Fall Risk Management Program Resource Guide to Calgary Zone Community-Based Services and Programs

For Clinicians Seeing Clients at Risk for Falls

AHS Fall Risk Management Program (Calgary) Seniors Health
Revised: April 2014

Available electronically: AHS Fall Risk Management Program, Calgary website:
http://www.albertahealthservices.ca/services.asp?pid=service&rid=1051701.

Link to Resource Guide:
http://www.albertahealthservices.ca/ps-1051701-fpp-resource-guide.pdf.

This Resource is a listing of services that relate to fall prevention – it does not imply endorsement of them.
If this guide is in need of updating, please contact the Fall Risk Management Program Office at 403-955-1550

Urban Resources

RURAL RESOURCES

Urban Resources

Ambulatory Community Physiotherapy Program – AHS Calgary Zone	
Contact	Contact information for the 55 clinics contracted by Alberta Health Services – Calgary Zone (including rural clinics) can be found at: www.InformAlberta.ca , by searching "Community Physiotherapy Calgary". For further clarification, the Program Coordinator can be reached through a general inquiries line at 403-943-0279, or email to communitypt@albertahealthservices.ca. Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1001414
Program Focus & Description	Provides funding for short- term, single discipline Physical Therapy interventions to specific populations as identified in the inclusion criteria. Not specific to fall risk assessment, however certain risk factors could be assessed during the course of an episode of care.
Inclusion Criteria	Within 12 weeks of a Fracture, Surgery, or other Medical Procedure requiring Physical Therapy intervention (may be the result of a fall: 1 assessment + 6 treatments). Intervention for *acute* musculoskeletal (MSK) injury or exacerbation may be provided to clients who meet the *Income Eligibility* (injuries and or exacerbations may be the result of a fall: 1 Assessment + 4 Treatments). Clients in each of the categories need to demonstrate a loss of function which decreases their ability to manage ADL.
Exclusion Criteria	Clients who are eligible for funding under other programs / agencies i.e. WCB, Motor Vehicle Collision Insurance. Certain condition-specific rehabilitation programs: (examples: Vestibular or Pelvic Floor).
Referral Process	No referral is necessary, self referral is acceptable. Income Assessment form is available at each clinic – supporting evidence must be provided.
Cost of Service	Funding for eligible clients is provided by the Ambulatory Community Physiotherapy Program. Additional equipment purchase is the responsibility of the client.
Fall Prevention Education Provided?	Individual treatment plans should be provided by the treating physiotherapist. These could address deficits in strength, balance, and gait. Specific fall prevention knowledge will vary by clinician and site.

Balance for Life – The Alex Seniors Health Centre	
Contact	The Golden Age Club Recreation Therapist - Liz Graves Phone: 403 – 920-0011 Fax: 403 – 920-0014 email: egraves@thealex.ca
Program Focus & Description	Exercise program for seniors 60+ focused on improving mobility, strength, balance, core stability, and independence in ADLs (including self-efficacy). Group activity offered once a week, for one hour, over a period of 11 weeks. Offered by The Alex Seniors Community Health Centre. The *Golden Age Club* provides the space (auditorium).
Inclusion Criteria	Seniors who are interested in improving their balance and willing to attend the program for 11 weeks. Voluntary sign-up.
Exclusion Criteria	Individuals who have already had a fall (these clients are referred to the Calgary Fall Prevention Clinic). Individuals who require 1:1 intervention.
Referral Process	Self-referral or referral by fitness instructors, family physicians, or other health care professionals. Recreation Therapist will discuss with Older Adult to ensure class is appropriate.
Cost of Service	Membership at Golden Age Club is encouraged as program is held in their auditorium.
Fall Prevention Education Provided?	Yes. Occasionally bring in a guest speaker depending on seniors' interests. Education also provided during the exercise class time.

Balance for Life – Whitehorn Village Retirement Community	
Contact	Manager of Programs: Carrie Erickson Phone: 403 – 271-2277 Fax: 403 – 271-2554
Program Focus & Description	Program is based on active living, with an exercise program aimed at frail to fit older adults to develop better balance (both static and dynamic). Target population is older adults, aged 55 years and over. Programs are offered twice a week. Balance for Life is a one hour fitness class offered twice weekly, Tuesday and Thursdays at 10:00 a.m. Class runs year round.
Inclusion Criteria	All of Whitehorn Village's Club Origin physical activity /active living classes require a signed Physician's Form, which is renewed annually.
Exclusion Criteria	An inability to be self-sufficient in a class setting.
Referral Process	Self-referral or referral from any advocate will be accepted. (Referral process is informal). Coordinator will discuss with the Older Adult to ensure classes appropriateness.
Cost of Service	Membership in Club Origin - $50.00 yearly. Drop-in class rate $5.00. Monthly fitness membership, unlimited classes - $30.00.
Fall Prevention Education Provided?	Education including: risk factors, strategies, good choices, active lifestyle, and more information provided throughout the program.

Calgary Community Aids for Independent Living (CCAIL)	
Contact	Sheldon M. Chumir Health Centre. Phone: 403-955-6955 Fax: 403-955-6910 Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1033651. Brochures: Available from www.seniors.gov.ab.ca.
Program Focus & Description	To promote client safety and functional independence at home or in a home-like setting by providing appropriate AADL equipment and medical supplies. Functional assessments are completed by an OT or RN in the client's home and/or community re: equipment needs. Equipment is authorized as appropriate. Compression stocking assessments are completed in the Clinic. Assessing for medical supplies is completed at home, in the Clinic or the community. Additional Community resource information is provided as needed.
Inclusion Criteria	Clients who have a chronic illness or disability that require equipment for longer than 6 months, live within the Calgary city limits and meet AADL's eligibility criteria.
Exclusion Criteria	Clients who are being seen by other community programs and facilities who have authorizers (e.g. Home Care, LTC), those active on WCB, those in acute care, and individuals who have treaty or Aboriginal Status.
Referral Process	Call the CCAIL office to make a referral. Referrals are accepted from clients (self-referral), physicians and healthcare providers. A home or clinic visit will be arranged for the assessment.
Cost of Service	There is no cost for the CCAIL assessment by the OT or RN. There may be a cost for AADL equipment (see point below). AADL's cost-share policy states Albertans pay 25% of the benefit cost to a maximum of $500 per individual or family per year. Low-income Albertans are cost- share exempt. For further information on AADL and their eligibility criteria, refer to the AADL website: http://www.seniors.gov.ab.ca/AADL/index.asp.
Fall Prevention Education Provided?	As clients are assessed, fall risk factors are included in the assessment. Multi-faceted education is provided by the assessing practitioner in the form of correct procedure, home environment safety issues, etc.

Calgary Fall Prevention Clinic	
Contact	Phone: 403-955-1506 Fax: One Line Referral 403- 955-1514 Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1004774 Pamphlets: Available (AHS order number: 605576)
Program Focus & Description	Fall prevention – Seniors aged 65+ and who have fallen in the past 12 months. Comprehensive fall risk assessment completed. A multi-dimensional assessment, which takes about 2 hours, is conducted in the client's home by a trained fall assessor (may be an occupational therapist, or physical therapist). Assessments are reviewed by the entire Fall Team (Geriatric Medicine Specialist, Pharmacist, Registered Dietitian, Social Worker, as well as disciplines previously mentioned). Specific recommendations are determined, letters are sent to family physician, referral source, and client. Recommendations may include referral to our FallProof™ balance training program, which is a small group session led by a Physical Therapist. Sessions are 1 hour in length, twice weekly, over a 3 month period. Other recommendations may include medication changes, investigations, referral to our Geriatric Medicine Specialist, referral to other AHS Calgary Zone programs, referral to external exercise programs, etc.
Inclusion Criteria	Clients must be: 65 years of age or older. Have fallen in the past 12 months. Be cognitively able to participate in the assessment.
Exclusion Criteria	Clients who are terminally ill with a life expectancy of less than 6 months.

Calgary Fall Prevention Clinic	
Referral Process	Via One Line Referral central intake (Fax: 403 -955-1514). Self-referrals will be accepted. Referrals primarily come from family physicians, specialty clinics, Emergency Departments, and rehab therapists working in acute or community settings. Common links include Adult Day Hospitals, Living Well, Geriatric High Risk Foot and Wound Clinic, Community Accessible Rehab (CAR).
Cost of Service	No charge.
Fall Prevention Education Provided?	Yes. Specific recommendations are given in the client letter, and small groups provided to balance training clients

Community Accessible Rehabilitation (CAR)	
Contact	South Calgary Health Centre. Phone: 403-943-9484 Sheldon M. Chumir Health Centre. Phone: 403-955-6900 Peter Lougheed Centre. Phone: 403-943-4786 **Website:** http://www.albertahealthservices.ca/services.asp?pid=service&rid=1008956.
Program Focus & Description	Outpatient rehabilitation services for those living in the community with complex chronic conditions. CAR is a client-centered, goal oriented, time limited, and active rehabilitation service. Treatment focus is on improving functional ability and self-management in order to allow participation in pre-existing roles including work (paid and unpaid), self-care, and/or leisure for adult clients who have a complex chronic condition. Two teams: Neuro /frail /elderly team and musculoskeletal (MSK)/upper extremity team. [Expertise in Vestibular Rehabilitation is provided at all 3 clinics*].*
Inclusion Criteria	Adult clients that have potential for functional improvement from active rehabilitation for the following: • Chronic health conditions. • Acute exacerbation of medical condition. • Adult clients who require a multidisciplinary approach to treatment for a complex chronic condition or requires one-to-one intervention of 45 minutes/visit or more from rehabilitation professionals.
Exclusion Criteria	Client requires services outside the scope of CAR. If other services exist which meet the client's needs. [Note: No treatment of back or neck injuries unless Neuro (Spinal Cord Injury), no single-joint Ortho conditions, and no post-surgical clients]. Client is a resident of a Long Term Care Facility.

Community Accessible Rehabilitation (CAR)	
Referral Process	Referral form (obtain from website) sent or faxed to one of the three CAR sites from a health care provider involved in the client's care. Referrals are often received from Home Care, Acute Care Hospitals, Community Therapists, and Physicians (Family Practitioners, Physiatrists, other specialists).
Cost of Service	CAR is provided under the publicly funded system. While there are no charges for treatment sessions, clients are expected to pay for materials and/or devices used as part of a home program (e.g. splints).
Fall Prevention Education Provided?	CAR is not a fall prevention program. However, CAR clients who are at risk of a fall could have some of their needs met through the course of treatment. Fall prevention is discussed on an individual basis with clients by OT or PT during treatment.

Day Hospital (Carewest)	
Contact	Glenmore Park Phone: 403 – 640-6480 Referrals Fax: Direct Referral @ 403 – 258-7681 Website: http://www.carewest.ca. Pamphlets: Available by calling the Day Hospital (see number above) and on web-site above (see What We Do / Programs / Community Programs / Day Hospital).
Program Focus & Description	Ongoing professional treatment /rehab for frail community-dwelling seniors with multiple medical concerns and functional changes. Program targets seniors whose quality of life is diminished because of physical, mental, emotional and/or social health problems, who have experienced declining health or have been recently discharged from hospital, and/or who cannot be easily cared for at home because of health & functional issues. Collaborative assessment & treatment completed by full professional interdisciplinary team, including social worker, physical therapist, occupational therapist, recreation therapist, physician, and nurse. Further assessment, treatment and/or consultation available from a speech language therapist, psychologist, geriatrician, geriatric psychiatrist and pharmacist. Clients normally make two visits per week for 3 – 4 months. Client centered -- functional goals and treatment plan developed in collaboration with client, family and other care providers. Holistic, integrated therapy and treatment program. Links to supportive services and discharge plan communicated to all involved.
Inclusion Criteria	Age 65 or older. Require treatment &rehabilitation by the interdisciplinary team (therapists, RN, MD). Agree to attend and participate in individual and group activities. Sufficient endurance to travel and attend for a minimum of two hours.

Day Hospital (Carewest)	
Exclusion Criteria	Unstable medical problems requiring inpatient support or inpatient investigations/specialists. Severe cognitive impairment; terminal illness with anticipated short survival; or requiring 2-person transfer, or continuous one-to-one care or supervision.
Referral Process	Direct Referral: fax form to 403-258-7681 or call 403-640-6480.
Cost of Service	No cost. (Clients pay for own transportation and lunch).
Fall Prevention Education Provided?	Yes. PT's, OT's, RN's and MD's provide some education during treatment. Plus, other education includes: environmental risk factors, aids, safe transfers, physical changes, emergency call systems, getting up from a fall, fear of falling, footwear, benefits of exercise, etc.

Integrated Home Care Services	
Contact	Transition Services; Single Point of Entry Phone:403 -943-1920 Fax: 403 – 943-1602 Website: http://www.albertahealthservices.ca/4482.asp.
Program Focus & Description	Integrated Home Care (IHC) helps clients to restore their health and /or prevent further disability, enable an early discharge from hospital, and/or to help people to continue to live in their home or community. Palliative care is also a focus. A client with home care services would receive fall risk screening and more in depth fall risk assessment as warranted. IHC provides in home assessment and treatment by an interdisciplinary team as needed. Fall risk screening is provided for all clients through the Resident Assessment Instrument (RAI). Further assessment of fall risk factors and interventions for risk factors are provided, as needed, by the IHC Home Care Case Manager.
Inclusion Criteria	Anyone with an Alberta Health Care number is eligible to receive an assessment. This assessment determines whether there is a need for IHC services. Transition Services and IHC collaboratively determine who may be eligible for IHC services.
Exclusion Criteria	N/A

Integrated Home Care Services	
Referral Process	Call Transition Services (TS) (Community Care Access) at 403-943-1920. Self referral or referral by family friends and neighbors are accepted. In the Emergency Department (ED), staff will page TS when they have a client they feel would be appropriate for TS to assess for referral to IHC. IHC Case Managers will let ED TS coordinators know in advance if they are sending a client to hospital (as will Care Centers). In Acute Care, TS (in collaboration with other clinical services) will identify clients who could potentially benefit from Home Care services. Case Managers on all the IHC teams have the ability to refer clients that are at high risk to fall or who have fallen to the Integrated Home Care Fall Prevention Team for more in depth assessment of fall risks. This team provides the client, the client's family, other Integrated Home Care professionals, and the family physician with recommendations to reduce the clients risk to fall and/or risk for injury from the fall. This team has the ability to liaise with or refer to the Calgary Fall Prevention Clinic.
Cost of Service	Alberta Health Services funds professional services provided by Home Care. If the client has private insurance coverage, like WCB, arrangements can be made to bill the insurance company. There may be a small fee for homemaking and companion services based on client income.
Fall Prevention Education Provided?	Integrated Home Care staff provides fall prevention education, in collaboration with the client and family, once fall risks have been assessed.

Kerby Centre	
Contact	Manager of Education and Recreation: Karen Stevens. Phone: 403 -705-3232 Fax: 403-705-3211
Program Focus & Description	Program is based on active living, with exercise programs aimed at frail ("Locomotion and Balance"), sedentary ("Balance Workout") and fit ("Agility Workout") seniors to develop better balance (both static and dynamic). Targeted population is seniors, aged 60 years and over. Wii Balance program is two seniors to one trainer using the Nintendo Wii Sports Games and Wii Fit to enhance and maintain balance. All three programs are group activities, offered once a week, for 1 hour, for 12 weeks (Fall, Winter and Spring semesters). **Locomotion and Balance** for *frail* seniors is a small group activity, maximum of 12 seniors. Warm-up is chair based with emphasis on large muscles of the legs and ankles. Balance activities are done using chair or parallel bars for support. Other balance equipment such as sit-fits, balance pad, etc are used. This tends to attract our older seniors (75+). **Balance Workout** is a small group activity, maximum of 12 seniors. Warm-up activities are done standing with some sitting activities. Majority of the balance activities are done free standing or using a chair for support. Other balance equipment such as sit-fits, balance pad, balance beam, stability trainers, etc is used in a variety of exercises. **Agility Workout** is a small group activity, maximum of 12 seniors. Warm-up activities are done standing, stationary as well as through locomotion. Agility activities are done using balance equipment, chairs and stairs. **Wii Balance** is training using the Nintendo Wii game system. The sports games are used initially to assess dynamic balance and then the Wii Fit is used for the specific static balance activities. This is only a drop-in activity at this time.
Inclusion Criteria	Voluntary sign-up. Staff in the Ed and Rec Office tries to direct seniors to the appropriate class level.
Exclusion Criteria	An inability to be self-sufficient in a class setting. If a participant requires assistance for activities such as transferring, transportation, etc., they must provide their own caregiver or not be eligible for the program.

Kerby Centre	
Referral Process	Referral process is informal. Self-referral and some referrals received from Physiotherapists, family physicians, and Home Care staff. If no referral received, coordinator will have a casual conversation with the senior and/or their family member to determine which exercise program would most benefit them.
Cost of Service	Locomotion and Balance is $25.00 with a Kerby Centre Membership (which is $20.00/calendar year). Balance Workout is $38.50 with a Kerby Centre Membership. Agility Workout is $38.50 with a Kerby Centre Membership. Wii Balance is $2.50 per drop-in session.
Fall Prevention Education Provided?	Education may be provided as part of the program.

Living Well With a Chronic Condition Program (Urban)

Contact	Phone: 403-943-2584 (403-9HEALTH) Website: www.albertahealthservices.ca/livingwellcalgary.asp Brochures: Available on the website above, or ordered through 403-943-2584 (403-9HEALTH)
Program Focus & Description	Chronic Disease Management: for adults with a long term health condition such as diabetes, heart disease, high blood pressure, chronic lung disease, osteoporosis, arthritis, or others. The aim is to help clients learn a healthy way to live with their chronic illness. The program consists of supervised exercise classes, general and disease-specific education classes, and self management workshops. In addition, the program offers limited dietitian and social work counseling services for clients with specified chronic conditions. **Exercise**: 13 community-based locations, including 5 rural sites. 60-90 minute classes are held 2-3 x/ week for 8 weeks. Clients are triaged into "Easy Going", "Get Going" and "Keep Going" classes according to their functional ability and are not diagnosis specific. The four elements of fitness are included in each class – endurance, strength, flexibility and balance. Balance training has the greatest emphasis in the "Easy Going" classes. Mandatory Criteria for Exercise Program: • All patients need to be ambulatory. • Exercise classes are only held on week days during the day. • If patient requires a caregiver, then caregivers are required to stay with patient during these sessions. Program is 8 weeks; patients attending sessions will require ability to transition out of this service after this time frame. Patients will be supported through this transition. Patients with cognitive deficits must have a completed Mini Mental State Exam (MMSE) form completed within the last 3 months sent with the referral form. Patients with scores ≥ 24 are eligible for participation. To expedite triage, send the following results with the exercise referral (if available and less than 2

Living Well With a Chronic Condition Program (Urban)	
Program Focus & Description	years old): • Exercise stress test • Myocardial perfusion imaging • Pulmonary function test (for patients diagnosed with asthma or COPD) **Education**: Both general and disease-specific (Diabetes, Hypertension, Cholesterol, Chronic Pain, COPD, etc) education occurs at all community sites. Specialty clinic partners provide expert instructors and Living Well provides the infrastructure and some instruction. Length and frequency of classes varies according to education topic and demand. **"Steady on your Feet**" provides information about falls risk and how to decrease your chance of falling. **Better Choices, Better Health™**: Self-management workshops are modeled after the Stanford Chronic Disease Self Management Program. Each session consists of 2.5-hour classes held once a week for 6 weeks. These are not disease-specific classes.
Inclusion Criteria	At least one chronic condition 18 years of age or older Must be cognitively capable of participating in group setting, except for one-on-one dietitian counselling Must be able to handle group situations without disrupting the class or group process and behave appropriately in a social setting. Patients with dementia or other memory issues who are unable to remember appointment times, or retain and utilize the tools and skills provided. Basic English except for programs offered in other languages • Cantonese/Mandarin – Exercise, some education and Better Choices, Better Health™ • Hindi/Punjabi – Some education topics and Better Choices, Better Health™ • Tagalog – Some education topics and Better Choices, Better Health™ • Spanish – Some education topics

Living Well With a Chronic Condition Program (Urban)	
Exclusion Criteria	Patients will be assessed on an individual basis; however the following patients do **not** meet our eligibility criteria for the service: • Patients with developmental disabilities.
Referral Process	Clients can self-refer or be referred by their physician, chronic disease nurse or another health care provider. There is centralized booking for all programs through 403-943-2584 (403-9HEALTH). (Referral form on website).
Cost of Service	Exercise = $80. Subsidy is available Better Choices, Better Health™ = No Charge Education = No Charge.
Fall Prevention Education Provided?	Falls Prevention education is taught in the class "**Steady on your Feet**." The education program is variable in length at each site and covers information on how to prevent falls and reduce falls risk in day-to-day life

Move ‘n’ Mingle Program

Contact	Coordinator – Rene Engel - Alberta Health Services (AHS) Fall Risk Management Program. Phone: 403 – 863-7708 Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1021904.
Program Focus & Description	Fall prevention and independent living exercise classes currently offered throughout city. This is a group Exercise Class of 45 minutes twice weekly, facilitated by a Certified Older Adult fitness instructor with additional “FallProof”™ education. The goal is to reduce falls or fall related injuries in seniors by working on core stability, postural alignment, leg strength and balance. Another focus is to help individuals remain independent by increasing flexibility, overall strength, endurance and range of motion. Fall Prevention Talks are offered at the sites. There are eight module topics: Finding Balance, Paying Attention to Changes, Strength & Strength, healthy Bones, Footwear & Foot Care, Home & Community Safety, tools to Stay Safe and Independent and Medications & Falls. Each lesson has a list of resources; is 30 minutes long and uses “plain language” to meet the learning needs of the older adult. Reflective questions are used to invite the participants to apply their learning. Move ‘n Mingle Fall Prevention Talks online: http://www.albertahealthservices.ca/3758.asp. Some sites have opportunity for the participants to mingle with others after class.
Inclusion Criteria	Targets Seniors (65+) who are at risk for falling and losing their independence and would not fit into mainstream programs due to income, culture, language, and/or isolation. Must be able to exercise safely and independently in a group exercise setting
Exclusion Criteria	Participants who have: • Unstable medical conditions • Cognitive issues that will result in an inability to safely exercise in a group setting • Difficulty safely standing up, maneuvering around to the back of the chair, and participating in standing exercises.
Referral Process	Contact Program Administrator @ 403 955 1550.
Cost of Service	No cost.

Fall Prevention Education Provided?	*Yes, As part of the class*

Osteoporosis Centre	
Contact	Phone: 403-955-8134 Address: Richmond Road Diagnostic and Treatment Centre. 1820 Richmond Road SW, Calgary, Alberta T2T 5C7 Website: http://www.albertahealthservices.ca/services.asp?pid=saf&rid=1069959.
Program Focus & Description	To assess and treat patients referred with osteoporosis, undiagnosed low bone mass, bone loss despite therapy, and metabolic bone disease. Outcomes sought include optimum patient assessment and treatment; education of referring physicians as appropriate; patient and community education regarding osteoporosis prevention. Team approach (physician, nurse, pharmacist, and dietitian) expands patient assessments and provides comprehensive education to health care professionals and the community-at-large. In addition to clinics, team presents monthly Bone Health classes open to patients and the public (at no charge). Team members also do presentations as requested by various community groups. Very strong link between falls and fractures – fall history included in assessment of all clinic patients. Team holds group medical visits, where more in depth information on nutrition and medication is discussed in Q & A format. Group medical visits typically hold 10 participants each session. These group visits are open to members of the public, however team requires participants to first attend the osteoporosis and bone health education class.
Inclusion Criteria	Patients must have low bone mass (per bone mineral density test); medical conditions/ medications which promote more rapid bone loss; bone loss detected via x-ray or surgery; and/or low trauma fractures.
Exclusion Criteria	Clients who are unable to attend an outpatient clinic.
Referral Process	Patients referred by family doctors, specialists, or other health agencies (e.g. TBCC) and assigned priority according to criteria such as age, recent/current fractures, risk of fracture, co-morbidities, etc. Physician referral required.
Cost of Service	Alberta Health Care for clinic visits.

Osteoporosis Centre	
	No charge for Bone Health classes.
Fall Prevention Education Provided?	Clients are referred to the Calgary Fall Prevention Clinic if in-depth assessment/treatment is required.

Seniors Health One Line Referral	
Contact	Phone: 403 – 955-1525 Fax: 403 – 955-1514 Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1010757
Program Focus & Description	The goal of the One Line Referral Service is to serve as a single point of entry for all referrals to Seniors Health Outpatient Services. This service is to support the work of physicians and community care providers by simplifying the process of accessing the most appropriate services for seniors in their care. The One Line Referral Service currently supports the following Seniors Health clinics: Calgary Fall Prevention Clinic (Bridgeland Seniors Health Centre) Seniors Health Clinics (Bridgeland Seniors Health Centre and Rockyview General Hospital)
Inclusion Criteria	Please refer to www.departmentofmedicine.com/MAS/ for the Medical Access Services guide, Seniors Health for program descriptions and criteria for admission.
Exclusion Criteria	
Referral Process	Triage Clinicians will evaluate referrals to appropriate clinic, service or program. Please complete the Central Access & Triage form (indicate Seniors Health Services requested). http://www.departmentofmedicine.com/mas/documents/mas_form_print.pdf Please include the following with your referral • Client Demographics. • Reason for Referral. • Family physician.

Seniors Health One Line Referral	
Referral Process Continued	• Past medical history, current medications. • Any recent, cognitive testing & recent consults. • Contact information for appointment booking. • Contact information for referring source
Cost of Service	No Cost
Fall Prevention Education Provided?	N/A

Transition Services (TS)	
Contact	Phone:403 -943-1920 Fax: 403 – 943-1602 Websites**:** Transition Services Community**:** http://www.albertahealthservices.ca/services.asp?pid=service&rid=1038160 Transition Services Acute Care: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1958
Program Focus & Description	Transition Services coordinates client movement between different levels of care Transition Services (TS) may see any client who presents to the Emergency Department (ED). The majority of clients seen by TS in ED are seniors within the Home Care program, or those from a Care Centre. TS in ED can provide walking aids to facilitate discharge, connect clients with community services, refer to Home Care, initiate referral to Specialized Geriatric Services, or admit client to RCTP/IT units. TS will see patients in acute care, sub-acute units, and in the community to collaboratively assess the need for RCTP, Supportive/Facility Living placement and/or Home Care. TS identify clients at risk to fall when referring them to these alternate levels of care.
Inclusion Criteria	
Exclusion Criteria	
Referral Process	Call Transition Services (Community Care Access) at 403-943-1920 if referring a client from the community setting. In ED, acute or sub-acute units, staff, clients or families themselves can refer to TS, located at those sites, for assessment.
Cost of Service	No cost to client

Transition Services (TS)	
Fall Prevention Education Provided?	TS staff may provide some basic fall prevention education or may make a referral for assessment of fall risks after client assessment.

University of Calgary Rehabilitation & Fitness Program	
Contact	Rianne Rogan Phone: (403)220-8112 E-mail: rehab@ucalgary.ca
Program Focus & Description	Programming for adults 3 semesters per year in 14-week sessions, 2x/week, 2 hours in duration For people with chronic physical disabilities (includes but not limited to: stroke, spinal cord injury, cerebral palsy, brain injury, MS) Participants meet with instructors one-on-one prior to the session and an individualized program is design based on the client's current ability level and goals. Exercises done in group setting, but each person has his/her OWN specific exercise program Volunteer and practicum student assistance available or you may bring your own caregiver. After the 14 week program, participants have the option of continuing or changing to an independent program (some stay for multiple terms in the program) Class times: Mon/Wed 10-12 & 2-4 Tue/Thurs 10-12, 2-4, 7-9pm Wed/Fri 12-2pm
Inclusion Criteria	Must be over 16 years
Exclusion Criteria	
Referral Process	Self-referral system GP consent required
Cost of Service	Rehab: Cost of service is $245 for first 14 weeks, and $185 if they return for another session.
Fall Prevention Education Provided?	

University of Calgary Joint Effort Program	
Contact	Emma Smith Phone: (403) 220-8814 E-mail: joint@ucalgary.ca activeliving.ucalgary.ca/joint-effort
Program Focus & Description	A 6-week exercise program for people with hip or knee osteoarthritis. 2x/week, 1 hr in duration. Joint Effort is ideal for people who don't qualify for surgery, need to prepare for surgery or have had a joint replacement. You will participate in a one hour individualized program design prior to the class. A one-hour group nutrition session is also included. After the 6 week program, participants have the option of doing a 6 week follow up class 1x/week for 1 hr. Class times: Mon/Wed 7-8pm Tue/Thursday 12:15-1:15pm or 5:30-6:30pm
Inclusion Criteria	
Exclusion Criteria	
Referral Process	Self-referral system GP consent may be required
Cost of Service	$329 for initial, $150 for follow up
Fall Prevention Education Provided?	

Rural Resources

Living Well With a Chronic Condition Program (Rural)	
Contact	Phone: 403-943-2584 (403-9HEALTH) Website: www.albertahealthservices.ca/livingwellcalgary.asp Brochures: Available on the website above, or ordered through 403-943-2584 (403-9HEALTH)
Program Focus & Description	Chronic Disease Management: for adults with a long term health condition such as diabetes, heart disease, high blood pressure, chronic lung disease, or others. The aim is to help clients learn a healthy way to live with their chronic illness. Exercise: 5 sites: Airdrie, Cochrane, Okotoks, Strathmore, and Vulcan. 60-90 minute classes are held 2-3 x/ week for 8 weeks. The four elements of fitness are included in each class – endurance, strength, flexibility and balance. Education: Both general and disease-specific topics are offered. Length and frequency of classes varies according to education topic. The following education classes are offered: Cholesterol and Blood Pressure Essentials (Airdrie, Cochrane and Didsbury) COPD – Breathing Matters (Airdrie, Cochrane, Okotoks, Strathmore and Vulcan) Diabetes Essentials (Airdrie, Cochrane and Didsbury) Eat Well for Good Health (Airdrie, Cochrane and Strathmore) My Path to a Smoke-Free Future (Airdrie and Okotoks) Ready, Set, Move! (Airdrie, Cochrane, Okotoks and Vulcan) Setting Goal and Staying Motivated (Airdrie, Cochrane, Okotoks and Vulcan) Steady on Your Feet (Airdrie and Cochrane) Waking Up to Healthy Sleep (Okotoks) Better Choices, Better Health™: Self-management workshops are modeled after the Stanford Chronic Disease Self Management Program. Each session consists of 2.5-hour classes held once a week for 6 weeks. These are not disease-specific classes
Inclusion Criteria	Any adult with a long-term condition can participate in Living Well. Individuals must be able to participate in a group setting both physically and cognitively. If the client is not able to participate

Living Well With a Chronic Condition Program (Rural)	
	independently, they must bring a support person. If an individual is not appropriate for Living Well, they will be connected with the appropriate program.
Exclusion Criteria	Not safe to exercise Not able to function in a group environment
Referral Process	Clients can self-refer or be referred by their physician, chronic disease nurse or another health care provider. There is centralized booking for all programs through 403-943-2584 (403-9HEALTH). (Referral form on website)
Cost of Service	Exercise = $80. Subsidy is available Better Choices, Better Health™ = No Charge Education = No Charge.
Fall Prevention Education Provided?	Falls Prevention education is taught in the class “Steady on your Feet” in Airdrie and Cochrane. The education program is 3 sessions and covers information on how to prevent falls and reduce falls risk in day-to-day life

Rural Enhanced Community Rehabilitation (RCER)

Contact	Offered in 7 communities: Canmore General Hospital: : Phone: 403-678-7200 Didsbury District Hospital Phone: 403-335-7206 High River General Hospital: Phone: 403-652-0115	Oilfield's General Hospital (Black Diamond Phone: 403-933-6506 Strathmore District Health Services: Phone: 403-361-7129 Vulcan Community Health Centre Phone: 403-485-3318 Willow Creek Continuing Care Centre Phone: 403-625-8617
Program Focus & Description	Outpatient rehabilitation services for those living in the community with complex chronic conditions. RCER is a client-centered, goal oriented, time limited, and active rehabilitation service. Treatment focus is on improving functional ability and self-management in order to allow participation in pre-existing roles including work (paid and unpaid), self-care, and/or leisure for adult clients who have a complex chronic condition. Seating Clinic available in High River Outpatient Modified Barium Swallow available in High River Balances classes are/can be offered at various sites (Canmore, High River, Strathmore, Didsbury)	
Inclusion Criteria	Adult clients that have potential for functional improvement from active rehabilitation for the following Chronic health conditions acute exacerbation of medical condition complex medical issues Adult clients who require one-to-one Physiotherapy intervention of 45 minutes/visit. Consulting support from multiple rehabilitation professionals.	
Exclusion Criteria	Client requires services outside the scope of RCER	

Rural Enhanced Community Rehabilitation (RCER)	
	If other services exist which meet the client's needs. [Note: No treatment of back or neck injuries unless Neuro (Spinal Cord Injury), no single-joint Ortho conditions, and no post-surgical clients]. Client is a resident of a Long Term Care Facility
Referral Process	Direct access. No referral required. Client will be screened on the telephone. Clients often referred from Home Care, Acute Care Hospitals, Community Therapists, and Physicians (Family Practitioners, Physiatrists, other specialists)
Cost of Service	RCER is provided under the publicly funded system. While there are no charges for treatment sessions. There may be charges for materials or equipment recommended for home programs
Fall Prevention Education Provided?	Canmore has a falls coordinator, and full assessment process. Other RCER sites do not provide a robust fall prevention program. However, all RCER sites accept community referrals for clients who have fallen or at risk of falling, and will connect with other resources to support community clients (i.e. Home Care and PCN). Fall prevention education and exercises are provided