Falls Prevention & Management Stakeholders Meeting

June 19th 2015
Kingston Frontenac Lennox & Addington Public Health
221 Portsmouth Ave., Kingston, Ontario
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Executive Summary

Rates of falls in South East (SE) Ontario are significant. In 2013, the incidence of fall-related emergency department visits for individuals 65 years or older was 16% higher in the SE Local Health Integration Network (LHIN) region compared to the provincial rate. Preventing falls as well as lessening the impact of falls would contribute to older adults leading healthy independent lives, and reduce the human and financial resources and pressures on the health care system.

In 2015, collaboration formed between a number of local and regional stakeholders in SE Ontario to create a Regional Integrated Falls Prevention Strategy Project Team. These partners formed a working group to organize a regional stakeholder meeting attempting to bring together members from across all sectors of elderly care and who are involved in falls prevention and management within our region. Seventy-eight participants from forty organizations were present for the meeting in June 2015 to discuss how to bring about change to the issue of falls. The need for a falls prevention and management strategy that integrates a broad range of stakeholders and health service providers across the region was strongly endorsed.

The linkages between services and organizations in our region were discussed in terms of the issues, gaps, positive and negative experiences of navigating our system, and possible solutions for the system’s improvement. Results from these discussions point to how our system of falls prevention and management could be improved to better serve our older adults. Participating stakeholders’ consensus has been summarized in the following report.

Themes from Discussions:

- Falls prevention and management needs to be seen as a priority. The Government of Ontario, the Ministry of Health and Long Term Care, and the SE LHIN need to provide continuous endorsement in order to legitimize the issue of falls. Advocacy is a vital component for this strategy.

- Local leaders are needed to champion the initiative. Regional stakeholders have come forward and shown commitment and dedication in advancing this strategy. This group must maintain a positive working relationship with all stakeholders involved and support their unique needs. A survey of existing exercise, falls prevention, and management services has been developed to inventory all programs and services within SE Ontario.

- Front line health service providers require:
  - easy access to consistent education
  - a source of updated information on best practices
  - knowledge of what services and initiatives are available within our region
  - more opportunities to collaborate, inform, and learn from one another
improving the ease of system navigation is needed to transform the current system into a person-centered system.

- Consistent language and definitions are important for common understanding. Statistical reporting should have consistent definitions and reporting criteria so that organizations can be compared fairly. Organizational boards ask that funders choose outcome measures that are easily obtained, and provide clear benchmarks when it comes to funding requirements.

- The relationship between organizations, health service providers, and their funders needs to be improved upon. Organizations and health service providers with a united mandate to reduce falls in older adults and others at risk should collaborate in their advocacy to funders; this can improve and strengthen partnerships between these three key stakeholders. A successful falls prevention strategy should not solely depend on a single funded initiative; rather in the strength of organizational collaboration to improve the quality of services provided.

- Regional Integrated Falls Prevention strategies exist in other jurisdictions in Ontario and around the world. Existing tools and resources should be compiled and made easily available and user-friendly for all health service providers. Future efforts should therefore be focused on tailoring these existing strategies to suit the needs of SE Ontario.

Advice for the Project Team and Next Steps

The following actions are recommended to the Project Team in order to advance the Regional Integrated Falls Prevention and Management strategy for Ontario’s SE LHIN region:

- Consolidate the current project team with expanded membership to include older adults and other key stakeholders such as primary care staff and first responders.

- Keep all stakeholders across the continuum involved and informed about the future proceedings through direct communication such as a newsletter.

- Actively advocate and promote the need for an integrated falls prevention and management strategy amongst the public and regional stakeholders.

- Conduct a comprehensive environmental scan to accurately document existing services and potential gaps of falls prevention and management services in the SE LHIN region.

- Ratify the project team’s mandate and resources for at least a three-year plan.

- Identify regional opportunities for collaboration and partnerships that are most likely to result in early success.

- Actively promote the falls prevention and management strategies within other existing strategic activities (e.g. Health Links, age friendly communities, etc.)
Background: History of the Working Group

Early in 2014, the SE LHIN and three local public health units had a collaborative portfolio dedicated to exercise and falls prevention. Simultaneous conversations on the topic of falls prevention sparked between the CSAH, Queen’s Department of Family Medicine, the SHKN, ONF, and KFL&A public health resulting in a joint application for a provincial IMPACT award that same year. The anticipated project prescribed implementing a Regional Integrated Falls Prevention Strategy for South East Ontario. The process of developing this application led to a number of conversations identifying gaps in services, systems and knowledge with a wider group of stakeholders (see Figure 1A). It became clear that there is a need for a strategy to improve our system’s capacity to address falls.

Although the application for the IMPACT award was unsuccessful in receiving funding, its success was ultimately in the coming together of key stakeholders to form a working group dedicated to falls prevention in older adults and to advancing the initiative. A full list of the working group members can be found in Appendix A. The working group regularly connected in person, by email and teleconference. Existing falls prevention frameworks and toolkits from Canada and around the world were reviewed and guided the group’s proceedings. It was decided that the first step in the project was to hold a large stakeholder group meeting bringing together all parties involved in falls prevention and management in the region in order to:

1) explore the current status of falls
2) identify needs
3) determine how the project should move forward

A Master of Public Health Student from Queen’s University was recruited by the CSAH to complete a practicum placement. The student would assist with the planning of the stakeholder meeting, co-authoring a meeting report, and conduct an environmental scan of existing falls prevention and management service in SE Ontario.

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**Figure 1A. Acronyms of stakeholders explained**

- **CSAH**: Center for Studies in Aging and Health
- **CoP**: Community of Practice
- **CPHC**: Community and Primary Health Care
- **HPE**: Hastings Prince Edward (Public Health)
- **KFL&A**: Kingston, Frontenac and Lennox & Addington (Public Health)
- **LGL**: Leeds, Grenville and Lanark (Public Health)
- **ONF**: Ontario Neurotrauma Foundation
- **SE CCAC**: South East Community Care Access Center
- **SE LHIN**: South East Local Health Integration Network
- **SHKN**: Seniors Health Knowledge Network
- **VON**: Victorian Order of Nurses
Regional Falls Prevention and Management Stakeholder Meeting

Meeting Preparation and Agenda

A half-day meeting was scheduled for the 19th of June, 2015 at the KFL&A Public Health Unit in Kingston, Ontario. Dianne LeBreton of clearshift inc. was engaged to design the event with input and feedback from the working group, and to facilitate the day’s discussion. The day’s agenda was drafted by the facilitator and amended by the working group members (see Appendix B). The meeting was configured to inform the working group of:

1) The identity of stakeholders in the region and those with an active interest in a more integrated and regional response to the issue
2) The current profile of falls prevention and management among organizations in our current system
3) The environmental factors that are influencing choices, performance, and results
4) The appetite for change among these stakeholders, beginning with an interest in developing closer ties among those present and organizations represented, and determining the willingness to continue in to the next stage of project team activity.

Figure 1B. A timeline of the working group’s history
The participants, for their part, would come to better appreciate the need and requirements for improving their own, and the region’s results in preventing and managing falls. They would:

1) Share information, experiences and insights about the conditions in which they work
2) Hear the experiences of others engaged in these activities elsewhere in the region
3) Offer their suggestions for building and coordinating the region’s capacity.

**Guiding Model: Queensland Stay on your Feet ®**
The Queensland Stay on Your Feet (SOYF) ® health continuum is a comprehensive model that illustrates the whole lived-experience of an older person moving through community settings, health status and health service interactions (Queensland Health statewide Falls Injury Prevention Collaborative Cross Continuum Working Group, 2007). Recognizing individual placement on the continuum is a helpful exercise to identify one’s role in a falls prevention and management strategy. The Queensland SOYF continuum was adapted to the care system in SE Ontario for use at the meeting (see Appendix C). It was displayed as a large banner at the meeting, and was a useful tool during meeting activities.

**Invitees and Participants**
A distribution list of stakeholder invitees was formed and invitations were sent to that distribution list until the week of the event. These stakeholders were representative of both the SE LHIN geography, and the various professions involved in the prevention and management of falls. The Queensland SOYF health continuum served as a guide to ensure breadth in our professional coverage across the continuum of care. Particular effort was made to achieve representation from primary and acute care providers (i.e., primary care physicians, health care service providers in hospitals and emergency service providers) as they were the most difficult to contact and recruit.

Over 100 organizations within the SE LHIN region were invited to participate. Invitees were contacted by email and telephone. Upon initial contact, the meeting goals were explained and the meeting format was described as highly discussion-based and participatory. We opened the invitation to anyone who had an interest in falls within the invitees’ organization in order to achieve an appropriate representative from each organization. A preparatory package was sent to all registered participants to introduce the facilitator and presenters, the meeting goals, the key question for the meeting, the agenda, the adapted SOYF continuum model, information regarding the venue, and included a reminder to bring networking resources to the meeting.

**Video Recording**
Although participation and networking was highlighted as a large part of the day’s event, it was decided that the event would be video recorded and made available online along with the presentation materials to accommodate those unable to attend. It is anticipated that these materials will maintain stakeholder engagement in the subject and will encourage participation in future forums.
The Meeting
Seventy-eight participants from over forty different organizations participated in the half-day meeting. Upon registration, participants were asked to place their name on the printed banner of the adapted continuum of care in an area that best represented their professional interests (Figure 2). Figure 3 describes the percentage of meeting participants that placed themselves at various locations on the continuum. Some participants placed themselves in a specific sector on the continuum, while others selected places between sectors of the continuum, and a number placed themselves across the entire continuum.

Figure 2. Adapted Queensland SOYF Continuum of Care, with participant representation.
After placing their names on the continuum, participants were sorted into three districts based on the geography they serve and were assigned seating upon arrival. Two tables were occupied by participants from the region of Leeds, Grenville and Lanark, five tables were occupied for participants from the Kingston, Frontenac, Lennox and Addington region, and four tables were occupied for participants from the Hastings and Prince Edward Counties. Participants serving more than one district were distributed and seated as evenly as possible throughout the room. Each table had an electronic note taker, one member from the working group, and five to seven formal participants. Electronic note takers were not formal participants, but were welcome to share their input during discussions; some were student volunteers from the Master of Public Health program at Queen’s University and others were team members from the CSAH. Please see Appendix D for a full list of meeting participants. Halfway through the meeting, a room reset had attendees move to tables based on where they had placed themselves on the continuum. This reset served to stimulate discussion with professional colleagues from the same sector.

Following introductory remarks, two working group members, Rhonda Lovell and Megan Jaquith presented information on key concepts and regional falls data. This led to table discussions of positive and negative aspects of the current falls prevention and management system in the region, and a full group discussion on the aspects deserving greater exploration. Another working group member, Dr. John Puxty, presented information on best practices and existing integrated falls prevention initiatives in Ontario and elsewhere. Informed of these possibilities, participants discussed the requirements for achieving better results locally, and the general consensus was
that a focus on improving organizational ties in the region was warranted. A session on brainstorming how to improve these ties led to a final conversation allowing participants to offer their advice to the working group for moving forward on the development of an integrated regional falls prevention and management strategy. The meeting ended with an overwhelming endorsement of the working group’s continued work.

Presentations:

“Data and Key Concepts” By Megan Jaquith and Rhonda Lovell

This presentation has been summarized in the key points below. Please visit http://sagelink.ca/falls_prevention_management_stakeholder_meeting_jun_19_2015 to view this presentation in full.

- Operating definition of a fall: “unintentionally coming to rest on the ground floor or other lower level with or without an injury”\(^1\). This definition was chosen for its inclusiveness of falls that may not result in injury.
- Rates of falls in the SE LHIN are significant. In 2013, the incidence of fall-related emergency department visits for individuals 65 years or older was 16% higher in SE Ontario compared to the provincial rate\(^2\). Approximately 14,000 per 100,000 older adults aged 65 and older were hospitalized due to falls in 2013\(^3\).
- Compared to other causes (i.e., transportation incidents, suicide, self-harm, and violence), fall-related injury has resulted in higher death rates, higher emergency department visits and hospitalizations, higher rates of permanent disability, and higher total costs and costs per capita\(^4\).
- Many falls are not captured or reported. Some are treated in acute care clinics, by primary care practitioners, through emergency response, or at home. Fallers can reject assistance if they feel they don’t need help at the time.
- It is clear that the underlying risk factors for falls are not being addressed. It is important to consider the whole person and the context in which they are living when thinking about falls prevention. Health promotion and prevention can happen at all levels of care and at all points of contact with the health care system.
- This meeting is bringing everyone together to investigate a system level approach, which requires strengthening system capacity, coordination, and communication.

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\(^2\) Ambulatory Emergency External Cause 2003-2013, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: April 10\(^{th}\), 2015
\(^3\) Population Estimates 2003-2013, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: April 10\(^{th}\), 2015
“Some best practices in Falls Prevention and Management” By Dr. John Puxty

Dr. John Puxty’s presentation gave a review of the current literature, existing frameworks, and a model falls prevention strategy. This presentation has been summarized in the key points below. Please visit [http://sagelink.ca/falls_prevention_management_stakeholder_meeting_jun_19_2015](http://sagelink.ca/falls_prevention_management_stakeholder_meeting_jun_19_2015) to view this presentation in full.

“The cost of a single hip fracture ranges between $15,000- $38,000. An individual has a 1 in 3 chance of returning to their pre-fall full mobility state. An individual has an equal chance of dying.”

- Three Cochrane reviews investigating various falls intervention strategies being implemented in different settings were summarized[^5]^[^6]^[^7]:
  - Findings showed that different types of interventions in different community settings were either successful or unsuccessful in decreasing the rate, risk, and number of falls experienced by older adults[^5].
  - Education alone was not found to be effective[^6] and multi-disciplinary multifactorial strategies were most likely to see a reduction in both rate and risk of falls in multiple settings[^7].
- Two standout models and frameworks have been developed on the topic of falls prevention and management.
  - The *Queensland SOYF* model was developed around the idea that falls prevention strategies should meet the needs of a continuum of older adults: from the healthy well individual, to those beginning to have challenges, to those who start seeking medical care, to the frail elderly (Queensland Health statewide Falls Injury Prevention Collaborative Cross Continuum Working Group, 2007).
  - The *2011 Integrated Provincial Falls Prevention Framework & Toolkit* highlighted the importance of an integrated approach to falls prevention in Ontario with provincial infrastructure. The framework was recommended to each LHIN in 2011.


Today 50% of the LHINs have an implemented integrated falls prevention strategy and 50% are in progress. The LHINs also have access to three statistics: falls related admissions from the emergency department, number of falls-related emergency department visits, and repeated emergency department visits for falls in the past year.

- A profile of our neighboring Champlain LHIN’s integrated falls prevention strategy was presented due to its novel approach (RGAC Falls Prevention Working Group Report, 2015). Here are some highlights:
  - Local public health units, the Regional Geriatric Program of Eastern Ontario, and the Champlain LHIN formed a steering committee and made a commitment for an integrated strategy.
  - A needs assessment was conducted to identify the regions assets and gaps. The committee built a logic model, developed, tested, and piloted an algorithm for primary care providers and a self-assessment tool.
  - They are currently developing a decision tree that will help older adults decide what types of exercise programs to engage in, allowing them to take control of their own decisions.

Meeting Results

Discussion questions were formulated around the day’s anchor question in order to better explore the linkages between services and organizations, analyze the positive and negative experiences of navigating our system, identify issues and gaps, and outline possible solutions. Electronic note takers summarized the discussions at each of their tables. The notes were analyzed, common themes and topics of discussion were extracted and described below. Please be advised that statements reflect the perspectives of some meeting participants, and may not have received the full meeting group’s consensus unless explicitly stated.
Themes from Discussions:

The Definition of a “fall”
The working definition of a fall presented during the first presentation was of considerable debate. Concerns were voiced that near falls and falls against objects (doors and furniture) contribute to injury and increased risk of falling, however are often not assessed. Suggestions to include “remote and toward the ground”, and “near falls or trips” were expressed. Common definitions for high, medium and low risk fallers were also recommended. The fear of falling was also mentioned as an important risk factor. The need for a consistent, all-encompassing definition to be used across our region for clarity amongst those who fall, organizations and health service providers will assist in understanding the nature of the problem, and in the consistency of falls reporting.

Target Population and Inclusivity
Older adults are often the central focus of falls prevention and management initiatives- however, there are some sub-populations of fallers (e.g., individuals with dementia, multiple sclerosis, and adults under the age of 65 with poly-morbidities), who do not feel they fit into these initiatives. Strong advocacy on behalf of these sub-groups was presented at the meeting, promoting their inclusion in an integrated regional falls prevention and management strategy. These sub-groups may not be considered older adults, are at risk or at an increased risk of falling, and therefore may not be given access into programming that targets older adults. Concerns were raised regarding selection criteria for programs to include these sub-groups of fallers. It became clear that the term ‘older adults’ was no longer adequate. Participants wanted the language to be inclusive of older adults, sub-groups of fallers, and both individual and population level approaches. However, funding opportunities for initiatives involving older adults are more widespread. Therefore, the term ‘older adults and others at risk’ was agreed upon for representing the target audience moving forward, as it is more inclusive and allows for consideration of multiple funding opportunities.

An Integrated Strategy
Just as the need for common language was expressed, the need for an integrated strategy for dealing with falls is also necessary. Participants voted in agreement that the current system is biased towards organizations, but not easy for either organizations or the public to navigate. However, there was unanimity in the decision that the system should to be biased
towards the person. A health care system with a person-centered focus must make every point of access appropriate for individuals to receive the care they are seeking.

“Every door should be the right door”

Common clinical tools for all practitioners are seen as desirable, albeit not supported by the literature. We need to recognize and address that organizations cater to different people across the continuum care, and have different needs. There is no perfect tool just as there is no perfect intervention for an entire population. **Evidence-based tools and interventions have already been developed and are available; they only need to be identified and adapted to suit our needs.** Many of these interventions are relatively easy to implement such as physicians prescribing exercise, using pedometers to track progress and set goals, and join walking and pole walking groups that develop a sense of community. A framework that compliments these tools and is adaptable to the individual needs of practitioners and persons has been recommended by multiple falls prevention frameworks and toolkits. An integrated strategy should also include common definitions and data recording outcomes across the continuum.

**Communication and Collaboration**

When asked what was energizing and draining about working with other organizations, ‘networking’, ‘collaborating’, and ‘sharing knowledge, resources, and data’ were listed as common energizers, and lack thereof was listed as drainers. **Consistent and easy access to education and information sharing among practitioners was mentioned multiple times throughout the day,** and was associated with events such as this meeting. Having a central place for knowledge distribution of what’s available will help with the dissemination and sharing of information. This can reduce duplication in the field and improve efficiency. Knowledge of who to communicate with and who is responsible for each role across the continuum of care will improve the connections between health service providers in our system. Knowledge of where individuals are referred to, services provided and follow-up was noted as desirable. All of these features can create an interagency network where appropriate communication and collaboration is achieved among health practitioners and across the continuum of care, resulting in an integrated system.

**Technology**

Learning from others and using innovative technology to better integrate our health care system is warranted. Some health care providers are still using paper records. **There is a need for Electronic Medical Records (EMR), which will allow for better integration among health service providers.** This technology exists, but it is not being widely used in health care because of privacy and confidentiality regulations. Some participants noted that, in the case of health care,
we want to achieve person-centered care, but we are hesitant to give individuals control over their own health care.

“The yellow card for vaccinations is still being asked for. I don’t have that, but I do have an iPhone.”

Participants gave examples of systems such as Rourke Baby Records that could be applied to older adults. This standardized evidence-based approach could be integrated into the EMR to identify high-risk fallers in order to refer them to appropriate care. These systems are implemented in Long Term Care (LTC), but not in primary care. Similarly, technology should be used to support exercise while being considerate of barriers that may exist because of the generational differences regarding comfort with technology.

Public Education and Awareness

Including the individual’s perspective and lived-experiences in the planning and evaluation of an integrated falls prevention and management plan encompasses the idea of person-centered care. A common, publically-accessible assessment tool, such as the ‘Staying Independent Checklist’ adapted by the Champlain LHIN, promotes self-assessment in the community, gives individuals’ active participation in their own health care, and provides the opportunity to have a conversation with their family physician to help them understand their risks of falls. It also allows for the disclosure of a falls prevention strategy in order to target social issues such as stigmatization and ageism. A public health campaign may be warranted to build public education and awareness. Falls are not an intuitive concern to everyone; however they affect a wide segment of the population including those in mid-adulthood (i.e., 35 to 64 years old), older adults, caregivers, and health service providers. Like other important public health campaigns, there needs to be considerable effort invested as these campaigns to ensure success (i.e., beyond just flyers and posters).

Governing Body

The need for a formal collaborative body of local stakeholders to champion a falls prevention and management strategy was expressed throughout the meeting’s proceedings. Many other falls prevention frameworks and toolkits recommend that an agency or committee group lead the initiative. An environmental scan of the 14 LHINs has shown that of the seven LHINs with an implemented strategy, six of them have a position or committee dedicated to the initiative.
Community Building

To better integrate our services, the relationship between communities and health care (e.g., acute care in hospitals, LTC, primary care practitioners, etc.) needs to be strengthened. Community building to promote falls prevention and management is necessary for a widespread audience. **Using an age-friendly lens is necessary to consider all needs and requirements of falls prevention.** Many risk factors for falls extend beyond our health care services and into the social determinants of health. Some participants expressed that physicians may not perceive falls prevention and management as their responsibility, thereby affecting health services and social support networks. The physical environment of facilities using restraints and assistive devices for older adults with disabilities because they are high risk fallers was discussed. Although some of these tools may reduce the risk of falls, they can also lead to the deterioration of health. LTC homes are integral to an age-friendly community, and therefore that culture needs to adapt that lens as well.

Changing our Ties & Creating Buy-In

**“We need to make falls prevention sexy!”**

Participants were asked what will be required to gain approvals and buy-in from their organizations in order to change the ties among our regional organizations. Comments were compared as a group, and the commonalities are outlined below. **The identification of falls as a priority was expressed as a requirement across all sectors for buy-in.**

Direct Health Care Providers

Consultation with health care providers is important for buy-in. These providers work directly with individuals and ultimately determine how strategies are implemented. Their direction is often disseminated from organizational boards, funding partners, or leading clinicians. In terms of primary care, the growing

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**The Social Determinants of Health**

- Income and Social Status
- Social Support Networks
- Education and Literacy
- Employment/ Working Conditions
- Social Environment
- Physical Environment
- Personal Health Practices and Coping Skills
- Healthy Child Development
- Biology and Genetic Endowment
- Health Services
- Gender
- Culture

The Public Health Agency of Canada, 2011
numbers of adults over the age of 55 will soon require all clinicians to be sensitive to the needs of an aging population. Current and consistent education will be required to prepare the system for this demographic change. A united mandate at all interfaces of care will assist in assuring buy-in from all parties. In asking staff to make falls prevention a priority, we should also be allowing staff to operate at their full scope of practice.

The Public
Educating the public on the severity of falls outcomes and the cost to the health care system will provide them with the understanding of the importance of the situation. Having people understand the risks and consequences of falls will enhance the uptake of preventative programs. To achieve public buy-in, the system needs to have a person-centered approach.

“If you plan for older people, you plan for everybody.”

Funding and Data Collection
Some health care leaders were present for the meeting’s discussion; these questions were directly addressed to them regarding what would be required to achieve buy-in to an integrated falls prevention strategy. Many mentioned that their funders mandate the direction of some of their organizational efforts. Organizations recognized the need for a business or strategic plan with a sustainability component in order to achieve buy-in from their funders; funders in turn seek accountability in the form of program outcome measures from organizations (see Figure 1). Many organizations reported receiving funding from the SE LHIN, and gave the following suggestions:

- Funding should be long term, as many pilot projects showing promise have not been continued. Changes in leadership impacts funding over the long term and this fact should be kept in consideration.
- Benchmarks for improvement should be clear, straightforward, and easily obtained.
- Surveys and questionnaires evaluating programs should not be lengthy, and should be easy to complete.

Comments around the methodology of funding were also mentioned. Concerns were expressed regarding the measures used to determine the need for funding, whether they were appropriate, and whether the data collected provided an accurate representation of the population’s need.
Newer programs showing small but meaningful outcomes require time to fully demonstrate their benefits and deserve further consideration before being discontinued prematurely.

Going Forward: Advice for the Project Team

As the meeting drew to a close, a final request for advice to the future project team gave participants the opportunity to voice their opinions and mention issues that were not highlighted during the full group discussion. A summary of these recommendations is below:

- **Keep the experiences of the person as the anchor.** We need to remind ourselves why we are working so hard for this initiative. The project’s mandate should be related to not just a reduction in the incidence of falls, or reducing costs to the health care system, but also improving the lives of individuals and the staff that we work with. As providers of health and other services, the system we design should be easiest for the consumer to navigate. Therefore, we need to consult the individuals we work with and keep their needs driving our actions.

- **Maintain all-inclusive communication.** Professional representation was portrayed by the adapted Queensland SOYF continuum of care model. There was a lack in
representation from acute care health professionals (e.g., emergency responders, emergency department physicians, and other staff.) Therefore, when reading this report, it must be recognized that not all stakeholders were present for these conversations. To move this initiative forward, strong efforts must be made to engage this section of the continuum in order to gain their input, as they play a key role in preventing falls and managing the consequences of falls. Keeping all stakeholders across the continuum involved and informed about the future proceedings is essential for effective communication.

- **Don’t reinvent the wheel.** An environmental scan is recommended to see what resources and services are already available and what best practices exist. Existing resources need to be compiled for use and made easily accessible for all health practitioners. If you are going to create new tools or resources, ensure they are user-friendly. Technology is a powerful resource that should be leveraged in health care. Privacy and confidentiality should not be viewed as a barrier, but instead as an important right that encourages respect of autonomy.

- **Success is not solely based on outcome measures,** but is also based on service provider or practitioner education and learning experiences. Creating opportunities for collaboration and networking among staff improves interagency connectedness and, ultimately system capacity. These opportunities should be easily accessible and encourage teaching and learning from each other. These actions may not result in immediate reductions of target benchmarks, but should be recognized by funders and organizational boards as important accomplishments with long term benefit.

- **Be cognizant of time.** Implementing and imbedding evidence-based interventions into standard practice is a long and difficult process. System-based changes such as the goals of this strategy are a major undertaking, and therefore this initiative should be designed with a sustainability plan in mind. Sustainability should be addressed and planned for when creating a strategic plan for this initiative.

- **Make it a strategic issue.** The Government of Ontario, the Ministry of Health and Long Term Care, and key stakeholders in the SE Ontario region need to support this initiative in order to legitimize the issue. The SE LHIN has already mandated a regional approach to falls prevention in its *Integrated Health Services Plan 2013-2016*. The fact that funding changes often occur when leadership changes should reaffirm the need to advocate for continued funding as a component of the strategy.

- **Have an age-friendly lens.** Falls is not only a health care issue; the social determinants of health must be considered and other relevant professionals should be invited to the
conversation. When trying to integrate services, geography can act as a barrier to accessing services, and the needs of rural communities can differ dramatically from urban ones. Ensure there is evidence of readiness in both geographies. Looking at the built environment and working with urban and rural planners will help to address the idea of prevention more broadly.

In order to maintain engagement and interest from such a large stakeholder group, a sign-up sheet was distributed for participants to sign up to receive information on the working group’s activities, or to express interest in being a part of the working group itself. Activities are currently underway to once again bring together the working group and invite interested stakeholders to participate, and to decide the future steps of this project. A survey of exercise, falls prevention, and management services in SE Ontario is being conducted in order to create an inventory of existing services and to identify service gaps. Once a formal steering committee has been re-engaged, the forging of a formal structure for this initiative will be constructed in order to proceed with the strategies suggested in this report.

Meeting Assessment

All meeting participants were asked to complete an assessment of the Falls Prevention and Management Stakeholder meeting. A copy of this assessment can be seen in Appendix E, followed by a summary of the assessment results in Appendix F. One assessment form had positive responses to the open ended questions, but contradicting negative rankings on the Likert scale. Therefore, rankings for the Likert scale for this particular assessment was recorded as invalid. Overall, results showed that participants highly enjoyed this discussion-based style of meeting and the use of a facilitator. Some participants would have liked more information on the current and successful LHIN fall prevention strategies to have been presented. Many of the comments in the open ended questions of the assessment related back to themes discussed in the meeting, indicating that participants were engaged and left the meeting with knowledge and new perspectives.

Next Steps

The following actions are recommended in order to advance the Regional Integrated Falls Prevention and Management strategy for Ontario’s SE LHIN region:

- Consolidate the current project team with expanded membership to include older adults and other key stakeholders such as primary care staff and first responders.
- Keep all stakeholders across the continuum involved and informed about the future proceedings through direct communication such as a newsletter.
- Actively advocate and promote the need for an integrated falls prevention and management strategy amongst the public and regional stakeholders.
• Conduct a comprehensive environmental scan to accurately document existing services and potential gaps of falls prevention and management services in the SE LHIN region.
• Ratify the project team’s mandate and resources for at least a three-year plan.
• Identify regional opportunities for collaboration and partnerships that are most likely to result in early success.
• Actively promote the falls prevention and management strategies within other existing strategic activities (e.g. Health Links, age friendly communities, etc.)
Appendix A. List of Working Group Members

The Center for Studies in Aging and Health at Providence Care

Mariel Ang, Master of Public Health Student at Queen’s University
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Julia Miller, Secretary
Dr. John Puxty, Co-Director

South East Community Care Access Center

Joanne Billing, Senior Director of Client Services
Jennifer Loshaw, Director of Client Services

Hastings Prince Edward Public Health Unit

Sheryl Farrar, Manager Injury Prevention
Carol Goodall, Public Health Nurse

Kingston, Frontenac, Lennox and Addington Public Health Unit

Rhonda Lovell, Public Health Nurse
Daphne Mayer, Research Associate
Kieran Moore, Associate Medical Officer of Health
Nancy VanStone, Research Associate, Knowledge Management

Leeds, Grenville & Lanark Health Unit

Jennifer Labelle, Public Health Nurse
Debora Steele, Psychogeriatric Research Consultant LLG
Ontario Neutrauma Foundation
Hélène Gagné, Program Director, Prevention

South East Local Health Integration Network

Megan Jaquith, Quality Improvement and Implementation Facilitator

Victorian Order of Nurses

Brenda Adams, Care and Service Manager

Community & Primary Health Care

Patti Lennox, Manager, Caregiver Support & Community Programs
## Appendix B. Meeting Agenda (abbreviated)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00am</td>
<td>1. welcome and orientation</td>
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<tr>
<td></td>
<td>Who is here. What we are to do. What does success will look like.</td>
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<tr>
<td>9:20am</td>
<td>2. initiating the dialogue</td>
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<tr>
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<td>Presentation of key terms, concepts and data followed by discussion of the system for falls prevention and management among older adults in our region</td>
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<tr>
<td>10:00am</td>
<td>3. break</td>
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<tr>
<td>10:10am</td>
<td>4. learning from the best</td>
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<tr>
<td></td>
<td>Presentation of recognized successes in this domain followed by discussions of what we wish to draw from them</td>
</tr>
<tr>
<td>11:00am</td>
<td>5. break</td>
</tr>
<tr>
<td>11:10am</td>
<td>6. transforming for the better</td>
</tr>
<tr>
<td></td>
<td>Brainstorming of ideas for improving the ties between our organizations in order to prevent and better manage more falls among older adults in our region</td>
</tr>
<tr>
<td>12:00pm</td>
<td>7. break</td>
</tr>
<tr>
<td>12:10pm</td>
<td>8. organizing the follow-through</td>
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<tr>
<td></td>
<td>Generation of advice to the meeting hosts with regard to the continuation of efforts in this matter, and determination of the group’s will in relation to such work</td>
</tr>
<tr>
<td>12:45pm</td>
<td>9. big finish</td>
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<tr>
<td></td>
<td>Last words on who will do what as a consequence of today’s discussion</td>
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<tr>
<td>1:00pm</td>
<td>10. meeting close</td>
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Appendix C. Adapted Queensland SOYF Health Continuum

Falls Prevention Management Continuum

- Healthy Active Aging [low risk]
  - Untargeted Interventions
    - Supporting healthy, active ageing for persons in the community

- Becoming Unsteady [at risk]
  - Targeted and Untargeted Interventions
    - Primary care, home & community services

- Increased Risk FALING
  - Targeted Supportive Interventions
    - Prevent more or serious falls, may be admitted to hospital or home with services

- Vulnerable [ongoing risk]
  - Targeted Risk Management Interventions
    - Falls programs, keep mobile to prevent excessive frailty. May be in residential or LTCH, possible discharge home

- Frail [high risk]
  - Targeted Protective Interventions
    - Post hospital rehab, residential or LTCH

Adapted from the Queensland Stay on Your Feet Model on Falls prevention in older people across the health continuum.
Appendix D. List of Regional Falls Prevention and Management Stakeholder Meeting Participants

Hastings Prince Edward:

Nicole Bobbette, OT, Queen’s FHT  
Rebecca Briscoe, Nurse Supervisor, Paramed Belleville  
Erin Chapman, Manager Rehab Therapies, Brockville General Hospital  
Mallory Freeburn, Director of Nursing, Hastings Manor  
Val Myles Gill, RCC Manager, Community Care for Central Hastings  
Cindy Kirkpatrick, Injury Prevention Program, HPE Health Unit  
Kathy Lee, RAI Coordinator, Hastings Centennial Manor  
Stephanie Lynch, Pharmacist, Queen’s FHT Belleville  
Debbie Manlow, The Prince Edward County Community Care for Seniors  
Kim McCoy, Director of Care, Hallowell House  
Wendy Sonneveld, Community Health Nurse, Mohawks Bay of Quinte  
Cathy Pearson, Executive Director, North Hastings FHT  
Karen Tiapale, OT, Chair for Falls Prevention Committee at Quinte Rehab  
Christine Trieu, Pharmacy Student, University of Waterloo  
Kerri-Anne Wilson, Director, Gateway CHC

Kingston, Frontenac and Lennox & Addington:

Alyssa Bedard, MPH Student at Queen’s University  
Rosemary Brander, PT, Senior Researcher and Program Evaluator, CSAH  
Angela Burns, MPH Student at Queen’s University  
Bernadine Cowperthwatie, Advanced Practice Nurse, Kingston General Hospital  
Phileen Dickinson, Web Projects and Instructional Design Lead, CSAH  
Catherine Donnelley, Associate Professor, School of Rehab Therapies, Queen’s University  
Lisa Ellison, MPH Student at Queen’s University  
Chris English, PSW, L&A SOS Board  
Marcia Finlayson, PhD, OT, Vice Dean of Health Sciences, Queen’s University  
Linda Galarneau, RN, St Mary’s of the Lake Hospital  
Colleen Grady, Executive Director, Loyalist FHT  
Patti Harvey, Program Manager, St Mary’s of the Lake  
Michelle Kenny, Client Services Supervisor, CanCare Health Services  
Joan King, RN, Loyalist FHT  
Cheryl Knott, NP, Providence Care
Jyoti Kotecha, Assistant Director, Queen’s Center for Studies in Primary Care
Mary Martin, Research Associate, Queen’s Center for studies in Primary Care
Callin Mulvihill, MPH Student at Queen’s University
Pamela Nicholson, Manager of Client Services, SE CCAC
Debbie O’Grady, Physical Activity Specialist for Falls Prevention, KFLA Public Health
Denise Owsianicki, Knowledge Broker, CSAH
Kasthuri Paramalingam, MPH Student at Queen’s University
Susan Peters, Nurse Practitioner, Lakeland FHT
Ayesha Ratnayake, Knowledge Broker, CSAH
Lorraine Ross, RPN, South Frontenac Community Health Services Corp.
Naythra Thevathasan, MPH Student at Queen’s University
Erin Thompson, OT, Ongwanada
Els Vreeken, Volunteer
Sarah Webster, Knowledge Broker, CSAH
Shirley Wildenbeest, Program Manager, Maple FHT
Ashley Williams, OT, Sharbot Lake FHT

Leeds, Grenville & Lanark:

Shelley Bender, Director of Care, Carveth Care Center
Sabrina Charlton, Lennox and Addington Seniors Outreach Services
Lindsay Hyde, OT, Upper Canada FHT
Paula Lewis, Assistant Director of Care, Carveth Care Center
Bev Markell, Administrative Coordinator, Upper Canada FHT
Wendy Powell, Telemedicine Coordinator, Rideau Community Health Services
Kim Schryburt-Brown, OT, Geriatric Mental Health Community Outreach
Debora Steele, Psychogeriatric Resource Consultant
Suzanne Thorson, PT, Brockville General Hospital

Regional/Provincial:

Etienne Bisson, International MS Falls Prevention Research Network
Sarah Emery, Eastern Ontario Centric Health Seniors Wellness Division
Sandra Kioke, LTC Best Practices Coordinator RNAO SE LHIN
Jennifer Kovacic, RAI and Restorative Care Coordinator, Belmont LTC
Dianne LeBreton, Facilitator, clearshift inc.
Marq Nelson, Regional Integration Lead, Osteoporosis Canada
Lee Plumpton, Paramed Home Health
Appendix E. Meeting Assessment- Questionnaire

FALLS PREVENTION AND MANAGEMENT STAKEHOLDER MEETING

Thank you for coming out to today’s meeting! Please take a few minutes to answer the questions below. Please **do not** include your name or affiliation on this sheet. Answers will be kept confidential.

1. I found the presentations enriched our table dialogues.
   
   1. Completely Disagree  
   2. Disagree  
   3. Neither Agree nor Disagree  
   4. Agree  
   5. Completely Agree

2. I found the table dialogues meaningful and in line with the day’s purpose.

   1. Completely Disagree  
   2. Disagree  
   3. Neither Agree nor Disagree  
   4. Agree  
   5. Completely Agree

3. I felt comfortable in the meeting room, and with the food and beverage selections available.

   1. Completely Disagree  
   2. Disagree  
   3. Neither Agree nor Disagree  
   4. Agree  
   5. Completely Agree

4. I would participate in another meeting related to this topic, or recommend that a colleague related to this topic attend one in the future.

   1. Completely Disagree  
   2. Disagree  
   3. Neither Agree nor Disagree  
   4. Agree  
   5. Completely Agree

5. What will you take away from this meeting?

   
   6. I suggest that meetings like this would be more effective if…

   
   7. Additional comments:
Appendix F. Meeting Assessment - Summary of Results

Questions 1-4: Likert Scale

Q1: I found the presentations enriched our table dialogues.
Q2: I found the table dialogues meaningful and in line with the day’s purpose.
Q3: I felt comfortable in the meeting room, and with the food and beverage selections available.
Q4: I would participate in another meeting related to this topic, or recommend that a colleague related to this…

Questions 5-7: Open Ended

Q5: What will you take away from this meeting?

Total Number of Responses: 40

Most Mentioned:
- Excellent opportunity of connect/network
- How much collaboration it will take
- The importance of governance/Provincial support
- Hope

Somewhat Mentioned:
- Knowledge of local resources and statistics
- Feeling of the project moving forward
- Big issue, lots of work to be done
- There are common concerns
- Many want a larger integrated falls prevention project
- Will use the information for organizations programming
- The need to advocate and the need for an organizational strategy
Q6: I suggest that meetings like this would be more effective if...

**Total Number of Responses:** 20  
**Note:** Many responses were positive feedback (moved to Question 7)

**Most Mentioned:**
- Better participant coverage (Ministry rep, front line staff, PSWs)

**Somewhat Mentioned:**
- Slides were provided, time to reflect and prepare answers to questions beforehand
- Successful/current LHIN falls strategies were discussed/presented

**Mentioned Once:**
- Provide a simple giveaway suggestion (to take back with us to our organization, do one of the following...)
- Presented a background of the working group, how they came together
- Too many organizations were invited
- Provided with a participant list
- Not on a Friday
- Flip charts were not required

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Q7: Additional comments:

**Total Number of Responses:** 21
| Most Mentioned:                    | - Thanks/Well Done/ Enjoyed/ Great Event  |
|                                  | - Effective facilitator                   |
|                                  | - Great set up                            |
|                                  | - Found it effective, excited to see the outcome |
| Somewhat Mentioned:              | - Not too long/did not exceed time limit  |
|                                  | - Very interactive                        |
| Mentioned Once:                  | - Use of breaks                           |
|                                  | - Be careful with food allergies and cross contamination |
|                                  | - Feeling that something “might actually happen” |
|                                  | - Great opportunity to network            |
|                                  | - Looking forward to the next one         |
|                                  | - Language:                               |
|                                  |   - Awkward anchor question, like the idea that fall management (VS prevention) is included as complete prevention is impossible and has negative consequences (eg. Increase restraints in LTC) |
|                                  |   - To “significantly” prevent and better manage more falls among adults at risk in our region |
|                                  |   - Redefine falls= remote “to the ground” |
|                                  |   - Asking us to vote on “endorsing” a strategy is moving forward is challenging. A “personal endorsement” is VERY different than an organizational endorsement for which many people cannot speak to. |
|                                  |   - This is a long term project and needs to have that vision align where possible with other healthy behavior initiatives. Screening tools are great, but there needs to be progress and access for those identified |
Additional Resources


