Brake the Break
The first community based partnership providing an Osteoporotic Refracture Prevention Service in metropolitan New South Wales

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Fracture Liaison Coordinator

Medicare Locals gratefully acknowledge the financial and other support from the Australian Government Department of Health
Background

OSTEOPOROSIS (OP) - under-diagnosed and undertreated

- Major health burden
  - 66% of Australians aged > 50 years
  - In 2012: >$2.7 billion
- Undetected until 1\textsuperscript{ST} OP fracture - minimal trauma fracture (MTF)
- Rates of screening ~ 20-30%
- Refracture risk DOUBLES after first MTF – and small fractures predict big
- ↓ refracture risk by >50% with early OP identification and management
  - In 10 years → NSW could saving $238m and avoid 242,000 refractures*
  - in 3 years → in South Eastern Sydney - $3m and >9000 fracture saved*

FALLS

- SESLHD Falls Prevention Plan 2013-2018 identified
  - High falls rate in St George area (Kogarah, Hurstville & Rockdale LGA)
  - Rockdale LGA: 31% more fall-related hospitalisations (2008/9-2009/10)

(*ref: NSW ACI Formative Evaluation)
Brake the Break

AIM:

Reduce the refracture rate after MTF in people aged 50 years and over, living in the St George area, through

✓ early screening and treatment initiation
✓ self-management
✓ referral to appropriate services

Agency for Clinical Innovation - Osteoporotic Refracture Prevention model of care
How does Brake the Break work?

1. Patient Identification and Referral into Service
   - SESLHD
     - ED: admissions records and direct referral
     - Extended Community services
   - Primary Health Care Referrals:
     - General Practice
     - Allied Health
   - Community Referrals:
     - Council & Community Networks
     - General Public

2. Brake the Break ORP Service
   - Staff - GP and Fracture Liaison Coordinator
   - Case identification
   - Osteoporosis screening - BMD
   - OP risk factor assessment
   - Initiation of relevant pathology
   - Assessment - Falls risk factors
   - Initiation of treatment
   - Self-management education
   - Communication with GPs

3. Patient referral on to...
   - GP for follow up and treatment initiation
   - SESLHD, Local Council and Community Health Promotion programs (e.g. Stepping on)
   - Allied Health, e.g. dieticians, exercise physiologists, optometrists
   - Medicare Local services e.g. Connecting Care
   - Specialist care if needed

4. Coordination and follow-up at 3, 6 and 12 months

5. Regular reporting to SESML and SESLD
Service summary to date

970 MTF patients identified

- 520 excluded: Admitted, NH, out of area, unable to contact
- 50 patients undecided
- 450 patients invited to attend clinic
- 170 patients attended clinic

230 patients declined: no response, already on OP Rx, normal BMD, not interested

- Mean age = 67.8 years
- Female = 78%
- BMD: Osteoporosis = 23.5%
  Osteopenia = 59.4%
- OP treatment recommended = 47%
Falls Risk Assessment: FRAT

**Assessment of falls risk in older people (Side 1)**
**(Falls Risk Assessment Tool-FRAT)**

Multi - professional guidance for use by the primary healthcare team, hospital staff, care home staff and social care workers.

This guidance has been derived from longitudinal studies of factors predicting falls in older people and randomised controlled trials that have shown a reduction in the risk of falling. (adapted for local use but originally designed by Queen Mary College, University of London)

**Definition** Fall - An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness (NICE 2004)

**Notes for users:**
1) Complete assessment form below. The more positive factors, the higher the risk for falling.
2) If there is a positive response to three or more of the questions on the form, then please see over for guidance for further assessment, referral options and interventions for certain risk factors.
3) Some users of the guidance may feel able to undertake further assessment and appropriate interventions at the time of the assessment.
4) Consider which referral would be most appropriate given the patient’s needs and local resources.

Name __________________________ Date of Birth ___________

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there a history of any fall in the previous year? How assessed? Ask the person.</td>
<td></td>
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<tr>
<td>2</td>
<td></td>
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<td></td>
<td>Is the patient/client on four or more medications per day? How assessed? Identify number of prescribed medications.</td>
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<td>3</td>
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<tr>
<td></td>
<td>Does the patient/client have a diagnosis of stroke or Parkinson’s Disease? How assessed? Ask the person.</td>
<td></td>
</tr>
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<td>4</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Does the patient/client report any problems with his/her balance? How assessed? Ask the person.</td>
<td></td>
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<td>5</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Is the patient/client unable to rise from a chair of knee height? How assessed? Ask the person to stand up from a chair of knee height without using their arms.</td>
<td></td>
</tr>
</tbody>
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**FALLS RISK ASSESSMENT TOOL, a validated instrument incorporating 5 questions:**

- Falls in last 12 months
- Taking 4 or more medications
- Diagnosis of stroke or Parkinson’s disease
- Reporting balance problems
- Unable to rise from sitting without using arms
Falls Risk Assessment Tool (FRAT)

Patients considered for referral to falls prevention programs

- with a FRAT score of $\geq 3$ alone
- Score of $<3$ + other identified falls risk factors
Summary of reported risk factors

No. of falls in past 12 months

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>No falls</th>
<th>1 fall</th>
<th>2 falls</th>
<th>3 falls</th>
<th>≥ 4 falls</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>32</td>
<td>100</td>
<td>23</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>19%</td>
<td>59%</td>
<td>13%</td>
<td>6%</td>
<td>3%</td>
</tr>
</tbody>
</table>

78 (44%) patients reported one or more other falls risk factors

- Sleep: 35 patients
- Bladder: 27 patients
- Vision: 20 patients
- Weakness/Sens Loss: 19 patients
- Analgesic/Sedative: 14 patients
- Low BP: 6 patients
- Dementia: 4 patients
- Epilepsy: 2 patients
Self-assessed falls risk

Total number of patients = 170

- High risk: 9 patients
- Medium risk: 38 patients
- Low risk: 114 patients

No. of patients reporting

No. of patients referred for falls prevention

NB: data not available for 9 patients
Referrals from Brake the Break

Total referrals = 58
Mean age = 72.6 years; Female = 84.5%; ≥2 Minimal Trauma Fractures = 62%
Thank you for your kind attention!