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

Gerontology 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

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

Joint outcomes:
- 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 she wants

Figures on this page are national and cumulative across 3 years.
Taking a Population Approach

• 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

Keeping Muriel independent and well at home

Falls and fracture prevention and rehabilitation

FLS Standards
Osteoporosis G/LS
Hip # Registry
Implementation criteria S&B
Consumer Resources

Outcomes Framework

Home Safety
Wellness
Primary prevention
Group based community strength and balance
In home strength and balance
Fracture Liaison Services
Supported hospital discharge
Medication review / visual acuity check
Vitamin D Aged residential care

Joint outcomes
Benefits to ACC
Benefits to health sector

ACC Case Management Teams
Osteoporosis G/LS
Hip # Registry
Implementation criteria S&B
Consumer Resources

Wellness
Primary prevention
Group based community strength and balance
In home strength and balance
Fracture Liaison Services
Supported hospital discharge
Medication review / visual acuity check
Vitamin D Aged residential care

Benefits to ACC
Joint outcomes
Benefits to health sector

ACC Case Management Teams
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 July 17
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

CS&B Posters

Health Centre Posters

TAG Criteria (available web only)

www.livestronger.org.nz

Unifying brand and approval tick

Booklet for Older People

Love Your Hips brochure
(for Muriel)
Other Resources