Falls Prevention Statewide Strategic Plan

***Mission**: Reduce the prevalence of falls and fall-related injuries among Iowans.*

***Vision**: By 2019, improve falls prevention, assessment, and care across all settings, in all communities, and for all Iowans.*

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1. Prevent falls from occurring among Iowans. (Primary Prevention)

- Objective 1.1: Increase the number of Iowans with personal awareness of falls risks.
    - Tactic 1.1-A: Incorporate fall risk assessments as part of annual exams and routine checks to identify risk prior to an adverse event or fall.
        - Educate providers on the importance of advanced, proactive, and routine falls risks assessments.
        - Ensure falls risks assessment and discussions are incorporated as part of chronic and comorbid conditions education and self-management, such as identification of medications, balance issues, and vision changes.
    - Tactic 1.1-B: Promote healthy aging conversations, inclusive of changing abilities and natural aging progressions, promoting associated tools and resources to support patients, i.e. physical activity recommendations, nutrition education, home agility tests.
    - Tactic 1.1-C: Encourage inclusion of family members as part of falls risk education and identification training, including personal health-related and environmental hazards.
    - Tactic 1.1-D: Ensure pediatric populations are inclusive in falls risk education, i.e. pediatric ED traumas, pediatric inpatient care.
    - Tactic 1.1-E: Advance person-centered falls awareness and education that considers culture, health literacy, and self-efficacy.

- Objective 1.2: Increase the percentage of Iowans who live in safe homes and communities.
    - Tactic 1.2-A: Promote universal design and home modification to assure home and setting accessibility and safety over time.
        - Utilize environmental assessments that enable identification of falls hazards in the home and residential settings, inclusive of structural, interior design, and environmental elements.
        - Support availability and coverage of home and residential settings modifications that equip existing structures for greater accessibility and decreased falls risk.
        - Promote universal design policies as part of building standards and/or codes to facilitate the creation of accessible and safe new constructions.
    - Tactic 1.2-B: Ensure accessibility and adaptive living considerations for the built environment and community design and development.
        - Partner with civic stakeholders, community planners, and other stakeholders to ensure that community design supports accessibility

and safety, such as walkability and safe pedestrian crossing.
        - Ensure consistent building policies and codes for residential facilities and buildings designed for adaptive living that ensure accessibility and safety.
        - Assure that environmental design addresses need of people with various physical and sensory abilities.

- Objective 1.3: Support increased access to and coverage of evidence-based falls prevention programs.
    - Tactic 1.3-A: Ensure public awareness and community promotion of available falls prevention and support programs, such as Tai Chi for Arthritis, Matter of Balance, etc.
        - Encourage inclusion of these resources and connections as part of falls risks assessment follow-ups.
        - Support provider and self-referral mechanisms for prevention programs.
    - Tactic 1.3-B: Increase the coverage and reimbursement mechanisms for falls prevention programs among payers.
        - Educate the provider community on the evidence-base and cost benefit of community falls prevention programs.
        - Collaborate with payers to align payer-based falls assessment and prevention efforts with evidence-base and comprehensive community-based support.
    - Tactic 1.3-C: Increase the inclusion of falls prevention assessment and support as part of employer wellness programs or benefits coverages.
        - Ensure employers are educated on return on investment as part of both worksite falls prevention and overall employee health and wellness.
    - Tactic 1.3-D: Enhance and maintain availability of evidence-based falls prevention and support programming and resources, including those based in community and healthcare settings.

2. Ensure identification of falls risks at all stages and settings. (Detection)

- Objective 2.1: Establish thorough fall injury prevention efforts that incorporate medication/pharmacy, medical and personal history, and lifestyle considerations.
    - Tactic 2.1-A: Promote comprehensive and thorough assessment completion that expands beyond simple compliance requirements and enhances accuracy.
        - Encourage policies and protocols that use clear and directive language to ensure consistent and optimal assessment and follow-up.
        - Ensure efficacy of assessment by ensuring that tools and report templates are designed to be practical and manageable for both patients, clinical staff, and non-clinical support personnel.
        - Ensure comprehensive medication assessment and review is routine and continuous as part of ongoing falls prevention and assessment processes.
    - Tactic 2.1-B: Increase the utilization of complementary assessment tools within and among facilities (as able and applicable) to enable consistent risk identification and collaborative care coordination.
        - Promote selection of evidence-based falls assessment tools that are the best tool for the patient population and setting.

        - Provide staff training to relevant staff to assure consistent risk score interpretation and appropriate care planning.
    - Tactic 2.1-C: Ensure meaningful use of assessments that expand beyond initial risk identification and identify next steps.
        - Incorporate thorough root-cause analysis to determine best intervention to mitigate identified risk and meet patient and population needs.
        - Incorporate guidelines or recommendations for risk re-evaluation post-initial assessment to capture changing risks and establish measures of progress.

- Objective 2.2: Enhance hospital and facility-based falls prevention strategies with emphasis on post-discharge transitions in care.
    - Tactic 2.2-A: Ensure hospital and facility-based falls assessment, identified risks, and related actions are communicated to the allied care team and patient support personnel during care transitions (including pharmacy, home health, long-term care, etc.)
        - Encourage sharing of information in the most appropriate and accessible means, including warm handoff, digital mechanism (i.e. fax), and/or electronic health technology.
    - Tactic 2.2-B: Establish strong connections with community partners and resources to maintain current status of resources and plan for ongoing referral mechanisms.
    - Tactic 2.2-C: Implement a follow-up strategy to ensure patients attend and/or engage with planned resources and providers to support the discharge plan.

- Objective 2.3: Ensure falls prevention and assessment coordination among all providers and stakeholders
    - Tactic 2.3-A: Establish mechanisms and recommendations to ensure coordination in falls assessments between care providers, clarifying expectations for sharing of assessment activities, results, and handoff of next steps, i.e. follow-assessment in new care setting and changes in patient status.
    - Tactic 2.3-B: Create processes for sharing of risk assessments and scores among all applicable patient care providers and stakeholders during all transitions of care, whether acute to long-term care, or facility to home and residential settings.
    - Tactic 2.3-C: Establish processes to ensure the coordinated and complete transfer of information among providers (including medication assessment and reconciliation) utilizing all appropriate and secure means availability, such as optimal and shared EHR access/use, the Iowa Health Information Network services, etc.
    - Tactic 2.3-D: Promote policies and workflows that specifically incorporate availability of providers (including pharmacy) time to fully counsel patients on falls risks, such as during times of change in medications or conditions.
    - Tactic 2.3-E: Seek to align evidence-based strategies across settings to ensure best quality patient care and falls prevention.
    - Tactic 2.3-F: Establish person-centered care coordination practices, placing the patient at the center and acknowledging patients as people in the completion of

assessments, identification of risk, and follow-up to assure individualized plans of care.

- Objective 2.4: Utilize mechanisms for falls risk detection that incorporate non-clinical assessment strategies
    - Tactic 2.4-A: Encourage emergency-responders and community paramedicine programs to provide patient education and home risk assessment when responding to falls-related calls.
        - Enable post-call follow-up to increase the likelihood of care coordination, assess current risk status, and assure follow-through with community referrals.
    - Tactic 2.4-B: Encourage managed care organizations to conduct routine surveillance by reviewing critical incidence reports, annual waiver assessments, etc., in order to improve provider response and remediate future events.
    - Tactic 2.4-C: Provide resources and training for home-based and other community service providers on how to identify people at risk for falls, conduct home assessments for environmental safety, and recommended evidence-based interventions.
    - Tactic 2.4-D: Develop a campaign for direct caregivers and family members to increase their awareness and identification of falls risk for individuals and home settings.
    - Tactic 2.4-E: Define roles that health coaches or patient care coordinators can play in promoting falls prevention, identifying risks, and recommending interventions to reduce future falls among patients that would include evidence-based falls prevention programming.

3. Improve the quality of falls care and management for all falls in all settings. (Management/Treatment)

- Objective 3.1: Implement proactive care coordination practices and strategies that enable comprehensive and coordinated patient/resident care.
    - Tactic 3.1-A: Establish defined processes for comprehensive and collaborative communication, emphasizing role at shift change, transitions in care, and centered upon patient goal of care.
    - Tactic 3.1-B: Create structured, multi-disciplinary falls plans that incorporate all members of the care team, both internal and external, to the fullest extent possible notwithstanding the patient and family/caregiver.
    - Tactic 3.1-C: Encourage involvement of a family caregiver as part of falls care and management efforts as an additional support for patient care and execution of care and prevention activities, particularly in the transition to home and residential settings.
    - Tactic 3.1-D: Design comprehensive processes for post-fall assessment to extend risk identification, status change, and care beyond report of injury and for the duration of the patient stay.
    - Tactic 3.1-E: Promote pharmacy collaborative practice agreements to establish enhanced prescriber collaboration, medication assessment and reconciliation activities, patient counseling and self-management, and secondary & tertiary prevention efforts.

- Objective 3.2: Establish processes for managing future fall risk once patients are identified that engage multi-disciplinary strategies (e.g., Otago) and involve patients and their caregivers' in self-management activities.
    - Tactic 3.2-A: Design inpatient care protocols that promote patient safety, mobility and balance (such as physical and occupational therapy exercises, use of support equipment, etc.) to reduce falls risk during the patient stay and after discharge.
    - Tactic 3.2-B: Develop a structured, multi-disciplinary falls plan for at-risk patients and their caregivers that is progressive and keeps the patient engaged in self-management throughout the stay and after discharge.
        - Define "points of care" opportunities for multi-disciplinary staff to educate patients about their falls risk, demonstrate self-management skills while in the facility, and take steps for ongoing risk reduction after discharge.
        - Include post-discharge care plan that supports use of evidence-based practices to maintain and expand patient mobility and balance (such as Otago, Matter of Balance, Stepping On or Tai Chi program involvement).

- Objective 3.3: Demonstrate person-centered falls care and management through active patient and family engagement strategies.
    - Tactic 3.3-A: Ensure patients receive adequate falls prevention education throughout their experience of care with an emphasis on personal awareness of risk and participation in prevention activities.
    - Tactic 3.3-B: Pursue involvement of a family caregiver as part of falls prevention and management efforts through shared education and defined roles in patient falls prevention support.
    - Tactic 3.3-C: Establish ongoing patient conversations to support patients throughout the experience of care and changes in falls risk status, within facilities, during transitions, and in the home and community.

- Objective 3.4: Promote increased resources to assure provider and patient/caregiver access to falls prevention and management education, programs, tools, and resources
    - Tactic 3.4-A: Encourage service payers to use available metrics and cost data to establish reimbursement rate for community-based programs.
    - Tactic 3.4-B: Promote the development of local falls prevention coalitions that connect community resources and promote available programs and tools for reducing falls across all ages.
        - Engage Area Agencies on Aging, local public health and health care systems to establish local or regional coalitions that will publicize and support expansion of evidence-based programs, awareness and educational materials and coordination of efforts.
    - Tactic 3.4-C: Utilize community-based settings and institutions (e.g., churches, libraries, senior centers, etc.) to promote local resources and tools, educate and engage family members and caregivers and offer falls prevention programs.

4. **Use data to drive population-based falls prevention and management strategies. (Data)**
    - Objective 4.1: Develop common falls prevention and management measure sets across the Iowa provider community.
        - Tactic 4.1-A: Align measures and data collection with national quality measure conventions, as practical (e.g. CMS, National Quality Forum (NQF)).
        - Tactic 4.1-B: Identify set of common quality measures to monitor falls risk, occurrence, and related injuries among patients.
        - Tactic 4.1-C: Encourage routine tracking and utilization of falls data by providers.

    - Objective 4.2: Enhance falls surveillance through development of an "Iowa suite" of standardized metrics.
        - Tactic 4.2-A: Utilize diverse sources of available data, including surveillance and claims/service-based reporting, to capture ongoing execution of falls strategies.
        - Tactic 4.2-B: Identify potential sources of data and sampling methodology options for capturing needed data.
        - Tactic 4.2-C: Support public availability and access of falls prevention and management surveillance data through establishment of a report highlighting current state of falls in Iowa.

    - Objective 4.3: Use data as a transformative suite to support transformation of the healthcare system in Iowa.
        - Tactic 4.3-A: Facilitate improvements in chronic care across settings through falls quality improvement and tracking activities.
            - Promote expansion of clinical care process measures beyond falls, to include other chronic conditions and co-morbidities.
            - Encourage surveillance of falls as part of chronic care continuum, inclusive of related conditions and social determinants of health.
            - Ensure incorporation of qualitative data to enable optimal understanding and tracking of progress.