

Preventing Older Adult Falls: A Vermont Learning Community Perspective

Executive Summary

More than one in four older U.S. adults aged 65 and older fall each year, resulting in an annual direct medical cost of \$31 billion for injuries related to falls.^{i,ii} Older adult falls are also the leading cause of unintentional injuries among older adults in the nation.ⁱⁱⁱ This is also true for the state of Vermont, which has high rates of both fatal and non-fatal injuries associated with falls among older adults. Falls are associated with numerous risk factors, many of which are modifiable through interventions.^{iv}

This issue brief provides an overview of a falls prevention learning community in Vermont developed by ASTHO in collaboration with the Vermont Department of Health (VDH) and the Vermont Public Health Institute. It features two counties that participated in the learning community, Bennington and Newport, and presents their demonstrated progress as a result of the program's implementation. It also provides strategies that other states and territories can use to promote and implement interventions to reduce older adult falls.

Background

Older adult falls are the leading cause of unintentional injuries nationally.^v In 2014, 125 Vermont adults ages 65 and older died as a result of a fall.^{vi} In addition, more than 1,600 hospitalizations occurred among older Vermont adults in Vermont and an additional 5,445 went to a Vermont emergency room due to a fall in 2014.^{vii} Falls occur as a result of various risk factors, many of which are preventable. These conditions include lower body weakness, vision problems, difficulties with walking and balance, use of medicines, as well as home hazards.^{viii}

The falls prevention learning community sought to raise awareness and increase referrals to the regional evidence-based program, FallScape, as well as provide other available resources to patients in different care settings. They accomplished this by building reciprocal relationships and systems among practitioners and administrators in organizations that serve the at-risk population. ASTHO selected the two community teams, Bennington and Newport, based on the following criteria: high number of falls reported by emergency medical services (EMS) data, high co-morbidities, and limited access to falls prevention services. Additionally, ASTHO ensured that selected teams had existing personnel certified in FallScape, as well as a free in-home program offered to older Vermonters designed with personalized screening, evaluation, and practices to help at-risk individuals reduce risks of falls. The project also sought to address health disparities by targeting the priority population in geographical areas with great needs. The two rural counties chosen for the project are among the lowest ranked in the state for both health factors and health outcomes, according to the 2016 County Health Rankings Study.^{ix}

Core Strategies

The primary component of the program involved increasing awareness and referrals to the existing falls prevention program, FallScope, to reduce falls among populations at risk. FallScope certified individuals supported the identification and engagement of stakeholders by the VDH and the Vermont Public Health Institute. They also took the lead on development and implementation of referral and tracking systems across care settings within their communities. The identified partners that they worked with included representatives from hospitals, ambulance service providers, as well other falls prevention programs.

In order to broaden the scope of the program, project partners also focused on getting administrators and practitioners to integrate customized screening and referral protocols into the standard workflow for providers in a variety of emergency, primary care, in-home and community care settings. A notable example of their involvement included North Country Hospital's Quality Improvement personnel's role in creating integrated falls screening fields into their Emergency Department MedHost electronic health record (EHR), as well as the EHR used for the annual Medicare Wellness visits.

Strategies for State and Territorial Health Agencies

- Strengthen existing community partnerships.
- Look for and cultivate project buy-in from senior hospital management.
- Treat falls prevention like a chronic disease, using language that practitioners and administrators understand.
- Enhance an understanding of the environment into which the project will integrate.
- Recruit diverse provider types.
- Assess the current state of falls prevention resources.
- Develop and disseminate additional falls prevention resources.
- Provide guidance on screening and referral tools.
- Engage healthcare payers from department leadership levels.

The program started with the two communities setting goals for increasing screening and referrals by developing aim statements. Aim statements are a measurable description of the overall mission and purpose. Throughout the project period, ASTHO and VDH provided technical assistance and support to the teams on the implementation of PDSA (Plan-Do-Study-Act) cycles via a series of in-person and virtual meetings. Virtual and in-person convenings, held throughout the various stages of the project, also facilitated engagement among the different partners.

Successes

The project reached 908 members of the target population through screening and referral processes in both Newport and Bennington counties. In addition, there was a decrease in incidence of falls-related EMS calls over the project period, compared to the previous calendar year. Newport reported 14 less calls from January-June 2016, as compared to January-June 2015, and Bennington reported 56 less calls over that same period.

The following table breaks down the project's reach:

	Older Adults Screened	Older Adults Screening positive for Fall Risk:	# of Adults referred to FallScope Program as a result of Screenings	# of Adults referred to other programs	# of patients who had PCP notified about using program	# providers able to do falls screening and refer.
Totals	314	275	115	68	100	36

Other areas of success include the creation of falls prevention toolkits in each community through the modification of a variety of resources, including CDC's Stopping Elderly Accidents, Deaths & Injuries (STEADI) algorithms^x. The STEADI algorithm is a tool that can help providers identify patients at low, moderate, and high risk for falls. Through this assessment, providers are able to detect modifiable risk factors as well as establish effective interventions. In addition to creating a falls prevention toolkit, both communities also experienced an increased awareness and referrals to the FallScope program as a result of presentations to groups involved in hospital physical therapy, primary care, Support and Services at Home, the Visiting Nurse Association, and the Council on Aging.

The program also succeeded in strengthening existing community partnerships and laying the foundation for additional partnerships. These partnerships resulted in tangible results, including coordination of patient release protocols, which allowed FallScope providers to share information with primary care providers. Additionally, implementation of the program also helped in increasing coordination and dissemination of data and resources between the VDH and community partners.

Lessons Learned

Some of the lessons learned from the state's perspective include the need to establish a cloud-based document center at the outset of the project to foster collaborative work on projects and enable shared access to resources (i.e. STEADI links, role descriptions, etc.). It will also be beneficial for project partners to identify evaluation needs at the outset and work with community team leaders to track and share the proper information.

Strategies for Sustainability and Spread:

- Demonstrating success through data and stories.
- Coordination with ongoing healthcare reform.
- Expansion into numerous types of healthcare settings.
- Continue to foster and leverage community partnerships.

One community found that while the STEADI tool was extremely useful in an in-patient setting, it was too long and difficult to implement in emergency departments. Their solution was to take the STEADI tool and extract a few key questions, which they were then able to add to their EHR system. They suggested that it might be helpful to tailor the tool to different settings, as different agencies have different priorities. They also stressed the importance of involving leadership and having a process owner at the facility. Creating great partnerships within the

hospital system, such as the hospital CEO and the IT/clinical informatics staff member, was one way that they were able to accomplish this.

State teams also stressed the importance of innovation. For example, as the number of referrals to FallScope increased, EMS no longer had the proper capacity to manage the referrals. In order to combat this challenge, the hospital began sending volunteers from the community to EMS to help build their capacity. Additionally, states found that the use of rapid PDSA cycles helped them quickly determine what was working and what was not working. Instead of focusing on getting everything right the first time, they were able to learn from their mistakes and move on, making improvements along the way.

Conclusion

The rising number of adults ages 65 and older, coupled with the high cost associated with older adult falls, illustrates the tremendous importance for states to incorporate and expand their falls prevention efforts. The first step is to integrate falls prevention into the clinical practice routine in order to identify populations at risk. Only then can we foster multi-sectoral engagement and identify evidence-based programs that can increase awareness and allow us to work towards the prevention of older adult falls.

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For More Information Contact:

Mandy Deutsch, MPH, MSW

Senior Analyst, Injury Prevention and Behavioral Health
Association of State and Territorial Health Officials (ASTHO)
2231 Crystal Dr, Suite 450, Arlington VA 22202
Email: adeutsch@astho.org
Tel: (571) 318-5445

Tequam Tiruneh, MPH

Analyst, Health Promotion and Disease Prevention
Association of State and Territorial Health Officials (ASTHO)
2231 Crystal Dr, Suite 450, Arlington VA 22202
Email: ttiruneh@astho.org
Tel: (571) 522-2303

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