FAST (Fall Arrest Strategy Training) and Balance Flow Yoga World Café Discussions

1. **What are your experiences and background (general introductory)**

Group 1: Community Engagement – Promoting the fall prevention message

- Several of the participants were either yoga instructors or had a combined yoga/physical therapy practice. There were also a number of physiotherapists. Three participants were from Saskatoon, one from Calgary, one from Michigan and one from Texas.

Group 2: Integrating Yoga into a Fall Prevention Plan

- No info provided

Group 3: Establishing best practice fall risk assessment and prevention in clinical settings

- No info provided

Group 4: Leading Fall Prevention Programs in the Community

- Various backgrounds – FIM leaders, Yoga instructors, physiotherapists, CRNS, etc.

Group 5: Remote/rural and vulnerable populations

- No info provided

2. **What are the facilitators and challenges you have experienced or have heard of?**

Group 1: Community Engagement – Promoting the fall prevention message

- Difficulty getting the word out
    - advertising is expensive
    - messaging is fragmented
    - cultural barriers & the "macho thing"
    - people in denial and not thinking about the future
- Technology and remote learning challenges
    - technology hard for some older adults
    - harder to safely push balance challenges
    - don't want to leave people out
- Messaging
    - difference between deficit ("need help") verses positive ('building balance/strength/etc..")
    - need a wider scope across ages
    - yoga is not seen as "strength training"
- Building a community or a network was noted as a way to get at many of the challenges

Group 2: Integrating Yoga into a Fall Prevention Plan

- Condition specific challenges with public yoga classes - do not get the participant's background and intake that you would get in other yoga therapy settings or professional practices.
    - How do public classes keep classes accessible to variety of populations, but keep participants safe and stay within scope of practice of a class instructor?
- Keeping classes safe
    - important to use language to give sense of control and safety, without sense of fragility or fear-mongering.
    - How do we know if yoga instructors are properly trained? Is there a process of training to ensure safety?
- Language focus on healthy aging, self-empowerment, and fall prevention not on performance;
    - people tend to focus on performance, competition and esthetics.
- The public (and especially the older adult population) don't know where to find yoga classes that are appropriate, safe and accessible for aging or fall-risk populations.
- Culture of yoga
    - has become a 'drop-in class' culture, which is conflicting with the value of community that is so important from the research.
    - primarily for the 'young, able-bodied and wealthy'
    - unfortunately yoga has become an ageist, ableist and elitist activity.
    - Instructors are often young able-bodied females with revealing clothing and marketed as acrobatics, therefore can be intimidating and challenging for aging population with diverse abilities to want to try it out.
- Cost

    - although class options are more affordable than private one-on-one coaching/training or therapy, it still leaves out a large portion of population that can't afford drop-in class rates.
    - Funding – challenging to find funding for community programs like yoga in long term care or senior centers.
    - If an affordable or free center is found to offer yoga (like a town hall or community center), then don't have props like chairs or mats like studios do.
- Facilitators
    - Reached out to retirement center to teach accessible yoga and mobility class to residents – there wasn't any funding fom the center, but residents and family pay instructor out of pocket.
    - Reached out to special associations: for example, a yoga professional has contract with National Ataxia Association to teach accessible online yoga classes (live and recorded library of videos).
    - Offer online classes – can make it accessible and affordable for many.
    - Connect with Accessible Yoga Association – a global community organization that leads the way in making yoga more accessible and inclusive to marginalized populations, including elderly and those with diverse abilities and socioeconomic backgrounds.

Group 3: Establishing best practice fall risk assessment and prevention in clinical settings

- Facilitators
    - Having lots of other perspectives including OT to help with adapting equipment
    - Multidisciplinary team helps to offer a team approach for clients
    - Using outcome measures i.e. Berg to help set goals and to work on areas of challenge
- Challenges
    - Not a lot of knowledge within the clinic and resources available as mostly younger clients
    - Helping a client with dementia to learn how to use a walking aid which could put her at more risk of falling
    - Individuals with decreased cognitive abilities often can't follow exercise programs
    - Sedentary lifestyles leads to weakness and increased risk of falls
    - COVID

Group 4: Leading Fall Prevention Programs in the Community

- You have to convince people they want to come to your class – important to name the program in a way to entice them. People have to be educated to the importance of exercise to prevent falls.
- More men should be involved – importance of how to title a program – need a varied level of difficulty to challenge the men in the class so they feel they are getting a benefit. They need to be convinced of the benefits of exercising to them. Men leaders can help entice men to try it.
- Caregivers are too tired to offer a program

- People don't think about falls until they have one – no thought of "Fall Proofing". When you are exercising you can recover better and reduce the severity of the fall.
- People need to be educated to react & regain balance (without thinking about it) – practice. Exposure and avoidance to risk are both needed.
- Exercises to keep us in shape should start pre-50 years of age – how to convince people.
- There is frustration that the emphasis is on post injury treatment rather than on prevention in the health care system.
- Some people don't participate in a program because they don't think they are good enough for the class. How to advertise to let them know they likely can come.
- People can do wall push-ups, use items around the house for weights, to exercise at home.
- Some instructors wonder how they can translate the info in the study videos to their programs. How to add this to the FIM program when you already don't have time to do the exercises you want to include. For example the punch-out exercise is important.

Group 5: Remote/rural and vulnerable populations

- Unclear what 'vulnerable' population means? Underserved, high risk?
- Virtual:
    - Pandemic opened up use and acceptability of digital platforms for health care and programming.
    - There was increased comfort with use by participants/ clients and hcp's because it was the only option for a while.
    - Concerns/ barriers that may miss the human connection and social aspects with online/ virtual platforms
    - Digital platforms need to be EASY to use for end users
- People who need programming most, may not KNOW they need it
    - Who benefits most?
    - Need to communicate the WHY
    - Suggestions through physician's offices (TV screens in waiting rooms)
- Marketing/ programming for farming communities needs to consider seasonality (e.g. seeding and harvest are times where there is likely to be lower uptake)

3. **Based on the research you heard about today, what would you recommend or do differently?**

Group 1: Community Engagement – Promoting the fall prevention message

- Increase opportunities for socialization -> pre and post sessions
- Developing communities
  (NOTE: There was a lot of discussion about creating communities and including socialization)
- Males may need more word-of-mouth messaging, target groups
- Yoga -> more sitting up rather than lying down to attract different groups

Group 2: Integrating Yoga into a Fall Prevention Plan

- Learned the body can be prepared for impact with falling
- Need to be thrown off balance to challenge it – it's ok to add some challenge (in yoga classes there is traditionally only a focus on keeping optimal alignment in a static position, and no practices that challenge dynamic balance or reactions).
- There is a lot of fear ending up in a position (?fallen) and need to support increasing confidence
- Incorporate upper body weight bearing activities more in yoga classes: Landing on hands, challenge reaction times, controlling descent.
- Yoga practices and principles inherently include the ingredients for fall prevention and fall arrest strategy training – so yoga professionals just need to be aware of what those are, and be sure to highlight them in class.

Group 3: Establishing best practice fall risk assessment and prevention in clinical settings

- Adding in upper extremity exercises
- Working on controlled falls using the wall
- Find ways to challenge balance (it has to be hard and wobbly)
- Need more reaction type of exercises
- Incorporate yoga into group exercises

Group 4: Leading Fall Prevention Programs in the Community

- Need to reach out to those nearby – integrate information from FAST videos into our programs. Marketing is important.

Group 5: Remote/rural and vulnerable populations

- Having an easily accessible and up to date clearinghouse/ list of resources of where community based programming is being offers, contacts, online/ vs in person would be helpful for hcp's thoughout the province and community members
- Consider how fall prevention/ promotion can be integrated into the rehab continuum (e.g. after someone receiving rehab post injury or surgery, provide referals or information re community-based options/ programming)

- Consider how best to serve those with more complex health needs (e.g. neuro conditions, multimorbidity) in the community.
- These groups may not be as mobile and have more challenges accessing community programming
- Community initiated and led programming is essential for uptake in rural and remote communities
- Better buy-in from community
- Tailored programming to meet unique cultural and other needs of rural/ remote communities
- Consider reaching out through platforms like the Ag Health & Safety Network (30K+ families) (through the CCHSA) to reach farm families (e.g. risk of falls, preventions tips, information on programming, link with FIM/ SOYF co-ordinators etc…)
- Rural and remote communities have potentially greater need/ risk for falls yet less resources and programming options compared to urban
- More research should target rural and remote communities/ participants
- Programming needs to be FUN (i.e. more than just exercise)
- Rural HCPs would like more information on HOW to design and implement community-based programming (opportunity for continuing ed)
- Consider potential higher inherent risk for falls in rural, remote & agricultural settings

4. **What are ways we can work together to decrease challenges and barriers for older adult participation?**

Group 1: Community Engagement – Promoting the fall prevention message

- Encourage learning of new technology; provide more tech support
- Promote remote reach of programming to the health care system; try to overcome resistance from some doctors
- Messaging about financial barriers; the investment is worthwhile

Group 2: Integrating Yoga into a Fall Prevention Plan

- Need more diverse instructors, classes and marketing that address aging population of different abilities and socioeconomic backgrounds.
- If you teach classes for older adults, perhaps market to the person's family (older adults may not be on social media; but their families are). Remember to also market where the older adult spends their day (radio, grocery, coffee shops, newspaper or other brochures).
- Reach out to regional or national associations (arthritis society, parkinson's foundation, rotary clubs, etc) for funding and opportunities to teach classes in-person and/or online.
- For those who have tech challenges to access online classes, perhaps they can gather at a community center, and someone can host/invest to set up tech in the center.

Group 3: Establishing best practice fall risk assessment and prevention in clinical settings

- Be great to have Forever…in motion up and running again
- Improved access to care - more programs, more funding, yoga, engaging rural communities
- Proactive vs reactive approach - screening of all adults
- Add to curriculum of training programs
- Virtual options/hybrid approach
- Integrate into other exercise programs
- Have Staying on Your Feet in Regina
- Add into post hip and knee exercises
- Balance exercises can be fun and add it into your exercises that you are already doing
- Develop a good referral network
- Find ways to engage more men - strength and agility training and not fall prevention
- Education
- Word of mouth to get people more interested
- Make it fun!

Group 4: Leading Fall Prevention Programs in the Community

- Wording of promotions; run programs in local sites convenient to potential participants. Avoid terms like Fall Prevention and use a benefit name – eg. Improved balance. Cost can be an issue – allow people to try the program for free before committing. Install information boards in your facility (eg. Nursing home) promoting your events/classes and why people should come. Many people don't think of preventing falls until they have one, maybe breaking bones. How to

convince them to “Fall Proof” themselves. Help people realize that regular exercise can help. You recover quicker from a fall. Fall severity is also lessened. Learn how to react and regain balance – must practice. We need both exposure and avoidance to danger to be prepared.

- We could let men know that these exercises are good for golfing. Promote strength and agility rather than “Fall Prevention”
- Men seem unaware of the issue that balance affects them as well as women. Their balance can be helped too.