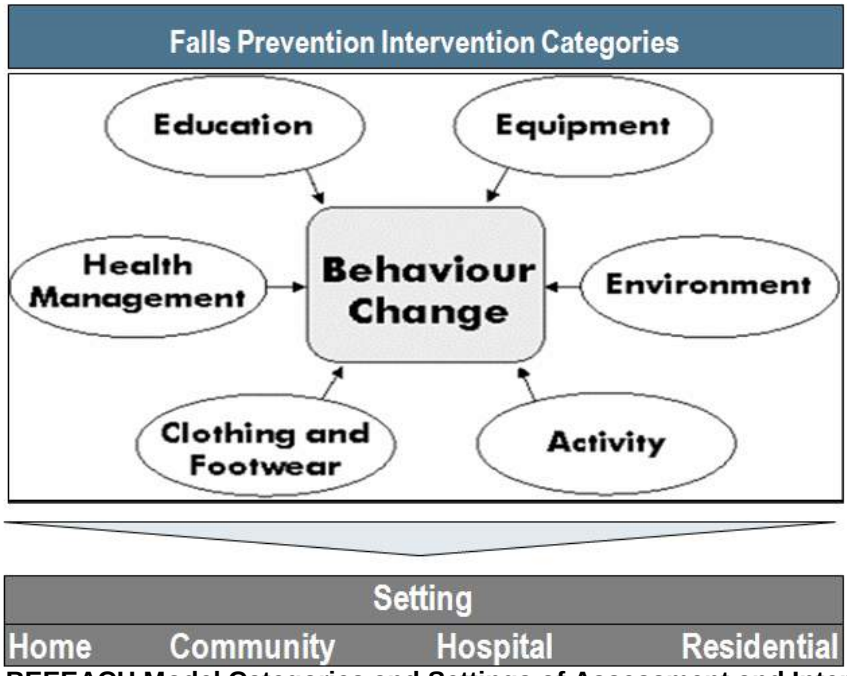


Figure 4: The BEEEACH Model Categories and Settings of Assessment and Interventions

Education

Targeted Education: Education encompasses a wide variety of activities and can target seniors, formal and informal caregivers, health care providers and community members. Education is important to raise awareness regarding the prevalence of falls in seniors and the seriousness of the impact of falls. Seniors and anyone that works with or deals with seniors should be educated on the risk factors of falls, how to prevent falls, what to do in case of falls and the different interventions and services available to them to support them in preventing falls. Education targeted to each audience with consistent messaging is critical. Education can include pamphlets provided to seniors through their health care providers, provision of seminars

for community dwelling seniors and health care providers and training of formal caregivers to provide a specific assessment or intervention (e.g. training PSWs to train seniors on home exercises).

Target audiences to consider in educating regarding falls and falls prevention may include but are not limited to the following:

- Seniors
- Seniors' families (informal caregivers)
- Primary care providers (family physicians, FHTs, etc.)
- Allied health professionals and support staff
- CCAC case managers and service providers
- PSWs
- Health care provider communities
- Community support services (CSS) staff and volunteers
- Community health workers
- Health promoters
- Pharmacists
- Orthopaedic specialists and surgeons
- Alternate care providers (chiropractors, massage therapists)
- Fitness instructors in community
- Volunteers working with seniors

The messaging to the public should be careful not to threaten seniors' sense of self identity or conjure up stigma, but should rather use monikers that older adults associate with independence and healthy aging. Such positive messaging can have a greater impact on seniors, and lessen the fear of falling and decrease in confidence and independence (Butler-Jones, 2010). Fear of falling can cause a senior to avoid activity and become weaker, leading to a higher chance of falling and injury due to falling. The "Engaging Seniors in Falls Prevention Guide" developed by the Hamilton Niagara Haldimand Brant (HNHB) LHIN is a great resource that will guide administrators in their education efforts targeted to seniors (see Table 5 in Section VI for more details).

There are a number of guides targeted to seniors available online that can be leveraged in educating seniors on falls prevention (see Table 10 in Section VI for a listing of select resources available).

Public Education: There are many tactics that can be used to educate the general public about falls prevention and falls prevention interventions. Often, key messages for the general public regarding falls prevention are consistent regardless of location. As such, public education will be discussed later on in this document as part of the provincial communication campaign led by the provincial structure under Section V.A.

<u>Equipment</u>

This category addresses not only the provision of equipment to reduce falls and impact of falls but also the modification of existing mobility aids used by seniors such as walkers and wheelchairs to reduce the risk of falling. There are also cases where seniors are not using their walkers or wheelchairs appropriately and require education in order to do so.

Examples of equipment that can be utilized by seniors to prevent falls or reduce injury from falls include hip protectors to prevent hip fractures upon falling, non-slip mats and chairs for tubs as well as grab bars. In long-term care (LTC) homes, bed and chair alarms ensure seniors are provided with the help they need when they fall or need assistance in getting out of a chair or bed.

New and innovative technologies have made advances in equipment to prevent falls. Sensor technology can be used in a variety of ways to help prevent falls. Sensors can be placed into soles of shoes to help better balance seniors as they walk. In addition, sensors can be worn by seniors (on their wrists or even ankles) to detect subtle gait and balance problems. Sensors can even be placed in different parts of seniors' homes to detect daily habits and motions that help determine falls risk. Another innovative technology to prevent injury from falls is cushioned or bouncy flooring. Cushioned flooring can absorb the energy of falls, thereby reducing the impact on the body and reducing injury.

Currently, tele-homecare is being considered by some LHINs. Tele-homecare will link patients with health care professionals to help them better manage their chronic diseases or other conditions in the comfort of their own home. It allows for remote monitoring of patients using advanced information communication technologies to deliver health services and exchange health information between patients and their health care providers. The advance of this new technology provides a great opportunity to remain independent while having a sense of security and support.

Existing and evolving technologies should be taken advantage of as an opportunity to assist seniors in the future.

Environment

Environment includes the internal environment where seniors live or stay for long periods of time as well as the external environment which is anything outside of that. As discussed in Section IV.B, there are many environmental risk factors that increase the risk of falling, some of which can be addressed through simple environmental modification. Modification to the internal environment includes improving the lighting, removal of clutter and objects in pathways and securing or removing loose mats and rugs. Many of these modifications may have to be done by caregivers and not seniors. Modification to the external environment includes snow and ice removal services, leaf removal services, and the fixing of uneven or broken sidewalks.

Activity

Activity in this case refers to physical activity/exercise to strengthen muscles, enhance stability and balance and delay the onset of diseases that increase the risk of falling. Exercise is one of the most recommended falls prevention interventions and is an important one for seniors at all risk levels. Different forms of exercise have proven to be effective in reducing falls (Gillespie et al, 2009). There are a number of best practice exercise programs, such as the Home Support Exercise Program (HSEP), which have been utilized by LHINs and other HSPs (see Table 8 in Section VI for more details) to successfully prevent falls. Exercise programs can be home-based where the seniors are educated and trained on a number of different exercise moves to perform regularly at home, or they can be offered through community-based centres to groups of seniors. Exercise can also be used by LTC residents and hospital inpatients to increase muscle strength and balance, and reduce the risk of falling.

Clothing and Footwear

It is not surprising that falls and hip fractures are more common in the winter months when icy conditions are common. The appropriate footwear and ice picks for canes can reduce slipping on icy surfaces. Non-slip socks can be provided to reduce slipping on surfaces indoors. Long dresses or undone shoelaces represent some common tripping hazards. Education with regards to modifying seniors' attire is vital.

Health Management

Health management can be divided into three different sub-categories: optimal management of underlying health conditions and addictions, medication management and modification of diet and nutrition.

Optimal management of underlying health conditions and addictions: The diseases and conditions listed in Figure 2 under medical risk factors need to be appropriately managed to reduce the impact of the disease(s) on the risk for falls. For example, successful incontinence management can reduce the number of times seniors rush to the washroom in the middle of the night thus reducing their risk of falling. Also, when a disease like osteoporosis is effectively managed, bone health is better and therefore falls due to frailty and weakness in addition to injury due to falls are prevented. Often, more than one underlying disease and/or condition are present making it more challenging to manage and prevent falls risk.

Seniors seldom admit to being addicted to alcohol or other drugs but these can easily cause a loss of balance and lead to falling. In addition, the inappropriate use of prescription medications such as pain medications creates further risk. It is up to caregivers and health care providers to recognize any of the signs indicating that an underlying addiction exists. Once an underlying addiction/mental health issue is identified, seniors should be referred to the appropriate mental health and addictions (MHA) agency for the specialized care they need. To adequately assess for underlying mental health and/or addictions, the health care provider community should be educated in the importance of considering addictions as a risk factor for falls as well as the MHA agencies that are available for access by their patients. This may require a shift in mindset and culture for health care providers outside of the MHA sector. It may be that some seniors are not necessarily addicted to alcohol but enjoy recreational use of it that is improper (e.g. drinking too much at once) and therefore lifestyle modifications need to be made to minimize falls risk.

Medication management: Seniors can be prescribed a large number of different medications. There may be opportunity to decrease the number of medications that cause dizziness or drowsiness. There can also be alternatives offered for such medications or the dosage can be decreased to mitigate the negative side effects. The MOHLTC offers the Meds Check program through local pharmacies that can be leveraged by each LHIN-wide Integrated Falls Prevention Program (see Section VI for more details on this program) to facilitate better management of medications by seniors.

The Central CCAC has demonstrated positive effects that medication management can have on reducing falls (see Table 8 in Section VI for more details) through its Medication Management Support Services Project by reducing falls by 46%.

In managing medications, the Beer's List (or Beer's Criteria) may be used to improve the use of medication by seniors. The Beer's List is a guideline and reference guide for health care

providers that indicates medications which are generally considered inappropriate when given to seniors (Fick et al, 2003).

Modification of diet and nutrition: Modification of diet and nutrition can help prevent diseases and disorders that may increase the risk of falls. A popular intervention is the use of vitamin D and calcium supplementation, specifically in women (MAS, 2008), to increase bone and muscle strength. This has been shown to reduce the risk of falls by more than 40% (MAS, 2008). Encouraging more nutritionally balanced eating practices to avoid malnutrition and dehydration which often occur in seniors can also decrease risk for falls.

Settings of Interventions

In considering interventions to provide as part of a program, the setting where the intervention will be provided needs to be considered. Interventions and how they are administered may differ depending on the setting in which they are provided. Interventions can be provided in the community (e.g. seniors' homes, through recreation centres, etc.), in residential care (LTC homes, retirement homes, supportive housing), and in hospitals. To ensure comprehensiveness of the program, interventions within the program should address all these settings. Figure 4 above outlines the categories of settings for falls prevention interventions.

Accessibility of Interventions

In providing and referring to the essential interventions as part of a LHIN-wide Integrated Falls Prevention Program, it is necessary that those interventions are easily accessible to seniors who need them including seniors with functional limitations such as with vision, hearing or mobility. Ensuring accessibility means providing a convenient location for the service and if this is not possible, then ensuring appropriate transportation measures are in place. It also means providing interventions that are affordable. For example, specialized footwear or home modifications that are required by some seniors to reduce falls can be costly and may not be carried out due to lack of funds. Accessibility also includes the ability to adapt the physical layout of care settings to individual needs of seniors with functional limitations. Cultural diversity and language barriers need to be taken into account. The approaches used in implementing certain interventions need to be culturally appropriate depending on the culture and language of the particular seniors. This is especially important in culturally diverse areas of Ontario.

Marginalized populations that may be more difficult to reach with falls prevention interventions need to be considered. Such populations include seniors isolated in their homes, the homeless, those who use shelters and hostels, seniors with cognitive impairment and those with mental health and addictions issues. An example of reaching such populations is through engaging EMS to visit homeless shelters to assess individuals for falls risk and refer them to the appropriate intervention. EMS can also visit at risk seniors in their own home during non-peak periods, especially in hard to reach areas. Street nurses and outreach teams play a critical role in reaching such populations. These particular examples demonstrate how important it is to reach beyond the traditional approach to improving the quality of life of seniors.

Uptake of Interventions

Understanding seniors' perspective is important to ensure continued uptake of the specific intervention in question. Since the success of many interventions is dependent on the change of behaviour in seniors, potential participants need to be consulted to ensure such interventions are realistic for them (McInness & Askie, 2004). Generally, older people tend to reject falls

prevention advice because they see it as a potential threat to their identity and autonomy. As such, it is important to focus messaging on the additional positive results of specific interventions rather than focusing messaging on preventing falls (Yardley, Donovan-Hall, Francis & Todd, 2006). To engage seniors, each LHIN-wide Integrated Falls Prevention Program should have linkages with local councils on seniors as described in Section IV.C. In addition, each LHIN-wide Integrated Falls Prevention Program can leverage current resources such as the "Engaging Seniors in Falls Prevention Guide" developed by the HNHB LHIN to better engage seniors in provision of the most appropriate interventions and how to provide such interventions (see Table 5 in Section VI for details).

To ensure seniors are utilizing interventions recommended to them appropriately, there needs to be a follow-up mechanism. Such a follow-up mechanism should be depicted in the referral algorithm described in Section IV.B. It is important to consider connecting with the caregivers, whether formal or informal, when following up with seniors especially those that require extra care and support. In addition to ensuring appropriate uptake, proper follow-up also allows input into the evaluation of interventions.

Clearly Outlined Screening, Assessment, Referral and Treatment Protocols

An essential component of a LHIN-wide Integrated Falls Prevention Program is an understanding by health care providers and caregivers of the screening, assessment, referral and treatment protocols to follow when encountering people who are at risk for falling. Each LHIN-wide Integrated Falls Prevention Program should therefore have a way of connecting all the pieces that make up the program. The program should outline for all the different possible entry points (if any) such as family physicians, CHCs, FHTs, MHA agencies, hospital EDs, mobile falls clinics or CCACs, what to do when falls risk is identified and what interventions are available to seniors in their catchment area.

- *Outline all the steps from screening to intervention and follow-up for all program participants*
- *List all the interventions available to seniors within a LHIN geographic area*

One way to ensure this understanding is through a LHIN-wide referral algorithm that outlines agreed upon protocols and all the interventions available to seniors within the LHIN in which they reside (see Appendix J for sample algorithms).

Leveraging Available Resources and Leading Practice Falls Risk Assessment Tools and Interventions

The resources and tools in this report in conjunction with the inventory of existing falls prevention interventions within each LHIN geography will inform the additional interventions that need to be considered in order to ensure the program is comprehensive. Since there are numerous leading practice assessment tools and interventions, a best practices consensus selection process should be developed to facilitate selection and implementation of the most appropriate practices to adopt based on the needs of each LHIN-wide Integrated Falls Prevention Program.

Once a LHIN-wide Integrated Falls Prevention Program is running, it needs to continue to be abreast of leading practices derived from current research to ensure they are leveraged where appropriate. To keep abreast of the literature, it is recommended that participants of each LHIN-

wide Integrated Falls Prevention Program join the "*Prevention of Falls in Older Adults Community Of Practice (CoP)"* organized by the Seniors Health Research Transfer Network (SHRTN) and sponsored by the Ontario Neurotrauma Foundation (ONF). This CoP is a group of people who make a commitment to advance the field of falls prevention by sharing knowledge with anyone engaged in falls prevention activities.

- *Development of best practice consensus selection process*
- *Each program to continue to be abreast of leading practices and the latest research*
- *Program to promote best practices amongst health care providers and caregivers*

Another noteworthy resource is the CFPC e-learning course, offered by the Ontario Injury Prevention Resource Centre (OIPRC). This course provides those working with older adults the knowledge and skills needed to apply an evidence-based approach to the prevention of falls and falls-related injuries. Participants learn how to design, implement and evaluate a falls prevention program tailored to their work or community setting. This is available to anyone who is interested for a nominal fee. Representatives from each of the 14 LHIN-wide Integrated Falls Prevention Programs as well as front-line staff involved in administering falls prevention interventions can enroll in this course to ensure a common level of understanding of falls prevention best practices (see Appendix K for more details on the course and registration).

Continued promotion of best practices amongst caregivers and health care providers is also essential throughout the program. This should to be championed by each LHIN-wide Integrated Falls Prevention Program. SHRTN has a library service that can provide paid caregivers of seniors with the up-to-date research in seniors' care including the falls prevention topics free of charge. Informal caregivers can also be given access upon request. It should be encouraged that paid caregivers within the program become SHRTN members to capitalize on this useful source of information. In addition, Section VI provides the latest best practice guidelines, guides, toolkits, web-based resources and programs that all LHIN-wide Integrated Falls Prevention Programs should review and utilize where applicable.

C. Local Integration and Inclusive Partnerships

Local integration and inclusive partnerships are important to the success of any major initiative. LHINs and PHUs would play a key role in each LHIN-wide Integrated Falls Prevention Program. Given the LHINs' mandate in integration and PHUs' mandate to build community partnerships, the two sectors can bring together a multitude of relevant partners to be part of a LHIN-wide Integrated Falls Prevention Program in each LHIN geographic area. To achieve the system level outcome of reduced falls for seniors, each LHIN-wide Integrated Falls Prevention Program should endeavor to involve all relevant sectors at the local level whether LHIN-funded, non-LHIN-funded or private. In involving new sectors and organizations, it is important that each LHIN-wide Integrated Falls Prevention Program nurtures and maintains the new relationships to effectively move the program forward.

Key Partnership amongst LHINs and PHUs

As discussed, the main two sectors in this falls prevention framework are the LHINs and public health. The LHINs and PHUs can mutually benefit from partnering in this initiative and in many areas may complement each other. With the common goal of improving the overall health of the population, collaboration between these two sectors will result in a stronger LHIN-wide Integrated Falls Prevention Program that is more effective at reducing falls and the impact of falls on seniors and their families.

- *Mutually beneficial relationships should be developed (or strengthened) between LHINs and PHUs through the collaboration on the program*
- *The LHINs' role can complement the PHUs' role in implementing the program*
- *Current boundary challenges between the two sectors will need to be addressed in some cases*

In committing to such a partnership, the challenges that may arise should be considered and addressed. With PHUs' involvement at the leadership level, differences in boundaries may be a challenge. Currently, there are 36 Ontario PHUs with boundaries that are not aligned with the current LHIN boundaries (see Appendix L for an illustration of the overlap of boundaries between the two sectors). Some LHINs overlap with more than one PHU and vice versa. As such, the LHINs and PHUs should determine measures to ensure the streamlined involvement of all 36 PHUs in the 14 LHIN-wide Integrated Falls Prevention Programs. Furthermore, 22 PHUs operate separately from the administrative structure of their municipalities whereas four are integrated into municipal structures. Thus, different processes of engaging PHUs depending on their governance structure may need to be determined.

The role of the LHINs and PHUs in this important partnership is described below.

Role of LHINs

In Ontario, the LHINs plan, integrate and fund health care services to meet their local community's health needs and priorities. LHINs work to improve the performance of the health care system in their geographies through engagement with local stakeholders. The LHINs fund the following sectors: CCAC, CHCs, CSS, hospitals, LTC, Regional Geriatric Programs (RGP) and MHA.

The LHINs can be integral to the 14 LHIN-wide Integrated Falls Prevention Programs given their experience in planning, overseeing implementation and monitoring of programs. During the planning phase, the LHINs may support the LHIN-wide Integrated Falls Prevention Programs in collecting an inventory of falls prevention interventions to inform the additional interventions required in the LHINs' geographic areas. It could encourage its HSPs to be involved in the program through its working relationship with those HSPs. As a health system manager and integrator, the LHINs can provide and utilize their integration and management expertise. With their programming experience, the LHINs could also support evaluation efforts of the program and suggest specific processes and data sources to be used for evaluation. Below are more details related to the LHINs' role within some of the BEEEACH model categories.

Education: Through its relationship with its HSPs and many community engagement endeavors, the LHINs can ensure targeted education sessions are provided to patients, families and health care providers where necessary. In educating health care providers, the LHINs can promote and encourage assessment of falls risk at key entry points into the program (e.g. CHC).

Environment: The LHINs can encourage the appropriate assessment of seniors' internal environment in the home, hospital and LTC homes.

Activity: The LHINs can ensure training is provided to increase the capacity of certain sectors and organizations in order to offer exercise programs to seniors. It can also ensure the co-ordination of community-based group exercise programs while encouraging hospitals, LTC homes and CCACs to focus on activating patients in hospitals, residents in LTC as well as independent seniors in their homes.

Health Management: The LHINs and their HSPs strive for effective and high quality patient care. The LHINs holds their HSPs accountable for certain deliverables in the provision of care. Through this mechanism, the LHINs can encourage an overall focus on falls prevention efforts within each sector and organization.

Role of Public Health

PHUs are required to take action to reduce falls as articulated in the Ontario Public Health Standards (OPHS) through primary prevention measures (see Appendix M for standards relating to falls). In particular, the Injury and Substance Misuse Standard requires that PHUs conduct epidemiological analysis of surveillance data, work with community partners to influence the development and implementation of healthy policies and programs that address falls across the life span, use a comprehensive health promotion approach to increase the capacity of priority populations to prevent falls and increase public awareness of the prevention of falls.

Almost all PHUs are involved in falls prevention for seniors (in addition to rest of the general population) and have been for many years. Based on their experiences and current activities, as described in more detail below, they can contribute tremendously to the LHIN-wide Integrated Falls Prevention Programs.

Aside from specific competencies that align with the BEEEACH model as outlined in the next section, PHUs offer several distinct capabilities that would be useful to the LHIN-wide Integrated Falls Prevention Programs. These fall broadly into three categories: collaboration, knowledge transfer, and targeted analysis.

Collaboration: PHUs have a long history in Ontario of leading and participating in cross-sector initiatives to address high priority issues, falls being one of them. PHUs are experts in facilitating partnerships (e.g. between care providers and community partners) and that ability will be crucial if each LHIN-wide Integrated Falls Prevention Program is to function effectively. Some PHUs are facilitating/leading/supporting the work of community-based falls prevention coalitions and have done so for several years. As well, PHUs are aware of what other local agencies, associations and interest groups are doing which offers opportunities to each LHIN-wide Integrated Falls Prevention Program to collaboratively leverage existing resources.

Knowledge Transfer: PHUs are experts in applying literature and evidence to local context and care settings. Often with many years of experience to build on, they can act as knowledge brokers and sources of best practices on falls prevention for other health care providers to drive priority setting and/or service planning. They can also point collaborators to existing resources and can identify and build opportunities for research/publications.

Targeted Analysis: With their strong epidemiological foundation, PHUs are well positioned to provide pertinent targeted analysis to facilitate the establishment of local program priorities. Given their focus on equity and social determinants of health, this analysis will likely inform key health planners and decision makers and focus on a broad range of factors. Once the program is established, the targeted analysis can then inform program planning, evaluation and reporting.

Along with their critical roles at the regional program level, PHUs can contribute to the LHIN-wide Integrated Falls Prevention Programs more directly through their activities that align with the BEEEACH model as follows.

Education: This is the area where PHUs may best contribute to LHIN-wide Integrated Falls Prevention Programs. PHUs would be integral in any public campaign and should be leveraged as part of the provincial falls prevention campaign discussed in Section V.A. In general terms, PHUs are experts in the application of communication/social marketing and media advocacy skills to serve as an educational support to the public. In addition to public education, PHUs can also focus on assisting with and implementing education opportunities for health care providers (formal and informal) (see Appendix N for examples of public health's current "education" activities). PHUs also have a role to play in building the capacity of priority populations to prevent falls including collaborating with and engaging community partners, mobilizing and promoting access to community resources, providing skill-building opportunities and sharing best practices and evidence for prevention.

Equipment: PHUs would work with others to ensure access for seniors to safe appropriate equipment as well as to information and training on its safe use. Examples include assisting community partners in applying for grants to receive equipment as well as advocating for subsidies or standards for equipment that prevent falls. This is an area where public health's connection to municipal and other levels of government can be leveraged, especially with respect to influencing healthy policies or programs, and the creation or enhancement of safe and supportive environments (see Appendix N for more examples of public health's current "equipment" activities).

Environment: PHUs would work with others, usually municipal planning services, to create more age-friendly structures as well as outdoor spaces that foster physical activity with the goal

being the creation of safe, healthy, livable and inclusive communities (see Appendix N for examples of public health's current "environment" activities).

Activity: While some PHUs can offer exercise programs, most of those who are engaged in the area of activity work with community partners to increase the opportunities for community members to participate in appropriate activities that increase strength and balance to reduce falls (see Appendix N for examples of public health's current work in this category).

Involvement of All Relevant Health Care Organizations at a Local Level Including LHIN-Funded, Non-LHIN Funded and Private Organizations

- *Identification of local organizations delivering falls prevention initiatives*
- *Engagement of partners in the planning stages*
- *Ensuring the core committee is manageable*

There are many falls prevention initiatives being implemented across the province by numerous organizations and as such, it is critical that each LHIN-wide Integrated Falls Prevention Programs is aware of such initiatives to be able to appreciate, coordinate and integrate with them. This is possible through collaborating and partnering with the different organizations that may be involved in falls prevention efforts at the outset of each LHIN-wide Integrated Falls Prevention Program. Through such partnerships, each LHIN-wide Integrated Falls Prevention Program can optimize the input and expertise of many different organizations, avoid duplication of work or interventions and maximize use of the limited resources available. To identify key falls prevention initiatives within one LHIN geographic area, a broad survey to all potential participants can be conducted. The results of this survey can then inform which organizations to involve and the role that each organization can play (see Appendix O for a sample survey template).

As part of coalition building and aligning action towards shared outcomes, it is important to ensure that all organizations, whether represented on the core committee or not, have an opportunity to provide input into the planning phase of each LHIN-wide Integrated Falls Prevention Program. Thereafter, as it can become unmanageable to include all parties of interest in the core committee described in Section IV.A, some partners can be included in sub-committees and others may be engaged through other methods such as partnership forums or other LHIN-wide events.

LHIN-Funded Sectors and Organizations

<u>Community Care Access Centres</u>

CCACs provide case management and home care services to eligible clients. Several of them have implemented falls prevention initiatives. As such, through CCACs, the LHIN-wide Integrated Falls Prevention Programs can target home-bound seniors that are CCAC clients as well as CCAC clinic clients. Even without specific initiatives, falls prevention fits comfortably within the typical role of a CCAC case manager in ensuring that the identified needs of clients (e.g. required mobility equipment or counseling for mental health issues) are met according to the client's treatment plan. Furthermore, the CCAC-funded providers of professional services (e.g. PT, OT and nursing) and personal support services (e.g. assistance with activities of daily living and instrumental activities of daily living) are well positioned separately and as a team to provide on-going support regarding falls prevention behaviours to CCAC clients.

From a broader falls prevention program perspective, CCACs offer an information and referral service where referrers, caregivers, community members, clients and potential clients can find information about falls prevention interventions available in their communities. Appendix P outlines how CCACs can contribute to a LHIN-wide Integrated Falls Prevention Program within some of the BEEEACH model categories.

Community Support Services

The CSS offers a wide range of falls preventions interventions in many communities throughout Ontario and has a rich history of undertaking service delivery through partnerships. Their role has frequently been the lead initiator or a primary partner in initiating falls prevention initiatives based on their strong relationships with other local care providers. While CSS providers typically have professional staff (including rehabilitation professionals), the bulk of the work is undertaken by volunteers which can increase the reach of the program in a very cost-effective manner. Appendix P outlines how CSS can contribute to a LHIN-wide Integrated Falls Prevention Program within some of the BEEEACH model categories.

Hospitals

Hospitals can contribute to falls prevention programs through both inpatient and outpatient services. As one of the more expensive venues for patient care, hospitals can act as a system resource that needs to be used appropriately within a broader falls prevention framework. Hospitals can play a key role in assessing for falls risk and referring patients to the appropriate intervention in the community. ED staff and other hospital staff can pay attention to falls risk when dealing with seniors over the age of 65. Once risks of falling are identified, the appropriate measures should be put in place for seniors when they are in the hospital as well as when they are discharged back into the community. To achieve the latter, hospitals should be knowledgeable of and link with community-based programs available to their senior patients. With extensive knowledge about falls prevention, hospitals are also the source of much of the system-level information that is used to describe the impact of falls in Ontario. There is also extensive clinical knowledge of falls prevention and management strategies within and associated with hospital partners, which includes leading clinicians and researchers. Hospitals are also a place where falls can and do still occur, which needs to be addressed within broader, acute-care patient safety initiatives. Appendix P outlines how hospitals can contribute to a LHIN-wide Integrated Falls Prevention Program within some of the BEEEACH model categories.

Regional Geriatric Programs

RGPs provide a comprehensive network of specialized geriatric services which assess and treat functional, medical, and psychosocial aspects of illness and disability in older adults who have multiple and complex needs. Working in collaboration with primary care providers, community health professionals, and others, they seek to meet the needs of the most frail and vulnerable seniors. RGPs are based at Academic Health Science Centres in Hamilton, Kingston, London, Ottawa and Toronto. They partner in education, research and the development of best practice.

From a falls prevention perspective, RGPs can contribute significantly at a program level through such competencies as knowledge brokering, program coordination and planning, and the provision of evaluation expertise with a focus on their traditional partners in the hospital sector.

At the patient level, RGPs can draw on geriatric inter-professional teams that provide comprehensive geriatric assessments and care planning. The assessments include medical and psychosocial falls risk identification to identify the cause of the fall, e.g. an undiagnosed or poorly managed medical problem. The plan to address the identified risk factors would be developed and then implemented along with partners in primary care.

While not necessarily present in every LHIN, RGPs have shown willingness to provide province-wide support as seen with the Senior Friendly Hospitals Strategy (see Appendix V for a description).

Community Health Centres (CHC)

CHCs provide primary health care with a prevention focus, often to marginalized populations. A health promoter is a typical staff position and they can provide or promote a wide range of falls prevention initiatives. The nature of the services CHCs provide depends on the needs of their populations as well as their resource constraints.

CHCs excel at forming partnerships and community engagement and therefore the LHIN-wide Integrated Falls Prevention Program concept would be very well received. CHCs are also typically very sensitive to barriers to accessing care. Any program needs to be designed in a way that overcomes barriers and is accessible to all regardless of limitations of income, language, culture, etc. Appendix P outlines how CHCs can contribute to a LHIN-wide Integrated Falls Prevention Program within each of the BEEEACH model categories.

Mental Health and Addictions

For MHA providers, falls and especially repeated falls, are often seen as an indicator and a symptom of poorly managed underlying mental health and addictions conditions or side effects of medications used to treat their condition. Providers in this sector typically work with those in other sectors to ensure that the client has the appropriate resources in place to address those risk factors for falls. If not addressed, mental health and addictions issues can lead to on-going falls even as other risk factors are mitigated. Appendix P outlines how MHA can contribute to a LHIN-wide Integrated Falls Prevention Program within some of the BEEEACH model categories.

Long-Term Care

LTC homes typically understand the high risk of falls among their residents and the tremendous impact that such falls could have on the residents, their families and the health care system. As an example, they would know that a large proportion of transport to hospitals from LTC homes is typically due to falls and their sequelae. Appendix P outlines how LTC homes can contribute to a LHIN-wide Integrated Falls Prevention Program within each of the BEEEACH model categories.

Non-LHIN Funded Local Public Sectors and Organizations (Other than Public Health) and Private Sectors and Organizations

There are many other opportunities for collaboration with non-LHIN funded organizations (in addition to PHUs described earlier) to achieve common goals through shared resources.

Through these collaborations, each LHIN-wide Integrated Falls Prevention Program can reach out to a larger number of seniors and in many cases intervene at an early stage to prevent falls. The social determinants of health can also be addressed to improve the health and wellness of healthy and low risk seniors, preventing falls from happening in the first place. The following section briefly outlines a number of suggested non-LHIN funded organizations worth considering as part of a LHIN-wide Integrated Falls Prevention Program. These organizations and the collaboration and alignment opportunities with each are described in more detail in Appendix Q. These organizations are listed in alphabetical order and not in order of importance.

Table 1: Summary of Select Public Non-LHIN Funded and Private Sectors and Organizations to Align with Locally - Listed in Alphabetical Order

Organization	Summary of Potential Collaboration and Alignment Opportunities
Non-LHIN Funded Local Public Sectors and Organizations	
Local Councils on Aging	• Engaging and obtaining seniors' perspective • Provision of education and communication to senior communities
Municipalities	• Engagement of city planners to build senior friendly cities • EMS' assistance in assessment of falls risk in seniors • Leveraging parks and recreation facilities to provide seniors falls prevention interventions • Align with Age Friendly Communities initiatives
Primary Care: Family Physicians and Family Health Teams	• Provide advice and education to seniors on preventing falls • Proper assessment for falls risk • Effective health management
Supportive Housing	• Provision of falls prevention interventions on-site
Private Organizations	
Retirement Homes	• Provision of falls prevention interventions on-site
Both Non-LHIN Funded Public and Private Sectors and Organizations	
Education	• Opportunities to influence curriculum for health care practitioners to include a falls risk and falls prevention component • Opportunities to create intern or resident positions for needed health care practitioners within the program

Effective Relationship Management at the Local Level

To maintain long lasting and mutually beneficial relationships, partners must make a continuous effort to understanding each others' mandates and to respect the expertise each partner brings to the initiative. Since one of the key roles of the LHINs and PHUs in this initiative is to facilitate integration and community partnerships, it is important for the LHINs and PHUs to demonstrate this type understanding. Regular communication with all partners is crucial to maintaining a strong relationship. One method of communication would be through the core committee or sub-committees as described in Section IV.A.

- *Knowledge and understanding of each partners' mandate*
- *Regular communication*
- *Engagement of leadership*

Through such effective relationship practices, each LHIN-wide Integrated Falls Prevention Program would consist of partnerships that would prove to be fruitful as organizations work together with their current resources and expertise to solve the common goal of reducing falls and fall injuries in the seniors population. In addition, innovative approaches and new ideas can be shared and investigated.

D. Local Performance Measurement

Performance management is a key aspect of implementing each LHIN-wide Integrated Falls Prevention Program, enabling the measurement of program effectiveness and the extent to which program goals and objectives are being achieved. Without performance management, positive outcomes cannot be demonstrated and tracking against program goals becomes difficult.

Local Indicators and Targets for Each LHIN-wide Integrated Falls Prevention Program to be Selected at Outset of Program

Indicators to monitor and evaluate the effectiveness of each LHIN-wide Integrated Falls Prevention Program at the local level need to be agreed upon at the outset of each program or as soon as possible. These indicators need to align with the local program's goals since they are a means of measuring how those goals are being met. Part of that work can include the development of a way to track the comprehensiveness of the program against the components of the BEEEACH model.

- *Alignment of indicators with program goals*
- *Measurement against aspects of BEEEACH model*
- *Setting local program targets*
- *Focus on proactive indicators vs. reactive*

Indicators, baselines and targets are important as they provide common and tangible goals to work towards. In cases where program goals are not being met, measuring a set of indicators can help determine some of the issues and gaps resulting in unmet goals.

Within a LHIN geography, outcome indicators can be used to measure LHIN-wide outcomes (e.g. decrease in falls overall) as well as intervention level outcomes (decrease in falls due to specific service offered to seniors such as exercise). Process measures can also be use to evaluate the extent to which required processes are adhered to ensure effective operation of the program (e.g. number of seniors asked if they had fallen within last year).

The focus at the local level should be on proactive indicators that move beyond the reactive, hospital-focused scope of the provincial indicators (described in Section V.B.) out into the community e.g. tracking the program's clients across sectors to see if they are moving appropriately from one set of services to another. Potential sources for this information include the output from the RAI-HC assessments conducted by CCACs, the electronic medical record system Perkinje used by CHCs and epidemiologic data related to falls which is regularly collected by PHUs.

There are many different approaches and frameworks to effectively measure an integrated program with the most well known and validated being the Balanced Scorecard performance measurement tool (Inamdar & Kaplan, 2002). The balanced scorecard allows for a comprehensive approach to performance management as it takes into account all aspects of a program or organization, including efficiency (see Appendix R for an example of a balanced scorecard of an existing LHIN-wide Integrated Falls Prevention Program).

Continuous Monitoring and Evaluation of each LHIN-wide Integrated Falls Prevention Program

Once goals and indicators are set, they need to be measured and reported on regularly. The continuous measurement of each LHIN-wide Integrated Falls Prevention Program would allow for ongoing improvement as the data provides the necessary information to identify any gaps and required changes.

Continuous monitoring of local programs allows:

- *Continuous improvement of program and data collection*
- *Public reporting*

Improvements to the type and way that data is collected can also be made when a program is continuously monitored and evaluated.

Through regular monitoring and evaluation, each integrated program can generate an annual plan for the year's activities (including targets for key indicators) and to then follow up with an annual report indicating and explaining the performance of the program against the plan. These plans and reports can then be shared between all the LHINs and PHUs before being finalized to allow for cross-fertilization of ideas and to ensure appropriate consistency. They should be public documents and be published on the internet, along with being distributed more broadly as appropriate.

Rationalized Collection of Falls-Related Data

With many HSPs delivering falls prevention interventions, there are also many collecting falls-related data using varying methods. Current collection methods being used should first be identified to determine which are most appropriate to leverage for each LHIN-wide Integrated Falls Prevention Program. Examples of some existing databases that can be used to collect data on falls are the Discharge Abstract Database (DAD) which provides information on acute inpatient care; and the National Ambulatory Care Reporting System (NACRS), which provides data for hospital-based and community-based emergency and ambulatory care.

- *Leverage current local measurement processes*
- *Develop required local data sources to meet data gaps*

The LHIN-wide Integrated Falls Prevention Programs can also leverage current data by extracting it from *intelli*Health. *Intelli*Health is a gateway to a repository of health care data that describes the population as well as the delivery of health care services in Ontario and can be accessed by all LHIN personnel (see Appendix S for access details). *Intelli*Health provides access to raw data that can be analyzed by the requester as well as predefined reports developed by *Intelli*Health such as *The Quarterly*.

Once existing measurement processes are leveraged, development of the additional required local sources for data (e.g. patient satisfaction surveys and tracking seniors participating in a LHIN-wide Integrated Falls Prevention Program) can be initiated.

Section V: Components and Key Actions for a Provincial Structure Responsible for Falls Prevention

The following section will describe the key actions for collaboration and alignment at a provincial and national level.

A. Inter-Program Coordination

Continuous Coordinated Efforts amongst all 14 LHINs

The provincial structure needs to have an effective working relationship with all 14 LHIN-wide Integrated Falls Prevention Programs. To accomplish such an effective working relationship, meetings for representatives of the 14 LHIN-wide Integrated Falls Prevention Programs can be organized for them to come together at least quarterly and provide updates to one another on their programs. The provincial structure would also lead communication efforts among all 14 programs such as internal updates that provide a provincial overview of falls prevention initiatives across the 14 programs. To develop such communications, the provincial structure would have to work closely with the programs to collect the required information on a regular basis. In addition, the provincial structure would coordinate the review of all the provincial indicators (described in Section IV.D) from all the programs as part of a provincial performance measurement process. Furthermore, the provincial structure would identify applicable education and training that should be provided to participants of all 14 LHIN-wide Integrated Falls Prevention Programs and coordinate such events.

- *Regular meetings with the 14 program representatives*
- *Regular communications to all 14 programs*
- *Measurement of provincial falls indicators across the 14 programs*
- *Coordinated education and training for all 14 programs*
- *Coordination of provincial communications*

By working with the 14 LHIN-wide Integrated Falls Prevention Programs, the provincial structure would lead an integrated provincial falls prevention campaign targetted to seniors, their families and health care providers. Although there are some communication campaigns that are delivered by multiple community partners collaboratively, for the most part, sectors or organizations tend to communicate to seniors within their catchment areas in silos. Many of the key messages with regards to falls prevention are similar regardless of the LHIN geography in which seniors reside. To ensure consistency in messaging and to avoid confusion amongst seniors, a provincial falls prevention communications campaign is necessary. This campaign would require collaboration amongst the provincial structure, the 14 programs and other applicable organizations (e.g. PHUs). The provincial structure would be charged with leading the campaign and developing the necessary materials. The 14 programs could then facilitate the campaign's implementation through the suggested core committees. An evidence-based communication campaign to consider is the *Finding Balance Campaign.* This campaign was developed in Alberta and is being implemented as part of one of the LHIN-wide Integrated Falls Prevention Programs currently in place.

Central Knowledge Exchange Management

Through strong working relationships with all 14 programs, the provincial structure can index up-to-date knowledge on all the 14 programs and thus can be the main contact for all inquiries about any of the 14 LHIN-wide Integrated Falls Prevention Programs. The provincial structure would be charged with planning knowledge exchange events for the 14 LHIN-wide Integrated Falls Prevention Programs to come together at least once a year. Such a forum would allow for continued knowledge exchange and relationship building amongst the organizations participating in the 14 programs.

- *One contact for all 14 LHINs regarding program inquiries*
- *Knowledge exchange forums*
- *A central web*

A central web-based resource is required to allow document sharing to support knowledge exchange amongst the 14 LHIN-wide Integrated Falls Prevention Programs. This web resource will need to be managed and updated regularly, which would be the task of the provincial structure. It also should be easily accessible by all 14 LHIN-wide Integrated Falls Prevention Programs to ensure a seamless and continuous uploading of documents. To ensure the web resource is up-to-date, there needs to be an associated process for the 14 LHIN-wide Integrated Falls Prevention Programs to follow. This process would be managed and monitored by the provincial structure.

B. Standardized Provincial Performance Measurement

A Small Number of Provincial Falls Indicators to be Regularly Monitored

From a provincial perspective, common indicators must be in place to measure the overall performance of each LHIN-wide Integrated Falls Prevention Program. This would allow for transparent comparisons and clear accountability across the 14 LHIN-wide Integrated Falls Prevention Programs. Since these indicators will be rolled up at a provincial level, they would be monitored by the provincial entity on a regular basis. This would avoid any unnecessary addition of workload to the program administrators across the province.

- *Indicators should be tracked on a quarterly basis by the provincial structure*
- *Use of readily available indicators*

Measurement of a provincial set of indicators aims to:

- *Increase transparency and accountability*
- *Demonstrate progress towards provincial goals*

The three indicators that must be monitored for every LHIN-wide Integrated Falls Prevention Program are listed in Table 2 below. These were developed by an Evaluation Sub-Committee (see Appendix T for membership) and validated by the Mobilization Committee. In developing this list of indicators, a rigorous process was followed. All the indicators measured by the existing LHIN-wide or multi-sector programs were collected, reviewed and analyzed. In addition, indicators found through the preliminary literature review were considered. Due consideration was given to other provincial performance management initiatives that also relate to falls prevention and it was ensured that the approach and indicators selected align with those.

In compiling this provincial list, the need to balance the data's ease of collection against its utility was carefully considered. With that in mind, the decision was made to proceed initially with fundamental indicators readily available from a reputable administrative database, NACRS, with well-established definitions and analysis methodologies. The use of this database would allow for relatively timely information to be compiled centrally and distributed to the programs. Acknowledging that the selected database is hospital-based and so fails to capture the extent of the issue beyond those institutions, it is felt that this represents the best option available for provincial purposes at this time. Should additional resources present themselves they should certainly be considered.

To ensure consistency among the 14 LHIN-wide Integrated Falls Prevention Programs, the provincial indicators should be tracked on a quarterly basis with performance measured against annual targets. Indicators should be calculated based on a rolling 12-month timeframe to smooth out the impacts of seasonality or other external factors and to provide a more realistic view of performance.

The indicators selected are presented as rates. Including and focusing on indicators involving rates of falls allows the programs to sidestep the on-going issue of the aging population whereby the absolute number of falls may rise as the population in the LHIN geographic area ages despite the work being done by the LHIN-wide Integrated Falls Prevention Programs.

Suggested Provincial Falls Prevention Indicators

Table 2 below lists the indicators to be measured by every LHIN-wide Integrated Falls Prevention Program to be rolled up provincially. Technical specifications for these indicators are provided in Appendix U.

Table 2: Proposed Provincial Falls Prevention Indicators

#	Indicator	Source	Proposed Target	Comparator	Comparator Explanation
1	Falls-related admissions to hospitals from ED per 100,000 for seniors aged 65 years and older	NACRS	Decrease from the year before	Falls-related admissions to hospitals from ED for those who reside in the LHIN divided by all admissions to hospitals from ED for those who reside in the LHIN	Allows the program to track the differences in rates of change between admissions related to falls and all admissions. If this ratio declines then admissions related to falls are decreasing faster than all admissions, even if the rate measured by Indicator #1 is increasing. In other words, there is another factor driving all admissions higher that the falls program is counteracting.

#	Indicator	Source	Proposed Target	Comparator	Comparator Explanation
				Average for the LHINs of Indicator #1	Allows the programs to compare themselves to the provincial average for Indicator #1. While not providing a target, this comparator does provide a benchmark against which the 14 programs can compare themselves. As an example, for those with below average performance (with Indicator #1 being higher than the comparator) this comparator could provide impetus for further investigation.
2	Number of falls-related ED visits per 100,000 for seniors aged 65 years and older	NACRS	**To publish publicly against** 10% reduction vs. baseline year for all those over the age of 65	Number falls-related ED visits/100,000 seniors residing in LHIN for those 65-75, 75-85, 85+ who reside in the LHIN	By providing information broken down by age range, this comparator allows the 14 programs to identify which age-related segment is responsible for their performance on Indicator #2 and to then respond appropriately.
				Average for the LHINs of Indicator #2	This comparator provides a benchmark against which the 14 programs can compare themselves.
3	Repeat ED visits for falls in the past 12 months at the beginning of the rolling 12 month period per 100,000 for people aged 65 years and older	NACRS	Decrease from the year before		

Annual Review of Provincial Indicator List

After the initial evaluation at the end of the first year of operation for the 14 LHIN-wide Integrated Falls Prevention Programs, the list of provincial indicators should be re-evaluated to ensure appropriateness of indicators and on-going alignment with program and provincial needs. There are a number of additional indicators that have been identified through this current process that merit future consideration and should therefore be considered at the time of indicator evaluation. These include hip fractures, quality of life indicators (if they can be produced with a reasonable amount of additional effort) and some indicator of collaboration and alignment at a provincial and/or national level. In addition, indicators identified through hospital quality improvement plans that are part of the *Excellent Care for All Act (ECFAA), 2010* process should be reviewed and considered.

When reviewing the current falls indicators list, other indicators used to track other provincial initiatives should also be reviewed to ensure on-going alignment and to avoid overlap with those indicators. Furthermore, indicator targets should be reviewed to ensure the appropriate balance between stretch goal and achievability.

C. Alignment and Collaboration with Provincial and National Organizations/Initiatives

Collaboration and Alignment with Existing Provincial and National Organizations and Initiatives

Provincial structure to:

- *Liaison between 14 programs and relevant organizations and initiatives*
- *Coordinate a provincial multi-sector collaborative*

The provincial structure would play a critical role in nurturing the 14 LHIN-wide Integrated Falls Prevention Programs' sustained alignment with the relevant ministries and provincial and national organizations and initiatives. The provincial structure would be the liaison between the 14 LHIN-wide Integrated Falls Prevention Programs and relevant ministries and provincial and national organizations and initiatives. This promotes not just the consistent alignment of all 14 LHIN-wide Integrated Falls Prevention Programs, but also avoids missed opportunities for alignment and collaboration. In the following sections, the relevant ministries as well as the relevant provincial and national organizations and initiatives that should be considered for alignment and collaboration are summarized. These are described in greater detail in Appendix V.

To foster collaboration amongst existing provincial and national organizations and initiatives, the provincial structure can organize an annual collaborative forum where all relevant parties would come together to identify knowledge gaps and research needs, exchange best practices and strengthen existing relationships as well as form new ones. This forum would include all organizations involved in the 14 LHIN-wide Integrated Falls Prevention Programs and any additional organization with an interest in falls prevention.

Relevant Ministries

The provincial structure would be charged with identifying the relevant ministries to establish linkages with to ensure continuous alignment and collaboration with the 14 LHIN-wide Integrated Falls Prevention Programs. These linkages would ensure the 14 LHIN-wide Integrated Falls Prevention Programs are informed of any new legislation or regulation that may affect their falls prevention efforts as well as any funding opportunities that could be applied to. The most important ministries which this entire framework is in alignment with (as described in Section I.D) are the MOHLTC and the MHPS. These two ministries as well as the provincial initiatives underway that are directly related to falls prevention are described below.

Ministry of Health and Long-Term Care:

The LHINs are accountable to the MOHLTC through the Ministry-LHIN Accountablility Agreements (LHINs, 2011). These agreements set out the funding and performance obligations of both parties as related to parts of the *Local Health System Integration Act, 2006* (LHINs, 2011). This act outlines the authority that has been delegated from the Ministry to the LHINs to manage their local health systems. The MOHLTC often funds provincial programs for implementation by the LHINs and or HSPs, some of which are relevant to falls.

MOHLTC Relevant Initiatives - Meds Check Program: The Meds Check Program is a program provided by the MOHTLC through local pharmacies that allows seniors to schedule a 20 to 30 minute one-to-one meeting with the community pharmacist to conduct a comprehensive medication review which is covered by OHIP. Seniors who are unable to leave their home to go to the pharmacy or live in a LTC home can take advantage of the *Meds Check at Home* and *Meds Check for LTC Residents* programs that are described below. The provincinal structure should work with the MOHLTC to leverage this service for LHINs to refer to as part of their LHIN-wide Integrated Falls Prevention Programs. The provincial structure would promote this service to the 14 LHIN-wide Integrated Falls Prevention Programs and provide them with the necessary information to allow them to take full advantage of Meds Check. This is not a LHIN-related initiative and therefore steps to align with this initiative need to be taken by the 14 LHIN-wide Integrated Falls Prevention Programs.

Meds Check at Home: This is intended for those seniors taking a minimum of three chronic prescription medications who are not able to attend their community pharmacy in person due to a physical and/or mental health condition and/or long distances between them and the local pharmacy. This particular program involves a pharmacist visit seniors' private homes for a one-on-one consultation. The pharmacist would conduct an assessment summary that includes a medicine cabinet clean-up during the visit and assessing the ability to remove unused medication for proper disposal at the pharmacy.

Meds Check for LTC Residents: This consists of a quarterly medication review and an annual in-depth medication analysis by the pharmacist working in the LTC home. The medication analysis would include medication selection, dosage, hours and route of administration, duration of therapy, treatments, allergies and drug interactions.

For more information about the MOHLTC Meds Check Program, visit: http://www.health.gov.on.ca/en/public/programs/drugs/medscheck/

Ministry of Health Promotion and Sport:

The PHUs in Ontario (specifically, the Boards of Health which are the governing entities of PHUs) are governed by the *Health Protection and Promotion Act, 1990* (MHPS, 2011c). The MHPS supports the 36 PHUs by providing direction and funding to enable local programs (MHPS, 2011c). In addition, the MHPS along with the MOHLTC published the OPHS which set organizational and governance standards that apply to all PHUs. PHUs administer health promotion and disease prevention programs in accordance to these standards. The OPHS establish the minimum requirements for fundamental public health programs including assessment and surveillance, health promotion and policy development, disease and injury prevention and health protection (Minister of Health and Long-Term Care, 2008). Like the MOHLTC described above, the MHPS also funds provincial programs that are often implemented by PHUs locally. The Health Communities Initiatives is one initiative relevant to falls prevention and described below.

MOHLTC Relevant Initiatives – Healthy Communities Fund: The Healthy Communities Fund (HCF) provides funding to community partnerships established to plan and deliver integrated programs (MHPS, 2011). Through HCF, there are three streams of funding: the Grants Project Stream, a Partnership Stream and a Resource Stream (MHPS, 2011). The MHPS aims to achieve six priorities through HCF, one of which is related to injury prevention (MHPS, 2011). As such, a number of partnerships involving PHUs may be funded by HCF. The provincial structure should ensure alignment of the 14 LHIN-wide Integrated Falls Prevention Programs with such existing partnerships.

Provincial and National Organizations and Initiatives

In this section, provincial organizations and initiatives for the provincial structure to potentially align with are summarized in Table 3 below. A more detailed description of each organization/initiative and the related opportunities for collaboration and alignment are provided in Appendix V. In the table below, these organizations are listed in alphabetical order as opposed to order of importance.

Table 3: Summary of Select Provincial and National Organizations and Initiatives to Align with Listed in Alphabetical Order

Organization/Initiative	Summary of Potential Collaboration and Alignment Opportunities
National	
Accreditation Canada	Leverage leading falls prevention practices of accredited organizations and promote accreditation to non-accredited organizations as accreditation requires falls prevention strategies to be in place.
Provincial	
Public Health Ontario (PHO)	Investigate opportunities for PHO to support the provincial structure and 14 LHIN-wide Integrated Falls Prevention Programs in provision of scientific and technical advice.
Ontario Neurotrauma Foundation (ONF)	ONF provides access to scientific expertise in best practice identification, implementation and evaluation while building capacity through research grants and other key support initiatives for an increased research uptake.

Organization/Initiative	Summary of Potential Collaboration and Alignment Opportunities
Ontario Osteoporosis Strategy	Alignment with the activities of the Ontario Osteoporosis Strategy to prevent hip fractures in seniors by preventing falls and osteoporosis, which often go hand in hand.
Ontario Seniors' Secretariat (OSS)	Leverage current communication mediums to seniors used by OSS to disseminate falls prevention messaging to seniors. Current falls prevention resources provided by the OSS such as the falls prevention seminars can also be leveraged.
Registered Nurses Association of Ontario	***Best practice guidelines:*** Leverage current nursing best practice guidelines related to falls. Leverage current nursing best practice guidelines and implementation resources that relate to falls. ***RNAO Long-Term Care Best Practice Coordinators Initiative***: Coordinators promote and support the uptake of evidence-based practices in LTC homes. A key area of focus is on falls prevention. This role can be leveraged by the provincial structure to promote best practices amongst LTC homes involved in each LHIN-wide Integrated Falls Prevention Programs.
Residents First Initiative by Health Quality Ontario	Align with current falls prevention initiatives being conducted by some LTC homes as part of Residents First and promote adoption of Residents First and use of Residents First tools online to enable effective falls prevention interventions within non-participating LTC homes.
Senior Friendly Hospital Strategy by the Regional Geriatric Program of Ontario	Align with current falls prevention initiatives delivered by some hospitals as part of the Senior Friendly Hospital Strategy. Promote the adoption of senior friendly hospitals to promote safe hospitals that prevent falls and utilize current falls prevention tools produced by participating hospitals.
Seniors Health Research Transfer Network Knowledge Exchange	Collaborate with SHRTN to leverage its knowledge base and the many services and opportunities it provide for its members such as the falls prevention community of practice and the library of service.

Continually Seeking Relevant Partnerships at the Provincial and National Levels

It is important for the provincial structure to continually be abreast of emerging organizations and initiatives to collaborate and align with at both a provincial and national level. The provincial structure would be the liason between the 14 LHIN-wide Integrated Falls Prevention Programs and any relevant provincial and national organizations and/or initiatives. This does not prevent partnership at a local level, however it streamlines collaboration and ensures all 14 LHINs are involved in important collaborative efforts. To become aware of new opportunities for collaboration, the provincial structure would need to be well connected in the health care field and take advantage of every networking opportunity on behalf of the 14 LHIN-wide Integrated Falls Prevention Programs. As new partnerships and collaborations are formed, the provincial structure should pay close attention to ensuring the old partnerships continue to be managed effectively. Continuing to collaborate with relevant provincial and national organizations would ensure alignment is maintained and processes and resources are always streamlined, resulting in better outcomes in falls prevention overall.

Section VI: Toolkit - Select Tools and Resources

As mentioned in Section IV, there are a number of best practice resources and toolkits that should be reviewed by every LHIN-wide Integrated Falls Prevention Program and shared amongst all the partners. The following section outlines some helpful resources along with the intended users, details of the resource and how to access the specific resource. It should be noted that although a main audience is listed for each resource, it does not restrict other audiences from utilizing the resource. In addition, these lists are not comprehensive and therefore there may be successful programs or helpful resources that were not included. These lists are based on the consultations and research conducted as part of this project. Within each table, items are listed in alphabetical order and not order of importance.

A. Select Available Guidelines

Table 4: Select Falls Prevention Guidelines

	Main Audience	Author, Year	Description	
Best practice guidelines for fall prevention in assisted living: Promoting active living	Community: CCAC, CSS, Supporting Housing and Retirement Homes	British Columbia Injury Research and Prevention Unit, 2008	These guidelines are an evidence-based, practical tool designed to assist staff and residents of Assisted Living to identify and reduce falls and related risk factors.	To order a copy, go to: http://www.publications.gov.bc.ca/search.aspx and search for "Promoting Active Living" or product code: **7610003388.**
Clinical Practice Guidelines: Prevention of Falls in Older Persons	Health care Professionals	American Geriatric Society /British Geriatric Society, 2010	These guidelines outline key recommendations for health care professionals to guide them in better assessing for falls risk and preventing falls in their patients.	Go to : http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2010/
Nursing Best Practice Guideline: Prevention of Falls and Fall Injuries in the Older Adult	Nurses in health care facilities	Registered Nurses' Association of Ontario, 2011	This comprehensive document provides evidence-based recommendations to support falls prevention and injury reduction.	Go to: http://www.rnao.org/Storage/12/617_BPG_Falls_rev05.pdf

B. Select Available Implementation Guides

Table 5: Select Falls Prevention Implementation Guides

	Main Audience	Author, Year	Description	Access
A Guide to How to Develop Community-Based Falls Prevention Programs for Older Adults: Preventing Falls	Community-Based Organizations (CBOs) (e.g. Public Health departments, home support service providers)	Centers for Disease Control and Prevention, 2008	This guide was developed to support CBOs in developing and implementing effective falls prevention programs. It defines the key elements of an effective program and provides information on how to develop these programs.	Go to: http://www.cdc.gov/ncipc/preventingfalls/CDC_Guide.pdf
Active Independent Aging: A Community Guide for Falls Prevention and Active Living	Anyone working with older adults living independently	Community Health Research Unit, University of Ottawa and City of Ottawa, 2004	This guide promotes the health and independence of older adults and veterans by providing information about falls amongst older adults, how to reduce hazards for falls, how to encourage older adults to be active and tools to make the community safer.	Go to: http://docs.communityconnection.net/activeagingguide.pdf?hl=en
Engaging Seniors: Better Practices for Falls Prevention	Health Service Providers	Hamilton Niagara Haldimand Brant Local Health Integration Network, 2008	The chapters in this guide follow a series of evidence-based recommendations to better engage older people in activities to prevent falls by addressing the many barriers to the acceptance and adoption of falls prevention advice by seniors.	Go to: http://www.hnhblhin.on.ca/uploadedFiles/Public_Community/Our_Priorities/Falls_Prevention/EngagingSeniorsPDF.pdf
Policy and Procedure: Falls Prevention and Management	LTC homes	Regional Geriatric Program of Toronto's Toronto Best Practice in LTC Initiative, 2006	This policy and procedure has been developed by a group of LTC Homes and the Regional Best Practice Coordinator in Toronto based on the RNAO Best Practice Guidelines on Prevention of Falls and Fall Injuries in the Older Adult and other best practice sources on the same topic. This policy and procedure is to be used as a guideline at the discretion of the LTC Homes to prevent falls in their homes.	Go to: http://rgp.toronto.on.ca/torontobestpractice/Policyprocedurefallspreventionmanagement.pdf
Recommended Practice Guidelines: Outcome Focused Physical Activity Programming for LTC Homes	LTC Homes	SHRTN – Activity and Aging Community of Practice, 2008	This document provides recommendations for how to effectively administer exercise programs for seniors living in LTC homes.	Go to: http://www.uwo.ca/actage/publications/PDFs/ACTIVE%20Guide%20Final%20February%202009%20Copyrights%20In-%20Clara.pdf

C. Select Available Toolkits

Table 6: Select Falls Prevention Toolkits

	Main Audience	Author, Year	Description	Access
A Framework & Toolkit for Prevention: Falls and Related Injuries in Residential Care	Long-Term Care	British Columbia Injury Research and Prevention Unit, 2010	The purpose of this report is to facilitate the translation of falls prevention evidence into practice within LTC homes through the presentation of a Public Health Framework for falls prevention.	Go to: http://www.injuryresearch.bc.ca/admin/DocUpload/3_20101220_144237Final_CEMFIA%20Framework_Nov%2015_2010.pdf
Falls Prevention Seminar Resource Kit	Anyone interested in hosting a seminar for seniors	Ontario Seniors' Secretariat, 2006	This resource kit includes PowerPoint presentations and handouts for use by presenters of the seminar. The seminar is designed to make seniors aware of how to prevent falls and maintain their independence through multi-factorial interventions.	For more information on how to host a seminar and/or request the resource kit, go to: http://www.seniors.gov.on.ca/en/seminars/falls.php
Geriatrics in Primary Care Toolkit: Falls	Primary Care: Family Health Teams and Community Health Centres	The Geriatrics Inter-professional Inter-organizational Collaboration (GiiC), on-going	The toolkit offers a systematic and inter-professional approach to falls prevention and includes many useful tools for falls risk assessment, algorithms, education of seniors and capacity building.	Go to http://giic.rgps.on.ca/ and create account if you don't have an RGP account (same account to access Falls Clinical Tools). You will be asked to create a user account which is reviewed and access is approved within a short period of time. Once your account is approved you may login to the GiiC website and gain access to the Toolkit. Toolkit components are listed at the top of the page. Registration is free. Falls is just one of many components of the Toolkit.
RNAO Best Practices Toolkit	Nursing	RNAO Long-Term Care Best Practices Initiative, 2007	This online toolkit contains evidence-based resources to support the development of falls prevention programs in LTC homes.	http://www.rnao.org/Storage/33/2731_LTC-Falls-5.pdf
Safer Healthcare Now! Getting Started Kit: Reducing falls and injuries from falls	All types of health care professionals involved in quality improvement	Safer Health care Now, 2010	The kit is intended to be a guide to assist health care professionals working across a range of sectors to implement falls prevention and injury reduction programs. The document highlights high impact, evidence-based strategies and represents the most current evidence, knowledge and practice, as of 2010.	Go to: http://www.saferhealthcarenow.ca/EN/Interventions/Falls/Documents/Falls%20Getting%20Started%20Kit.pdf

	Main Audience	Author, Year	Description	Access
Senior Friendly Hospital Toolkit: Falls Clinical Tools, Learning Resources and Materials for Patients and Families	Hospitals	Regional Geriatric Program of Toronto (RGP), on-going	This toolkit compiles resources developed by the RGP of Toronto's Network of 28 hospitals and also provides access to the very best of frailty focused resources from around the world.	Copy and paste this link in the URL: http://seniorfriendlyhospitals.ca/ and create account if you don't have an RGP account (same account to access the GiiC toolkit). You will be asked to create a user account which is reviewed and access is approved within a short period of time. Once approved, you may login to the senior friendly hospitals site to access toolkit. To access fall tools, click on the "Processes of Care" tab and choose falls from the drop down menu. Registration is free. Falls is just one of many components of the toolkit.

D. Existing LHIN-wide/Regional and Multi-Sector Falls Prevention Programs

Table 7: Existing LHIN-wide/Regional and/or Multi-sector Falls Prevention Programs

LHIN	Name of Initiative	Program Overview	Sectors/ Organizations Involved	Contact
Central West (CW)	Falls Prevention Action Group (FPAG)	FPAG is a sub group of the Services for Seniors Core Action Group (SSCAG) that assisted the LHIN in developing a falls prevention framework and services by identifying: • Existing falls prevention service capacity of HSPs • Falls prevention services access issues in the LHIN • Efforts and best practices in providing and coordinating falls prevention services • Recommendations to the SSCAG with a falls prevention framework and services	• LHIN • HSPs currently funded by the LHIN • CSS • 4 PHUs	For more information go to: http://www.centralwestlhin.on.ca/home.aspx
Champlain	Integrated Falls Prevention Program	This program is currently operating in one geographic sub-region. The program provides the following services: • Comprehensive assessment of patient and home followed by services plan • Education to seniors/caregivers using a mobile clinic set up in senior's centres, churches, senior's housing complexes, retirement homes • Best practice education & outreach to service providers Advocacy on issues related to falls prevention Program is to be evaluated at 3, 6 and 12 months post initiation.	• LHIN • CHC • Hospital • CSS • CCAC • FHTs • Ottawa Public Health • Osteoporo-sis Canada • Regional Geriatric Program of Eastern Ontario	For more information go to: http://gtarehabnetwork.ca/downloads/bpd/bpd2011-rapidpodium-pearce.pdf

LHIN	Name of Initiative	Program Overview	Sectors/ Organizations Involved	Contact
Hamilton Niagara Haldimand Brant (HNHB)	Falls Prevention Planning Framework	Key leaders and stakeholders were engaged through two LHIN-wide meetings on falls prevention and completed the following: • Leveraged current work • Built new partnerships with key organizations • Contributed to the LHIN-wide Falls Prevention Planning Framework • Identified a variety of interventions that exist • Developed strategies to reduce falls at a local and LHIN-wide level The following interventions are coordinated through the LHIN-wide strategy: • Exercise programs • Home maintenance • Travelling falls clinic • Improving continence care	• LHIN • CCAC • Hospital • CSS • Public Health • CHC	For more information go to: https://ospace.scholarsportal.info/bitstream/1873/13273/1/284491.pdf
Mississauga/ Halton (MH)	Falls Prevention Initiative	A multi-sectoral steering committee met frequently to develop a strategic framework for falls prevention to help reduce pressures on EDs and hospitals. Deliverables completed include: • A framework for falls prevention • A survey of falls prevention efforts • Inventory of falls prevention efforts Initiative is currently looking at how to increase the capacity of community centres, parks & recreation, and seniors centres to contribute to falls prevention. The services provided through this program include: • Expansion of the Outpatient Falls Prevention Clinic: To provide comprehensive interdisciplinary care to complex, frail seniors who have had many falls • In-home exercise program: Provided to frail seniors and primarily homebound older adults • Older Adult Specialist Certification for fitness instructors in Parks and Recreation department: To	• Hospitals • Public Health • LTC • CSS • CHC • CCAC	For more information go to: http://www.mississaugahaltonlhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Mississauga%20Halton%20Falls%20Prevention%20Project%202008%20report.pdf

LHIN	Name of Initiative	Program Overview	Sectors/ Organizations Involved	Contact
		increase capacity of parks and recreation to decrease likelihood of falls in community-dwelling seniors		
North Simcoe Muskoka (NSM)	Integrated Regional Falls Program	An integrated program that provides a number of services related to falls prevention in a coordinated fashion under the following headings: 1) Health Promotion and Risk Reduction • Community-based (FHTs and CHCs) falls screening clinics • SMART Program: Exercise for seniors in their homes and in high senior population settings • Mobile Seating and Mobile Clinic: assessment of walkers and manual wheelchairs • Public education • Through CCAC, facilitate community linkages and provide home support for seniors who have fallen 2) System Navigation • 211: A single point of entry within NSM for general questions related to falls and related resources • Falls Resource Inventory • Accessibility Resource Centre • Central Intake and Triage into Program 3) Specialized Geriatric Services • Specialized falls screening clinic • ED Support Service • Day Hospital for Falls Prevention • Provider Education	• CCAC • CSS • Public Health • EMS • MHA • Acute Care • Hospitals • CHC	For more information go to: http://www.nsmlhin.on.ca/
North West (NW)	1) Falls Injury Prevention Collaborative	A coalition of partners from across the health care sector in Northwestern Ontario which provides a venue for the discussion and sharing of falls and falls injuries, and develop strategies, resources, and plans for the implementation of Falls Best Practice Guidelines. This initiative ended March 2011.	• Hospitals • LTC • CSS	For more information go to: www.fallprevention.ca
	2) Residents First	This is a Health Quality Ontario (HQO) initiative. In this particular LHIN, this initiative will focus on falls prevention and leverage the work of the Falls Injury Prevention Collaborative.	• HQO • St. Joseph's Care Group	

LHIN	Name of Initiative	Program Overview	Sectors/ Organizations Involved	Contact
South West (SW)	Grey Bruce Falls Prevention and Intervention Program	A program that implements best practice interventions to address the needs of older adults, who are at various risk levels of falling, through an integrated and coordinated approach. Current strategies include: • Self screening through the "6 warning signs" self screening tool • Home Support Exercise Program • Multi-factorial and Comprehensive Risk Assessments • Increase awareness of falls risk, early identification, prevention and screening • Finding Balance social marketing campaign • Referral of seniors who have fallen to the program by EMS	• Hospital • EMS • Primary Care (FHTs) • CCAC • Public Health • CHC • CSS • LTC • Osteoporo-sis Canada	For more information go to: http://www.publichealthgreybruce.on.ca/injury/Older-Adults/GB_Falls_Program/Index.htm

E. Select Leading Falls Prevention Interventions

Table 8: Select Falls Prevention Interventions

Program	Description
CCAC Medication Management Support Services	• A home-based service providing medication safety, simplicity and accuracy • Through this program, eligible seniors are assigned a dedicated nurse to assess medications currently taken by the senior • By working with a pharmacist and the client's family doctor as necessary, medication issues that often lead to falls are resolved • Follow up is conducted to ensure medication recommendations are adhered to • This program has resulted in a 46% reduction in falls
Home-Based Exercise Program	• Developed by the Canadian Centre for Activity and Aging • Consists of 10 simple, progressive exercises proved to increase balance and functional mobility • Delivered by PSWs and senior volunteers to seniors in their home on an individual basis • PSWs and senior volunteers are trained by qualified facilitators
Sage Advice & Gentle Exercises for Seniors	• Implemented by a number of agencies under the auspices of Community Care City of Kawartha Lakes • A 10-week program designed to be led by peer volunteers and conducted with groups of seniors • The program is structured around four main components: education, exercise, nutrition and social interaction • A facilitator manual is available which provide: o Week-by-week instruction guide o Educational video information o Tip sheets and handouts o Information on exercise video o Program support • This program has been deemed successful as it has sustained itself over 10 years and has been delivered to thousands of participants and continues to grow For more information or for "Sages" Program tools call 705-324-7323 Or e-mail sages@community-care.on.ca
Seniors Maintaining Active Roles Together (SMART) Program	• Provided by Victorian Order of Nurses (VON) • 12-week group exercise or home exercise programming and education for high-risk seniors in home and in high-senior population settings • To assist those implementing this program, VON has developed the "Leading practices in the development of the VON Canada SMART Program Document". This document can be accessed at http://www.von.ca/en/special_projects/docs/SMART_LeadingPractices.pdf
STAND UP!	• Initiated in Montreal, Quebec • Provides a 12-week education and exercise program designed to improve balance amongst older adults • Consists of three components: group exercises, exercises at home, and discussion sessions on falls prevention • Can be offered in a community setting by group format • Evidence shows that STAND UP! is effective in maintaining physical activity among older adults beyond the 12-week intervention
Stay on Your Feet	• Developed in Australia and piloted in three areas in Ontario with funding by ONF • Targeted to non-institutionalized seniors • Address footwear, vision, physical activity, balance and gait, medication use, chronic conditions, and home and public environmental hazards. • Multiple strategies were implemented including awareness raising, community education, policy development (with both state and local governments), home hazard reduction, media campaigns, and working with clinicians and other health professionals • Resulted in a 22% reduction in self-reported falls and a 20% reduction in hospitalization rate

F. Select Falls Prevention Web Based Resources

Table 9: Select Falls Prevention Web Based Resources

Portal/ Catalogue	Audience	Author	Description	Access
Best Practices Catalogue	Administrators of falls prevention interventions	Ontario Injury Prevention Resource Centre	This online catalogue lists a number of international best practices programs for falls prevention in older adults.	Go to: http://www.oninjuryresources.ca/BestPractices/proglistfall-related.htm
Canadian Best Practices Portal	Administrators of falls prevention interventions	Public Health Agency of Canada, ongoing	This portal contains more than 300 best practice interventions that focus on chronic disease prevention, injury prevention and health promotion, 17 of which are falls prevention interventions. The portal is an easily searchable database that is accessible to anyone.	Go to: http://cbpp-pcpe.phac-aspc.gc.ca/intervention/search_history/22931/view-eng.html
Falls in Long-Term Care	LTC: Nurses and care providers	Baycrest Health Science Centre	This website provides information and resources on how to implement a falls prevention program in a LTC home. This website was developed as part of a research study examining falls in Ontario LTC homes and aims to disseminate information about falls in LTC including results of the study.	Go to: http://www.fallsinltc.ca/index.htm
Online Health Program Planner	• Public Health Program Administrators • Health promoters	Public Health Ontario	This resource links anyone interested in program planning to key resources, including documents and resource centres. It also provides access to sample plans, including situational assessments and evidence-based interventions with completed logic models.	Go to: http://www.thcu.ca/ohpp/plan_library.cfm#112775
Ontario Injury Prevention Resource Centre (OIPRC)	Administrators of falls prevention interventions	SMARTRISK	A web resource providing a series of tools, best practice resources and educational opportunities for the prevention of injury including falls. OIPRC's objectives include increasing the knowledge, skill and confidence of injury prevention practitioners and promoting best practice.	Go to : http://www.oninjuryresources.ca/about_the_centre/
Preventing Falls: What Works – A CDC Compendium of Effective Community-Based Interventions from Around the World	• Public Health Practitioners • Health service providers • Anyone implementing falls prevention interventions	Centers for Disease Control and Prevention, 2008	This *Compendium* includes specific exercise based, home modification related and multifaceted interventions that have rigorous scientific evidence of effectiveness and provides relevant information about these interventions.	Go to: http://www.cdc.gov/HomeandRecreationalSafety/images/CDCCompendium_030508-a.pdf

G. Select Available Guides Targeted to Seniors

Table 10: Select Guides and Toolkits Targeted to Seniors

Title	Audience	Author, Year	Description	Access
A Guide to Programs and Services for Seniors in Ontario	Seniors	Ontario Seniors' Secretariat 2010	A resource for seniors that provides information on the many programs and services that are available to them. Falls prevention programs are listed under section 5, "Emergency Services and Public Safety"	Go to: http://www.seniors.gov.on.ca/en/seniorsguide/docs/seniors_guide_final_english_web.pdf
Smart Moves Toolkit	Seniors and Caregivers	SMARTRISK , 2005	This toolkit provides information to seniors on how to prevent falls. It is a large-type booklet divided into four main categories: bone health, exercise, medication management and home modifications. Seniors who have received this toolkit have reported increase in uptake supplements for bone health, increase in exercise and lower use of painkillers.	Go to: http://www.smartrisk.ca/downloads/smartmoves/toolkit.pdf
The Safe Living Guide: A Guide to Home Safety for Seniors	Seniors	Public Health Agency of Canada (PHAC), 2008	This guide provides seniors with advice on how to prevent injuries by keeping their home safe with respect to falls or any other hazards. It includes checklists to facilitate the home safety check process as well as real-life stories from seniors who have made their home safer.	Go to: http://www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/public/injury-blessure/safelive-securite/safelive-securite-eng.pdf

APPENDICES

APPENDIX A – Falls Related Data

Percent (%) of Hip Fractures Due to Falls in Ontario

	# of Hip Fractures Due to Falls	# of All Hip Fractures	% of All Hip Fractures Due to Falls
Female (65+)	5,662	5,930	95.5
Male (65+)	2,027	2,157	94.0
Total	7,689	8,087	95.1

Percent (%) of Injuries Due to Falls in Ontario

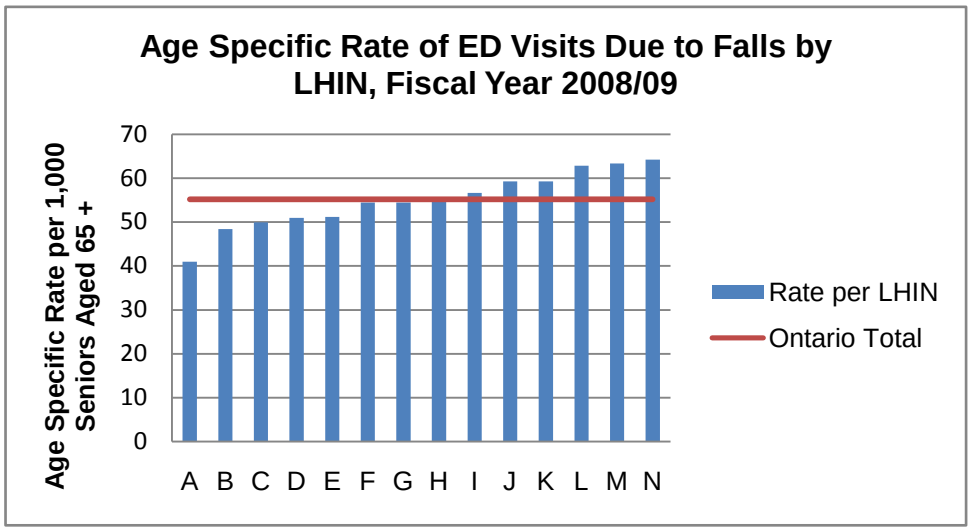
	# of Injuries Due to Falls	% of All Inuries Due to Falls
Female (65+)	18,335	52.5
Male (65+)	8,430	43.0
Total	26,765	49.1

Data Sources for Both Graphs:

Hospitalization: Discharge Abstract Database (CIHI), *Intelli*health Ontario, Ministry of Health and Long-Term Care (MOHLTC)

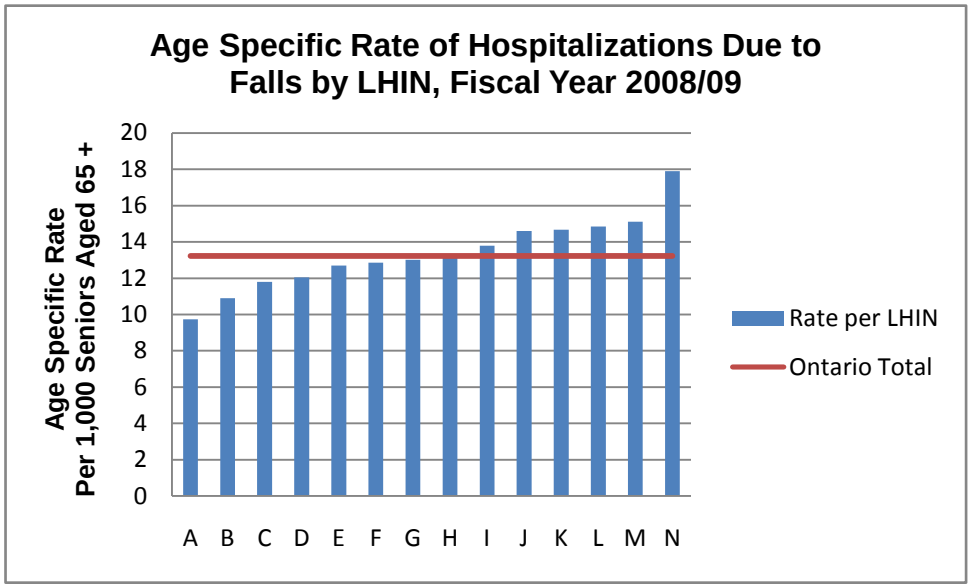
Population Estimates LHIN: (Statistics Canada and Ontario Ministry of Finance), *Intelli*health Ontario, MOHLTC

ED Visits Due to Falls by LHIN



Data Source:
Intellihealth Ontario, MOHLTC

Hospitalizations Due to Falls by LHIN



Data Source:
Intellihealth Ontario, MOHLTC

APPENDIX B – Integrated Provincial Falls Prevention Mobilization Committee Membership

	Name	Title	Organization	Sector
1	Bernie Blais (Co -Chair)	CEO	North Simcoe Muskoka LHIN	LHINs
2	Dr. Paul Roumeliotis (Co-Chair)	Medical Officer of Health and CEO President	Eastern Ontario Health Unit Association of Local Public Health Agencies	Public Health
3	Athina Perivolaris	Advanced Practice Nurse, Professional Practice Office	Centre for Addiction and Mental Health	Mental Health Hospitals
4	Dr. Barbara Liu	Executive Director	Regional Geriatric Program of Toronto	Regional Geriatric Programs
5	Candace Chartier	Chief Operating Officer	Omni Health Care	Long-Term Care
6	Dana Khan	Senior Manager	Client Services, Waterloo Wellington Community Care Access Centre	Community Care Access Centres
7	Dr. Lee Donohue	Board Director General & Family Practice Assembly	Ontario Medical Association	Physicians
8	Elizabeth Birchall	Executive Director	Community Outreach Programs in Addictions	Community Mental Health
9	Dr. Heather Manson	Director of Health Promotion, Chronic Disease and Injury Prevention	Public Health Ontario Ontario College of Family Physicians	Public Health Ontario Family Physicians
10	Heather McConnell	Associate Director, International Affairs and Best Practice Guidelines Program	Registered Nurses' Association of Ontario	Registered Nurses
11	Hélène Gagné	Program Director, Injury Prevention	Ontario Neurotrauma Foundation	Ontario Neurotrauma Foundation

	Name	Title	Organization	Sector
12	Kasia Filaber	Director, Clinical Services	The Four Villages Community Health Centre	Community Health Centres
13	Kitty Liu	Manager, Corporate Projects	St. John's Rehab	Hospitals
14	Ralph Ganter	Senior Director, Planning, Integration & Community Engagement	Erie St. Clair LHIN	LHINs
15	Susan Draper	Advanced Practice Nurse	Soins Continus Bruyère Continuing Care	Hospitals
16	Valmay Barkey	CEO	Community Care City of Kawartha Lakes, CHC site representing the Ontario Community Support Association	Community Support Sector

APPENDIX C – Summary of Literature Review Findings

A Preliminary Literature Review on Falls Prevention for the Elderly

PLANNING UNIT PRODUCT # 172

Prepared by the Planning Unit
Health System Planning & Research Branch
Health System Strategy Division
Ministry of Health and Long-Term Care
January 2011

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Please take the time to complete an anonymous two-minute Literature Review Survey to inform us how this review met, or did not meet, your needs

Date: 2010-01-17, Author: QuachU-HSP&Res, Version: v1.0
File Path: T:\Planning\Final Copies of Lit Reviews, Lit Review List, and Summary Doc\172. A Preliminary Literature Review on Falls Prevention for the Elderly

OBJECTIVES

The objectives of this preliminary literature review were to identify: (1) best practices in formulating and implementing a falls prevention program/strategy for the elderly; (2) factors affecting falls based on setting, relevant subpopulations and other relevant segmentation; (3) best practice interventions to prevent falls and processes used to determine the most suitable intervention; and (4) performance indicators used to measure leading interventions and accountability frameworks/structures.

SEARCH METHODS FOR IDENTIFICATION OF STUDIES

Individual peer-reviewed articles and review articles were identified through the Ontario Ministry of Health and Long-Term Care's computerized library database, PubMed, and Google Scholar. Grey literature was identified through Google and relevant government websites. A search was conducted on the PubMed Health Services Research (HSR) Queries search interface using the Medical Subject Heading (MeSH) terms identified below and the "process assessment" and "appropriateness" search categories. The search was limited to English sources and therefore may not capture the full extent of initiatives in non-English speaking countries. Due to the extensive existing research on falls prevention for the elderly, this preliminary review focused on reviews and meta-analyses published from 2005 to 2010*.
The MeSH terms "Accidental Falls", "Risk Factors", "Aged", "Frail Elderly", "Accident Prevention", and "Aged, 80 and over" were used in combination with the following keywords to identify relevant articles and documents for this review: "formulation", "development", "implementation", "falls prevention", "accountability", "structure", "best practice*", and "framework".

A total of 48 references were identified and cited in this review: 38 review articles, four original research papers from peer-reviewed journals, and six documents from the grey literature. In total, the searching for relevant material and the writing of this review took approximately 1.5 weeks to complete by one person. As a result, the review may not have captured all the information available and the results from it are therefore preliminary.

SUMMARY OF MAIN FINDINGS

Best practices in formulating and implementing falls prevention programs/strategies

Limited research was found on identifying best practices in formulating and implementing program/strategies, although, one article noted that an important barrier to the implementation of proven prevention programs is the lack of a delivery system. The same article found no trials investigating the most effective way to deliver fall and fracture prevention strategies. However, two documents made relevant recommendations:

A 2004 WHO report suggested that effective falls prevention strategies include: comprehensive and inclusive partnerships with clearly defined responsibilities and goals, education and communication, the development of local strategies, and sufficient resources.

One review concluded that patient input to ensure compliance in interventions may be important to achieve maximum participation rates.

Factors affecting falls – by setting, subpopulations and other segmentation

Overall, risk factors affecting falls for the elderly are diverse with one review noting more than 400 potential factors identified in the literature encompassing physiological (e.g., muscle weakness), sociodemographic (e.g., age, gender), medical (e.g., neurological disorders), pharmacological (e.g., the use of psychotropic drugs) and environmental (e.g., physical environment) factors.

In particular, several reviews examining the risk factors/risk associated with falls for the elderly in a variety of settings identified psychotropic drugs such as sedatives and hypnotics, antidepressants, benzodiazepines and non-steroidal anti-inflammatory drugs (NSAIDs) as contributing to a higher risk of falling.

For specific settings or subpopulations, numerous risk factors were identified (see sections 2.1-2.3) but there was limited systematic analysis (e.g., meta-analyses) determining the most common risk factors.

The exception was a meta-analysis analyzing 74 studies and including 31 factors associated with falls for older people living in the community. The authors found that the strongest factors were: history of falls, gait problems, walking aids use, vertigo, Parkinson disease, and antiepileptic drug use.

Best practice interventions to prevent falls and processes used to determine the most suitable intervention

Overall, interventions that have been considered in a variety of settings included exercise-based interventions, home/environmental evaluation and/or modification, vitamin D and multifactorial interventions (i.e., interventions with multiple components) (see sections 3.1 - 3.3 for other interventions specific to each setting). The evidence suggests that:

Exercise-based interventions were effective in reducing the rate of falls in the community and inpatient settings (i.e., hospitals), but findings were mixed for nursing home/residential care facilities.

Home modification interventions may be beneficial for those with severe visual impairment and others at higher risk of falling (e.g., frail elderly). In the long-term care setting, multifactorial interventions that include environmental evaluation and intervention was determined as a best practice in one document.

Vitamin D supplementation was found to be effective in nursing care facilities. In the community, the findings were mixed. However, two reviews suggested vitamin D may be effective for specific groups in the community (e.g., elderly women, those with lower vitamin D levels).

The effectiveness of multifactorial interventions was found in the community setting, particularly for certain high risk groups and in the nursing home/residential care setting. However, a meta-analysis comparing multifactorial versus exercise-alone interventions in reducing recurrent falls among community-dwelling older people found that exercise-alone interventions were about five times more effective compared to multifactorial ones. Results were mixed in the inpatient setting.

Similarly, a 2008 Medical Advisory Secretariat (MAS) review on effective interventions in reducing the probability of a community-dwelling elderly person's falling and/or sustaining a

fall-related injury was identified in this preliminary review. In particular, key findings for effective interventions found that:

Long-term exercise programs in mobile seniors and environmental modifications in the homes of frail elderly persons will effectively reduce falls and possibly fall-related injuries in Ontario's elderly population.

A combination of vitamin D and calcium supplementation in elderly women will help reduce the risk of falls by more than 40%.

No literature on best practices for processes in determining the most suitable intervention was identified in this preliminary literature review.

Performance measurements/accountability frameworks

The predominant outcome measurements identified in the literature across various settings were the rate of falls, the number of falls (e.g., per person) and the number of "fallers".

No accountability frameworks/structures were identified in the preliminary search for this review.

* It should be noted that although the search was limited to reviews and meta-analyses published from 2005 to 2010, a total of eight references published prior to 2005 were included and cited in this preliminary literature review.
Date: 2010-01-17, Author: QuachU-HSP&Res, Version: v1.0 File Path: T:\Planning\Final Copies of Lit Reviews, Lit Review List, and Summary Doc\172. A Preliminary Literature Review on Falls Prevention for the Elderly

Date: 2010-01-17, Author: QuachU-HSP&Res, Version: v1.0 File Path: T:\Planning\Final Copies of Lit Reviews, Lit Review List, and Summary Doc\172. A Preliminary Literature Review on Falls Prevention for the Elderly

APPENDIX D – Additional Consultations

In addition to consulting the LHINs, PHUs and Mobilization Committee members, the following were also consulted:

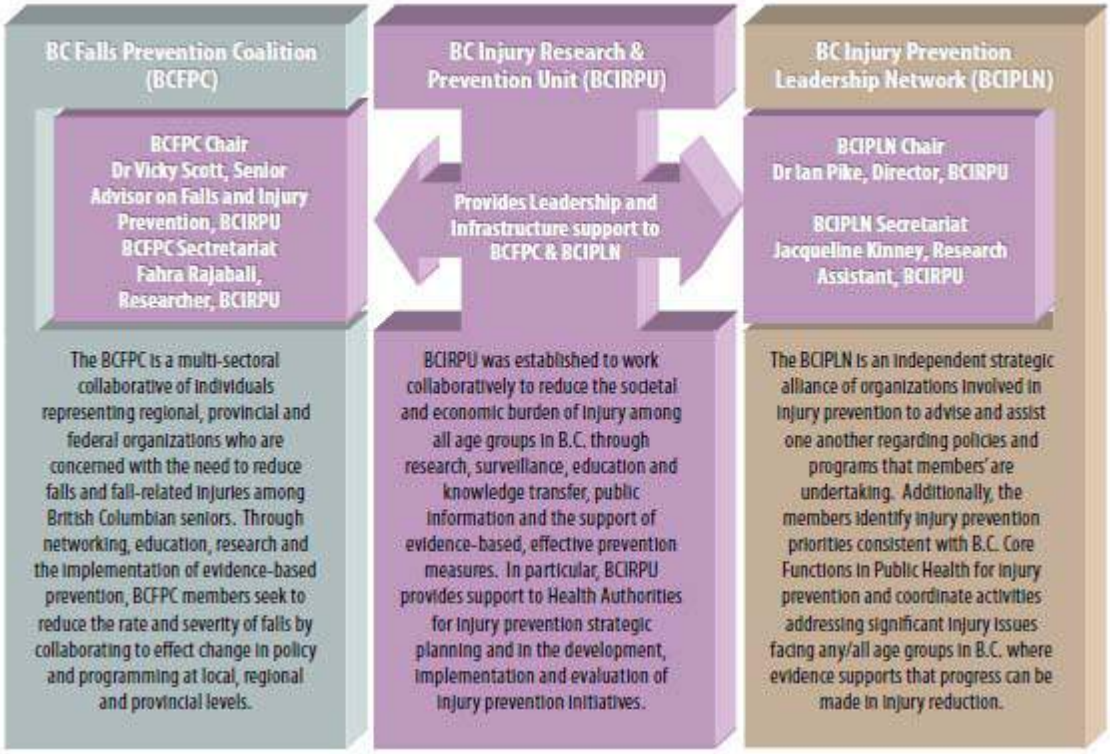
Select Subject Matter Experts Consulted

Name	Title	Organization	Province
Dr. Vicky Scott	Senior Advisor	B.C. Injury Research & Prevention Unit and the BC Ministry of Health Services	British Columbia
Dr. Mark Speechley	Associate Professor, Department of Epidemiology & Biostatistics	University of Western Ontario	Ontario

Select Programs and Initiatives Interviewed

Organization	Name of Program/Initiative
Central CCAC	Medication Management Support Services
Accreditation Canada	Falls Prevention Required Organizational Practices
Health Quality Ontario	Residents First
Ministry of Health and Long Term Care	Excellent Care For All Act
Ontario Osteoporosis Canada	Ontario Osteoporosis Strategy
Ontario Seniors Secretariat	---
Seniors Health Research Transfer Network	Falls Prevention Community of Practice
Saint Elizabeth Health Care	Falls Prevention Program

APPENDIX E – Falls Prevention Model in British Columbia



The figure above illustrates the Falls Prevention Infrastructure in British Columbia. The BC Injury Research Prevention Unit (BCIRPU) is integrated within the BC Falls Prevention Coalition (BCFPC) and the BC Injury Prevention Leadership Network (BCIPLN). This demonstrates how the BCIRPU is integral to the leadership and infrastructure needed to address falls and fall-related injuries within B.C.

Unique in this model is the Senior Advisor on Falls and Injury Prevention position (Dr. Vicky Scott) that was created by the BCIRPU and BC Ministry of Health. Through Dr. Scott's leadership, the momentum of falls prevention efforts across the Province has been maintained.

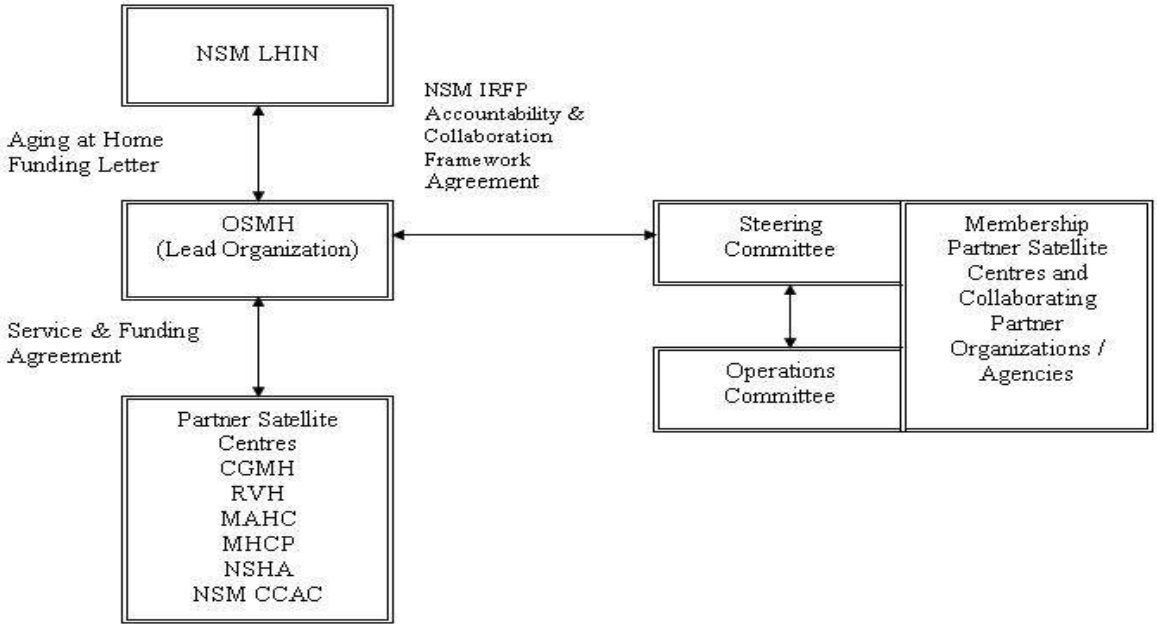
Source: ***http://www.health.gov.bc.ca/library/publications/year/2006/falls_report.pdf***

APPENDIX F – Sample Governance Structure

Governance & Leadership of the North Simcoe Muskoka Integrated Regional Falls Prevention Program (IRFP)

The most significant early accomplishment of the IRFP has been identification of a governance structure to support IRFP success, decision-making and accountability. Under the leadership of Orillia Soldiers' Memorial Hospital, CCAC and the LHIN a governance structure was defined and further revised based on input from regional CEOs. The structure supports OSMH through establishment of a regional IRFP Steering Committee and IRFP Operations Committee while concurrently outlining the reporting relationship between OSMH, the LHIN and Partner Satellite Centers.

NSM Integrated Regional Falls Program
Leadership and Governance Framework



APPENDIX G – Sample Accountability Documentation

North Simcoe Muskoka Integrated Regional Falls Prevention Program Accountability Framework

NORTH SIMCOE MUSKOKA INTEGRATED REGIONAL FALLS PROGRAM

Accountability and Collaboration Framework

Date: October 16, 2009

Project Initiator: North Simcoe Muskoka LHIN

Organizational Lead: Orillia Soldiers Memorial Hospital

Project Director: Sandra Easson-Bruno, Project Director Regional Seniors' Health

BACKGROUND

The Integrated Regional Falls Program (IRFP) links together acute care hospitals, primary care and community service organizations to provide an integrated program of services to North Simcoe Muskoka (NSM) seniors age 65+ or 55+ with an age related condition who have fallen and who are at risk of falling. The IRFP will provide assessment and intervention regarding falls and falls prevention through community-based Screening Clinics, specialized Falls Assessment Clinics and the OSMH Geriatric Day Hospital. The program will also provide assessment, intervention and, as appropriate, case management support to reduce future falls and fall-related injuries in seniors who present with a fall in the six NSM LHIN region Emergency Departments. The successful development and implementation of the IRFP is an important step in bridging gaps and in improving the quality, efficiency and effectiveness of care in order to reduce the number falls and fall-related injuries in NSM.

This Accountability and Collaborative Framework has evolved out of the work of the Regional

Falls Program Planning Committee. The Committee has been made up of 3 working groups:

- Service Delivery Task Force
- Evaluation Task Force
- Budget Task Force

Through the commitment and dedication of the members of the Falls Committee and the working groups the foundation for the IRFP has been created. The Accountability and

Collaborative Framework is the next step in the ongoing development of an integrated regional program.

ACCOUNTABILITY & COLLABORATION FRAMEWORK

Purpose

The purpose of this document is to define the mutual and joint responsibilities and undertakings

of the parties to this agreement in support of their common commitment to an effective, quality based IRFP in NSM that:

a) Ensures regional service planning is inclusive, comprehensive and builds upon existing resources;
b) Identifies and implements regional strategies for service integration, co-ordination, and continuous quality improvement;
c) Improves care through information dissemination and standards implementation;
d) Evaluates and reports on all aspects of performance through approved reporting formats; and
e) Responds to performance results with appropriate strategies.

The Agreement

The IRFP is a regional program that unites health care providers and organizations in a common cause of collaboration and mutual accountability. The IRFP is not a legal entity however, this agreement does constitute a commitment between or among the parties.

Accordingly, nothing in this agreement or arising from this agreement shall be construed to confer on any signatory any authority or power to act for or to undertake any obligation or responsibility on behalf of, another party or on behalf of the , except as otherwise provided for in this agreement.

Moreover, nothing in this agreement either removes or restricts, or should be construed to remove or restrict, any powers of the individual parties or their governing boards to consider and make policy decisions with respect to issues that are specific to their organization. The governance structure of each of the participating parties and organizations will be unaffected by this agreement.

Guiding Principles

The parties agree to be equally accountable to the following in guiding deliberations, decisions and actions:

IRFP Purpose

The purpose is to develop an IRFP for NSM seniors and their caregivers. The program is intended to:

- Reduce the frequency of falls by NSM seniors.
- Reduce the number of Emergency Department visits related to falls for NSM seniors.
- Reduce the severity of injury incurred by NSM seniors who fall.
- Reduce the number of admissions to acute care for NSM Seniors who have fallen.

IRFP Guiding Principles

The IRFP supports the mandate of the NSM Year 2 Aging at Home (AAH) Initiative:

AAH Goal

- To reduce adverse events for seniors in their homes wherever they live focusing on falls and medication issues.
- To provide a person with innovative and enhanced community supports to keep them at home and independent.
- To avoid inappropriate hospital admission.
- To facilitate timely discharge from an Emergency Room.

In addition, development and implementation of the IRFP is guided by the need for:

- regional equity and accessibility
- access to specialized services (comprehensive)
- early system entry and ease of navigation
- system response matching fall-risk (responsive)
- community-based care with appropriate use of acute care resources
- inter-sectoral and inter-professional collaboration
- centralized leadership
- standardization with regional variations
- knowledge transfer and change in practice as equal in importance to assessment and diagnosis
- evidence-based practice AND innovation
- and recognition that people WILL fall so, for some, the goal is to reduce the frequency of falls and falls-related injuries

Accountability

In demonstrating accountability to one another and to the integrity of the IRFP, the parties will ensure that all seniors receive an appropriate level of care in an appropriate setting. The parties will act responsibly in accordance with professional and clinical service standards; use resources wisely and efficiently within the funding available, share information deemed vital and relevant to the IRFP purpose, and measure and report on performance against pre-determined outcomes.

Innovation

The parties are steadfastly committed to acting upon as well as contributing to the latest advances in medical technology and best practices. The parties will undertake to develop appropriate policies, procedures and mechanisms aimed at fostering an environment that encourages individual initiative, creativity and problem solving, that enables professional development through continuous learning, and that recognizes and rewards high performance and team excellence.

Undertakings & Mutual Accountabilities

The parties agree, voluntarily and for both self and mutual interests to be jointly accountable to one another for the results achieved, and to be governed by the guiding principles set out in this agreement.

The parties agree that the development of program priorities, policies, standards and protocols will require and be dependent upon their active participation in the IRFP Steering Committee.

The parties further agree that the development of IRFP services in their organizations will be done within the context of the strategic directions and priorities of the IRFP to the benefit of seniors, their families, and their staff.

While the parties will take on different roles and responsibilities, they nonetheless undertake a common commitment to:

a) Provide shared leadership in guiding the development and organization of an IRFP system across NSM;
b) Build on current successes to enhance and support the continued improvement of the prevention, treatment and support services model to ensure ongoing sustainability in the delivery of falls and fall-prevention services for seniors and their families; and
c) Build on collaborative and productive working relationships with other falls care related initiatives in NSM.

In pursuit of their shared vision and mission of improving the quality and delivery of IRFP services in the region, the parties acknowledge the need, from time to time, to show flexibility on their individual organization's pursuits for the purpose of facilitating the benefits that can accrue from working together and building a sustainable IRFP through the Steering Committee and Operating Committee.

In the spirit of collaboration and regional integration, all parties agree to work together to:

a) Identify strategies that meet local and regional needs for service integration, coordination and quality improvement;
b) Facilitate meaningful patient and provider involvement in the planning, implementation and evaluation of IRFP activities;
c) Comply with IRFP reporting requirements;
d) Respond to performance results that may include shifting where and how IRFP services are delivered; and
e) Support the direction and activities of the IRFP Operating and Steering Committee.

Governance & Leadership

The partners agree that the IRFP requires a structure to oversee its strategic direction, operating protocols and day-to-day activities as well as to plan for its further evolution. Accordingly, this structure will include a Lead NSM Organization (OSMH) accountable to report data to the LHIN. Outcomes are a collective accountability of the member organizations of the IRFP. The work of this Lead Organization will be supported by a regional Steering Committee and regional Operations Committee. The Lead Organization is accountable to the LHIN. Satellite Centres (organizations employing IRFP staff) will provide local leadership in the implementation and evaluation of IRFP services.

Steering Committee

The parties voluntarily agree to participate as full members of the IRFP Steering Committee.

The parties agree that the IRFP Steering Committee will assume policy leadership in the development and implementation of the IRFP and, accordingly, will engage all partners and appropriate health care providers in pursuit of accountability of the IRFP.

Acting at all times in a manner that is consistent with the guiding principles noted above, the IRFP Steering Committee will be responsible for:

a) Setting strategic direction for the IRFP;
b) Monitoring the IRFP to ensure and enhance the quality of patient care across the continuum of services;
c) Ensuring the delivery of falls services across the region in the most cost-effective manner possible without compromising the quality of patient care;
d) Monitoring appropriate and specific performance indicators, benchmarks and metrics to monitor the efficiency and effectiveness of integrated regional falls services across NSM;
e) Approving and monitoring the regional financial operating plan;
f) Approving proposal and budget submissions to the Local Health Integration Network via the lead organization;
g) Approving common standards and integrated policies and protocols for monitoring quality, utilization and access indicators in the delivery of integrated regional falls services to the population of Simcoe-Muskoka;
h) Ensuring transparency in the use of provincial funding to support the program;
i) Approving and monitoring the health human resource plan;
j) Establishing and maintaining effective communications and linkages with all parties and stakeholders, especially seniors; and
k) Addressing such other issues and matters as may be deemed pertinent and important to IRFP planning, implementation and/or evaluation.

The IRFP Steering Committee will be supported in its mandate and work by a Regional Operations Committee with its own clearly defined Terms of Reference, approved by the Steering Committee, and such other task groups as may be created from time to time for specific purposes.

The IRFP Steering Committee will have a reporting relationship to the parties and NSM LHIN as well as to other parties of interest as determined from time to time.

Operations Committee

The parties agree the IRFP Operations Committee, comprised of a combination of clinical and operational leaders from around the NSM region, will support the IRFP Steering Committee by assuming responsibility for the clinical and, as appropriate, operational leadership of the IRFP.

Acting at all times in a manner that is consistent with the guiding principles noted above, the

IRFP Operations Committee will be responsible for:

a) Developing annual regional goals and objectives for the IRFP and monitoring progress toward those ends within the context of the strategic plan set by the IRFP Steering Committee;

b) In collaboration with the Lead Organization, developing and monitoring an annual regional financial operating plan;
c) Establishing consistent clinical and, as appropriate, administrative practices across the region;
d) Developing IRFP plans attending to regional education and staff orientation, information technology, health human resources and communication
e) Identifying core indicators and a framework for monitoring and trending data;
f) Ensuring the equitable allocation and utilization of resources;
g) Identifying and making appropriate recommendations to the IRFP Steering Committee for action on IRFP– wide issues, including recommendation to increase cost effectiveness and/or to enhance service delivery.

The IRFP Operations Committee will have well-defined responsibilities and accountabilities set out in a definitive role description that is approved by the IRFP Steering Committee.

The IRFP Operations Committee will have a reporting relationship to the IRFP Steering

Committee through the Chair (Project Director) as well as to other parties of interest as determined from time to time.

Lead Organization to the IRFP

It is agreed that the Orillia Soldiers' Memorial Hospital (OSMH) is the Lead Organization for the

IRFP and will be responsible for ensuring the parties to this agreement are providing the full range of services agreed to in the NSM LHIN Aging at Home funding letters .

In fulfilling this responsibility as the Lead Organization, OSMH will, within the available resources, maintain the ability, capacity and infrastructure to meet the needs of NSM seniors who require falls-related services.

The Lead Organization will accomplish this work, in concert with the Partner Satellite Centres, under the policy leadership of the IRFP Steering Committee. In fulfilling its responsibilities to the IRFP, the Lead Organization will be responsible to the LHIN and have authority to do the following:

a) Provide the overall administrative leadership in the implementation and coordination of the IRFP, including responsibility for the Project Director;
b) Ensure that a structure for effective governance and leadership is in place; and
c) Ensure, within the available resources, the following patient care services are available within the region as discussed and determined by the NSM LHIN in consultation with the IRFP Steering and Operating Committees and approved by the MOHLTC Aging at Home Strategy:

- Central Intake & Triage – complimenting existing system entry points, this service is to serve the role as interim entry point within NSM for specialized questions regarding falls and fall-related resources and as a central intake and triage location for referrals to specific IRFP services
- Falls Screening Clinics – a regional screening service to support family health teams, community health centers and locations with high populations of seniors (i.e. Retirement Homes, senior housing complexes, etc.).
- Emergency Department Support Service – a regional service supporting seniors presenting with falls and fall-related injuries in the NSM region's six Emergency Departments. The service will include assessment and, as appropriate, intervention and intensive case management services.

- Specialized Falls Assessment Clinics – a specialized interdisciplinary ambulatory clinic to be located at OSMH for seniors living in the community who have fallen or who are at risk of falling. The plan in the future is to rotate satellite clinics across the NSM LHIN to provide care closer to home.
- OSMH Geriatric Day Hospital Expansion – OSMH Day Hospital resources will be expanded to support seniors requiring ongoing assessment and intervention regarding falls and falls prevention on a regional basis.
- Manager with appropriate clinical expertise in geratrics – The Manager will support the clinical evolution of the IRFP, mentor the clinical staff funded by the IRFP and provide consultative services for some of the more difficult and complex cases. With a managerial role, this individual shares responsibility for the service delivery with the partner satellite program for the Falls Screening Clinic and Emergency Department Support Service staff and services. This individual will strive to build strong links between all components of the IRFP and facilitate system change across NSM.
- Regional Supports – regional resources will include:
    - CCAC Client Care Coordinator access to facilitate regional CCAC linkages and supports for seniors on service;
    - Physiotherapist and Occupational Therapist access to facilitate assessment and interventions, with particular emphasis on in-home safety assessments;
    - Pharmacist access to review medications;
    - Access to clerical support for appropriate services.

The Lead Organization will ensure an appropriate liaison is maintained with VON in the catchment areas served by the Program.

In collaboration with the Partner Satellite Centres and under the administrative leadership of the IRFP Steering Committee, the Lead Organization will be accountable for the following:

a) Acting as the transfer payment agency (or paymaster) for the funds allotted to the program to ensure that the Satellite Centres are reimbursed in accordance with the level of care provided;
b) Ensuring appropriate financial management information and budgeting systems are established and utilized for reporting purposes;
c) Providing the Satellite Centres with appropriate financial and statistical information, including performance indicators for the program, per the quality standards and protocols established by the IRFP Regional Operations Management Committee;
d) Ensuring consistent and accurate reporting of program activities in annual planning submissions and quarterly reports as required by NSM LHIN;
e) Developing effective and transparent transfer payment mechanisms that ensure an opportunity for all Satellite Centres to participate in the planning, decision-making and policy setting around same;
f) Working with the Satellite Centres to ensure a shared strong understanding of the funding modalities and related definitions for IRFP programs;
g) Ensuring the standardization of IRFP equipment, services and clinical protocols across the program;
h) Providing administrative support services to the IRFP Steering Committee as required;
i) Negotiating annual service volume targets in partnership with the satellite hospitals; and
j) Providing IRFP financial statements explaining funding and its allocation;

Partner Satellite Centres

IRFP Partner Satellite Centres (organizations employing IRFP staff funded by IRFP funds), will provide support as outlined below and as may be appropriate to their role in servicing seniors who have fallen or are at risk of falling within their geographic catchment area (as approved by the IRFP Steering Committee and the LHIN).

Partner Satellite Centres are responsible for ensuring their concerns about IRFP services and/or programming or any potential changes in their ability to deliver IRFP services and/or programming as required are raised in the appropriate committee sufficiently early enough for adequate discussion or support of same.

In collaboration with the Lead Organization and under the policy leadership of the IRFP Steering Committee, the Partner Satellite Centres will be responsible for supporting the delivery of one or more of the following services funded by the IRFP budget or AAH budget:

- Emergency Department Support Service – a regional service supporting seniors presenting with falls and fall-related injuries in the NSM region's six Emergency Departments. The service will include assessment and, as appropriate, intervention and intensive case management services. This best practice is occurring with increasing frequency both provincially and nationally. To maximize outcomes, the familiar "Geriatric Emergency Management" model is being limited to providing care to seniors who present in an area Emergency Department with a fall and is being paired with an intensive case management component. This hybrid model is intended to support to seniors who have fallen and/or are at risk of falling with follow-up to reduce Emergency Department visits. Under this service, each area Emergency Department will have access to a nurse several times a week. Specific roles for staff in regard to this service, include:
    - Assessing seniors presenting in area Emergency Departments with falls;
    - Linking discharged seniors from area Emergency Departments who have fallen or are at risk of fall-related injuries with appropriate resources;
    - Providing follow up in seniors homes where triaged as appropriate until they are appropriately linked into resources and their fall risk is reduced; and
    - Mentoring Emergency Department colleagues and implementing standardized regional approaches to care.

- Specialized Falls Assessment Clinics – a specialized interdisciplinary ambulatory clinic to be located at OSMH for seniors living in the community who have fallen or who are at risk of falling. The plan in the future is to rotate satellite clinics across the NSM LHIN to provide care closer to home. Specific roles for staff in regard to this service, include:
    - Assessing seniors referred to the Clinic regarding falls and fall-risk;
    - Linking seniors with appropriate resources;
    - Providing follow up in where triaged as appropriate; and
    - Mentoring health care provider colleagues and implementing standardized regional approaches to care.

Partner Satellite Centers will be accountable for ensuring:

a) The provision of evidence based and best practice for falls related care using agreed upon protocols;
b) The development of care plans that provide for continuity of care, patient education, and seamless transition across the continuum of care for all seniors;
c) Mechanisms are in place to review the results of quality improvement activities, to support the planning of improvement actions/processes, and to monitor the effectiveness of said actions;

d) Implementation of the service delivery strategy as well as regional standards, policies and protocols as developed by the IRFP Steering Committee including employing and overseeing staff in collaboration with the Manager of IRFP
e) Participation in the development of any new or expanded service proposals;
f) Input is provided through the IRFP Steering Committee and the IRFP Operations Committee on issues related to program effectiveness, implementation, resources and services;
g) Valid and reliable data is collected, performance is monitored and outcomes are evaluated and
h) Written agreements for contracted and/or purchased services are in place and performing to the standards set forth in said agreements.

Collaboration Partners Responsibilities

a) Act at all times in a manner that is consistent with the guiding principles the IRFP as mandated by NSM LHIN Year 2 Aging at Home Initiative. (Appendix A), the IRFP Operations Committee
b) Agree to work collaboratively with IRFP Steering and Operating Committees to uphold the IRFP guiding principles
c) Communicate local health issues and needs that may emerge from the community as they relate to the Integrated Regional Falls Program.
d) Demonstrate accountability to one another and to the integrity of the IRFP, to ensure that all seniors receive an appropriate level of care in an appropriate setting.
e) Act responsibly in accordance with professional and clinical service standards; use resources wisely and efficiently within the funding available, share information deemed vital and relevant to the IRFP purpose, and measure and report on performance against predetermined outcomes
f) Committed to acting upon as well as contributing to the latest advances in medical technology and best practices.
g) Undertake to develop appropriate policies, procedures and mechanisms aimed at fostering an environment that encourages individual initiative, creativity and problem solving, that enables professional development through continuous learning, and that recognizes and rewards high performance and team excellence.

Dispute Resolution

Any disagreement or dispute which might arise between the partners will be resolved harmoniously, creatively and constructively through a process of consensus decision making. In the event that an agreement is not forthcoming and the parties are at an impasse, the following protocol will be invoked:

a) An impasse is defined as an unresolved or unmanageable disagreement that has discernable and measurable negative consequences for the IRFP.
b) Best efforts will be given to resolving the impasse in a timely manner by openly acknowledging and applying the guiding principles noted above.
c) If warranted, a skilled and experienced facilitator or mediator who does not have a vested interest in the outcome will assist the parties in finding an agreement or resolution of the disagreement or impasse. The mediator/facilitator would be chosen from a roster of qualified individuals determined by the IRFP Steering Committee as an early business priority.
d) Any costs involved in selecting and appointing a facilitator or mediator will be absorbed by the parties on an equal basis to a pre-determined limit (i.e., the costs of a facilitator/mediator's services will be shared equally by the IRFP and the other party(ies) to the dispute or disagreement).
e) The facilitation or mediation will, unless otherwise agreed to by the parties, follow a specific timetable so as to ensure an expedited process such that the consequences of continued disagreement do not compromise the goal(s) of the IRFP.

f) If, at the end of the facilitated or mediated process, an acceptable solution is not forthcoming, the facilitator/mediator may at the request of the parties propose non-binding recommendations aimed at assisting a resolution of the matter.
g) In the event the issue, dispute or impasse cannot be resolved, the parties will determine if it is grounds for termination of their agreement.

The above protocol does not apply to issues of alleged professional misconduct, incompetence, incapacity, unethical or inappropriate behaviour. Such issues will be dealt with under established medical rules and regulations as promulgated by appropriate committees as approved by the Board of Directors of each party.

Mississauga Halton Falls Prevention Initiative Steering Committee Terms of Reference

Mississauga Halton
Falls Prevention Initiative Steering Committee
Terms of Reference

Purpose

The Mississauga Halton (MH) Falls Prevention Initiative Steering Committee ("the Committee") will guide the implementation of the Mississauga Halton Fall Prevention Framework for older adults.

Responsibilities

The work of the Committee will facilitate and inform the enhancement and implementation of fall prevention activities and strategies across the continuum of care in the Mississauga Halton LHIN catchment area ("Mississauga Halton"). Recommendations captured in the Mississauga Halton Falls Prevention report will guide the work of the Committee.

The Committee will act as a champion for seniors fall prevention locally, regionally, provincially and nationally by:

- Providing leadership and direction, through an integrated approach, to enhance community wide awareness about the risk and impact of falls on older adults
- Advocating for the implementation of Fall Prevention strategies in Mississauga Halton
- Oversee the implementation of the Aging at Home funded Fall Prevention Projects
- Leveraging resources for falls prevention
- Sharing falls prevention best practices and lessons learned
- Staying informed of falls prevention initiatives locally, regionally, provincially and nationally

Objectives

To prioritize the Mississauga Halton Framework for Falls prevention components for implementation.

To identify the resources required for implementation and sustainability of the Framework components.

To identify gaps in the health continuum with regard to fall prevention and recommend strategies for practice, policy and research.

To strengthen the linkages across providers and sectors.

To support and create opportunities to provide education and enhance awareness around fall prevention

To inform policy development and compliance with accreditation standards at all levels of service.

To guide decision-making around service planning and the allocation of human resources related to fall prevention.

To support the implementation of falls risk screening and prevention activities for older adults in Mississauga Halton.

To support the development of an evaluation framework for fall prevention in Mississauga Halton.

Accountability

The Mississauga Halton Falls Prevention Steering Committee will be accountable to:

- The Credit Valley Hospital for the Aging at Home funded projects.

Chairperson

The Chairperson will be selected from the membership. Term of chair will be two years.
Responsibilities:
Drafts agenda for each meeting.
Ensures meeting date and location are set.
Keeps the meeting on time and on topic.
Contacts members for input as needed.
Orients new members to committee.

Secretary

Administration support to the Chair is provided by the Credit Valley Hospital.

Membership

Membership is open to any interested individual or agency member including community health care providers, alcohol and drug addiction agencies, service groups, recreation, community support networks, teaching institutions, workplaces, retailers, private sector, municipal government and other groups pertinent to the work of the MH Falls Prevention Initiative

Members will sit as Core members or Resource (associate) members. Core membership will be ongoing with each member being responsible for replacing him or herself with someone from his or her sector, if he or she can no longer be part of the committee.

A core member is an individual, agency or organization that attends meetings on a regular basis, is actively implementing funded projects, and is active in all decision making processes.

A resource member (associate member) is an individual, agency or organization, that do not regularly attend meetings, may or may not participate actively in funded projects and is not active in any decision making process .

Members can participate on the Steering Committee and/or work/task group.

Core Steering Committee roles and responsibilities:

Understand the purpose of the MH Falls Prevention Initiative, framework and resource guide.
Have professional knowledge and/or experience directly related to the purpose of the committee.
Attend bi-monthly meetings
Set priorities
Share the work of the group within their organizations and other senior groups they are connected to.
Participate on a working group, or funded project.
Advocate for the implementation of Fall Prevention strategies within their sector.
Oversee the implementation of the Aging at Home funded fall prevention projects.
Leverage resources for falls prevention

Share falls prevention best practices and lessons learned
Stay informed of falls prevention initiatives (local, regional, provincial and national)
Contribute to Falls Prevention knowledge and share broadly

Resource member's roles and responsibilities

Have a general understanding of the purpose, goals and objectives of the committee.
Have an interest in falls prevention
Support the work of the MH Falls Prevention Initiative in the community.
Promote and/or participate in local activities when able.

Decision making

Decisions will be made by consensus whenever possible (defined as an approach that the majority supports and others can live with). If consensus is not possible, a final decision-making process will be one of democratic (majority) vote with a quorum of 50% + 1. The Chair will vote only in the case of a tie. If we do not have quorum at a meeting and a decision is required it will be solicited via email.
Decisions regarding the allocation of funds to specific initiatives are made in consultation with the regular attendees at the steering committee meetings. Decisions related to the aging at home funded projects outside of steering committee meetings will occur with the aging at home lead, and the Credit Valley hospital.
If the Chair requires consultation of members between regular coalition meetings the chair will consult with at least four active members representing four different sectors.
Day to day operational decisions will be made at the discretion of the Chair.

Work/Task Group

Work groups will be formed to address priority components of the framework. Work groups are accountable to the steering committee and will provide regular updates.

Use of email distribution list

Communications will be sent out to the membership via an email distribution list. Users of the list are: Administrative support, MH Falls Prevention Coordinator, and the Chair. Members wanting to communicate with the membership are to send information to the MH Falls Prevention Coordinator who will organize information for sharing via email in the monthly newsletter or an email containing many news items.
The distribution list is to be used to share information related to falls prevention. Promotion of products or services for sale is not permitted.
Please do not "reply all" when receiving a communication directed at all members.

Conflict of interest

The purpose of this section is to provide guidance to Core and Resource members as to what would constitute a conflict of interest in their participation on the MH Falls Prevention Initiative steering committee or work group. Committee Members have an obligation to disclose all extraordinary pecuniary interests. Extraordinary pecuniary interests are interests which are beyond those interests that the Committee could reasonably assume exist.

It is required that members give the other members notice of material personal interest in a matter that relates to the work of the committee. Where a member has a material personal interest in a matter that

relates to projects or issues considered by the initiative, in addition to the duty to disclose that interest, the member must not be present while the committee or group is discussing that matter and, importantly, must not vote on the matter.

Members are accepted to join the initiative on the basis of their interest, expertise and for the purpose of obtaining representation from as many organizations as possible who are working to improve the health of seniors.

Examples of types of interest that a member should disclose:
A conflict of interest if any contract or proposed contract in relation to which the member directly or indirectly might receive benefit.
A family/personal relationship to potential consultant bidding on work related to the Mississauga Halton Falls Prevention Initiative.

Meetings

Meetings will be held bimonthly or at the call of the Chair.
A minimum of 4 meetings will be held a year April 1 to March 31.

Core Members

Agency/organization	Name	Sector
Credit Valley Hospital	Helen Anderson Monica Marquis Pauline Chalmers	Hospital
Trillium Health Centre	Laurie Bernick	Hospital
Halton Healthcare Services	Jacqueline Minezes Kim Kohlberger	Hospital
MH Halton LHIN	Priti Patel	Health
Toronto Public Health	Debbie Cameron	Public Health
Peel Public Health	Mary Anne Kozdras	Public Health
Halton Public Health	Gisele Franck	Public Health
Peel Senior Link	Steve Kavanagh JoAnn Zomer	Supportive Housing
City of Mississauga	Julie Mitchell Jayne Culbert	Recreation & Parks
Yee Hong	Susan Griffin Thomas	Long Term Care
VON Peel	Suzette Avila Kimberly Martinez	Community Care SMART Coordinator
Acclaim Health	Polly Griesbach	Community Care
Osteoporosis Society	Elizabeth Stanton Kate Harvey	National Osteoporosis
Ontario Neurotrauma Foundation	Helene Gagne	Provincial/Research
Alzheimer's Society of Peel	Krista-Leigh Lutes	Community Care
MH CCAC	Willemien Stanger	Community Care
Parkinson's	Open	

Seniors for Seniors	Barbara Burnett	Private sector SDL
Senior/resident of our LHIN	Barbara Watt	Volunteer
Personal Support Workers	Open	
Diabetes	Open	
Mental Health	Open	

Resource/Affiliate members

Agency Organization	Name	Sector
Fresh Food Box	Brenda Moher	Community outreach
Active Halton	Frank Prospero	Parks & Recreation/seniors centres Halton
India Rainbow	Shika Bedi	Day programs
Seniors Life Enhancement Centres	Lorena Smith	Day Programs
Square One Seniors Centre	Laura Surman	Seniors centre
HNHB LHIN	Jenny Barretto	Health

Central West LHIN Falls Prevention Action Group Terms of Reference

Central West LHIN

Falls Prevention Action Group – September 2010

TERMS OF REFERENCE

Purpose

The Falls Prevention Action Group (FPAG) is a sub-group of the Services for Seniors Core Action Group, which will examine current falls prevention strategies and services in the Central West LHIN.

Information and recommendations from this group will assist the LHIN in developing a falls prevention framework and services. This need has been identified in the Central West LHIN's initial Integrated Health Services Plan, the Aging at Home Directional Plan and Year 1 and 2 Detailed Plans, and the development of the LHIN's Health System Plan. It has been further identified in the recent Integrated Health Service Plan 2.

The Falls Prevention Action Group's work will inform further the integration opportunities based on a falls Prevention framework to leverage existing resources to support services for seniors.

Major Activities

The major activities of the Falls Prevention Action Group will document:

- Existing falls prevention service capacity of Health Service Providers
- Falls Prevention services access issues in the LHIN
- Efforts and best practices in providing and coordinating falls prevention services across the province
- Recommendations to the Services for Seniors Core Action Group with a falls prevention framework and services to improve the provision and coordination of these services.

Falls Prevention Action Group Members

The Falls Prevention Action Group will include:

- Representatives of HSPs that are currently funded by the Central West LHIN for falls prevention services
- Senior Consultant, Planning, Integration and Community Engagement, Central West LHIN (and other LHIN staff as appropriate).
- Central West CCAC
- William Osler Health System

- Representative from Headwaters Health Centre
- Representative from the Community Support Service Sector
- Representative from Long Term care sector
- Representative from Public Health – Peel,
- Representative from Toronto Public Health
- Representative from Guelph Dufferin-Wellington Public Health
- Representative from York Region Public Health

Meetings

Monthly meetings will be held during the initial project period. Meetings will be held at the Central West LHIN offices.

Facilitator

The meetings will be supported by the Senior Consultant, Planning , Integration and Community Engagement, Central West LHIN

Decision – Making

The Falls Prevention Action Group will adopt a consensus model of decision making. As such, deliberations of the Falls Prevention Action Group will seek to build consensus based on the best interests of residents of the Central West LHIN. Where consensus cannot be reached, the Falls Prevention Action Group will present a summary of the deliberations to the Services for Seniors Core Action Group of the Central West LHIN.

APPENDIX H – Sample Self Fall Risk Assessment

6 Warning Signs of Falls

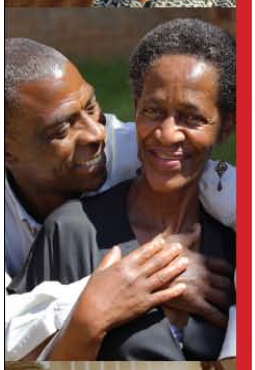
If you are over 65 years of age:

- ❑ **Previous Falls:** One fall in the past 6 months
- ❑ **Fear of Falling:** Afraid that you will fall
- ❑ **Medications/Drugs:** Using sedatives, fluid pills, recreational drugs, blood pressure pills or more than 4 medications
- ❑ **Balance and Mobility:** Any problems with balance or unable to raise from a chair
- ❑ **Medical Conditions**: For example Stroke or Parkinson's Disease, osteoporosis, arthritis
- ❑ **Vision Problems:** Blurred/double vision, difficulty seeing steps or walking in dim light

If you have checked two of the warning signs you are at an increased risk for falling.

Further screening and information contact a health care provider or CCAC call ***1-888-371-2112***

Connecting you with care
Votre lien aux soins
South West CCAC / CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Sud-Ouest



Top 10 Tips to Reduce Your Chance of Having a Fall

1. Slow down and take time to be safe.
2. Be physically active for a total of 30 to 60 minutes most days.
3. Have your vision and hearing checked regularly.
4. Discuss your medication & supplements with your doctor or pharmacist.
5. Eat a healthy balanced diet, drink plenty of water & limit your alcohol.
6. When walking outside, be aware of your surroundings and watch where you step.
7. Use safety equipment such as canes, walkers, grab bars & rubber bath mats.
8. Wear non-slip shoes, boots & slippers that fit well & seek treatment for foot problems.
9. Use a night-light and keep a flashlight by your bed.
10. Complete the home safety checklist in the "Are You in Jeopardy" booklet.

Preventing Falls in Grey Bruce
www.thehealthline.ca or
www.publichealthgreybruce.on.ca
Funded by the Aging at Home Strategy

APPENDIX I – Validated and Reliable Screening/Assessment Tools

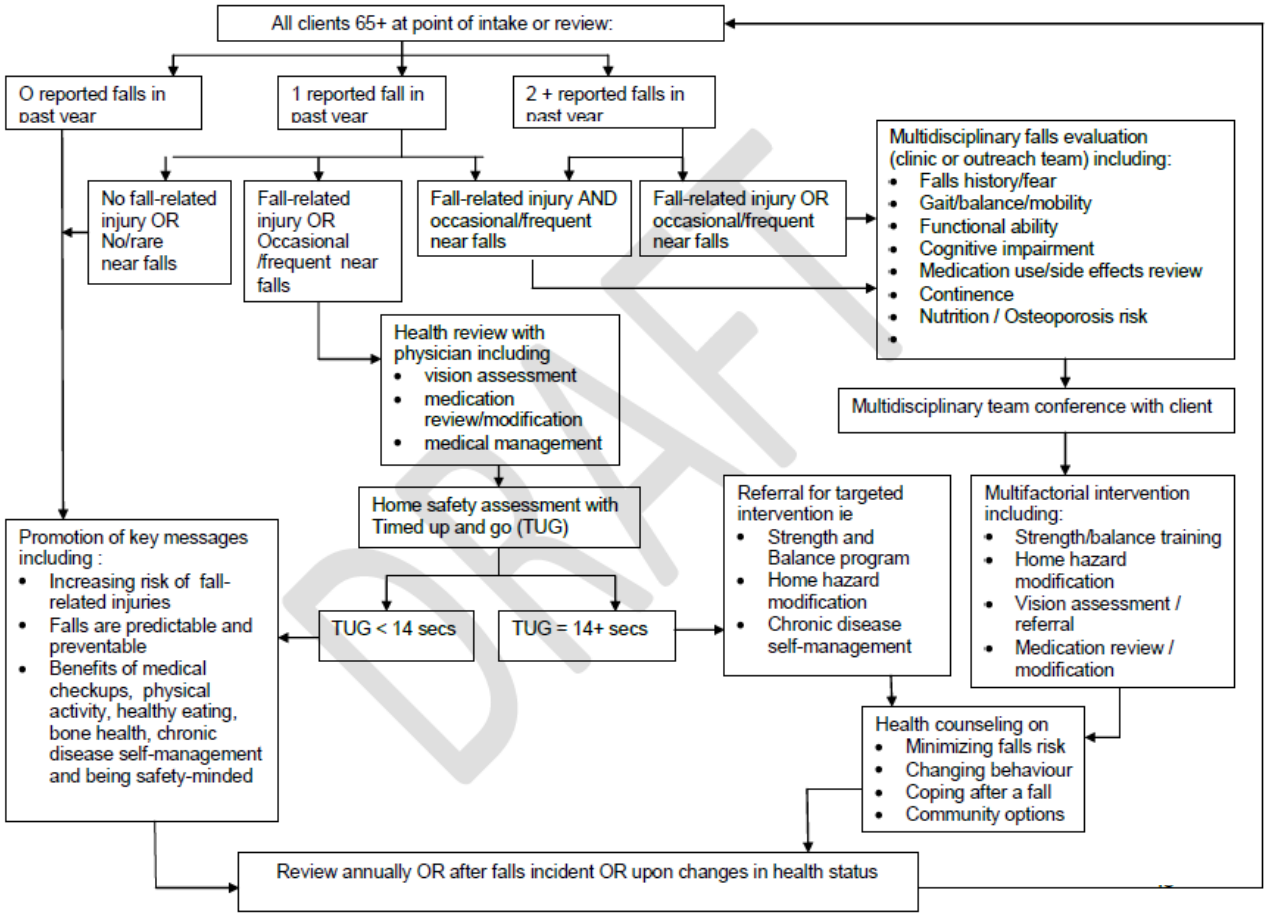
Fall-risk assessment tools by type and number of validation and reliability studies conducted in each setting

Tool	Community	Supportive Housing	Long-term care	Acute
Functional Mobility Assessment Tools				
Activity-based balance and gait			1	
Area ellipse of postural sway			1	
Berg balance scale	3	1		1
CTSIB	1			
Dynamic gait index	1			
Elderly mobility scale				1
Floor transfer	1			
5 min walk	1			
Five-step test	1			
Functional reach test	4		2	1
Lateral reach test	1			
Maximal step length	1			
Mean velocity of postural sway			1	
Mobility interaction fall chart			2	
100% Limit of stability	1			
POAM-B	1			
Postural balance		1		
Postural stability tests	1			
Quantitative gait assessment	1			
Rapid step test	1			
Step up test	1			
Tandem stance	1			
Timed chair stands			1	
Timed up and go	2		1	
Timed walk			1	
Tinetti balance scale	1			
Tinetti balance subscale			1	
Multi-factorial Assessment Tools				
Balance self efficacy test	1			
Conley scale				1
Downton index			1	1
Elderly fall screening	1			
Fall-risk assessment				2
Fall-risk screening test	1			
Geriatric postal screen	1			
Home assessment profile	1			
Morse fall scale			1	3
Physiological and clinical predictors		1		
STRATIFY				3

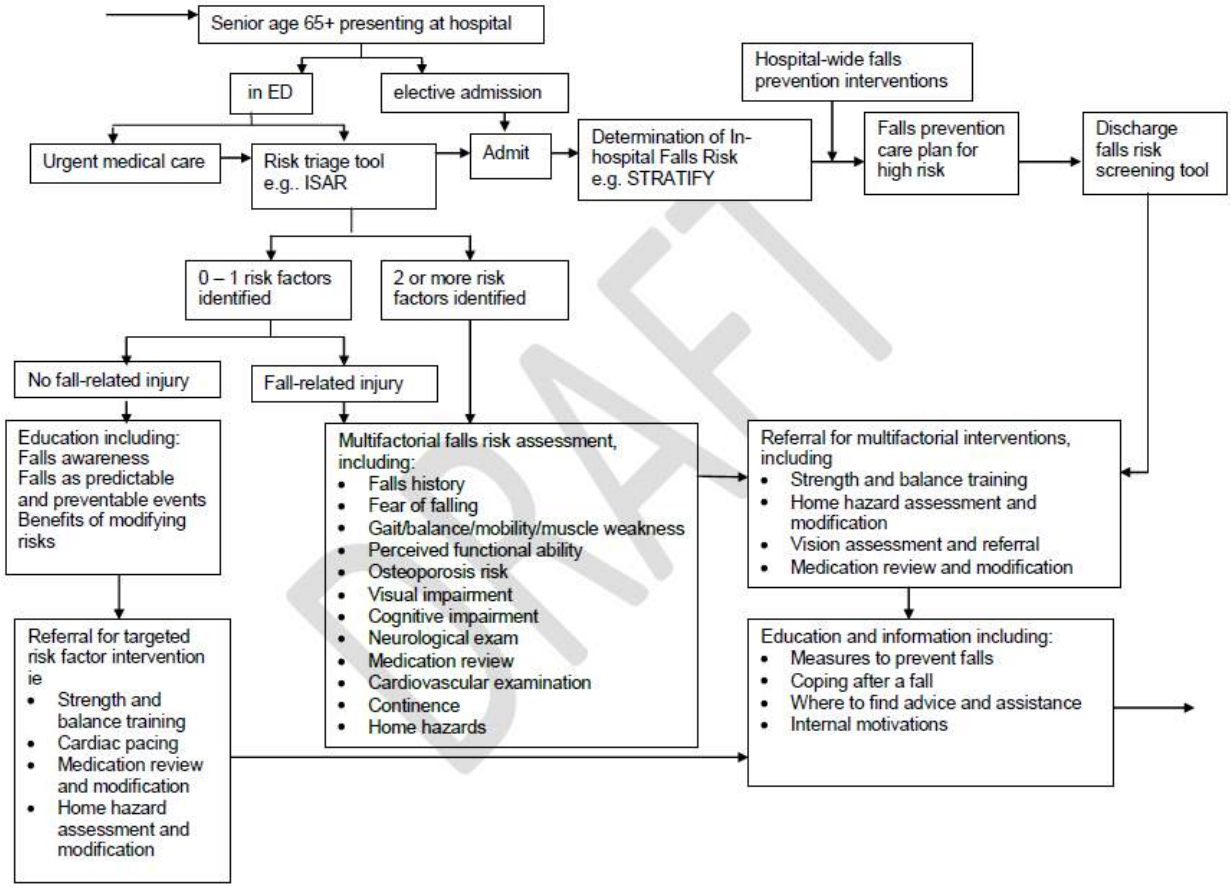
For the source article "*Multifactorial and functional mobility assessment tools for fall risk among older adults in community, home-support, long-term and acute care settings"* go to: http://ageing.oxfordjournals.org/content/36/2/130.full

APPENDIX J – Sample Algorithms

Community Care Falls Algorithm - developed for the Mississauga Halton Falls Prevention Project 2007-2008



Acute Care Falls Algorithm - developed by Mississauga Halton Falls Prevention Project 2007 - 2008



APPENDIX K – Canadian Falls Prevention Curriculum Details

The Canadian Falls Prevention Curriculum

Curriculum Background

The Canadian Falls Prevention Curriculum (CFPC) was developed and pilot-tested as a training curriculum for those working in the area of falls prevention among older adults (those 65 and over). The CFPC uses the Canadian Injury Prevention and Control Curriculum, developed by the Canadian Collaborative Centres for Injury Prevention and Control, as its model.

Leadership for this project is provided by the British Columbia Injury Research and Prevention Unit (BCIRPU) and its partners, the Alberta Centre for Injury Control and Research (ACICR), the PEI Centre for the Study of Health and Aging and the PEI Seniors Falls Prevention Coalition, together with a national advisory committee of stakeholders (government and non-government).

The CFPC will give participants the knowledge and skills needed to operate from an evidence-based approach to falls and fall-related injury prevention among seniors. The course will provide insight into how to involve seniors as partners in the development of effective strategies and interventions. Participants will also learn about current effective programs, and the reliability and validity of existing resources and tools for screening and assessing fall risk.

For seniors, the risk of falling and sustaining an injury is influenced by a broad set of health determinants, including physical, behavioural, environmental, social and economic factors. These wide-ranging contributors to falls can only be ameliorated by the coordinated and sustained approach of a multisectoral team of health professionals and community leaders who are well informed in evidence-based practices for prevention.

Course Outline

Through a combination of techniques (e.g., lecturing, visual aids, group discussion, and a group project), participants will master the following content:

1. Defining the Problem
2. Identifying the Risk Factors
3. Examining Best Practices
4. Implementing the Program
5. Evaluating the Program

The Canadian Falls Prevention Curriculum

CFPC

Registration Form
Waterloo Workshop (June 28-29, 2010)

Name: _____

Title: _____

Organization: _____

Address: _____

City: _____ Postal Code: _____

Phone: (_____)_____ Fax: (_____)_____

Email: _____

Please indicate special dietary or accessibility requirements:

Cost- $200 (free for Public Health Unit Staff)

Please choose **method of payment**:

( ) Cheque (payable to SMARTRISK)

( ) VISA ( ) Mastercard ( ) AMEX

Card Number: _____ Exp. Date: _____/_____

Signature: _____

Name on Card (please print): _____

Send Form to: SMARTRISK, 36 Eglinton Ave. W., Suite 704
Toronto, ON, M4R 1A1
Phone: 416-596-2700 • Fax: 416-596-2721
Email: cmeurehg@smartrisk.ca
Attention: Claude Meurehg

Cancellation Policy: Registration confirmation will be forwarded upon receipt of payment. No refunds will be granted two weeks prior to the workshop date. A waiting list will be maintained so please notify us as soon as possible if you are unable to attend.

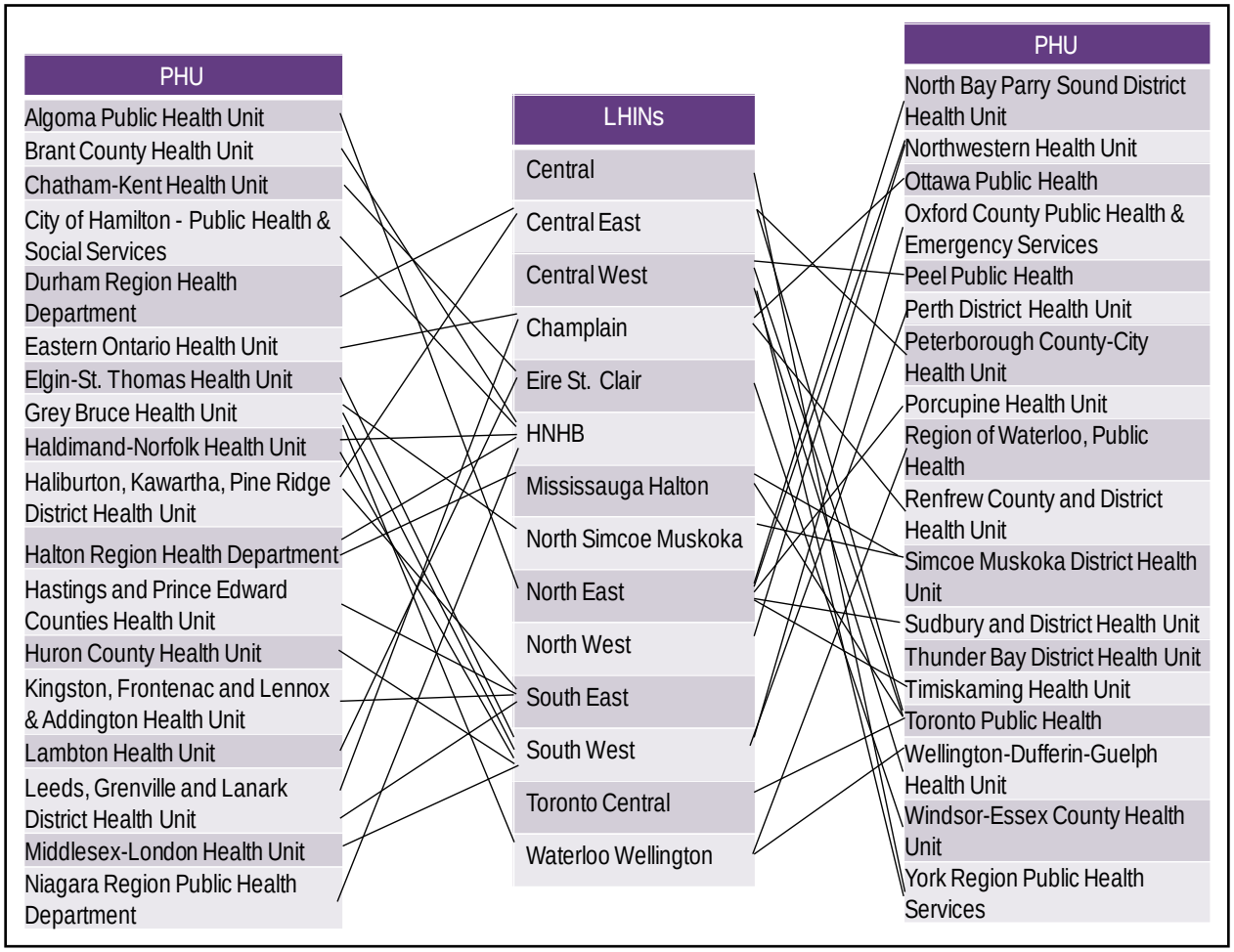
APPENDIX L – Overlap in LHIN-PHU Boundaries

LHIN	LOCATION	PUBLIC HEALTH UNIT
Erie St. Clair	Chatham	Chatham-Kent Health Unit
	Point Edward	Lambton Health Unit
	Windsor	Windsor-Essex County Health Unit
South West	Clinton	Huron County Health Unit
	London	Middlesex-London Health Unit
	Owen Sound	Grey Bruce Health Unit
	Simcoe	Haldimand-Norfolk Health Unit
	St. Thomas	Elgin-St. Thomas Health Unit
	Stratford	Perth District Health Unit
	Woodstock	Oxford County Public Health & Emergency Services
Waterloo Wellington	Fergus	Wellington-Dufferin-Guelph Health Unit
	Owen Sound	Grey Bruce Health Unit
	Waterloo	Region of Waterloo, Public Health
Hamilton Niagara Haldimand Brant	Brantford	Brant County Health Unit
	Hamilton	City of Hamilton - Public Health & Social Services
	Oakville	Halton Region Health Department
	Simcoe	Haldimand-Norfolk Health Unit
	Thorold	Niagara Region Public Health Department
Central West	Brampton	Peel Public Health
	Fergus	Wellington-Dufferin-Guelph Health Unit
	Newmarket	York Region Public Health Services
	Toronto	Toronto Public Health
Mississauga Halton	Barrie	Simcoe Muskoka District Health Unit
	Oakville	Halton Region Health Department
	Toronto	Toronto Public Health
Toronto Central	Toronto	Toronto Public Health
Central	Newmarket	York Region Public Health Services
Central East	Peterborough	Peterborough County-City Health Unit
	Port Hope	Haliburton, Kawartha, Pine Ridge District Health Unit
	Toronto	Toronto Public Health
	Whitby	Durham Region Health Department
South East	Belleville	Hastings and Prince Edward Counties Health Unit
	Brockville	Leeds, Grenville and Lanark District Health Unit
	Kingston	Kingston, Frontenac and Lennox & Addington Health Unit
	Port Hope	Haliburton, Kawartha, Pine Ridge District Health Unit
Champlain	Brockville	Leeds, Grenville and Lanark District Health Unit
	Cornwall	Eastern Ontario Health Unit
	Ottawa	Ottawa Public Health
	Pembroke	Renfrew County and District Health Unit

LHIN	LOCATION	PUBLIC HEALTH UNIT
North Simcoe Muskoka	Barrie	Simcoe Muskoka District Health Unit
	Owen Sound	Grey Bruce Health Unit
North East	Kenora	Northwestern Health Unit
	New Liskeard	Timiskaming Health Unit
	North Bay	North Bay Parry Sound District Health Unit
	Sault Ste. Marie	Algoma Public Health Unit
	Sudbury	Sudbury and District Health Unit
	Timmins	Porcupine Health Unit
North West	Kenora	Northwestern Health Unit
	Thunder Bay	Thunder Bay District Health Unit

Source: http://www.health.gov.on.ca/english/public/contact/phu/phuloc_mn.html

Figure of Overlap in Boundaris of LHINs and PHUs



APPENDIX M – Ontario Public Health Standards Relating to Falls

Assessment and Surveillance

Requirement

1. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current), in the areas of:

- Alcohol and other substances;
- Falls across the lifespan;
- Road and off-road safety; and
- Other areas of public health importance for the prevention of injuries.

Health Promotion and Policy Development

Requirements

2. The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs, and the creation or enhancement of safe and supportive environments that address the following:

- Alcohol and other substances;
- Falls across the lifespan;
- Road and off-road safety; and may include
- Other areas of public health importance for the prevention of injuries as identified by local surveillance in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).

4. The board of health shall increase public awareness of the prevention of injury and substance misuse in the following areas:

- Alcohol and other substances;
- Falls across the lifespan;
- Road and off-road safety; and may include
- Other areas of public health importance for the prevention of injuries, as identified by local surveillance in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).

Health Protection

Requirement

5. The board of health shall use a comprehensive health promotion approach in collaboration with community partners, including enforcement agencies, to increase public awareness of and adoption of behaviours that are in accordance with current legislation[14] related to the prevention of injury and substance misuse in the following areas:

- Alcohol and other substances;
- Falls across the lifespan;
- Road and off-road safety; and may include
- Other areas of public health importance for the prevention of injuries as identified by local surveillance in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).

Source:
http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds/pdfs/ophs_2008.pdf

APPENDIX N – Examples of Public Health's Current Activities within the BEEEACH Model

BEEEACH Model Category	Example Activities
Education	**Public Education** • Resources for seniors e.g. exercise video for older adults • Ongoing support to a seniors theatre troupe for injury prevention message delivery to seniors • Workshops on healthy eating by a registered dietician offered in each community targeted to seniors **Provider Education** • Development of resources/toolkits to help providers maximize seniors involvement in falls prevention initiatives through age-friendly communication • Creation, implementation and evaluation of a strategy to reduce falls in the acute care setting which includes the development of a falls risk assessment tool, clinical interventions, teaching materials for staff and families and more • Partnership with local CCAC to develop and pilot a strategy to reduce falls for frail elderly clients that includes components to address exercise, medication risk, bone health, the home environment and behaviour modification • Approaching retirement homes with a falls prevention toolkit and encouraging them to implement such a program • Playing a consultant role with local long-term care homes and hospitals for vitamin D supplementation and falls prevention policy development • Providing curriculum support to early childhood education, Personal Support Worker (PSW) and Registered Practical Nurse programs to address falls prevention across the lifespan • Providing train-the-trainer sessions to community facilities/agencies to increase capacity to prevent falls in seniors in the community
Equipment	• Assisting community partners in applying for grants to receive equipment • Advocating for subsidies or standards for equipment that prevent falls • Providing written information about equipment to be available at points of purchase • A travelling falls risk assessment clinic for fitting of assistive devices
Environment	• Advising, and advocating, with municipal planning services on o creating supportive environments o pedestrian friendly urban planning o safe built environments (e.g. building codes to make bathroom grab bars mandatory) o road and sidewalk maintenance o building environments to address the unique needs of older adults • Working with local accessibility committee that audits and rewards accessible and safe businesses • Surveying seniors on potential hazards for falls at the flu clinic • Creating a tool kit to promote the inclusion of enhanced structural features designed to reduce falls in the built environment for those building or renovating homes • Providing information and skill building opportunities in communities around home/church safety checks • Conducting a home safety assessment clinic with the associated home repairs

BEEEACH Model Category	Example Activities
Activity	• Public health-organized walking groups, Home Support Exercise Program (HSEP), tai chi • Teaching home exercises to improve strength and balance and protect health • Providing group or individualized exercise programs for seniors in rural areas • Combining exercises for strength and balance, falls prevention messaging and socialization opportunities for low income older adults residing in Ontario subsidized housing • Training service providers on balance and strength building exercise programs (HSEP and Stand UP!) • Providing free physical activities e.g. tai chi, swimming, yoga so that seniors will try and become more active

APPENDIX O – Sample Survey Used to Collect a LHIN Inventory of Falls Prevention Initiatives by CW LHIN

Falls Prevention Questionnaire

Falls Prevention Questionnaire

Service Name

Acronym (If Used)

Areas Served

Site (If Shared)

Mailing Address

Office Phone

Fax

Website

Organization Email

Primary Contact

1. Describe your falls prevention initiative?

2. Is your initiative a screening program?

◯ No ◯ Yes

If yes, what do you do when you find a client who is identified as a high risk client?

3. Are you managing a falls prevention program?

◯ No ◯ Yes

If yes, please describe the program

4. What age is your initiative geared for? Please check all that apply:

☐ Age: <55
☐ 55-64
☐ 65-74
☐ 75-84
☐ 85+
☐ Gender: Females
☐ Males

Falls Prevention Questionnaire

5. Is your program specific to client characteristics? If yes, please check all that apply:

- [ ] Diversity: by faith
- [ ] by language
- [ ] by cultural
- [ ] disease specific

Other (please specify)

6. Where is your program offered? Please check all that apply:

- [ ] Citywide
- [ ] Hospital
- [ ] Supportive housing
- [ ] Clinic setting
- [ ] Individuals home
- [ ] Community Agencies
- [ ] LTC

7. Are additional materials and training manuals available?

- ◯ No
- ◯ Yes

If yes, please describe (provide copies if available)

8. Does your initiative address any of the below? Please check all areas addressed:

- [ ] Balance
- [ ] Flexibility
- [ ] Education
- [ ] Lower body strength
- [ ] Empowerment
- [ ] Motivation for adherence
- [ ] Endurance
- [ ] Social support for behaviour change

Other (please specify)

9. Do you do an initial risk assessment?

- ◯ No
- ◯ Yes

Falls Prevention Questionnaire

9b. If Yes, what risks are assessed? Please check all that apply

- ☐ Alcohol substance abuse
- ☐ Balance/gait
- ☐ Environmental hazards
- ☐ Fear of falling
- ☐ Foot wear/problems
- ☐ Home haszards
- ☐ Inactivity
- ☐ Incontinence
- ☐ Medical condition
- ☐ Medications
- ☐ Mental health/cognition
- ☐ Mobility aid
- ☐ Nutrition
- ☐ Previous falls
- ☐ Sensory impairment

Other (please specify)

10. How do you address the risks? Please check all that apply:

- ☐ Financial support
- ☐ Food access
- ☐ Hazard reduction/modification
- ☐ Individual counselling
- ☐ Medical Care
- ☐ Policy Change
- ☐ Practice standards
- ☐ Referral to a program
- ☐ Social support/Self-help

Other (please specify)

11. Are there written guidelines for what you do?

- ◯ No
- ◯ Yes

If yes, (please describe)

12. Are there methods in place to ensure quality of the program over time?

- ◯ No
- ◯ Yes

If yes, please describe what:

Falls Prevention Questionnaire

13. Do you test for functional ability before and after?

◯ No ◯ Yes

If yes, do the scores improve following the program

14. Does the program include performance measures?

◯ No ◯ Yes

14b. If yes, please check all that apply:

☐ Easy to use ☐ Appropriate ☐ Sensitive to pre-post changes

15. Do you have a plan to manage falls risk during the activities?

◯ No ◯ Yes

If yes (please describe)

16. Is there physical activity?

◯ No ◯ Yes

16b. If yes, please check all that apply:

☐ Group based ☐ Trained/Qualified Instructors

☐ Supervised ☐ Opportunities for social interaction

Other (please describe)

Falls Prevention Questionnaire

17. Are there strategies for linking clients and/or the initiative with health care providers?

◯ No ◯ Yes

If yes (please describe)

18. What unique challenges have your efforts faced? (please describe)

19. What is not available to your clients to help them prevent falls? (please describe)

20. What top 3 recommendations would you make to a committee developing a regional falls prevention framework?

1.
2.
3.

21. Do you know any other organizations that is promoting falls prevention services?

Other comments?

Thank you!

APPENDIX P – Role of LHIN Funded Sectors and Organizations within the BEEEACH Model

Community Care Access Centres

BEEEACH Model Category	Role of Community Care Access Centres (CCAC)
Education	Client and caregivers education can be provided informally by case managers and care providers through on-going conversations about risk factors and possible interventions or more formally through tools such as evidence-informed brochures. For case managers, some education may be required to ensure a consistent set of referrals post fall or after a Resident Assessment Instrument for Home Care (RAI-HC) assessment indicates that a client is at high risk of falls. The RAI-HC not only provides a risk assessment, but also provides client assessment protocols (CAPs) that assist with the clinical assessment and care planning process. CAPs alerts the case manager to the client's potential challenges or needs and triggers the Case Manager to initiate a more in-depth review of the relevant causes. For service providers such as personal support workers (PSWs), training can be provided by CCAC staff on key topics such as proven falls prevention interventions or potential falls risk factors for seniors. Part of this training can also include a post-fall checklist to be forwarded to the client's case manager after falls to identify the immediate causes of falls and generate additional preventative interventions.
Equipment	CCAC case managers can link or direct clients where to access basic equipment. If clients' needs are more complex then the CCAC would provide a knowledgeable clinician to conduct a focused assessment and develop a care plan assuming that the client meets the relevant eligibility criteria. Some CCACs are working with technological equipment to improve communication between case managers, service providers and clients. As an example, one CCAC has developed a dedicated PSW team for a group of high risk seniors that can respond to un-scheduled calls through the use of an emergency button linked to a PSW's cell phone. From a falls perspective this allows for a quicker assistance response as well as improving the chances that the immediate cause of the falls can be determined.
Activity	If clients are eligible for CCAC physiotherapy or occupational therapy services then those professionals would develop and implement falls-reduction strengthening and exercise programs for them or link them to community-based exercise programs. Case Managers also link CCAC clients and non-CCAC clients to community exercise programs.
Clothing & Footwear	Where warranted, Case Managers, professional service providers and PSWs can advise clients about the risks involved in particular clothing/footwear choices.

BEEEACH Model Category	Role of Community Care Access Centres (CCAC)
Health Management	Falls-related health management for CCACs would typically take the form of linkage with primary care providers regarding changes in physical or cognitive status, medications, and referrals to falls clinics or to Specialized Geriatric Services.

Community Support Services

BEEEACH Model Category	Role of Community Support Services (CSS)
Education	The CSS sector can provide specific falls prevention education sessions to seniors as well as provide venues for other providers at which such messages can be shared. There is a move now to capture those sessions electronically so that they can be shared broadly and re-broadcast as required.
Activity	Some CSS providers deliver exercise programs for seniors. These typically include an exercise portion (such as tai chi) as well as sessions on falls-related risk factors, such as muscle weakness and loss of balance. The group settings for these activities contribute to socialization and positive peer supports in tackling key risk factors.

Hospitals

BEEEACH Model Category	Role of Hospitals
Education	Patient and family education can occur in both inpatient and outpatient settings. Patient education can be part of a discharge plan before a patient is released from the hospital. Connecting at-risk clients with community resources will be an important function for those who may not immediately require services such as those provided by CCAC. Provider education within the hospital is important to prevent falls within this setting.

Environment	Some hospitals are participating in the Senior Friendly Hospital Strategy to promote safer hospital environments for seniors and reduce adverse events such as falls. Despite this and many other falls prevention programming provided for inpatients in hospital, there are still falls hazards in the hospital environment that may lead to falls and fractures. It is thus important to include falls in acute care patient safety initiatives. In terms of other roles, some hospitals may offer home assessments to higher-risk patients to assess the home environment. The determination of that risk level is usually made by hospital staff based on the information provided by patients and their caregivers.
Activity	Some activation of patients may occur in the hospital setting. Hospitals can provide targeted physical activity to patients to increase strength and balance and avoid de-conditioning.
Health Management	Addressing acute health issues is the hospital's focus. Effectively managing patients' health can avoid complications that may lead to increased fall risk. Underlying conditions that can contribute to falls risk may also be revealed, enhancing understanding of the falls risk of a particular patient. Emergency visits related to falls, present an ideal opportunity to undertake screening and assessment activities and if necessary, refer to a specialized falls prevention clinic or other intervention. Finally, effective management of falls and their sequelae within the acute sector can increase the likelihood of discharge to home.

Community Health Centres

BEEEACH Model Category	Role of Community Health Centres (CHC)
Education	CHCs have expertise in community engagement and reaching seniors in the community who may need falls prevention education. They may also have a large number of clients participating in senior-focused programs and accessing clinical services. This existing client base can be leveraged to facilitate the education process. An important part of this client education effort is working through some of the anxieties, stigma or other barriers to behaviour change that the seniors may be experiencing. A potentially powerful message is that the clinician and the client are working together to keep the client at home while avoiding crises such as broken bones. Delivering that message also takes training and practice on the part of the clinicians working with the clients. The CHC is often well-positioned to provide training of providers in falls risk assessments and prevention practices, and appropriate referrals.
Equipment	CHCs can assist seniors living in the community in accessing needed equipment.

Environment	Many CHCs offer home visits by clinicians that include home safety assessments and the development of plans to address key risk areas e.g. poor lighting.
Activity	Few CHCs have PTs or OTs on staff who can offer special exercise programs for seniors to maintain wellness and prevent falls. Those CHCs without such services in-house can work with other organizations to implement other such programs for a wider group of seniors who would benefit from them.
Clothing & Footwear	Some CHCs offer shoe clinics, others would provide advice on appropriate dress and refer patients to suitable community practitioners if required.
Health Management	As primary care providers, health management is central to the work of CHCs and so is provided in a falls prevention context. Medication management is one area in particular where there may be opportunity for additional partnerships between pharmacists and CHCs since many CHC do not have a pharmacist on-site.

Mental Health & Addictions

BEEEACH Model Category	Role of Mental Health & Addictions (MHA)
Education	As part of regular service provision, MHA providers would educate clients on potential harm from their behaviours with falls being part of that message.
Environment	Part of case management for MHA clients is to ensure that they are in the appropriate environment. For example, if those with responsive behaviours are in the right setting and are receiving the appropriate care, then they are less likely to fall when displaying reactive behaviours. Oftentimes, environments where MHA clients find themselves such as supportive housing and boarding houses lack appropriate falls prevention resources and as such each LHIN-wide Integrated Falls Prevention Program would provide the opportunity for MHA case managers to make suggestions and improvements.
Activity	Some MHA providers would develop and implement exercise programs where seniors move in a safe environment and overcome their fear of falling, although these are typically not on a large scale.
Health Management	MHA providers focus a significant part of their falls prevention work on poly-pharmacy. Understanding how the aging of clients changes the impact that medications and drugs (including alcohol) have and the potential for cumulative acquired brain injury from repeated falls are two other areas where MHA providers can contribute significantly with respect to falls prevention.

Long-Term Care

BEEEACH Model Category	Role of Long-Term Care (LTC)
Education	Educating residents, their families and staff about the proven interventions to reduce the likelihood and impact of a fall is critical to the success of falls prevention initiatives in an LTC home. Some larger organizations have gone so far as to designate a falls prevention PSW, whose full-time job it is to educate residents and their families on the importance of falls prevention and to improve compliance with the recommended mitigation strategies.
Equipment	Equipment can be of use in preventing falls among LTC residents. Devices such as low beds and resident lifts can all contribute to a reduction in the incidence of falls. While these pieces of equipment will not prevent all falls, using devices such as hip protectors can reduce the impact of falls that do occur. Compared to the cost of treating a broken hip, hip protectors appear quite cost-effective. For hip protectors in particular, overcoming resident resistance often presents a challenge that can be mitigated by the selection of more comfortable and unobtrusive options and training staff on their use and application.
Activity	While historically it may have been common for LTC home staff to do activities of daily living for residents, for some LTC homes the thinking is shifting to more of a restorative focus. LTC providers who encourage residents to do appropriate tasks on their own in a monitored environment can improve resident functioning, thereby improving their quality of life. Combined with rehabilitation programs focused on improving or maintaining resident function, this shift towards activation can reduce the incidence and impact of falls in this setting.
Clothing & Footwear	Footwear is particularly relevant in LTC homes given the high proportion of residents with conditions such as diabetes that can make feet readily susceptible to damage e.g. from wheel chairs. As well, many residents would also have gait issues that could be addressed through appropriate footwear. Residents and staff can be encouraged to use appropriate footwear as part of falls prevention.
Health Management	A large part of falls-related health management in LTC homes starts with screening for common medical and pharmacological conditions that are risk factors for falls such as diabetes, osteoporosis, and poly-pharmacy. Once residents have been identified as being at risk then medical personnel and other staff can apply suitable risk mitigation strategies including effective foot care.

APPENDIX Q – Desciption and Role of Non-LHIN Funded Public Sectors and and Private Organizations

Non-LHIN Public Funded Sectors and Organizations

Organization	Description and Role
Education Institutions	Education institutions to partner/collaborate with are those who train relevant health care practitioners such as personal support workers (PSW) and nursing personnel. In partnering with such institutions, it would be possible to influence the curriculum to ensure that health care practitioners who will be working with seniors are educated around the importance of falls prevention and identifying the risk for falls in seniors. In addition, should the program need to hire any health practitioners, partnering with the education sector provides opportunities to create residency and intern positions within a falls prevention program.
Local Councils on Aging	Local Councils on Aging are formed in many cities and regions across Ontario (see Appendix W for list and contacts of Ontario Councils on Aging). These bodies are usually non-profit, voluntary organizations that are a collective voice for seniors, advocating for better experience for seniors in their communities to all levels of government. Members often include seniors, members from the community and interested groups and organizations. Many Councils on Aging offer programs to seniors as well as provide communication and education to the senior community. Thus, local councils on aging can offer great insights around seniors' perspectives, needs and considerations with respect to falls prevention interventions. They can also facilitate the provision of certain falls prevention interventions and promote them amongst the seniors that they serve.
Municipalities	There are currently 444 municipalities in Ontario (see http://www.mah.gov.on.ca/Page1591.aspx for a list of municipal governments in Ontario). Ontario municipal governments support prosperous and safe communities through delivering local services in the areas of emergency medical services (EMS), fire, police, emergency management and preparedness), city planning and economic development, building regulation, housing, parks and recreation, road maintenance and operations and waste management to name a few. Of particular interest to each LHIN-wide Integrated Falls Prevention Program would be engagement of and collaboration with the city planners, EMS and parks and recreation. In engaging city planners, each LHIN-wide Integrated Falls Prevention Program can advocate for communities to be built such that they are senior friendly and ensure falls prevention is considered during the planning stages. This will address a number of external environmental risk factors that increase the risk for falling for seniors. There are examples of EMS supporting the LHIN in falls prevention initiatives by visiting and assessing seniors for falls risk in their home and referring to the appropriate interventions. EMS providers are often very willing to support the community in programs that help reduce and contain the demand on paramedic services. Parks and recreation usually offer recreational programs and services targeted to seniors. They can therefore support the LHIN-wide Integrated Falls Prevention Programs by offering interventions out of some community facilities. Each LHIN-wide Integrated Falls Prevention Program can enhance the capacity of this sector to better assess for falls and refer to the appropriate interventions by training the sector's employees and volunteers. Some municipalities are also actively involved in the "Age Friendly Communities" initiative. Age Friendly Communities are communities that have policies, programs,

	services and environments that support and enable citizens to age actively. An age friendly community for example would have properly lit streets at night, maintained sidewalks and streets and the appropriate number of benches in long stretches of walkways. It is therefore essential to align with those specific municipalities and promote such an initiative to other municipalities in an effort to create healthy communities that will improve the health of the population, a shared goal between municipalities, PHUs and LHINs.
Primary Care: Family physicians and FHTs	In implementing interventions as part of each LHIN-wide Integrated Falls Prevention Program, it is important to effectively engage non-LHIN funded primary care providers and ensure they are effectively integrated into each LHIN-wide Integrated Falls Prevention Program. They are often seniors' first and most frequent contact point with the health care system and are looked to for trusted health care advice. Primary care providers treat their senior patients for a wide variety of issues including the effective management of chronic diseases such as diabetes. Given the large number of health concerns that seniors can have, it is imperative for each LHIN-wide Integrated Falls Prevention Program to recognize that the issue of falls may be competing with other health care issues that are sometimes seen as more important. Primary care providers should therefore be educated on the importance of falls prevention and its significant impact on the health care outcomes of their patients. Such education should show the direct and indirect link of falls to death and compare this to other diseases and conditions. Furthermore, this sector may not necessarily be fully aware of all the falls prevention interventions that could be accessed by their patients. Education with regards to the available services by providing a documented list, for example, can help this sector in referring their patients once a falls risk is identified. Primary care can be involved in many ways including proper assessment for falls, education of seniors regarding falls risk and appropriate referral to required falls prevention interventions. All of these require targeted and continued education of the sector. For primary care to integrate falls risk assessment into their practice, simple assessment tool(s) should be suggested (e.g. one to two basic questions that they can ask their patients) to determine falls risk. This will minimize the time spent during the clinical interaction while meeting the falls-related needs of the senior patients. Each LHIN-wide Integrated Falls Prevention Program should refer to the "*Engaging Primary Care in LHIN Processes Toolkit" for* more effective strategies on how to engage this sector. (http://www.lhincollaborative.ca/Page.aspx?id=1900&ekmensel=e2f22c9a_72_562_1900_4)
Supportive Housing	Supportive housing units are designed for people who only need minimal to moderate care (e.g. homemaking or personal care) to live independently. Supportive housing buildings are often owned by municipal governments or non-profit groups (e.g. faith groups, seniors' organizations, service clubs and cultural groups). The services delivered by supportive housing providers in many cases are funded and therefore regulated by the Ministry of Health and Long-Term Care. Supportive housing units are typically a congregate of seniors and therefore afford great opportunity for partnership and collaboration to provide interventions on-site to increase participation of seniors in falls prevention activities. Such interventions would include educations to seniors on how to decrease their risk of falls or provision of exercise programs onsite. Given the low to moderate care needed by seniors living in these residences, partnering with supportive housing translates into targeting those that are often at low to moderate risk for falling and therefore successfully preventing falls much earlier on. Currently, Sage Advice & Gentle Exercises for Seniors (SAGES) - a low-cost falls prevention program - is successfully being delivered by a community support services (CSS) agency in a supportive housing environment in partnership with a municipality (see Table 8 for more details on the SAGES program).

Private Sectors and Organizations

Organization	Description and Role
Retirement Homes	Similar to supportive housing, these residences are intended for people who only need minimal to moderate support with their daily living activities. Retirement homes however, are privately owned and not regulated by the MOHLTC for the support services they provide. Nonetheless, there are hundreds of retirement homes in Ontario that house many seniors over the age of 65. Similar to supportive housing, partnering with these homes provides access to a large number of seniors to provide falls prevention programming for and allows intervention at early stages, reducing the risk for falls more effectively. New legislation (*Retirement Homes Act, 2010, S.O. 2010, c. 11)* was recently developed to regulate retirement homes which include standards around resident falls.

APPENDIX R – Sample Balanced Scorecard from the North Simcoe Muskoka LHIN

Integrated Regional Falls Program (IRFP) - North Simcoe Muskoka LHIN

Scorecard 2009-2011

Reporting Period: 2010-2011 Q1

Domain/Indicator	Previous Period: (2009-2010 YE)	Current Period: (2010-2011 Q1)	Variance	% Variance	Trend	Baseline (2009-2010 YE)	Year to Date*	Notes/Explanation
Financial Health								
LHIN Funding - Total Budget					Decreasing			
LHIN Funding - Total Actuals					Decreasing			
LHIN Funding - Total Variance					Decreasing			
Patient Access/Safety								
Number of Clients Served					Decreasing			
Number of Clients 65+					Decreasing			
Number of Clients 75+					Decreasing			
Fall-Related ER Visits					Decreasing			
Fall-Related IP Admissions from ER					Decreasing			
No. of Falls while in IRFP Service					Decreasing			
% Clients with Severity of Harm >=2*					Decreasing		**no data**	
Organizational Health								
Client Satisfaction*					Decreasing		**no data**	
Staff Satisfaction*					Decreasing		**no data**	

* ***Note:*** *"Year to Date" Values of selected Indicators have been averaged for the fiscal year selected, as applicable*

APPENDIX S – *Intelli*Health Access Details

*Intelli*Health is a gateway to a repository of health care data that describes the population as well as the delivery of health care services in Ontario. This repository can be accessed by all LHIN personnel. *Intelli*Health provides access to raw health-related data (including data related to falls) that can be analyzed by the requester. It also provides predefined reports developed by *Intelli*Health.

Falls-related data that can be accessible through *Intelli*Health includes but is not limited to:

- Hospitalizations for falls among long-term care home (LTCH) residents
- Hospitalizations for falls among seniors (age 65+) in the community

LHIN staff that wish to become *Intelli*health users should contact intellihealthontario@ontario.ca.

APPENDIX T – Membership of the Evaluation Sub-Committee

	Name	Title	Organization
1	Dr. Phil Groff	President and CEO	SMARTRISK
2	JoAnn Heale	Senior Health Analyst, Health Analytics Branch	Ministry of Health and Long-Term Care
3	Neman Khokhar	Senior Manager Health System Performance & Measurement	North Simcoe Muskoka LHIN
4	Heather McConnell	Associate Director, International Affairs and Best Practice Guidelines Program	Registered Nurses' Association of Ontario *Member of the Integrated Provincial Falls Prevention Mobilization Committee*
5	Jayne Morrish	Research Associate	SMARTRISK
6	Brian Putman	Senior Analyst, Health System Performance	North Simcoe Muskoka LHIN
7	Michelle Rey	Manager, Public Reporting	Health Quality Ontario

APPENDIX U – Provincial Falls Indicator Technical Specifications

Technical Specification for Indicator # 1

INDICATOR DESCRIPTION	**INDICATOR NAME**	**Falls-related admissions to hospitals from Emergency Department per 100,000 seniors aged 65 years and older**
	INDICATOR DESCRIPTION Detailed description of indicator	Rate of admissions to inpatient care resulting from a fall among seniors (ages 65+) who reside in the LHIN
NUMERATOR	**CALCULATION**	Admissions to inpatient care – number of emergency visits with at least one fall diagnosis reported and a disposition status of transferred to inpatient care
	DATA SOURCE	National Ambulatory Care Reporting System(NACRS) (both final and interim quarterly datasets)
	EXCLUSION/INCLUSION CRITERIA	**For all include:** AM case type = EMG (unscheduled emergency visit) ICD-10 diagnosis code = W00-W19^ Patient province of residence = Ontario Age at visit = 65 years or older **Repeat visits also include:** Disposition status = 6, 7 (admitted to inpatient care) **Admissions to inpatient care also include:** Disposition status = 6, 7 (admitted to inpatient care) **Exclude:** Transfer from type = hospitals (acute, psych, gen/spec rehab, etc) Note: this is a distinct count of admissions, i.e. an admission with more than one fall diagnosis is only counted once
DENOMINATOR	**CALCULATION**	Number of Ontario residents ages 65 years and older in the year and for the geography used in the numerator
	DATA SOURCE	Ontario Population Estimates, Statistics Canada and Ontario Ministry of Health (for rates using final NACRS data) Ontario Population Projections, Statistics Canada and Ontario Ministry of Finance (for rates using interim NACRS data)
	EXCLUSION/INCLUSION CRITERIA	Exclude age at visit < 65 years
GEOGRAPHY & TIMING	**TIMING/FREQUENCY OF RELEASE** How often, and when, are data being released *E.g. Be as specific as possible…..data are released annually in mid-May*	NACRS final data are updated annually, generally three – six months after fiscal year-end NACRS interim data are updated monthly and quarterly Population estimates and projections are updated annually

	LEVELS OF COMPARABILITY Levels of geography for comparison	LHIN of patient residence
	TRENDING Years available for trending	Beginning 2002 fiscal year; interim quarterly data are available
ADDITIONAL INFORMATION	**LIMITATIONS** Specific limitations	Since this analysis is by patient, only patients with a valid HN can be included as patients with an invalid HN are assigned the same dummy number and can't be distinguished from each other. This is less likely to be an issue for seniors.
	COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	

Technical Specification for Indicator # 2

INDICATOR DESCRIPTION	**INDICATOR NAME**	**Number of falls-related ED visits per 100,000 seniors aged 65 years and older**
	INDICATOR DESCRIPTION Detailed description of indicator	Rate of visits to inpatient care resulting from a fall among seniors (ages 65+) who reside in the LHIN
NUMERATOR	**CALCULATION**	Visits – number of emergency visits with at least one fall diagnosis reported
	DATA SOURCE	National Ambulatory Care Reporting System (both final and interim quarterly datasets)
	EXCLUSION/INCLUSION CRITERIA	**Include:** AM case type = EMG (unscheduled emergency visit) ICD-10 diagnosis code = W00-W19^ Patient province of residence = Ontario Age at visit = 65 years or older **Exclude:** Transfer from type = hospitals (acute, psych, gen/spec rehab, etc) Note: this is a distinct count of visits, i.e. a visit with more than one fall diagnosis is only counted once
DENOMINATOR	**CALCULATION**	Number of Ontario residents ages 65 years and older in the year and for the geography used in the numerator
	DATA SOURCE	Ontario Population Estimates, Statistics Canada and Ontario Ministry of Health (for rates using final NACRS data) Ontario Population Projections, Statistics Canada and Ontario Ministry of Finance (for rates using interim NACRS data)
	EXCLUSION/INCLUSION CRITERIA	Exclude age at visit < 65 years
GEOGRAPHY & TIMING	**TIMING/FREQUENCY OF RELEASE** How often, and when, are data being released *E.g. Be as specific as possible…..data are released annually in mid-May*	• NACRS final data are updated annually, generally three – six months after fiscal year-end • NACRS interim data are updated monthly and quarterly • Population estimates and projections are updated annually
	LEVELS OF COMPARABILITY Levels of geography for comparison	LHIN of patient residence

	TRENDING Years available for trending	Beginning 2002 fiscal year; interim quarterly data are available
ADDITIONAL INFORMATION	**LIMITATIONS** Specific limitations	Since this analysis is by patient, only patients with a valid HN can be included as patients with an invalid HN are assigned the same dummy number and can't be distinguished from each other. This is less likely to be an issue for seniors.
	COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	

Technical Specification for Indicator # 3

INDICATOR DESCRIPTION	**INDICATOR NAME**	**Repeat ED visits for falls in the past 12 months at the beginning of the rolling 12 month period per 100,000 seniors aged 65 years and older**
	INDICATOR DESCRIPTION Detailed description of indicator	Rate of repeat (two or more) emergency visits with at least one fall diagnosis reported for Ontario seniors (65+ years) with a valid health number (HN) who reside in the LHIN
NUMERATOR	**CALCULATION**	Number of Ontario seniors (with valid HN) who had two or more emergency visits where there was at least one fall diagnosis reported in the previous 12-months
	DATA SOURCE	National Ambulatory Care Reporting System (NACRS-final data for previous fiscal year; interim data for current fiscal year), Canadian Institute for Health Information
	EXCLUSION/INCLUSION CRITERIA	**Inclusions:** AM case type = EMG (unscheduled emergency visit) ICD-10 diagnosis code = W00-W19^ Patient province of residence = Ontario Patients with valid health number (HN) – HN status = H Age at visit = 65 years or older # visits per patient > 1 Note: this is a count of patients with 2 or more distinct visits, i.e. a visit with more than one fall diagnosis is only counted as one visit
DENOMINATOR	**CALCULATION**	Number of Ontario residents ages 65 years and older in the year and for the geography used in the numerator
	DATA SOURCE	Ontario Population Estimates, Statistics Canada and Ontario Ministry of Health (for rates using final NACRS data) Ontario Population Projections, Statistics Canada and Ontario Ministry of Finance (for rates using interim NACRS data)
	EXCLUSION/INCLUSION CRITERIA	Exclude age at visit < 65 years
GEOGRAPHY & TIMING	**TIMING/FREQUENCY OF RELEASE** How often, and when, are data being released *E.g. Be as specific as possible…..data are released annually in mid-May*	• NACRS final data are updated annually, generally three – six months after fiscal year-end • NACRS interim data are updated monthly and quarterly • Population estimates and projections are updated annually

	LEVELS OF COMPARABILITY Levels of geography for comparison	Analysis is by geography of patient residence as reported at visit, e.g. LHIN of patient residence
	TRENDING Years available for trending	Beginning with the 2002 fiscal year for final data (start of ICD-10 reporting); interim quarterly data are available for the current fiscal year
ADDITIONAL INFORMATION	**LIMITATIONS** Specific limitations	Since this analysis is by patient, only patients with a valid HN can be included as patients with an invalid HN are assigned the same dummy number and can't be distinguished from each other. This is less likely to be an issue for seniors.
	COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	The time period "previous 12 months" is chosen to smooth out short-term, quarterly variations and to thus facilitate comparisons between LHINs and across time.

APPENDIX V – Desciption of Provincial and National Organizations and Initiatives

Organization / Initiative	Description of organization and Collaboration and Alignment Opportunities
Accreditation Canada	Accreditation Canada is a not-for-profit organization that is committed to improving quality and safety in health services through accreditation. In Ontario, Accreditation Canada's clients include hospitals, community care access centres, community-based programs and services and long-term care (LTC) homes. In Ontario alone, more than 400 organizations are accredited through Accreditation Canada (See Appendix X for a list of accredited organizations in Ontario). Most of these organizations are hospitals and LTC homes. Accredited organizations must comply with a number of "Required Organizational Practices" (ROPs) that have been identified in six patient safety areas as applicable. One of these areas, named the "Risk Assessment" area, houses two ROPs relevant to falls prevention: the "Falls Prevention ROP" and the "Home Safety Risk Assessment ROP". Through the falls prevention ROP, accredited organizations are required to have a falls prevention strategy that is implemented and evaluated. The Home Safety Risk assessment ROP was introduced in 2011 and therefore not all accredited organizations would comply to this as of yet. This ROP mandates that a safety risk assessment (which includes assessment of fall hazzards amongst many other hazzards in the home) is conducted for all clients receiving services in the home. The provincial structure would work with the 14 LHIN-wide Integrated Falls Prevention Programs to identify the accredited organizations within their catchment area and determine how they are meeting the ROPs related to falls. In addition, the provincial structure would work with the 14 LHIN-wide Integrated Falls Prevention Programs to ensure their goals and interventions that may have an impact on accredited organizations are aligned with the ROPs addressing falls. For more information on Accreditation Canada, visit http://www.accreditation.ca/
Public Health Ontario (PHO)	Public Health Ontario (PHO) is an arm's-length government agency dedicated to protecting and promoting the health of all Ontarians and reducing inequities in health. PHO provides expert scientific and technical support to health providers, the public health system and partner ministries in making informed decisions relating to many areas including surveillance and epidemiology, health promotion and chronic disease and injury prevention to name a few. With a mission of supporting health care providers and the public health system through scientific advice and practical tools, the PHO would be a great partner as it could provide that level of support to the provincial structure as well as the 14 LHIN-wide Integrated Falls Prevention Programs. For more information about the PHO, visit http://www.oahpp.ca/
Ontario Neurotrauma Foundation (ONF)	The ONF is an applied health research organization with a focus on the development of knowledge and its implementation in order to reduce the impact of neurotrauma through the prevention of these injuries and to improve the quality of life for those Ontarians living with a spinal cord or acquired brain injury. Falls cause 60% of head injuries in older adults and for this reason, ONF has been involved since 2003 in the identification, implementation and evaluation of best practice interventions aimed at reducing seniors falls. ONF was instrumental in identifying the Australian best practice intervention Stay On Your Feet and piloting its implementation in three Ontario communities (Grey Bruce, Kingston and Elliot Lake) with sustainable results in two of those communities. Based on this initial experience, ONF has gathered scientific knowledge and expertise in the field and has provided ongoing support and leadership to various initiatives over the years including leadership and sponsorship of the SHRTN Falls Prevention Communities of Practice. With the mission of bringing

	research into practice and policy, ONF provides access to scientific expertise in best practice identification, implementation and evaluation while building capacity through research grants and other key support initiatives for an increased research uptake. For more information about the ONF, visit http://www.onf.org
Ontario Osteoporosis Strategy	Osteoporosis is related to falls in that falls can lead to fractures and the presence of osteoporosis can increase the risk and severity of the fracture. Osteoporosis is a highly debilitating condition in which bones become less dense and fracture more easily. Thus, osteoporosis can also be a risk factor for falls as it diminishes an individual's bone strength, making them more prone to fall when standing or walking. The goal of the osteoporosis strategy is to reduce fractures, morbidity, mortality and costs from osteoporosis through an integrated and comprehensive approach aimed at health promotion and disease management. Since both this strategy and the Integrated Falls Prevention Framework have a shared goal of reducing hip fractures, it is necessary that the two align and work together to effectively prevent and manage both osteoporosis and falls in seniors. For more information about the osteoporosis strategy, visit: http://www.osteostrategy.on.ca/
Ontario Seniors' Secretariat	The Ontario Seniors' Secretariat (OSS) is a secretariat operating out of the Ministry of Tourism and Culture that works to improve the quality of life for Ontario seniors. One of the many ways the OSS works to achieve this is through providing seniors with the information they need about vital programs and services, healthy lifestyles and aging and maintaining close working relationships with relevant seniors' organizations. The provincial structure should leverage communication mediums used by the OSS as part of the provincial falls prevention campaign described in section V.A. These mediums can also be leveraged to provide seniors in Ontario access to the falls prevention interventions available to seniors as part of each LHIN-wide Integrated Falls Prevention Program. In working with the OSS, the provincial structure can also leverage the OSS's partners and align with them as necessary with respect to falls prevention. Through its commitment to help inform seniors about healthy aging, the OSS provides a one day falls prevention seminar that is designed to inform seniors on how to prevent falls and maintain their independence. The structure can incorporate such a seminar as part of the overall provincial falls prevention campaign and assist LHIN-wide Integrated Falls Prevention Programs in hosting the seminar. These seminars can be requested by seniors or anyone looking to conduct an education session. OSS has also developed a resource kit (as outlined in table 6 in Section VI) for presenters to facilitate their conducting the seminar. For more information on the Ontario Seniors' Secretariat, visit: http://www.seniors.gov.on.ca/en/index.php
Registered Nurses Association of Ontario	The Registered Nurses' Association of Ontario (RNAO) is the professional association representing Registered Nurses in Ontario. Through funding from the Ministry of Health and Long-Term Care (MOHLTC) it has developed an evidence-based best practice guideline, *"Reducing Falls and Injury from Falls in the Older Adult*", to increase all nurses' confidence, knowledge, skills and abilities in the identification of adults within health care settings at risk of falling and to define interventions for the prevention of falling and reduction of injury (see Table 4 for access details). This guideline, updated in May 2011, is at the centre of many of the falls prevention efforts seen in health care settings across the province. Several other guidelines, related to the risk factors for falls, are also available through the RNAO website at the address below. RNAO also has a LTC Best Practice Coordinators initiative which is described below.

	For more information on RNAO, visit http://www.rnao.org/bestpractices. ***RNAO Long-Term Care Best Practice Coordinators:*** This initiative, also funded by MOHLTC, promotes the uptake of evidence-based practices by long-term care homes to promote quality resident care. LTC Best Practice Coordinators, one per LHIN, work with LTC homes and community partners to support integration of best practices. One of the six areas of primary focus is falls prevention.
Residents First Initiative by Health Quality Ontario	Residents First is a LTC quality improvement initiative driven and supported by the MOHLTC and is implemented by the LHINs at the local level. This initiative is aimed at strengthening the sector's capacity for quality improvement and facilitating comprehensive and lasting change. Currently, approximately three quarters of Ontario's LTC homes are engaged in some aspect of the program and the goal is to have all Ontario LTC homes participate (see Appendix X for all LTC homes participating in Residents First). Training and education is provided in different ways under four different streams: Leading Quality, Facilitating Improvement, Learning Collaboratively and Becoming LEAN through Process Improvement. Under the learning collaboratively stream, LTC homes can chose to focus on a number of various topics, one of them being falls prevention. To date, over 70% of participating LTC homes declared falls prevention as their primary topic of focus within this stream. Each LHIN-wide Integrated Falls Prevention Program should be aware of which LTC homes are participating within its respective LHIN to leverage their current falls prevention practices. Each LHIN-wide Integrated Falls Prevention Programs should also promote the adoption of Residents First to enable more effective falls prevention practices within the LTC sector. The provincial structure would keep abreast of this initiative and update the 14 LHIN-wide Integrated Falls Prevention Programs as necessary. Residents First also provides a number of quality improvement tools for all LTC homes to access (see http://www.residentsfirst.ca/resources). These tools should be leveraged and promoted amongst LTC homes participating in the LHIN-wide Integrated Falls Prevention Programs. For more information on the Residents First initiative, visit: http://www.residentsfirst.ca/
Senior Friendly Hospital Strategy by the Regional Geriatric Programs of Ontario	The Senior Friendly Hospital Strategy is a systematic approach that promotes evidence-based practices in geriatric care within acute hospital settings to prevent adverse events, functional decline and complications that seniors are at a high risk of during their inpatient stay. To enable this strategy, a framework was developed which consists of five domains: Organizational Support, Processes of Care, Emotional and Behavioural Environment, Ethics in Clinical Care and Research, and Physical Environment. The Processes of Care domain addresses the topic of falls prevention in hospital settings. This strategy has been rolled out by the Toronto Central LHIN, with support from the RGP of Toronto, to a number of Toronto Hospitals based in the Toronto Central LHIN. Plans are currently in place to roll out the strategy provincially to all hospitals within Ontario. The RGP Toronto has developed a toolkit based on the Toronto experience with the Senior Friendly Hospital Strategy (see Table 6 in Section VI for details). The provincial structure should work with RGPs of Ontario to determine how to best align hospital falls prevention interventions that are currently provided or referred to as part of each LHIN-wide Integrated Falls Prevention Program with the Senior Friendly Hospital Strategy. The two parties should work together to leverage leading practices of the falls prevention activities implemented by hospitals that showed success in preventing falls due to the Senior Friendly Hospital Strategy. For more information on the Senior Friendly Hospital Strategy, visit: http://rgps.on.ca/senior_friendly_hospital_strategy

Seniors Health Research Transfer Network Knowledge Exchange	SHRTN Knowledge Exchange is part of the SHRTN Collaborative, which is a partnership between the SHRTN Knowledge Exchange, SHRTN Alzheimer Knowledge Exchange and Ontario Research Coalition. The SHRTN Knowledge Exchange facilitates knowledge exchange between caregivers, researchers and policy makers through many avenues including CoPs and the library service. SHRTN's vision is to be the "place to go" in Ontario for the latest knowledge and best practices about seniors' health and health care. Thus, it is critical to collaborate with SHRTN and leverage its knowledge base and the many services and opportunities it provides for its members. There is potential for SHRTN to be an integral part of the overall provincial falls prevention framework. *Communities of Practice (CoPs):* CoPs are groups of people who work together over time to identify innovations, translate evidence and help implement changes to improve care of seniors. SHRTN has many CoPs including the *Prevention of Falls in Older Adults CoP*, which commenced in the winter of 2010. As previously discussed, members of every LHIN-wide Integrated Falls Prevention Program should become members of this CoP (see http://beta.shrtn.on.ca/nodes/shrtn-ke/cop/content/51 for more details). The provincial structure should also be an active member of the CoP. This is important to keep abreast of updated falls prevention research and leading practices and to leverage the most current resources. In addition, CoP members would benefit by influencing current practices through sharing knowledge from their experiences. *Library of Service:* SHRTN provides free access to evidence through its library of service to paid caregivers of seniors. Library services are provided through five seniors' health information specialists working out of five partner sites. Through this service, paid caregivers can request references as well as literature reviews to name a few. As previously discussed, each LHIN-wide Integrated Falls Prevention Program should promote use of best practice and the use of this service amongst its paid caregivers. The provincial structure would work with the 14 LHIN-wide Integrated Falls Prevention Programs to ensure this service is adequately encouraged through various means. For more information on SHRTN, visit: http://beta.shrtn.on.ca/

APPENDIX W – Ontario Councils on Aging

Council for London Seniors

Box 5777, Rm. 202 1490 Richmond St.

London, On N6A 4L6

Telephone: (519) 433-0625

Fax: (519) 433-4548

Council on Aging for Lanark, Leeds & Grenville

4 George St. S.

Smiths Falls, On K7A 1X4

E-mail: **coa@freenet.carleton.ca**

Council on Aging for Renfrew County

PO Box 831

Pembroke, On K8A 7M5

Telephone: (613) 735-1745

Fax: (613) 735-1748

Council on Aging for York Region

194 Eagle St.

Newmarket, On L3Y 1J6

Telephone: (905) 895-2381

Fax: (905) 895-9001

Council on Aging of Ottawa-Carleton

256 King Edward Ave., Ste. 300

Ottawa, On K1N 7M1

Telephone: (613) 789-3577

Fax: (613) 789-4406

Council on Aging Windsor Essex County

2090 Wyandotte St., 3rd Fl.

Windsor, On N8Y 3X1

Telephone: (519) 971-9217

Fax: (519) 971-8789

Frontenac-Kingston Council on Aging

23 Carlisle St.

Kingston, On K7K 3X1

Telephone: (613) 541-1336

E-mail: **coa@adan.kingston.net**

Hastings & Prince Edward Council on Aging

C4-344 Front St.

Belleville, On K8N 5M4

Telephone: (613) 962-9159

Fax: (613) 962-9163

Lambton Senior Association

Lambton Health Unit 160 Exmouth St.

Point Edward, On N7T 7Z6

Telephone: (519) 383-8331

Fax: (519) 383-7092

Mayor's Advisory Council for Kitchener Seniors

Senior's Division, City of Kitchener 22 Frederick St., Box 118

Kitchener, On N2G 4G7

Telephone: (519) 741-2227

Fax: (519) 741-2723

E-mail: **kcouncil@city.kitchener.on.ca**

Peterborough Senior Citizens Council 440 Water St.

Peterborough, On K9H 7K6

Telephone: (705) 742-7067

Fax: (705) 741-6193

E-mail: **jarb@ptbo.igs.net**

Seniors Advisory Council for the Region of Sudbury

Elm Towne Sq., 2nd Fl. 43 Elm St., Unit 37

Sudbury, On P3C 1S4

Telephone: (705) 671-1647

Fax: (705) 671-2479

E-mail: **senadco@cyberbeach.net**

Toronto Mayor's Committee on Aging

Dept. of the City Clerk, City Hall

Toronto, On M5H 2N2

Telephone: (416) 392-0127

Fax: (416) 392-0071

Source: ***http://www.web.net/ohc/docs/coa.htm***

APPENDIX X – Accredited Organizations in Ontario

ONTARIO

Ajax
Ballycliffe Lodge Nursing Home
Revera Long Term Care - Central East "A"

Alexandria
Hôpital Glengarry Memorial Hospital

Alliston
Good Samaritan Nursing Home
Stevenson Memorial Hospital

Almonte
Almonte General Hospital

Amherstview
Helen Henderson Nursing Home

Arnprior
Arnprior and District Memorial Hospital

Atikokan
Atikokan General Hospital

Aurora
Community Home Assistance to Seniors (CHATS)
The Southdown Institute

Aylmer
Chateau Gardens Aylmer

Barrie
Royal Victoria Hospital of Barrie

Barry's Bay
St. Francis Memorial Hospital
Valley Manor Incorporated

Beaverton
Lakeview Manor

Belleville
Belmont Long Term Care Facility
Pathways To Independence
Quinte Health Care Corporation
Westgate Lodge Nursing Home

Blind River
Anishnabie Naadmaagi Gamig Substance Abuse Treatment Centre
Blind River District Health Centre/Pavillon Santé du District de Blind River

Bowmanville
Mamwood Lifecare Centre
Strathaven Lifecare Centre

Bracebridge
The Pines Long Term Care Home

Brampton
Aberdeen Health and Community Services
Extendicare Brampton
Helping Hands Nursing Services Inc.
Holland Christian Homes Inc.
Regional Municipality of Peel, Long Term Care Division
Unger Nursing Homes Ltd.
William Osler Health Centre

Brantford
Brant Community Healthcare System
Lansdowne Children's Centre

Brockville
Brockville General Hospital

Burlington
Brantwood Lifecare Centre
BSC Enterprises Inc. O/A Homewell Senior Care
Joseph Brant Memorial Hospital Corporation
Maple Villa Long Term Care Centre
Mount Nemo Christian Nursing Home
Unger Nursing Homes Ltd.

ONTARIO

Cambridge
Cambridge Memorial Hospital
Fairview Mennonite Homes
Hilltop Manor Cambridge
Saint Luke's Place

Campbellford
Campbellford Memorial Hospital

Cannifton
E.J. McQuigge Lodge

Cannington
Bon Air Residence

Carleton Place
Carleton Place and District Memorial Hospital

Chapleau
Services de santé de Chapleau Health Services

Chatham
Chatham-Kent Health Alliance Grand Campus

Chesley
Elgin Abbey

Cobourg
Northumberland Hills Hospital

Cochrane
MICs Group of Health Services

Collingwood
Bay Haven Nursing Home Inc.
Collingwood General & Marine Hospital

Corbeil
Nipissing Manor Nursing Care Center

Cornwall
Cornwall Community Hospital
Eastern Ontario Health Unit
Glen Stor Dun Lodge
Mohawk Council of Akwesasne
Sandfield Place
St. Joseph's Continuing Care Centre

Deep River
Deep River and District Hospital/Four Seasons Lodge

Delaware
Middlesex Terrace

Delhi
Delhi Long Term Care Centre
R.T. Respiratory Therapy Services Inc.

Dryden
Dryden Regional Health Centre

Dundas
Wentworth Lodge

Dunnville
Grandview Lodge
Haldimand War Memorial Hospital

Elliot Lake
St. Joseph's General Hospital Elliot Lake

Elmira
Chateau Gardens Elmira

Embrun
Foyer St. Jacques Nursing Home

Englehart
Englehart and District Hospital Inc.
Northview Nursing Home

ONTARIO

Espanola
Espanola General Hospital

Etobicoke
CANES Community Care
ESS – Etobicoke Services for Seniors
Highbourne Lifecare Centre
Neurologic Rehabilitation Institute of Ontario

Exeter
South Huron Hospital Association

Fergus
Groves Memorial Community Hospital

Fort Erie
Crescent Park Lodge

Fort Frances
Riverside Health Care Facilities Inc.

Gananoque
Carveth Care Centre

Geraldton
Geraldton District Hospital

Glenburnie
Fairmount Home for the Aged

Goderich
Alexandra Marine and General Hospital

Greater Town of Napanee
Friendly Manor Nursing Home

Grimsby
West Lincoln Memorial Hospital

Guelph
Eden House Care Facility Inc.
Homewood Health Centre
St. Joseph's Health Centre Guelph
Trellis Mental Health and Developmental Services

Hagersville
Norcliffe Lifecare Centre
West Haldimand General Hospital

Haileybury
Extendicare Tri-Town Nursing Home

Haliburton
Haliburton Highlands Health Services

Hamilton
Brain Injury Services of Hamilton
Extendicare Hamilton
Grace Villa
Hamilton Continuing Care (H.C.C.)
Hamilton Health Sciences
Idlewyld Manor
Marchese Health Care O/A Mezentoo Inc.
Parkview Nursing Centre
Shalom Village
St. Joseph's Healthcare Hamilton
St. Joseph's Home Care
St. Olga's Lifecare Centre
The Wellington Nursing Home
Townsview Lifecare Centre
Victoria Gardens Long Term Care Centre

Hanover
Hanover and District Hospital

Hawkesbury
Hôpital Général de Hawkesbury and District General Hospital Inc.

Hearst
Hôpital Notre-Dame Hospital (Hearst)

Hornepayne
Hornepayne Community Hospital

ONTARIO

Huntsville
Fairvern Nursing Home (Huntsville District Nursing Home Inc.)
Muskoka Algonquin Healthcare

Ingersoll
The Alexandra Hospital, Ingersoll

Kapuskasing
Extendicare/Kapuskasing Nursing Home
North Centennial Manor Inc.
Sensenbrenner Hospital

Kemptville
Kemptville District Hospital

Kenora
Lake of the Woods District Hospital
Migisi Alcohol and Drug Treatment Centre

Kingston
Frontenac Community Mental Health Services
Kingston General Hospital
Ongwanada
Providence Care Centre
Regional Treatment Centre (Ontario) Correctional Service of Canada
Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston
Rideaucrest Home

Kingsville
The Royal Oak Long Term Care Centre

Kirkland Lake
Extendicare/Kirkland Lake Inc.
Kirkland and District Hospital

Kitchener
Grand River Hospital
Oakwood Retirement Communities Inc.
Pace Homecare Services Inc.
St. Mary's General Hospital, Kitchener
Sunnyside Home
Trinity Village Care Centre

Lakefield
Extendicare Lakefield

Leamington
Franklin Gardens Long Term Care Home
Leamington District Memorial Hospital

Limoges
Foyer St. Viateur Nursing Home

Lindsay
Community Care City of Kawartha Lakes
Extendicare Kawartha Lakes
Homestead Oxygen and Medical Equipment
Ross Memorial Hospital

Listowel
Listowel and Wingham Hospitals Alliance

Little Current
Manitoulin Health Centre

London
Chateau Gardens - London
Chelsey Park (Oxford)
Child and Parent Resource Institute
Comcare Health Services
Dale Brain Injury Services Inc.
Extendicare/London
Kensington Village Nursing Home
London Health Sciences Centre
McCormick Home
Professional Respiratory Home Care Service Corp.
Rexall Specialty Pharmacy
Sifton Properties
St. Joseph's Health Care, London
The Fertility Clinic, London Health Sciences Centre
WOTCH Community Mental Health Services

Manitouwadge
Manitouwadge General Hospital

ONTARIO

Marathon
Wilson Memorial General Hospital

Markham
First Health Care Services of Canada Inc.
Markham Fertility Centre
Markham Stouffville Hospital Corporation
ParaMed Home Health Care
Saint Elizabeth Health Care

Mattawa
Algonquin Nursing Home
Hôpital de Mattawa Hospital Inc.

Meaford
Meaford Long Term Care Centre

Merrickville
Hilltop Manor

Midhurst
Corporation of the County of Simcoe (Homes for the Aged)

Midland
Georgian Bay General Hospital
Jarlette Health Services

Mississauga
Astra Fertility Group
Calea Ltd.
Closing the Gap HealthCare Group
Community Health Services - Canadian Red Cross
ISIS Regional Fertility Centre
Mississauga Lifecare Centre
NewLife Fertility Centre
Peel Senior Link
Provincial Long Term Care
Revera Long Term Care - Region 2
Revera Long Term Care - Region 3
Revera Long Term Care - Region 5
Revera Long Term Care - Region 7
Revera Long Term Care - Region 6
The Credit Valley Hospital
Trillium Health Centre
Tyndall Nursing Home Limited

Moosonee
Sagashtawao Healing Lodge

Mount Forest
North Wellington Health Care Corporation
Saugeen Valley Nursing Center

Muncey
Nimkee NupiGawagan Healing Centre Inc.

Napanee
Lennox and Addington County General Hospital
The John M. Parrott Centre

New Liskeard
Temiskaming Hospital

Newmarket
Canadian Mental Health Association - York Region Branch
Southlake Regional Health Centre
Southlake Residential Care Village
York Region Health Services - Long Term Care & Seniors Branch

Niagara Falls
Oakwood Park Lodge
Valley Park Lodge

Nipigon
Nipigon District Memorial Hospital

North Bay
Cassellholme
North Bay General Hospital
Northeast Mental Health Centre

North York
Casa Verde Health Centre
North York General Hospital

ONTARIO

Oakville
Acclaim Health and Community Care Services
Halton Healthcare Services Corporation
Regional Municipality of Halton
Revera Long Term Care - Region 5
Wyndham Manor LTC Facility

Ohsweken
Six Nations of the Grand River Health Services

Orangeville
Headwaters Health Care Centre

Orillia
Orillia Soldiers' Memorial Hospital

Oshawa
Extendicare Oshawa
Grandview Children's Centre
Hillsdale Estates
Hillsdale Terraces
Lakeridge Health Corporation

Ottawa
Bess and Moe Greenberg Family Hillel Lodge - Ottawa Jewish Home for the Aged
Bruyère Continuing Care
Canadian Mental Health Association, Ottawa Branch
Carefor Health & Community Services
Centre Vista Centre
Children's Hospital of Eastern Ontario
City of Ottawa Long Term Care Branch
CommuniCare Therapy
Extendicare (Canada) Inc. Eastern Ontario
Fresenius Medical Care Canada Inc.
GEM Health Care Services Inc.\Services de santé GEM Inc.
Hôpital Montfort
Inspiration Medic Inc.
Ottawa Children's Treatment Centre / Centre de traitement pour enfants d'Ottawa
Queensway Carleton Hospital
Retire-At-Home Services
Revera Health Services
Royal Ottawa Health Care Group
Salvation Army Ottawa Grace Manor
St. Patrick's Home of Ottawa Inc.
The Glebe Centre Incorporated
The Hospice at May Court
The Ottawa Fertility Centre
The Ottawa Hospital/L'Hôpital d'Ottawa
The Perley and Rideau Veterans' Health Centre

Owen Sound
Grey Bruce Health Services Owen Sound Regional Hospital

Palmerston
Royal Terrace

Parkhill
Chateau Gardens Parkhill Long Term Care Centre

Parry Sound
Lakeland Long Term Care
West Parry Sound Health Centre

Pembroke
Marianhill Inc.
Miramichi Lodge
Pembroke Regional Hospital Inc.

Penetanguishene
Mental Health Centre Penetanguishene

Perth
Lanark Lodge
Perth Community Care Centre

Peterborough
AON Inc.
Extendicare Peterborough
Fairhaven
Five Counties Children's Centre
Murad Younis HealthCare Inc
Nightingale Nursing Registry Ltd.

ONTARIO

OMNI Health Care, Ltd.
Peterborough Regional Health Centre
ProHome Health Services

Petrolia
Fiddick's Nursing Home Limited

Pickering
Community Lifecare Inc.

Picton
H.J. McFarland Memorial Home
Picton Manor Nursing Home

Plantagenet
Pinecrest Nursing Home

Port Stanley
Extendicare Port Stanley
Extendicare Southwestern Ontario Inc.

Red Lake
Red Lake Margaret Cochenour Memorial Hospital

Renfrew
Bonnechere Manor - Long Term Care Facility
Groves Park Lodge
Renfrew Victoria Hospital

Richmond Hill
1to1 Rehab Inc.
All-Care Health & Staffing Services
Mariann Home
Ontario Addiction Treatment Centres
Preferred Health Care Services
York Central Hospital

Sarnia
Bluewater Health
Canadian Mental Health Association - Lambton County Branch
Pathways Health Centre For Children
Vision Nursing Home

Sault Ste. Marie
Extendicare Tendercare
Extendicare Van Daele
F.J. Davey Home
Sault Area Hospital

Scarborough
Bellwood Health Services Inc.
Carefirst Seniors and Community Services Association
Extendicare Scarborough
Rouge Valley Health System
Scarborough Support Services for the Elderly
St. Paul's L'Amoreaux Centre
Tendercare Living Centre
The Scarborough Hospital
The Wexford Residence Inc.
Yee Hong Centre for Geriatric Care

Schumacher
Extendicare/Timmins Nursing Home

Simcoe
Norfolk General Hospital
Norview Lodge
The Norfolk Hospital Nursing Home

Sioux Lookout
Sioux Lookout Meno Ya Win Health Centre

Smiths Falls
Broadview Nursing Centre
Perth and Smiths Falls District Hospital

Smooth Rock Falls
Smooth Rock Falls Hospital

St. Catharines
Brain Injury Community Re-entry (Niagara) Inc.
Extendicare St. Catharines
Hotel Dieu Shaver Health and Rehabilitation Centre
Niagara Health System

ONTARIO

St. Marys
Wildwood Care Centre Inc.

St. Thomas
St. Thomas-Elgin General Hospital

Stirling
Stirling Manor Nursing Home

Stoney Creek
Heritage Green Nursing Home
Stoney Creek Lifecare Centre

Stouffville
Parkview Home Long Term Care

Stratford
Huron Perth Healthcare Alliance
Ontario Home Oxygen and Health
peopleCare Stratford Inc.

Strathroy
Middlesex Hospital Alliance
Sprucedale Care Centre Inc.

Sturgeon Falls
Hôpital général de Nipissing Ouest The West Nipissing General Hospital

Sudbury
Extendicare Falconbridge
Extendicare York
Finlandia Hoivakoti Nursing Home
Hôpital régional de Sudbury Regional Hospital - (HRSRH)
Pioneer Manor, Long-Term-Care Facility
St. Joseph's Villa of Sudbury

Sutton
River Glen Haven Nursing Home

Tavistock
peopleCare Tavistock
Revera Long Term Care - Region 3

Terrace Bay
The McCausland Hospital

Thorold
Regional Municipality of Niagara Seniors Services

Thunder Bay
Brain Injury Services of Northern Ontario
City of Thunder Bay Homes for the Aged
Dilico Anishinabek Family Care
J.R. Crooks Healthcare Services Inc.
Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre
North West Community Care Access Centre
Partners In Rehab
St. Joseph's Care Group
Thunder Bay Regional Health Sciences Centre

Tilbury
Tilbury Manor Long Term Care Facility

Tillsonburg
Tillsonburg & District Multi-Service Centre
Tillsonburg District Memorial Hospital

Timmins
Timmins and District Hospital/L'Hôpital de Timmins et du District

Toronto
Baycrest Geriatric Health Care System
Bellwoods Centres For Community Living Inc.
Belmont House (Toronto Aged Men's & Women's Homes)
Bloorview Kids Rehab
Bridgepoint Health
CanCare Health Services Inc.
Cedarvale Terrace Long Term Care Home
Centre for Addiction and Mental Health
Circle of Home Care Services (Toronto)
City of Toronto, Long Term Care Homes and Services Division
Community Care East York
Community Head Injury Resource Services of Toronto
COTA Health
CReATe Fertility Centre

ONTARIO

Drs. Paul & John Rekai Centre
Elm Grove Living Centre Inc.
Exclusive Care Services/Exclusive Palliative Care Inc.
Extendicare Rouge Valley
Fairview Nursing Home
Hellenic Home for the Aged Inc.
Maynard Nursing Home
Mount Sinai Centre for Fertility and Reproductive Health
Mount Sinai Hospital
NHI – Nursing & Homemakers Inc.
Nisbet Lodge
North Park Nursing Home Limited
Norwood Nursing Home Limited
PACE Independent Living
Premier Homecare Franchising Inc. (Premier Homecare Services)
Providence Healthcare
Runnymede Healthcare Centre
S.R.T. Med-Staff
Sherbourne Health Centre Corporation
Spectrum Health Care
SPRINT (Senior Peoples' Resources in North Toronto Inc.)
St. Clair O'Connor Community Nursing Home
St. John's Rehab Hospital
St. Joseph's Health Centre
St. Michael's Hospital
Storefront Humber Inc.
Sunnybrook Health Sciences Centre
Surrey Place Centre
The Hospital for Sick Children
The O'Neill Centre
The Salvation Army - Isabel and Arthur Meighen Manor
The Salvation Army Toronto Grace Health Centre
Toronto Cosmetic Clinic Inc.
Toronto East General Hospital
Toronto Rehabilitation Institute
University Health Network
Vermont Square
VHA Home HealthCare
Villa Colombo Homes For the Aged Inc.
West Park Healthcare Centre
Women's College Hospital
Youthdale Treatment Centres

Trenton
Crown Ridge Place
Trent Valley Lodge Ltd.

Tyendinaga Mohawk Territory
Mohawks of the Bay of Quinte

Vaughan
FunctionAbility Rehabilitation Services Inc.
Specialty Care Inc.

Walkerton
South Bruce Grey Health Centre

Wallaceburg
LaPointe-Fisher Nursing Home Limited

Walpole Island
Walpole Island Health Centre

Wardsville
Babcock Community Care Centre

Waterloo
CarePartners
KidsAbility - Centre for Child Development
Pinehaven Nursing Home

Wawa
Lady Dunn Health Centre

Weston
Humber River Regional Hospital

Whitby
Durham Mental Health Services
Fairview Lodge
Ontario Shores, Centre for Mental Health Sciences
Partners in Community Nursing
Personal Attendant Care Inc.

Wikwemikong
Ngwaagan Gamig Recovery Centre Inc. (Rainbow Lodge)

ONTARIO

Willowdale
Extendicare Bayview

Winchester
Dundas Manor Limited
Winchester District Memorial Hospital

Windsor
Extendicare Southwood Lakes
Hotel-Dieu Grace Hospital
Regency/Chateau Care Corporation
Rivera Long Term Care – Region 1
Windsor Regional Hospital

Wingham
Braemar Retirement Centre
Town and Country Support Services

Woodslee
Country Village Health Care Centre

Woodstock
Woodstock General Hospital

Source:
http://www.accreditation.ca/uploadedFiles/National%20Accredited%20Organizations.pdf

APPENDIX Y – Long-Term Care Homes Participating in Residents First

Residents First

Participating Homes

Designed for the Sector by the Sector

Residents First was shaped and developed with the input of a broad range of long-term care sector stakeholders. These groups continue to have input on an ongoing basis as members of the provincial steering committee that is guiding implementation. Members include:

Concerned Friends of Ontario Citizens in Care Facilities

Institute for Safe Medication Practices Canada (ISMP Canada)

Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS)

Ontario Association of Residents' Councils (OARC)

Family Councils' Program

Ontario Health Quality Council (OHQC)

Ontario Long Term Care Association (OLTCA)

Ontario Long Term Care Physicians

Ontario's Local Health Integration Networks (LHINs)

Quality Healthcare Network (QHN)

Registered Nurses' Association of Ontario (RNAO)

Seniors Health Research Transfer Network (SHRTN)

Residents First is supported by the Ontario Ministry of Health and Long-Term Care.

Year One (2009-10)

Central East LHIN

Bendale Acres
Centennial Place Long-Term Care Centre
Community Nursing Home – Port Hope
Community Nursing Home – Pickering
Extendicare Kawartha Lakes – Lindsay Hillsdale Estates
Leisureworld Caregiving Centre – Ellesmere
Leisureworld Caregiving Centre – Scarborough
Mon Sheong Scarborough Long-Term Care Centre Seven Oaks
Shepherd Lodge
Specialty Care Case Manor
Tendercare Living Centre
The Wexford Residence
The Wynfield

Central LHIN

Carefree Lodge
Casa Verde Health Centre
Cummer Lodge – North York
Leisureworld Caregiving Centre – Richmond Hill
Mon Sheong Richmond Hill Long-Term Care Centre
Parkview Home Long-Term Care
Specialty Care Bloomington Cove
Specialty Care Bradford Valley
Ukranian Canadian Care Centre
Villa Colombo Vaughan
Villa Leonardo Gambin
York Region Newmarket Health Centre

Central West LHIN

Kipling Acres
Leisureworld Caregiving Centre – Brampton Meadows
Leisureworld Caregiving Centre – Brampton Woods
Leisureworld Caregiving Centre – Etobicoke
Speciality Care Woodhall Park

Champlain LHIN

Bonnechere Manor
Extendicare Laurier Manor (Gloucester)
Extendicare Medex
Hillel Lodge (The Bess and Moe Greenberg Family)
Marianhill Nursing Home

Erie St. Clair LHIN

Lambton Meadowview Villa County Home for Aged
North Lambton Lodge
Sun Parlor Home for Senior Citizens

Hamilton Niagara Haldimand Brant LHIN

Arbour Creek Long-Term Care Centre
Blackadar Continuing Care Centre
Clarion Nursing Home
Deer Park Villa
Douglas H. Rapelje Lodge
Edgewater Gardens Long-Term Care Centre
Gilmore Lodge
Hamilton Continuing Care
Hardy Terrace Long-Term Care Home
Henley House – St. Catharines
Heritage Place
Idlewyld Manor

Continued on next page...

Participating Homes

John Noble Home
Leisureworld Caregiving Centre – Brantford
Linhaven
Meadows of Dorchester
Northland Pointe
Park Lane Terrace
Pine Villa Nursing Home
Shalom Village Nursing Home
St. Joseph's Lifecare Centre
St. Joseph's Villa – Dundas
Tabor Manor
The Village of Wentworth Heights
The Woodlands of Sunset
United Mennonite Home
Upper Canada Lodge

Mississauga Halton LHIN

Erin Mills Lodge Long-Term Care Home
Leisureworld Caregiving Centre – Mississauga
Leisureworld Caregiving Centre – Streetsville
Post Inn Village
Specialty Care Mississauga Road
Tyndall Nursing Home
Villa Forum
Wesburn Manor
Yee Hong Centre – Mississauga

North East LHIN

Extendicare Falconbridge – Sudbury
Finlandia Nursing Home
Leisureworld Caregiving Centre – North Bay

North Simcoe Muskoka LHIN

Stayner Nursing Home
Victoria Village Manor
Woods Park Care Centre

North West LHIN

Bethammi Nursing Home (St. Joseph's Group)
Dawson Court
Geraldton District Hospital: John Owens Evans Residence
Grandview Lodge – Thunder Bay
Hogarth Riverview Manor – Thunder Bay
McCausland Hospital Long-Term Care
Northwood Lodge
Pinecrest Home
Pioneer Ridge Homes for the Aged
Princess Court
Rainycrest Home for the Aged
Roseview Manor
Versa Care Centre – Thunder Bay
Wilson Memorial General Hospital Chronic Care

South East LHIN

Fairmount Home for the Aged
Helen Henderson Nursing Home
Providence Manor/Providence Care

South West LHIN

Brucelea Haven
Lee Manor
McCormick Home

Toronto Central LHIN

Baycrest Centre for Geriatric Care
Cardinal Ambrozic Houses of Providence
Castleview Wychwood Towers
Drs Paul and John Rekai Centre
Fudger House
Garden Court Nursing Home
Kensington Gardens
Lakeshore Lodge
Lakeside Long-Term Care Centre
The O'Neill Centre
True Davidson Acres
Wellesley Central Place
West Park Long-Term Care

Waterloo Wellington LHIN

Elliott Home
Leisureworld Caregiving Centre – Elmira
Parkwood Mennonite Home
Saugeen Valley Nursing Centre (Mount Forest)
The Westmount
Trinity Village Care Centre

Source: ***http://www.residentsfirst.ca/***

APPENDIX Z – Acronyms List

Definition	Acronym
ALC	Alternative Level of Care
BCIPLN	British Columbia Injury Research and Prevention Unit
CAP	Client Assessment Protocol
CBO	Community Based Organization
CCAC	Community Care Access Centres
CFPC	Canadian Falls Prevention Curriculum
CHC	Community Health Centre
COP	Community of Practice
CSS	Community Support Services
DAD	Discharge Abstract Database
ECFAA	Excellent Care for All Act
ED	Emergency Department
EMS	Emergency Medical Services
ESC	Evaluation Sub-Committee
GiiC	Geriatrics Inter-professional and Inter-organizational Collaboration
HCF	Healthy Communities Fund
HSEP	Home Support Exercise Program
HSP	Health Service Provider
LHIN	Local Health Integration Network
LHINC	Local Health Integration Network Collaborative
MAS	Medical Advisory Secretariat
MHA	Mental Health & Addictions
MHPS	Ministry of Health Promotion and Sport
MLAA	Ministry-LHIN Accountability Agreement
MMSS	Medication Management Support Services
MOHLTC	Ministry of Health and Long-Term Care
NACRS	National Ambulatory Care Reporting System
OIPRC	Ontario Injury Prevention Resource Centre
ONF	Ontario Neurotrauma Foundation
OPHS	Ontario Public Health Standards
OSS	Ontario Seniors' Secretariat
OT	Occupational Therapy
PHAC	Public Health Agency of Canada
PHU	Public Health Unit
PSW	Personal Support Worker
PT	Physiotherapy
RAI-HC	Resident Assessment Instrument for Home Care
RGP	Regional Geriatric Program
RNAO	Registered Nurses Associating of Ontario
ROP	Required Organizational Practice
SAGES	Sage
SHRTN	Seniors Health Research Transfer Network
TUG	Timed Up & Go
VON	Victorian Order or Nurses
WHO	World Health Organization

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Ontario
Local Health Integration Network