

Restructuring Primary Care Practices to Manage Geriatric Syndromes: The ACOVE-2 Intervention

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Despite evidence suggesting that primary care physicians do not address geriatric conditions adequately in practice, most efforts to change physicians' practice behaviors have been ineffective or too expensive to implement and sustain.

In its second phase, the Assessing Care of the Vulnerable Elders (ACOVE-2) project has developed an intervention aimed at improving the care that primary care physicians provide for three geriatric conditions—falls, urinary incontinence, and cognitive impairment/dementia. The intervention addresses specific processes of care identified in the first phase of the ACOVE project (ACOVE-1) as important to the care of community-dwelling older persons. Beginning with case finding, the intervention uses a standardized multicomponent practice-change effort. The condition-specific intervention employs four methods of changing medical practice: efficient collection of condition-specific clinical data, medical record prompts to encourage performance of essential care processes, patient education materials and activation of the patient's role in follow-up, and physician decision support and physician education. Moreover, the costs of the intervention are low. The effectiveness of the intervention in improving the processes of care for these conditions and clinical outcomes will need to be evaluated in controlled trials. *J Am Geriatr Soc* 51:1787–1793, 2003.

Key words: geriatric assessment; incontinence; falls; dementia; healthcare delivery

As a result of the increased burden of disease and disability associated with aging, older persons require more health care than younger persons.¹ This care is expensive, and the cost is rising at a faster rate than

healthcare costs for younger persons.² In spite of these high expenditures, studies have shown that the care that older persons receive is frequently inadequate, especially for geriatric conditions (e.g., incontinence, falls, dementia, undernutrition).³ Although for some conditions (e.g., diabetes mellitus,⁴ screening for lipid disorders⁵) the optimal care of older persons is less well established than for younger persons, there is substantial evidence, based on published research, about how most geriatric syndromes and diseases of older persons should be managed.⁶ Frequently, this evidence has also been published as practice guidelines, quality indicators, and evidence-based medicine reports, but merely agreeing upon standards of care does not mean that physician behavior will change or best practices will be implemented. In fact, the term “knowledge-practice gap” has been used to describe the difference between evidence-based effective management and care actually provided.⁷

Implementing changes to improve the care of older persons in existing clinical settings has been remarkably difficult. Previous attempts to change physician performance through traditional continuing medical education have been largely ineffective.⁸ Many factors, including physician knowledge, attitudes, and behaviors, contribute to this inertia.⁹ Physician barriers to adhering to guidelines have been well described.⁹ These include lack of awareness or familiarity with the guidelines, disagreement with specific guidelines or guidelines in general, disbelief that the performance of guideline-specified care processes will lead to desired outcomes, lack of self-efficacy to perform the care process, and inability to overcome existing practice habits. Additional obstacles include patient factors and environmental factors, such as lack of time, resources, or reimbursement.⁹ Many of these barriers apply to the management of geriatric conditions. For example, inadequate case recognition, lack of physician knowledge about management, poor patient adherence, and inadequate follow-up are likely to perpetuate the provision of care that is inconsistent with evidence-based standards. Perhaps most important, clinicians commonly believe that evidence-based care takes more time.⁹ For most clinicians and healthcare systems, adding time to each encounter is simply not a viable option.

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In response, researchers have begun attempts to change physician performance in the context of modifying the basic structure of care. Innovative models, such as group visits¹⁰ and chronic care clinics,¹¹ have been developed and evaluated, but few models focus on changing practice within individual primary care physicians' offices without adding personnel or implementing costly structural improvements (e.g., computerized medical records). The Assessing Care of Vulnerable Elderly Persons (ACOVE) project developed a definition of vulnerable elders and then developed and documented a set of process of care quality indicators covering 22 conditions important for older persons.^{3,4,6} In response to the deficiencies demonstrated in the care of geriatric conditions, the second phase of the ACOVE (ACOVE-2) project developed a model to improve the care of older persons in community-based physicians' practices using existing resources. This paper describes how this model has been implemented in community-based primary care physicians' offices as part of a controlled clinical trial.

DESCRIPTION OF THE PROGRAM

Overview

The ACOVE-2 intervention was designed to improve the primary care provided to outpatients aged 75 and older who have at least one of three geriatric conditions: urinary incontinence, falls, or cognitive impairment/dementia. The intervention is integrated into the context of a regularly scheduled visit and begins with case finding, which is followed by a standardized multicomponent practice-change effort (Figure 1). For each condition, the intervention addresses specific processes of care identified in ACOVE as important to the care of older persons residing in the community.^{12–14}

If an older person is identified as having bothersome incontinence, falls (or fear of falling), or memory loss, a condition-specific intervention is initiated that employs four methods of changing medical practice.

1. efficient collection of condition-specific clinical data, including information collected by nonphysicians and automatic orders for simple procedures
2. medical record prompts to encourage performance of essential care processes
3. patient education materials and activation of the patient's role in follow-up
4. physician decision support and physician education

Intervention Components

Identifying Cases

A mechanism was implemented to screen patients for the relevant conditions. In the practices presented here, patients received a telephone call from an employee of the practice before a scheduled clinic visit to ask a brief series of questions to identify bothersome incontinence, memory loss, or falls or fear of falling (Figure 2). (Other means of screening could include in-office administration of the screen by office staff or administration of a patient previsit questionnaire.) These screening questions were designed for clinical rather than research purposes, and positive re-

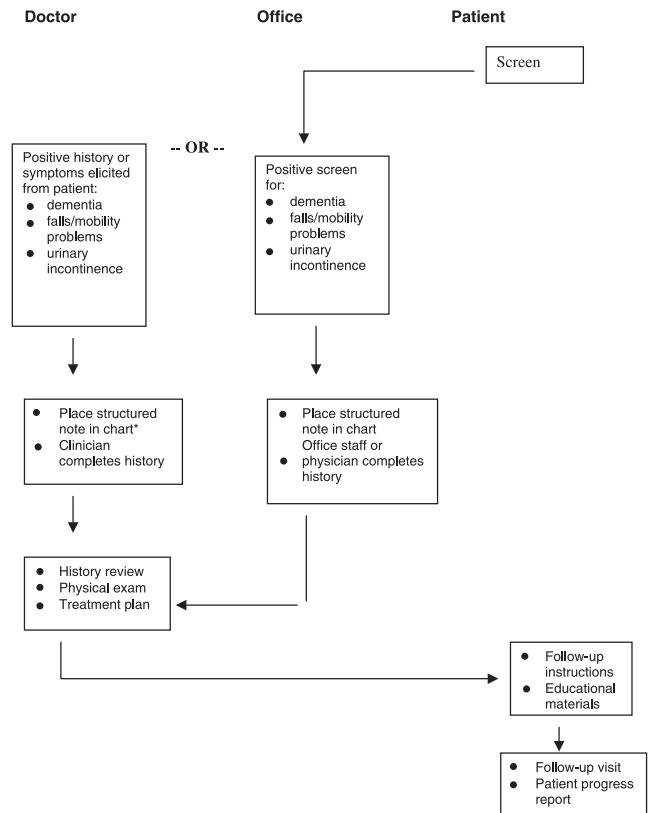


Figure 1. Assessing Care of the Vulnerable Elders-2 intervention process. *If the physician elicits symptoms, the physician has the materials readily available to insert them into the chart.

sponses aimed to identify clinical situations that should prompt a physician response. For example, rather than using a validated screen for identification of incontinence, a single question was constructed to identify incontinence that was bothersome enough that the patient would like to know more about how it could be treated. In this manner, only conditions of clinical importance were brought to the physician's attention. If patients were unable to respond to the questions (e.g., due to cognitive impairment), or if they preferred, a proxy was allowed to answer these items. The patient's (or proxy's) answers to these questions were given to his or her provider at the time of the clinic appointment.

Initiating the Intervention

Screening results (positive or negative) were placed on the patient's chart at the time of the visit. For patients who had a positive screen based on answers to previsit questions, additional condition-specific materials, including a structured visit note, were attached to the medical record at the time of the patient's scheduled visit. (These materials were also readily available in each examining room in the event that the clinician identified a case that the case-finding method described above did not detect.) If multiple conditions were triggered, the attachment of condition-specific materials was prioritized so that the physician was not inundated with forms to be completed at a single visit; the priority was memory loss, then falls, and finally incontinence. A physician could address more than one

Name: _____
 Study ID #: _____

Appointment date & time: _____
 Dr. _____

ACOVE-2: PATIENT/SURROGATE SCREEN

If patient is confused, an attempt is made to find a surrogate before any questions are asked. At any point, the patient may turn the call over to a surrogate for other reasons (e.g., hard of hearing, too sick to talk)

(New) In the **PAST 12 MONTHS**,
 OR
 (Established) Since your **LAST VISIT HERE**,

(CONDITION TRIGGERED)

1. Have you (if surrogate, has he/she):

- | | YES | NO |
|--|----------------------------|--------------------------|
| Fallen 2 or more times <i>(*Falls)</i> | <input type="checkbox"/> * | <input type="checkbox"/> |
| Fallen and hurt yourself or needed to see a doctor because of the fall <i>(*Falls)</i> | <input type="checkbox"/> * | <input type="checkbox"/> |
| Been afraid that you would fall because of balance or walking problems <i>(*Falls)</i> | <input type="checkbox"/> * | <input type="checkbox"/> |
| Had a problem with urinary incontinence (or your bladder) that is bothersome enough that you would like to know more about how it could be treated <i>(*UI)</i> | <input type="checkbox"/> * | <input type="checkbox"/> |

2. Patient: 3-item recall

- Patient recalled: 2-3 items
- * **1 item, no surrogate available** *(*Dementia)*
- * **0 items, no surrogate available** *(*Dementia)*
- * **Refused, no surrogate available** *(*Dementia)*
- Refused, no surrogate needed

If a patient fails the 3-item and a surrogate is available, the screening process starts over (the incontinence and falls data from the patient are discarded). The results are those given by the surrogate PLUS the results of the 3-item recall, if it was done.

3. Surrogate: Have you noticed that _____ has recently had more trouble than in the past with memory for day-to-day happenings around the house, such as remembering where he/she put things, recalling recent events, forgetting what you told him/her, or what he/she told you, remembering plans, appointments or phone calls?

- * **Yes** *(*Dementia)*
- No/Don't know

* indicates positive screen

(Medical Group logo here)

Patient Name: _____
 Med. Rec.# _____

Figure 2. Assessing Care of the Vulnerable Elders-2: Patient/Surrogate Screen.

condition during a visit or may have decided to schedule subsequent planned visits to address the other conditions.

Collecting Clinical Data

The content of the data collection forms was derived from literature reviews, quality indicators created for the ACOVE project, and clinical judgment. An example of a structured visit note is provided in Figure 3. Structured visit notes for other conditions are available upon request from the first author. A portion of this note contained history items (e.g., circumstances of fall, mobility) and simple procedures (e.g., vision screening) that the office staff could expediently complete to facilitate the physician's approach to the condition. The clinician decided how much and what to delegate. The structured visit note then guided the physician to consider potentially important historical and examination elements and suggested diagnostic tests that might be performed. The structured note also facilitated development of an impression and plan that was supported by patient education materials and physician decision support resources.

Patient Education Materials

Condition-specific patient information (e.g., home safety checklist and information about pelvic floor exercises, driving, and dementia), much of which was adapted from the National Institute on Aging's Age Pages, and condition-specific local community-based resources to facilitate management (e.g., community-based exercise groups, transportation assistance) were assembled for dementia, falls, and urinary incontinence. These information handouts were available in each clinician's examination room, in bins mounted on the office wall or hanging file folders on a portable stand, to facilitate treatment. The materials were designed to enhance patient understanding of the condition and to augment adherence to the treatment plan while reducing the effort required by clinicians to educate and instruct the patient. The materials also extended the management options beyond what the medical system could otherwise offer. For example, these materials facilitated patients accessing community-based services that were not provided by their physician or health plan.

Follow-Up Sheet

A condition-specific follow-up sheet was attached to the patient materials to stimulate continuity of care for the condition on the part of the patient and the physician. Specifically, this sheet prompted the patient to monitor the response to treatment and report problems or complications (including inability to adhere to the recommended treatment) to the clinician.

Decision Support and Physician Education

Each physician practice group participated in one small, 3-hour educational group session led by a geriatrician that demonstrated practical approaches to each of the three conditions within the context of a busy practice without adding length to the visit. Although these sessions provided some insight that conducting the recommended assessments might allow for billing at higher levels, the focus of the session was not on billing. Brief, written decision-support

information adapted from the American Geriatric Society's *Geriatrics at Your Fingertips*¹⁵ was also provided that described the management of each of the conditions. In addition, after several weeks of piloting the intervention, small group sessions were held with physicians to review charts of patients who triggered the intervention and to discuss physicians' experiences with restructuring the care for these conditions. At that time, the physicians were asked to make modifications in the protocol that would help facilitate in-office implementation and clinical management of the conditions.

Implementing the Intervention in Medical Groups

As part of a study that will assess the effectiveness of this intervention on processes and some outcomes of care, two medical practices (each composed of nine physicians, one also using a nurse practitioner) have implemented this system of caring for these conditions. One of the practices had geriatricians available, and a consultation could be requested at any physician's discretion. The other practice had no easily accessible geriatrician available. Both practices served patient populations that had large numbers of retirees and were primarily white and somewhat affluent. Persons aged 65 and older were estimated to represent 50% to 60% of each practice. With respect to payor mix for their older patients, one practice cared for almost exclusively managed care patients and the other for mostly fee-for-service Medicare patients. Each practice was required to address all three conditions using all components of the intervention, but they had flexibility in how the components were administered and the content of these components. For example, the practices modified the content of the structured visit notes to fit within their own guidelines (e.g., rules concerning when a neuroimaging test could be ordered for cognitive impairment). Groups also had considerable latitude in how the components were implemented (e.g., how much of the intervention office staff performed, rather than physicians). In a further modification of implementation, one group that relied primarily on dictated notes chose to reformat the structured visit note as a dictation template. The major barrier encountered in implementing the intervention was inconsistency in how enthusiastically physicians adopted the intervention. Although some quickly embraced the changes, others were slower converts, and some remained skeptical.

Costs Associated with the Program

The costs of this program included those required for start-up and those needed to maintain the program. Start-up costs included establishing a screening mechanism, customizing forms, identifying condition-specific local community-based resources, training physicians and office staff, and installing clinic materials. The estimated start-up costs vary depending upon how much time must be devoted to obtaining physician and staff "buy-in" and the extent to which the practice group revises the materials. Other start-up costs are estimated here for a medical group of 10 participating physicians. These include purchasing and stocking 20 rolling files of materials (\$1,600), creating and photocopying physician and medical assistant training manuals (\$80), physician training (\$1,250 honorarium for

PATIENT VISIT: FALLS/MOBILITY PROBLEMS

Reason for Visit: Fall since last visit (or in last year, if new patient) (MA: Complete Q1-5)
 Fear of falling due to balance/trouble walking only (MA: Complete Q4-5 only)

History of Present Illness:

- NO**
- Date last fall occurred: _____
 - Circumstances of fall: **YES** **NO**
 Loss of consciousness.....
 Tripped/stumbled over something.....
 Lightheadedness/palpitations.....
 Unable to get up within 5 minutes.....
 Needed assistance to get up.....
 - Orthostatics: (Measure after 1-2 min. in specified position)
 Lying: BP: ____/____ Pulse: ____
 Standing: BP: ____/____ Pulse: ____

4. Uses device for mobility? **YES**
- Cane.....
 Walker.....
 Wheelchair.....
 Other, specify: _____
5. Vision:
 Noticed recent vision change.....
 Eye exam in past year.....
- If **NO** eye exam in past year,
 visual acuity today:
 OS: 20/____ OD: 20/____ OU: 20/____

6. Psychotropic medications (specify): **YES** **NO**
 Neuroleptics: _____
 Benzodiazepines: _____
 Antidepressants: _____

7. 2 or more drinks alcohol each day **YES** **NO**
 8. Other conditions (e.g., Parkinson's, CVA, cardiac, neuropathy, severe OA), specify: _____

Examination:

1. **Cognition:** 3-Item recall: PASS FAIL If FAIL → Cognitive status:

2. **Gait:** NORMAL ABNORMAL

- Up-and-Go: ____ sec
Abnormal if: -Hesitant start -Heels do not clear toes of other foot
 -Broad-based gait -Heels do not clear floor
 -Extended arms -Path deviates

If indicated,
Timed-

-Stand from chair,
-Walk 10 feet,
-Turn around,
-Walk back,
-Sit down

3. **Balance:** **YES** **NO**
 Side-by-side, stable 10 sec....
 Semi-tandem, stable 10 sec..
 Full tandem, stable 10 sec....

- If indicated: **YES** **NO**
 Can pick up penny off floor.....
 Resistance to nudge.....

4. **Neuromuscular:** **YES** **NO**
 Quad strength: Can rise from chair w/o using arms...
 If indicated, hip ROM and knee exam:

- YES** **NO**
 Rigidity (e.g., cogwheeling).
 Brady kinesia.....
 Tremor.....

Diagnosis / Treatment Plan / Medical Decision Making:

Lab/Tests: EKG **Impression:** Strength problem Severe hip/knee OA
 Holter monitoring Balance problem Other: _____
 Other: _____ Parkinsonism

Treatment:

- Patient education handout:
 "Falls"
 "Home safety checklist"
 Strength/balance exercises:
 Upper body Lower body
 Community resources
 Community exercise program
 Other: _____
- Referral for PT
 Assistive device: _____
 Referral for home safety inspection/modifications
 Change in medication(s): _____
 Referral for eye exam
 Cardiology consult
 Neurology consult

Provider's Signature _____

Date of Service _____

See PATIENT CLINICAL SUPPLEMENT:

(Medical Group logo here)

Patient Name: _____

Med. _____

Rec.# _____

Figure 3. Patient Visit: Falls/Mobility Problems.

1.5 days of the geriatrics expert), and medical assistant training (\$400). Practice physician and medical assistant time spent receiving training is assumed to be noncompensated. Thus, total start-up costs are estimated at \$3,330 per practice.

Maintenance costs included time spent administering screens, additional staff time needed for the historical and examination components delegated to office staff, and the costs of stocking and updating the forms. This cost estimate assumes that each of the physicians sees 300 patients aged 75 and older during the course of a year, patients are screened when they are new to the practice and annually, medical assistants spend an average of 3 minutes screening each of these patients and an additional 3 minutes completing a designated portion of the patient history for the 30% of patients who have a positive screen, and medical assistants are compensated at a rate of \$12 per hour. Under these assumptions, the costs of medical assistant screening and history-taking time for 3,000 patients in a practice would be \$2,340, and the costs of stocking materials would be \$150; the total costs per patient screened would be 83 cents or \$2.77 per patient who screened positive. These costs do not include any additional physician time spent during the office visit to address these conditions. Based on the assumptions describe above and 240 office days per year, approximately 5.2 additional minutes per day of office staff time per physician would be required to administer the intervention to all persons aged 75 and older. Thus, the additional time to implement these practices would be unlikely to disrupt office flow sufficiently to require additional hiring or substantially lengthen wait times.

DISCUSSION

The structure of office-based clinical care is steeped in tradition. As noted by the Institute for the Future, "There has been little real change in the way physicians practice medicine since the invention of the telephone."¹⁶ As part of a study to improve the quality of care provided to older persons, the office-based management of three common and inadequately managed geriatric conditions was restructured.³ This restructuring was designed to overcome some of the major obstacles that contribute to inadequate care. Prior research has demonstrated deficits in case recognition (on the part of clinicians and patients) and physician knowledge of management concerning these conditions.^{17–20} Lack of patient adherence to treatment plans and inadequate follow-up (by patient and clinician) also may contribute to less-than-optimal outcomes. In addition, lack of time and resources are likely to be major barriers to the treatment of these conditions, which may be given less importance than other mainstream clinical conditions. Recognizing these obstacles, this model of care attempts to increase case recognition, educate and guide clinicians about essential care processes, provide patient education, and enhance follow-up while minimizing disruption of practice procedures and flow.

In addition to systematic attempts to overcome these barriers, the ACOVE-2 intervention draws upon organizational and educational principles that have been demonstrated to be effective in changing provider behavior.⁸ It also is consistent with a chronic care model that includes

community resources and health system changes, to create an informed, activated patient and a prepared, proactive provider.²¹ Nevertheless, this restructuring of care recognizes that changes, even if effective, must fit within the cost constraints of the current healthcare environment. Accordingly, the intervention was designed to be low-tech to facilitate its use within most practice settings and relatively low-cost, using only existing personnel whose roles have been modified. These advantages will facilitate dissemination if the intervention proves to be effective in changing the process of care. Moreover, the intervention will be easily adaptable to electronic medical records systems once these become more widely available.

It is important to recognize that this restructuring goes beyond simply providing tool kits to physicians. In fact, practitioners needed to demonstrate a commitment that they wanted to improve care for these conditions before the model could be implemented. This interest in change was an important factor in selecting sites and has been noted as a key issue in dissemination of research findings into practice.⁷ Once this commitment was secured, a critical step was working with the physicians to develop a model that they could use. In addition, the training component, which focused on the practical aspects of how a clinician can manage these conditions without adding substantially to the length of the visit, was essential. Merely providing the results of screening has not resulted in practice change or improved clinical outcomes.^{22,23}

Several limitations to this model of care must be recognized. First, this change was accomplished in the context of a research study. Thus, the decision to adopt this model was based on factors other than those that naturally guide adoption of innovations (knowledge, persuasion, decision, implementation, and confirmation).²⁴ Nevertheless, some guiding principles (relative advantage, complexity, compatibility, trialability, and observability) that promote behavior change with respect to adoption of innovation²⁴ were specifically and systematically incorporated in the development of the intervention. Because this program was initiated in the context of a research project, economic factors may have assumed less importance in deciding whether to adopt and implement these changes. Although the ACOVE-2 changes in care delivery were designed to have modest effects on the length of visits, any additional time must be justified by recognizable clinical value or increased compensation. Otherwise, the change will not be sustained. The current evaluation study relies on recognition of clinical value, although physicians were free to bill at higher levels if they believed that the additional evaluation justified doing so. In addition, the community-based practice had the assistance of health services researchers who had considerable experience in models of geriatric healthcare delivery. Moreover, the geriatrician who led the small group educational session was a senior academician. Whether other geriatricians could have similar influence remains uncertain. The generalizability of this model also is uncertain. Both of the practices in which implementation occurred were well-established, financially successful groups. Furthermore, the intervention has been limited to three conditions. It is unclear whether other geriatric conditions would fit this intervention format as well and whether the complexity of

addressing numerous conditions might overwhelm the practices. Most likely, physicians will need to prioritize multiple conditions, both geriatric and general medical, if more than one or two are present concurrently. Finally, the relative advantage of this model of geriatric practice compared with other potential methods of addressing these conditions is uncertain.

The effectiveness of this reorganization of medical care must be evaluated using a formal research design. Such a controlled trial is in progress. In the meantime, this demonstration of restructuring of office care for three common geriatric conditions indicates that substantive changes are feasible in community-based practices within the context of a research project.

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FALLS/MOBILITY PROBLEMS – Initial Visit

Reason for Visit: Fall (*Start at A*)
 Fear of falling ONLY (*Go to B*)

History:

A: Last fall: In past 4 wks >4 wks ago
 Circumstances of fall:

| | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| Loss of consciousness..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Tripped/stumbled over something..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Lightheadedness / palpitations..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Unable to get up within 5 minutes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Needed assistance to get up..... | <input type="checkbox"/> | <input type="checkbox"/> |

B: Knee or hip pain.....
 Currently uses device for mobility?
 Cane.....
 Walker.....
 Wheelchair.....
 Other, *specify*:.....
 2 or more drinks alcohol per day.....

| | | |
|--|--------------------------|--------------------------|
| Other medical conditions: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision: | | |
| Noticed recent vision change..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye exam in past year..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychotropic medications (<i>specify</i>): | | |
| Neuroleptics: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Antidepressants: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Benzodiazepines: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| a) IF YES to benzodiazepines, discontinued? ← | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Reason for benzodiazepine continuation: _____ | | ↘ |

Examination:

Lying: BP: ____/____ Pulse: ____ *(if no exam in past year)*
 Visual Acuity: OS: 20/____ OD: 20/____ OU: 20/____
 Standing: BP: ____/____ Pulse: ____

3-Item recall: **PASS** (2-3 words)
 FAIL (0-1 word) → Cognitive status:

Tinetti score: _____
 (Risk: 19-24; High risk: <19)
OR

Gait: **NORMAL** **ABNORMAL**

Timed-Up-and-Go: ____ sec
 (Normal ≤ 15 sec)

Abnormal if: -Hesitant start -Heels do not clear toes of other foot
 -Broad-based gait -Heels do not clear floor
 -Extended arms -Path deviates

-Stand from chair
 NOT using arms,
 -Walk 10 feet,
 -Turn around,
 -Walk back,
 -Sit down

| | | | | | |
|----------------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| <u>Balance:</u> | YES | NO | <i>If indicated:</i> | YES | NO |
| Side-by-side, stable 10 sec..... | <input type="checkbox"/> | <input type="checkbox"/> | Can pick up penny off floor..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Semi-tandem, stable 10 sec..... | <input type="checkbox"/> | <input type="checkbox"/> | Resistance to nudge..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Full tandem, stable 10 sec..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Hip Rotation **NORMAL** **ABNORMAL**

| | | | | |
|---|--------------------------|--------------------------|--|--------------------------|
| <u>Neuromuscular:</u> | YES | NO | YES | NO |
| <i>Quad strength:</i> Can rise from chair w/o using arms..... | <input type="checkbox"/> | <input type="checkbox"/> | Rigidity (<i>e.g., cogwheeling</i>)..... | <input type="checkbox"/> |
| <i>If indicated, hip ROM and knee exam:</i> | | | Bradykinesia..... | <input type="checkbox"/> |
| | | | Tremor..... | <input type="checkbox"/> |

Lab/Tests:

EKG Bone mineral density
 Holter (OH) Vitamin D level
 Other: _____

Impression:

Strength problem Parkinsonism
 Balance problem Severe hip/knee OA
 Gait problem Other: _____
 Cognitive impairment

Treatment:

| | |
|---|---|
| <input type="checkbox"/> Exercises: <input type="checkbox"/> Upper body <input type="checkbox"/> Lower body | <input type="checkbox"/> Referral for PT |
| <input type="checkbox"/> Community exercise program | <input type="checkbox"/> Assistive device: _____ <input type="checkbox"/> New <input type="checkbox"/> Review |
| <input type="checkbox"/> Home safety checklist given | <input type="checkbox"/> Referral for home safety inspection/modifications |
| <input type="checkbox"/> Community resource list given | <input type="checkbox"/> Change in medication(s): _____ |
| <input type="checkbox"/> "Falls" handout | <input type="checkbox"/> Referral for eye exam |
| <input type="checkbox"/> Footwear discussion/handout | <input type="checkbox"/> Cardiology consult |
| <input type="checkbox"/> Vitamin D 800 IU/day or ____ IU/day | <input type="checkbox"/> Neurology consult |
| <input type="checkbox"/> Ca carbonate 1200-1500 mg/day (Ca citrate if on PPI) | <input type="checkbox"/> Other: _____ |

Follow up: within 6 weeks
 within _____

Falls/Mobility Problems: Patient Follow-up Information

Name: _____

Today's date: _____

Falls are a common problem for older people and can lead to serious complications. In most cases, relatively simple things can help minimize this problem. Prevention of falls requires looking at many possible causes. Working with your doctor to identify these causes can reduce your risk of falling.

Your treatment plan:

- Patient education material: Falls
- Strength/balance exercises: Upper body Lower body
- Community exercise referral
- Assistive device: _____
- Physical therapy referral: _____
- Home safety checklist
- Other: _____

Additional instructions: _____

Please answer the following questions on the day of your next visit and bring this form with you to give to the nurse practitioner or doctor:

1. Did you have any problems with the treatment your doctor prescribed?

- No Yes (explain): _____

2. Have you fallen since your last visit?

- Yes No, but I feel unsteady and I'm afraid I'll fall No, and I'm NOT afraid I'll fall

If you continue to fall or feel so unsteady that you are afraid of falling, here are some questions you might discuss with the nurse practitioner or doctor at your next office visit:

- Do I need any more tests to find the cause of my unsteadiness or falling?
- Are any of my medications making me unsteady?
- Do I need physical therapy or strengthening exercises?
- Should I be using a device to help support me, like a cane or walker?
- Would hip protectors be of any benefit for me?
- Do I need modifications in my home like grab-bars or rails? How do I get these installed?
- Are there any community resources, such as classes that could help me?
- Should I be referred to a specialist?

Remember:

If you have any questions about your treatment or other concerns, do not hesitate to call this office for assistance.

Use ballpoint pen and press hard!

#120034

Name: _____

Date of visit: _____

MR #: _____

Date of birth: _____ Male Female

Dr: _____

PATIENT SURVEY

Please answer questions 1-5. Check all that apply to you.

- | | Yes | No |
|--|----------------------------|--------------------------|
| <i>Have you:</i> | | |
| 1. <i>Fallen</i> 2 or more times in the past 12 months? | <input type="checkbox"/> * | <input type="checkbox"/> |
| 2. <i>Fallen and hurt yourself since your last doctor's visit?</i> | <input type="checkbox"/> * | <input type="checkbox"/> |
| 3. Been <i>afraid of falling</i> because of balance or walking problems? | <input type="checkbox"/> * | <input type="checkbox"/> |
| 4. Had urinary incontinence (<i>lose your urine</i>) that is <i>bothersome</i> enough that you would like to know how it could be treated? | <input type="checkbox"/> * | <input type="checkbox"/> |
| 5. Over the past 2 weeks, how often have you been bothered by: | | |
| a) little interest or pleasure in doing things? | | |
| <input type="checkbox"/> 0 Not at all | | |
| <input type="checkbox"/> 1 Several days | | |
| <input type="checkbox"/> 2 More than half the days | | |
| <input type="checkbox"/> 3 Nearly every day | | |
| b) feeling down, depressed, or hopeless? | | |
| <input type="checkbox"/> 0 Not at all | | |
| <input type="checkbox"/> 1 Several days | | |
| <input type="checkbox"/> 2 More than half the days | | |
| <input type="checkbox"/> 3 Nearly every day | | |

FOR OFFICE USE ONLY:

3-item recall results: *0 *1 2 3 *Refused/Unable

*Current dx of cognitive impairment

PHQ-2 results: 0-2 *3-6

MD/NP: Current dx of heart failure? *Yes No

WHITE: Patient chart

YELLOW: Clinic file

PINK: UCLA

Falls

Adapted from the American Geriatrics Society Patient Education Forum by the UCLA Division of Geriatrics

What are the risks of falls?

The chances of injury from falling increase as one gets older. About half the falls older people have are due to accidents and about half are health-related. Most falls result in a quick recovery. However, some falls, particularly those that result in fractures, cause permanent disability and can even shorten lives.

Falls cause more bone fractures in older people because osteoporosis (weak bones) affects 1 in 4 women age 60 or older and nearly half of all people over age 75. By the age of 90, one woman in 4 has fallen and fractured her hip.. A serious fall often results in a loss of confidence, fear of falling, and a dependence on others.

How do falls occur?

As one gets older, eyesight and hearing decline. Reflexes tend to slow. There is less coordination and muscle strength to take action in avoiding a fall. Medical conditions like heart disease or low blood pressure can affect balance. Medications or the use of alcohol may cause lightheadedness. Arthritis can throw a person off balance. In addition, people often aren't aware of the fall hazards they have in their homes.

What are the symptoms that may lead to falls?

Feelings of dizziness, lightheadedness, or weakness may be caused by underlying medical problems or a fall may be the first symptom of serious illness, such as a heart attack, stroke, internal bleeding, or pneumonia. It may also be the first sign of a serious drinking problem. A fall that causes a bone fracture may be the first sign of osteoporosis.

What should I do after a fall?

If you are injured after a fall, obtain medical assistance. Even if there appears to be little or no injury, call your doctor. If you have severe pain in your hip or groin, call an ambulance or emergency number and get immediate emergency treatment. . It is possible to fracture a hip and still be able to get up. In addition, a fall may be the first symptom of other serious illness. Your doctor or an emergency department physician will examine you and may order x-rays or other tests.

How can I take care of myself to avoid falls?

- Have your vision and hearing checked regularly and, if necessary, corrected.
- Use a cane, walker, or walking aid if advised to do so.
- If you are on medication, take it regularly and as directed.
- Tell your doctor if you think your medication affects your balance or causes dizziness.
- Exercise daily to keep muscles in tone and help prevent osteoporosis.
- Eat calcium-rich food, such as dairy products and green vegetables, to help prevent osteoporosis.
- Discuss specific medications for osteoporosis with your doctor.

Preventing falls in your home

Homes can be full of fall hazards. Common ones include slippery floors, worn rugs and stair treads, furniture in the way, poor lighting, and trailing electric cords.

- Try to have nonslip floors. Use nonskid mats, especially on floors that may get wet.
- Carpet and stair treads should be tacked down firmly. Replace or cover worn areas on carpet or treads.
- Use good lighting. Have light switches at both ends of stairs and hallways.
- Have a small night light on in case you need to get up at night.
- Don't have loose or trailing electric cords across the floors.
- Arrange furniture so it is not in the way when you walk around the house.
- Install grab bars for the bathtub, shower, and toilet.
- Don't use a long bathrobe you can trip over.
- Store food and regularly used items where they can be easily reached.

Preventing falls in your daily activities

- Get up slowly after lying down or resting. Sit down if you feel lightheaded.
- Wear rubber-soled, low-heeled shoes that fasten securely.
- Exercise daily to keep muscles firm and joints flexible. Stop and rest if you feel faint.
- Limit your use of alcohol.

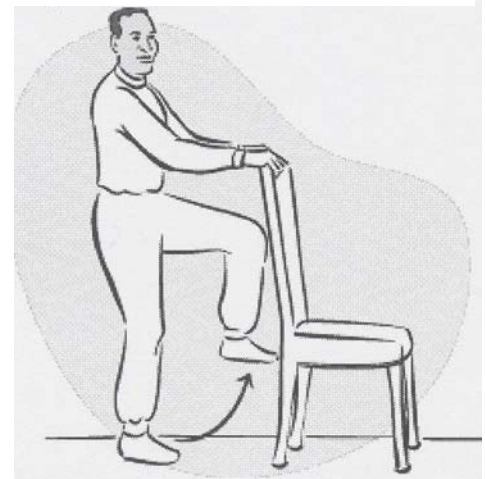
Lower Body Strength/Balance Exercises

Hip Flexion

Strengthens thigh and hip muscles. Use ankle weights, if you are ready to. Stand to the side or behind a chair or table, holding it with one hand for balance. Take 3 seconds to bend your left knee and bring it as far toward your chest as possible. Stand straight throughout, without bending at the waist or hips. Hold position for 1 second, then take 3 seconds to lower your left leg all the way down. Repeat with right leg; alternate legs until you have done 8 to 15 repetitions on each side. Rest; then do another set of 8 to 15 alternating repetitions.

Summary:

1. Stand straight, holding tall, stable object for balance.
2. Slowly bend one knee toward chest, without bending waist or hips.
3. Hold position.
4. Slowly lower leg all the way down.
5. Repeat with other leg.



Hip Extension

Strengthens buttock and lower-back muscles. Use ankle weights, if you are ready to. Stand 12 to 18 inches away from a table or chair, feet slightly apart. Bend forward from the hips, at about a 45-degree angle, holding onto the table or chair for balance. In this position, take 3 seconds to lift your left leg straight behind you without bending your knee, pointing your toes, or bending your upper body any farther forward. Hold the position for 1 second. Take 3 seconds to lower your left leg back to the starting position. Repeat with right leg. Alternate legs, until you have repeated the exercise 8 to 15 times with each leg. Rest; then do another set of 8 to 15 alternating repetitions with each leg.

Summary:

1. Stand 12 to 18 inches from table.
2. Bend at hips; hold onto a table.
3. Slowly lift one leg straight backwards.
4. Hold position.
5. Slowly lower leg.
6. Repeat with other leg.



Knee Flexion

Strengthens muscles in back of thigh. Use ankle weights, if you are ready to. Stand straight, very close to a table or chair, holding it for balance. Take 3 seconds to bend your left knee so that your calf comes as far up toward the back of your thigh as possible. Don't move your upper leg at all; bend your knee only. Take 3 seconds to lower your left leg all the way back down. Repeat with right leg. Alternate legs until you have done 8 to 15 repetitions with each leg. Rest; then do another set of 8 to 15 alternating repetitions.

Do knee flexion as part of your regularly scheduled strength exercises, and add these modifications as you progress: Hold table with one hand, then one fingertip, then no hands; then do exercise with eyes closed, if steady.

Summary:

1. Stand straight; hold onto table or chair for balance.
2. Slowly bend knee as far as possible so foot lifts up behind you.
3. Hold position.
4. Slowly lower foot all the way back down.
5. Repeat with other leg.

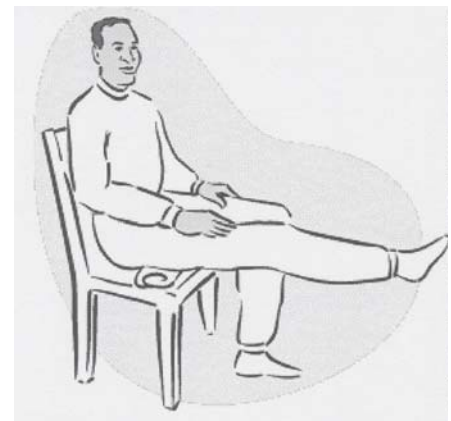


Knee Extension

Strengthens muscles in front of thigh and shin. Use ankle weights, if you are ready to. Sit in a chair, with your back resting against the back of the chair. If your feet are flat on the floor in this position, you should place a rolled-up towel under your knees to lift them up. Only the balls of your feet and your toes should be resting on the floor. Rest your hands on your thighs or on the sides of the chair. Take 3 seconds to extend your right leg in front of you, parallel to the floor, until your knee is straight. With your right leg in this position, flex your foot so that your toes are pointing toward your head; hold your foot in this position for 1 to 2 seconds. Take 3 seconds to lower your right leg back to the starting position, so that the ball of your foot rests on the floor again. Repeat with left leg. Alternate legs, until you have done the exercise 8 to 15 times with each leg. Rest; then do another set of 8 to 15 alternating repetitions.

Summary:

1. Sit in chair. Put rolled towel under knees, if needed.
2. Slowly extend one leg as straight as possible.
3. Hold position and flex foot to point toes toward head.
4. Slowly lower leg back down.
5. Repeat with other leg.



Side Leg Raise

Strengthens muscles at sides of hips and thighs. Use ankle weights, if you are ready to. Stand up straight, directly behind a table or chair, feet slightly apart. Hold onto the table to help keep your balance. Take 3 seconds to lift your right leg 6 to 12 inches out to the side. Keep your back and both legs straight. Don't point your toes outward; keep them facing forward. Hold the position for 1 second. Take 3 seconds to lower your leg back to the starting position. Repeat with left leg. Alternate legs, until you have repeated the exercise 8 to 15 times with each leg. Rest; do another set of 8 to 15 alternating repetitions.

Summary:

1. Stand straight, directly behind table, feet slightly apart.
2. Hold table for balance.
3. Slowly lift one leg to side, 6-12 inches.
4. Hold position.
5. Slowly lower leg.
6. Repeat with other leg.
7. Back and both knees are straight throughout exercise.



Plantar Flexion

Strengthens ankle and calf muscles. Use ankle weights, if you are ready to. Stand straight, feet flat on the floor, holding onto the edge of a table or chair for balance. Take 3 seconds to stand as high up on tiptoe as you can; hold for 1 second, then take 3 seconds to slowly lower yourself back down. Do this exercise 8 to 15 times; rest a minute, then do another set of 8 to 15 repetitions. As you become stronger, do this exercise first on your right leg only, then on your left leg only, for a total of 8 to 15 times on each leg. Rest a minute, then do another set of 8 to 15 alternating repetitions.

Summary:

1. Stand straight, holding onto a table or chair for balance.
2. Slowly stand on tip toe, as high as possible.
3. Hold position.
4. Slowly lower heels all the way back down.

Variation, as strength increases:

Do the exercise standing on one leg only, alternating legs.



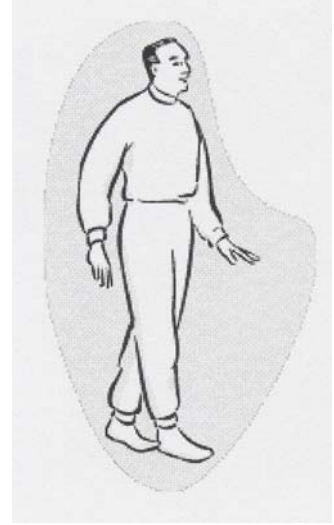
Lower Body Strength/Balance Exercises

Anytime/Anywhere

These types of exercises also improve your balance. You can do them almost anytime, anywhere, and as often as you like, as long as you have something sturdy nearby to hold onto if you become unsteady.

Examples:

- *Walk heel-to-toe. Position your heel just in front of the toes of the opposite foot each time you take a step. Your heel and toes should touch or almost touch. (See Illustration.)*
- *Stand on one foot (while waiting in line at the grocery store or at the bus stop, for example). Alternate feet.*
- *Stand up and sit down without using your hands.*



Upper Body Strength Exercises

Arm Raise

Strengthens shoulder muscles. Sit in a chair, with your back straight. Your feet should be flat on the floor, spaced apart so that they are even with your shoulders. Hold hand weights straight down at your sides, with your palms facing inward. Take 3 seconds to lift your arms straight out, sideways, until they are parallel to the ground. Hold the position for 1 second. Take 3 seconds to lower your arms so that they are straight down by your sides again. Pause. Repeat 8 to 15 times. Rest; do another set of 8 to 15 repetitions.



Summary:

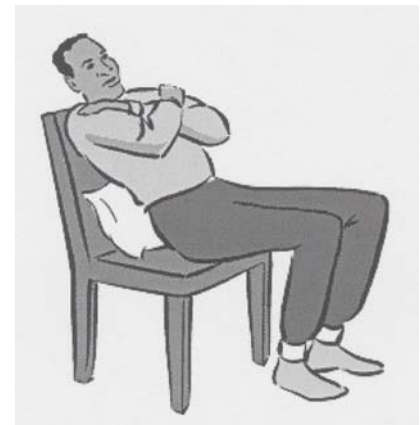
1. Sit in chair.
2. Feet flat on floor; keep feet even with shoulders.
3. Arms straight down at sides, palms inward.
4. Raise both arms to side, shoulder height.
5. Hold position.
6. Slowly lower arms to sides.

Chair Stand

Strengthens muscles in abdomen and thighs. Sit toward the middle or front of a chair and lean back so that you are in a half-reclining position, with back and shoulders straight, knees bent, and feet flat on the floor. Be sure to place pillows against the lower back of the chair first, to support your back and keep it straight. Using your hands as little as possible (or not at all, if you can), bring your back forward so that you are sitting upright. Your back should no longer be leaning against the pillows. Keep your back straight as you come up, so that you feel your abdominal muscles do the work; don't lean forward with your shoulders as you rise. Next, with feet flat on the floor, take at least 3 seconds to stand up, using your hands as little as possible. As you bend slightly forward to stand up, keep your back and shoulders straight. Take at least 3 seconds to sit back down. Your goal is to do this exercise without using your hands as you become stronger. Repeat 8 to 15 times. Rest; then repeat 8 to 15 times more.

Summary:

1. Place pillows against back of chair.
2. Sit in middle or toward front of chair, knees bent, feet flat on floor.
3. Lean back on pillows, in half-reclining position, back and shoulders straight.
4. Raise upper body forward until sitting upright, using hands as little as possible.
5. Slowly stand up, using hands as little as possible.
6. Slowly sit back down.
7. Keep back and shoulders straight throughout exercise.



Biceps Curl

Strengthens upper-arm muscles. Sit in an armless chair, with your back supported by the back of the chair. Your feet should be flat on the floor, spaced apart so that they are even with your shoulders. Hold hand weights, with your arms straight down at your side, palms facing in toward your body. Take 3 seconds to lift your left hand weight toward your chest by bending your elbow. As you lift, turn your left hand so that your palm is facing your shoulder. Hold the position for 1 second. Take 3 seconds to lower your hand to the starting position. Pause, then repeat with right arm. Alternate until you have repeated the exercise 8 to 15 times on each side. Rest, then do another set of 8 to 15 alternating repetitions.

Summary:

1. Sit in armless chair, with your back supported by back of chair.
2. Feet flat on floor; keep feet even with shoulders.
3. Hold hand weights at sides, arms straight, palms in.
4. Slowly bend one elbow, lifting weight toward chest. (Rotate palm to face shoulder while lifting weight.)
5. Hold position.
6. Slowly lower arm to starting position.
7. Repeat with other arm.



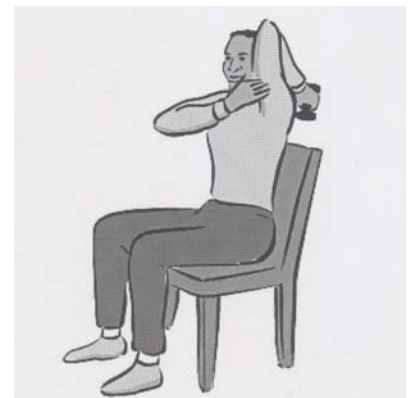
Triceps Extension

(If your shoulders aren't flexible enough to do this exercise, see alternative "Dip" exercise, on next page.)

Strengthens muscles in back of upper arm. Sit in a chair, toward the front. Your feet should be flat on the floor, spaced apart so that they are even with your shoulders. Hold a weight in your left hand, and raise your left arm all the way up, so that it's pointing toward the ceiling, palm facing in. Support your left arm by holding it just below the elbow with your right hand. Slowly bend your left arm so that the weight in your left hand now rests behind your left shoulder. Take 3 seconds to straighten your left arm so that it's pointing toward the ceiling again. Hold the position for 1 second. Take 3 seconds to lower the weight back to your shoulder by bending your elbow. Keep supporting your left arm with your right hand throughout the exercise. Pause, then repeat the bending and straightening until you have done the exercise 8 to 15 times with your left arm. Reverse positions and repeat 8 to 15 times with your right arm. Rest; then repeat another set of 8 to 15 repetitions on each side.

Summary:

1. Sit in chair, near front edge.
2. Feet flat on floor; keep feet even with shoulders.
3. Raise one arm straight toward ceiling.
4. Support this arm, below elbow, with other hand.
5. Bend raised arm at elbow, bringing hand weight toward same shoulder.
6. Slowly re-straighten arm toward ceiling.
7. Hold position.
8. Slowly bend arm toward shoulder again.



Alternative "Dip" Exercise For Back of Upper Arm

Sit in a chair with armrests. Lean slightly forward, keeping your back and shoulders straight. Hold onto the arms of the chair. Your hands should be level with the trunk of your body, or slightly farther forward. Place your feet slightly under the chair, with your heels off the ground and the weight of your feet and legs resting on your toes and the balls of your feet. Slowly lift yourself up, using your arms, as high as you can. This pushing motion will strengthen your arm muscles even if you aren't yet able to lift yourself up off of the chair. Don't use your legs or feet for assistance, or use them as little as possible. Slowly lower yourself back down. Repeat 8 to 15 times. Rest; repeat another 8 to 15 times.

Summary:

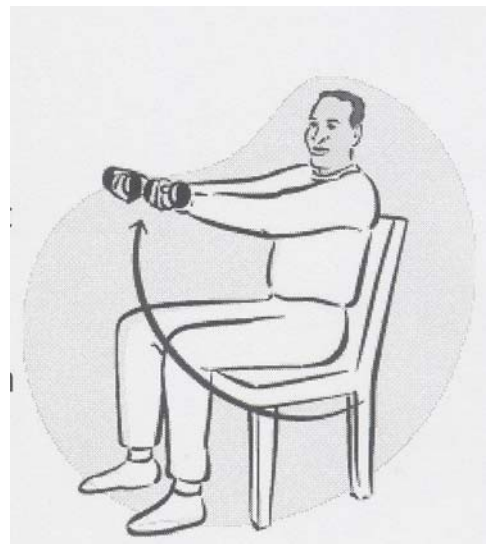
1. *Sit in chair with armrests.*
2. *Lean slightly forward, back and shoulders straight.*
3. *Grasp arms of chair.*
4. *Tuck feet slightly under chair, weight on toes.*
5. *Slowly push body off of chair using arms, not legs.*
6. *Slowly lower down to starting position.*

Shoulder Flexion

Strengthens shoulder muscles. Sit in a chair, with your back straight. Your feet should be flat on the floor, spaced apart so that they are even with your shoulders. Hold hand weights straight down at your sides, with your palms facing inward. Take 3 seconds to lift your arms in front of you, keeping them straight and rotating them so that your palms are facing upward, until your arms are parallel to the ground. Hold the position for 1 second. Take 3 seconds to lower your arms so that they are straight down by your sides again. Pause. Repeat 8 to 15 times. Rest; do another set of 8 to 15 repetitions.

Summary:

1. *Sit in chair.*
2. *Feet flat on floor; keep feet even with shoulders.*
3. *Arms straight down at sides, palms inward.*
4. *Raise both arms in front of you (keep them straight and rotate so palms face upward) to shoulder height.*
5. *Hold position.*
6. *Slowly lower arms to sides.*



Community Resources for FALLS - Westside

Agencies

Arthritis Foundation
4311 Wilshire Boulevard #530
Los Angeles CA 90010
323-954-5750
www.arthritis.org/Communities/Chapters
Provides a variety of services, programs, and classes.

Stroke Activity Center
Help Line: 310-575-1699
www.strokesocal.org
Serves stroke survivors and caregivers in LA. Provides education and support regarding stroke.

Senior Centers

Offer classes and services, as well as social activities and meals. Please contact the Senior Center in your area for specific programming/information.

Santa Monica Sr Center
1450 Ocean Avenue
Santa Monica CA 90401
310-479-4119
310-458-8644

Felicia Mahood Center
11338 Santa Monica Boulevard
Los Angeles CA 90025
310-479-4119

Pico-Robertson Storefront
8838 W. Pico Boulevard
Los Angeles CA 90035
310-271-3306

Freda Mohr Multipurpose Center
330 North Fairfax Avenue
Los Angeles, CA 90036
323-937-5900

Fairfax Senior Center
7929 Melrose Avenue
Los Angeles CA 90046
323-653-1824

Roxbury Park Community Center
471 S. Roxbury Drive
Beverly Hills CA 90212
310-550-4761

Culver City Senior Center
4153 Overland Ave
Culver City CA 90230
310-253-6700

Israel Levin Senior Adult Center
201 Ocean Front Walk
Venice CA 90291
310-396-0205

Santa Monica Family YMCA
1332 6th Street
Santa Monica CA 90404
310-393-2721

Food/Meal Delivery

County of Los Angeles Area Agency on Aging
213-738-4004
www.dcss.co.la.ca.us
Please call to locate delivery organization in your area

City of Los Angeles Area Agency on Aging
213-368-4000
www.cityofla.org/DOA
Please call to locate delivery organization in your area.

Community Resources for FALLS - Westside

Transportation

City Ride

213/323/310/818 808-7433

www.transitchannel.com/cityride

Transportation program for individuals in the City of Los Angeles aged 65 or older and persons with mobility impairments. Registrants may purchase a book of 66 transit scrip once quarterly and use them to obtain MTA monthly bus passes and discounts on taxis, private lift vans and CityRide/Dial-a-Ride services.

ACCESS Transportation Services

800-827-0829

800-827-1359 TDD

www.asila.org

Countywide transportation program for the elderly and disabled and their caregivers. Application available by phone or online.

Santa Monica Big Blue Bus

310-451-5444

www.bigbluebus.com

Senior discounts available with Medicare card or DMV Senior Citizen ID.

City of Beverly Hills Senior Adult Shuttle

310-275-2791

www.ci.beverly-hills.ca.us

Offers shared-ride shuttle service by appointment only, for Beverly Hills residents only.

Home Safety/Durable Medical Equipment (DME)

Home Secure Programs: Home Secure installs, for free or at very low cost, safety and security devices to assist people with disabilities on a fixed or limited income. Several different community agencies offer this service:

Jewish Family Service

323-937-5855

Delta Sigma Theta

2528 West Boulevard

Los Angeles CA 90016

323-735-5799

George & Helen Thomas Sr Ctr

2475 Washington Boulevard

Los Angeles CA 90018

323-734-9091

Durable Medical Equipment (DME): Although most DME is covered by Medicare/Medi-Cal/private insurance, there are restrictions as to kind, combination, and length of use. Additionally, some DME is not covered by any insurance (ie: over-bed tables). Please ask the individual company about cost/coverage. Inclusion on this list does not constitute an endorsement of any kind. Please check your local yellow pages for additional DME companies.

Carepoint Health Service

1314 Westwood Blvd

Los Angeles CA

310-441-5350

General Medical Co.

1935 Armacost Ave

Los Angeles CA

310-820-5881

Continental Hospital Supply

325 W Cerritos Ave

Glendale CA

818-547-3374

Century Home Healthcare Inc.

11852 Santa Monica Blvd # 2

Los Angeles CA

310-571-3355

Westside Home Medical Equip.

2743 S Robertson Blvd

Los Angeles CA

310-204-2375

Community Resources for FALLS - Westside

Exercise/Flexibility Programs

Physical exercise is important for health maintenance for senior adults. Please contact the individual programs/ organizations for schedules/additional information. Check the local Senior Center for classes, as well. Inclusion on this list in no way constitutes an endorsement by UCLA Geriatrics.

**LA Dept of Parks and Recreation
Cheviot Hills Pool**
2643 Motor Ave
Los Angeles, CA 90064
310-202-2844

Venice High School
2490 Walgrove Ave
Los Angeles CA 90066
310-575-8260

Westside Family YMCA
11311 LaGrange Avenue
Los Angeles California 90025
310-477-1511

Mar Vista Pool
11430 Woodbine Ave
Los Angeles, CA 90066
310-390-2016

Roxbury Park Community Center
471 S. Roxbury Drive
Beverly Hills CA 90212
310-550-4761

Santa Monica Family YMCA
1332 Sixth Street
Santa Monica CA 90406
310-393-2721

Rustic Canyon Pool
601 Latimer Road
Pacific Palisades, CA 90402
310-230-0137

Santa Monica JCC
2601 Santa Monica Blvd.,
Los Angeles California 90404
310-828-3433

Culver Palms Family YMCA
4500 Sepulveda Boulevard
Culver City CA 90230
310-390-3604

Stoner Park Pool
1835 Stoner Ave.
Los Angeles, CA 90025
310-575-8286

Westside JCC
5870 West Olympic Blvd.,
Los Angeles California 90036
323-938-2531

**City of Los Angeles Pools
Westwood Recreation Center**
1350 Sepulveda Blvd
Los Angeles CA 90025
310-478-7019

Palisades-Malibu YMCA
821 Via de la Paz
Pacific Palisades California 90272
310-454-5591

Community Resources for FALLS - Westside

Exercise/Flexibility Programs (continued)

Brentwood Yoga
11740 San Vicente
Los Angeles CA 90049
310-442-5900

Yoga Works Main Street
2215 Main Street
Santa Monica CA 90405
310-393-5150

Bay Cities JCC
2601 Santa Monica Blvd.
Santa Monica, CA 90404
310-828-3433

Yoga Works Montana
1426 Montana Ave 2nd Floor
Santa Monica CA 90403
310-393-5150

Israel Levin Senior Adult Center
201 Ocean Front Walk
Venice CA 90291
310-396-0205

Pan Pacific Park Senior Club
141 South Gardner Street
Los Angeles CA 90036
323-939-0275

Other Useful Websites/Information

Community Resources:

www.la4seniors.com
www.hollywood4seniors.com
www.aging.ucla.edu
www.centerforhealthyaging.com

Governmental Sites:

www.dmv.ca.gov (Dept. of Motor Vehicles)
www.lapublichealth.org (Dept. of Health)

Veterans Information:

www.jwv.org (Jewish War Veterans)
www.va.gov (Veteran's Administration)
www.nvlsp.org (Veteran's Legal Services)

Emergency Response Systems:

www.protect-your-parents.com
www.lifelinesys.com

Hip Protectors

www.hipprotector.com
www.hipsaver.com
www.safehip.com