Whole of System
Falls and Fracture Management in New Zealand

September 2017

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Alliances at all levels of the system
Working together - more in common than not...

• Value of older people in our society
• Fall & fracture is an injury & more....
• Sustainable approach to funding Health & Insurer – ACC collaborating with partners
• Evidence @ population level

Common goal to keep Muriel independent & well @ home
Consumer beliefs, their lives and aspirations, our perceptions

Co-design
Falls and fracture outcomes for New Zealand’s older people - a whole of system approach
A new way of working - 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 requirements

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.
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 / Hip Fracture Registry
• 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 and Community Strength and Balance programmes** – supporting the needs of older people with both individual and group-based.

- **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 for New Zealand.
Whole of System Approach

Central Agency and DHB - contribution to support delivery.

A national outcomes and best practice framework guides the design of local services, setting of delivery expectations and monitoring of results.

The benefits for the health system will be less than predicted claims costs, fewer admissions to hospital and aged residential care, and reduced hospital length of stay.

For an older person the benefit will be improved quality of life and independence.
Taking a Population Approach

- 83% - keeping the ‘well old’ well at home
- 15% - identifying and targeting those at risk (<65 if appropriate)
- 2% - improved quality of care to meet individual needs - rehab and prevention
• 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.
Seeing the whole – aligning activities to mutually reinforce the impact on outcomes

Keeping Muriel independent and well at home

Primary prevention
- Group based strength & balance
  - In home strength and balance
  - FLS
- Effective rehab secondary prevention
  - Medication review / visual acuity check
  - Vitamin D Aged residential care

Hip # Registry
ANZ Hip # Guidelines / CCS
Implementation criteria S&B
Osteoporosis guidance
FLS Standards
Consumer Resources
Cross-sector alliance group / NZ Falls and Fracture System

National Advisory Group
Lead Agency Network
Fracture Liaison Nurse Network

Local District Alliance Leadership Teams

District Wide Working Groups x21
- Consumer
- Clinical Leaders
- Planning and Funding
- Primary and secondary care
- Community providers
- Ambulance

Working together at multiple levels

- Government agency priority – NZ healthy ageing strategy
- Alignment of policy environment
- Network of clinical leaders to drive change across the country – share models/approaches
- Accountable for local outcomes and benefits for all involved
- Focus on service design and delivery across the whole system...integrating falls and fracture prevention
Fewer fall injuries

FALLS 65+ ACC CLAIMS
Fewer fall injuries

FALLS 65+ ACC CLAIMS (FRACTURE, NON FRACTURE)
Fewer serious harm fall injuries
Falls Hospital Bed Days by Type (Other, Fracture, Fractured NOF)
Improved recovery in hospital

% OF FRACTURED NECK OF FEMUR PATIENTS OPERATED ON SAME OR NEXT DAY

<table>
<thead>
<tr>
<th>Years</th>
<th>Percentage</th>
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<tr>
<td>2012</td>
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<td>2013</td>
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New resources (these plus more)
Shared resources
National Service Coverage August 2017

FLS & In home Strength & Balance
- 80% of local health systems
- 86% of population

Group Strength and Balance
- 95% of local health systems
- 96% of population
Making it easy for older people & their families - www.livestronger.org.nz
In summary

• Establish common goals based on all perspectives
• Align activities and effort nationally & locally
• Measure outcomes together
• Work together at multiple levels
Thank you – acknowledgement to all partners