LIVE STRONGER FOR LONGER

PREVENT FALLS & FRACTURES

Working together to improve outcomes for older people; prevention and rehabilitation

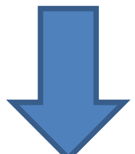
Gerentology Nurses Conference 2017

Meet Muriel

- Independent; loves her kids and grandkids
- Lives in her own home
- Wants to stay that way for as long as possible
- Why its been important to talk about Muriel

Working together- making a difference for Muriel

- Changing demographics
- Fall is an injury & more….
- Evidence @ population level
- Sustainable approach to funding Health & ACC



Common goal

A new way of working for ACC

Falls are the most common cause of serious injury, and occasionally death, in our public hospitals.

The Commission's **reducing harm from falls** programme has introduced a number of simple interventions to help address falls-related harm. This programme works alongside and supports existing programmes in the sector.

Every week in 2010–12, on average, **2 patients fell** and broke their hips in New Zealand hospitals. This rate has now almost halved.

Having a fall can add a month to someone's hospital stay, and is very costly.

ACC is committed to:

- **creating alliances** across key stakeholders to support a population level approach
- making a **contribution** as a partner in the health system
- **building on the previous work** by the Health Quality & Safety Commission and DHBs which focuses on in-hospital falls
- **aligning reporting** with the Ministry's PP23

Cross-agency collaboration

Recognising that most falls occur in the community ACC has supported the expanded focus to preventing community-based falls.

ACC's contribution supports:

- Fracture Liaison Services
- In-home Strength and Balance
- Community Group Strength and Balance

HQSC's ongoing focus:

- Leadership and guidance, including annual April Falls 'campaign' and establishing regional clinical leadership network ***(lead, engage and sustain the gains)***
- Continue to be the 'go-to' for evidence-based resources, such as the 10 Topics ***(maintain the evidence base)***
- Ongoing measurement for improvement – i.e. QSMs and outcome framework (with ACC) ***(measure and monitor)***

What are the key components of the falls and fracture system?

- **Wellness** - **Community Strength & Balance**, Safer Homes, consumer information, support older people to stay well and independent in their own homes.
- **Fracture Liaison Services (FLS)** - coordinator-based, secondary fracture prevention services implemented by health care systems that identify those with or at risk of fragility fractures
- **In-home Strength and Balance programmes**, support older people not able to attend community group-based classes
- **Early supported discharge** - service delivery models that enable flexibility in the place of rehabilitation for older people
- **Integration effort** – enables the ability to build partnerships, pathways and an outcomes framework to support the falls & fracture system

Why does the new approach matter?

Aligned Investment → **Joint outcomes** → **Partner benefits**

DHB $s

ACC $s

- less falls (7163)
- less fractures (2523)
- less hip-fractures (443)
- fewer premature deaths (89)
- independent and well at home
- better quality of life
- active part of their communities

Muriel achieves the outcomes **<u>she</u>** wants

DHB:
- Reduced hospital demand (4,786 bed days)
- Reduced ARC demand (146 less admitted)
- Higher efficiencies

Note: Figures above are very conservative, just based on prevented hip fractures

ACC:
- Less claims cost
- Effective prevention
- Increased value to case management, clients and partners

Figures on this page are national and cumulative across 3 years.

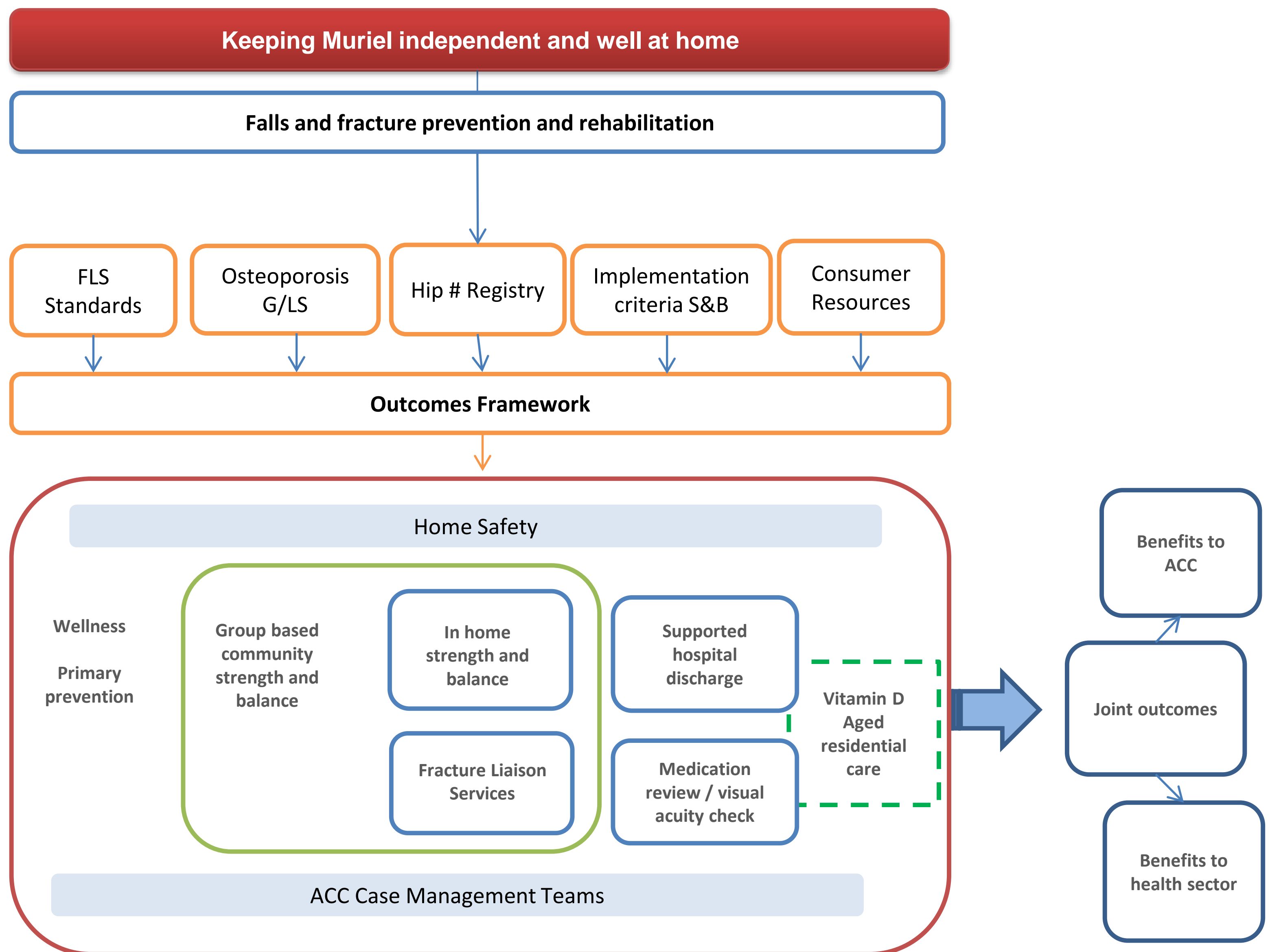
Taking a Population Approach

low risk | medium risk | high risk
83% | 15% | 2%

Needs Based Proactive Care

- 83% - keeping the ‘well old’ well at home
- 15% - identifying and targeting those at risk (<65 if appropriate)
- 2% - modernisation of services to ensure effectiveness – rehab and prevention

Falls and Fracture System Blueprint



OUTCOMES AND BEST PRACTICE FRAMEWORK

1 INDEPENDENT & WELL AT HOME MEASURES

Patient Reported Outcome Measures.

2 FEWER FALL INJURIES MEASURES

Falls 65+ ACC Claims.
Falls 65+ Fracture vs Non Fracture.
Falls 65+ Total/Medical fees/Entitlement.
Ambulance Fall Incidents 65+.

3 FEWER SERIOUS HARM FALLS & FRACTURES MEASURES

Falls Hosp Admissions (Source).
Falls Hosp Admissions (Type).
New ACC entitlement claims – fracture vs non-fracture.
Bisphosphonate on discharge for #NOF.

POSITIVE AGEING

Social services

1 Independent & well at home

Home care support

Supported discharge

Healthy bones

Restorative care

Community nursing

Safer homes

2 Fewer fall injuries

3 Fewer serious harm falls & fractures

4 Improved recovery (hospital & home)

5 Integrated falls & fracture care across the system

BEST PRACTICE FRAMEWORK

Consumer Resources

FLS Standards

Osteoporosis Guidance

Implementation Criteria strength & balance

Implementation Criteria Supported Discharge

Hip Fracture Registry & Clinical care standards

4 IMPROVED RECOVERY (HOSPITAL & HOME) MEASURES

Hospital

Falls Hosp Bed Days (Type).
% #NOF Operated on same or next day.
Falls Hosp ALOS.
Acute readmissions for #NOF.

Home

% of people living in ARC dispensed Vitamin D.
ACC length of claim.
Home care support (ACC/InterRAI).
Entitlement services (ACC clients).

5 INTEGRATED FALLS & FRACTURE CARE ACROSS THE SYSTEM MEASURES

Older people that have received in home strength and balance services.
Older people that have received community group strength and balance services.
Older people seen by Fracture liaison services.

NB: Measures in regular denote indicators currently live. Measures in italics denote indicators under development.

* Work in progress (Draft)

Fracture Liaison Service

- Older people who have sustained a fragility fracture in the past are much more likely to have another fracture – potentially hip.

- The **Fracture Liaison Service** identifies those with or at risk of fragility fractures and:
  - prescribes/recommends bisphosphonates
  - refers to an evidenced based strength and balance programme.

Early Supported Discharge

Evidence shows that hospital is not the best place to rehab older people

ACC is working with **Auckland, Waikato and Canterbury** DHBs to pilot a new funding model for the Non Acute Rehabilitation (NAR) event that enables flexibility in the place of rehabilitation for older people.

In-Home Strength and Balance

- **There is strong evidence that in-home strength and balance and strength programmes such as the OEP can reduce the rate of falls by 32%.**

- Most appropriate for those who have poor strength & balance and are too frail for or have no access to community group-based falls prevention exercise programmes.
- This programme is not suitable for people in rest home or hospital care.

- ACC has partnered with DHBs to support the expansion of in-home strength and balance programmes in their regions.

- A Technical Advisory Group (TAG) was set up by ACC, to provide criteria based on evidenced best practice for an in home strength and balance programme.

Community Group Strength and Balance

- There is evidence that community-based, multi-functional exercise programmes, targeted at improving strength and balance in older people **can reduce the risk of falling by 29%**.
- A population based approach is needed if a significant reduction in falls across the older population can be achieved.
- In practice, this means that many thousands of people across NZ at risk of falling, should participate in effective, evidence-based community group strength and balance classes.

Nine TAG criteria (abbreviated)

1. Improve balance and leg strength to reduce the risk of falling
2. Include baseline and on-going assessment
3. Include exercises that provide individual challenges
4. Balance exercises one third of the total exercises
5. Include minimum of one hour weekly group + 10 weeks home-based exercise
6. Strategy to support on-going regular activity
7. Trained instructors
8. Enrolled through a health professional or self/community referrals
9. Available to people at increased risk of falling

Lead Agencies

- Lead Agency functions are to:
  - increase access to and availability of approved community classes.
  - ensure classes meet and continue to meet the 9 TAG criteria
  - participate in the Local Falls Working Group
  - connect older people with appropriate classes (or back into the pathway)
  - promotion the benefits of community group strength and balance

Service Coverage

To date:

Falls and Fracture system

80% of local health systems

86% of population

To be completed 3DHBs, MidCentral, Waikato (part2)

Community Group Strength and Balance Lead Agency

95% of local health systems

96% of population

To be completed MidCentral

As at 20 July17

Strength and Balance referral criteria

- To determine the likely benefit of strength and balance training ask all people aged 75 years and over (Maori & Pacific Island people 65 years & over) living in the community:
  - ***Have you slipped, tripped or fallen in the past year?***
  - ***Do you have to use your hands to get out of a chair?***
  - ***Are there some activities you have stopped doing because you are afraid you might lose your balance? Do you worry about falling?***

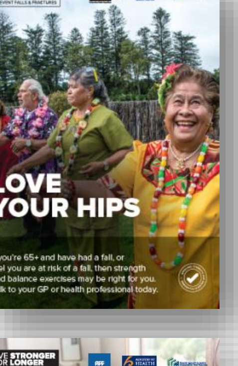
- A positive response to any of these questions identifies strength and balance deficits and indicates this person is likely to benefit from strength and balance exercises.

New Resources

Booklet for Older People

Love Your Hips brochure
(for Muriel)

CS&B Posters



Health Centre Posters

Unifying brand and approval tick

www.livestronger.org.nz

TAG Criteria (available web only)

Other Resources