

## State Policy Toolkit for Advancing Fall Prevention

“I challenge state health leaders to study the data, assess their state, and consider adopting at least one policy strategy this year that could lessen the burden of preventable injury and death within their home state.”

Paul Halverson, DrPH, Director, Arkansas Department of Public Health and State Health Officer; President, Association of State and Territorial Health Officials (Safe States Alliance, 2011)

# Table of Contents

Introduction .....	3
How to use this Toolkit .....	6
Goals:	
Increase awareness of the issue and effective prevention strategies among stakeholders. . . .	7
Increase provider participation in fall prevention practices .....	10
Increase funding opportunities and investments for fall prevention .....	16
Enhance data surveillance collection, analysis and system linkages .....	18
Increase the availability and accessibility of community programs and services .....	20
Build and leverage an integrated, sustainable fall prevention network. ....	23
Improve fall prevention activities in places where older adults reside .....	25
Institute ongoing evaluation of state efforts and outcomes .....	26
Legislative Options .....	28
References .....	32
Appendix A: Resources to develop effective advocacy skills .....	34
Appendix B: Additional Suggested Resources .....	35
Appendix C: Process of discovery and development. ....	37

NCOA and its Falls Free<sup>®</sup> partners are grateful for the advice and feedback provided by stakeholders, grantees, and especially the dedicated members of the State Coalitions on Fall Prevention Workgroup’s Awareness and Advocacy Committee. This toolkit is designed as a resource of opportunities, strategies and examples of what is possible to achieve through education and engagement of key stakeholders. It will be maintained as a web-based document that can be updated with new ideas and examples of effective advocacy.

## Suggested Citation:

Beattie, B.L. & Schneider, E.S. (2012). State Policy Toolkit for Advancing Falls Prevention. Washington, DC: National Council on Aging.

## Introduction

This State Policy Toolkit for Advancing Fall Prevention is designed to assist states and their fall prevention coalitions to reduce the growing number of falls and fall-related injuries and deaths among older adults through increased awareness, education and training of providers and investments in effective community solutions. These basic tenets are taken directly from the [Promoting a National Falls Prevention Action Plan](#) and the [Safety of Seniors Act of 2007, PL 110-202](#). The long term goals of this work are in support of the [Falls Free<sup>®</sup> Logic Model](#) designed to promote two long term goals:

- Decreased falls, fall-related injuries, and fall-related deaths
- Increased life expectancy, independence, and quality of life

The activities and learning's of communities implementing evidence-based fall prevention strategies should be leveraged to facilitate broad systems change and the implementation of a sustainable statewide fall prevention initiative. The key to successful systems change is well planned and targeted stakeholder engagement to advance strategic objectives. Elements relative to this toolkit were put forth in the [National Prevention, Health Promotion and Public Health Council's 2010 Annual Status Report](#) (National Prevention Council, 2010, p. 9) which recommended five targets to effect change through a shared vision that serves:

- Policy: establish and enforce evidence-based laws, regulations and standard institutional practices that promote prevention, create healthy environments and foster healthy behaviors
- Systems Change: establish procedures and protocols within institutions and networks that promote prevention, create healthy environments and foster healthy behaviors
- Environment: create social and physical environments that promote healthy choices
- Communication and Media: raise awareness and strengthen social norms
- Program and Service Delivery: offered in a variety of clinical and community settings

The framework chosen for the State Policy Toolkit for Advancing Fall Prevention reflects the [Falls Free<sup>®</sup> Logic Model](#). It offers users short, medium and long range strategic opportunities to affect policies that can promote systems change, reduce barriers and facilitate reaching the long term goals. It also offers strategies, processes and tools that can assist in affecting policies and examples of successful efforts linked to each of the opportunities. The most effective policy changes are grounded in scientific evidence, embraced by a broad-stakeholder base, and promote results from successful evidence-based programs and testimonials; these concepts have been enfolded into the model.

It is not within the purview of this toolkit to impart basic advocacy skills training. Look to Appendix A for resources to develop effective advocacy skills and guidelines as well as recognize pitfalls of advocacy activities. Several online resources and webinars are also recommended to increase the effectiveness of state and coalition efforts to promote fall prevention through targeted stakeholder engagement, policy and systems change.

States partnership and promotional efforts should operate with the understanding that policymakers are always looking for solutions and innovations that are cost effective or cost neutral. Knowledgeable champions and partners can assist policymakers to make the best decisions and choices. There are some basic organizational elements and cultural requirements that serve as underpinnings of an effective statewide fall prevention effort; moreover, state wide systems change needs to start with state leadership that reflects fall prevention as a priority best achieved through collaboration. Three partners are essential to success and effective systems change: State Department of Public Health, State Unit on Aging and the State Coalition on Fall Prevention. Suggested indicators

of commitment by these partners are listed below. Not all indicators are applicable or practical but offer opportunities for advancing effective fall prevention through collaboration:

- A broad and focused commitment to fall prevention through collaboration by the **State Department of Public Health (DPH)** as evidenced by:
  - Inclusion in the State Injury Prevention Plan with measureable goals and objectives.
  - Commitment by the Director, DPH and the state's Chief Medical Officer to the implementation of a statewide sustainable fall prevention initiative.
  - Commitment by the State Injury Prevention Office to identify and address barriers to implementing a state wide fall prevention initiative.
  - Commitment by the Director, DPH to give priority to surveillance activities for falls prevention and offer timely, useful data to stakeholders.
  - Commitment to identify key data resources across the state and partner with data managers to improve the capture and quality of those data deemed important to fall prevention.
  - Commitment to developing a process for policy analysis, implementation, monitoring and evaluation.
  - Commitment to providing technical assistance to local health departments, especially in policy training and development of core competencies for Injury and Violence Prevention.
  - Commitment to exploring fall prevention opportunities in all grant proposals/federal/block grants.
  - Recognition and activation of that commitment at the local public health department level, including adoption of the [Standards and Indicators for Local Health Departments Injury and Violence Prevention Programs](#) as put forth by the National Association of County and City Health Officials (NACCHO) and Safe States Alliance.
  - Activation of media and communication strategy to bring awareness to the issue and to the ongoing initiative and partner activities.
  - A commitment to partnering with the State Unit on Aging (SUA) and to enfolded other sections within the DPH such as Chronic Disease.
  - A Memorandum of Understanding (MOU) with the SUA outlining each organization's goals and responsibilities in the partnership—while a formal MOU is preferred, a less formal agreement will suffice ,in recognition of expediency and/or in states where partnering is already occurring.
- A **State Unit on Aging** commitment to falls prevention and collaboration as evidenced by:
  - Recognition of fall prevention as a priority in the state aging service plan with measureable goals and objectives.
  - Commitment by the Director, SUA and published guidance for the investment of Title III D funds in evidence-based programs that include fall prevention.
  - A commitment to partnering with the DPH.
  - A commitment to increasing the skills and education level of local aging services partners and champions of fall prevention.
  - Recognition of fall prevention as a priority by Area Agencies on Aging.
  - Inclusion of fall prevention services in the delivery of Home and Community-Based Services (HCBS) and implementation of all initiatives designed to help older adults safely age in place.

- Training of intake staff/Aging and Disability Resource Centers (ADRCs) to make appropriate referrals.
- The development and ongoing maintenance of a web resource identifying the contact information for local evidence-based (EB) programs.
- An MOU with the DPH outlining each organization’s goals and responsibilities in the partnership--—while a formal MOU is preferred, a less formal agreement will suffice, in recognition of expediency and/or in states where partnering is already occurring.
- The third key partner is a strong, committed **State Coalition on Fall Prevention** as evidenced by:
  - Broad-based representation, strong organizational support and committed leadership.
  - Development of goals in support of state efforts and adoption of the Falls Free© Logic Model.
  - Creation of a policy working group in collaboration with DPH and SUA.
  - Creation of an evaluation working group in collaboration with DPH and SUA.
  - Development of a strategic plan to broaden the base of the coalition to strengthen its goals and working group activities.
  - Working partnership with the DPH and SUA.
  - Collaborative planning and activation of media and communication strategies to bring awareness to the issue and to the ongoing initiative and partner activities.
  - Members’ organizations view fall prevention as a priority, which aligns with their overall mission.

The first goal of a successful state fall prevention effort is the Committed Partnership between DPH, SUA and the Fall Prevention Coalition at state and local levels. In collaboration, the DPH, SUA, and other state level departments should identify and activate a clear vision and agenda for this work with strong consideration given to a common name/brand.

Example: Hawaii Department of Health has identified falls as a public health priority. In Hawaii’s Injury Prevention and Control Program’s (IPCP) Injury Prevention Plan (2012-2017), fall prevention was recommended as one of the eight injury areas in need of strengthening statewide. In 2011, the Executive Office on Aging initiated a Statewide Task Force on Falls Prevention, bringing together a multidisciplinary team to develop recommendations to combat the rising epidemic of falls among Hawaii’s elderly population.

The Coalition should be represented in planning and execution decisions. An **Implementation Team** should also be appointed, which may be fulfilled by elements of the Coalition. For guidance on suggested membership refer to the Centers for Disease Control and Prevention (CDC)/National Center for Injury Prevention and Control (NCIPC) NCIPC Core Violence and Injury Prevention Program, 2011, which states:

*An integrated team approach is central to a successful program. Management and implementation teams at state and local levels should comprise representatives from the state health department; state and local falls prevention coalitions; the AoA’s State Unit on Aging (SUA) and Area Agencies on Aging (AAA); relevant community-based organizations; leaders in physical activity promotion; health care providers; insurers; and businesses.*

Note: in 2012 the Administration on Aging (AoA) became the Administration on Community Living (ACL)

In collaboration with the Coalition or Implementation Team, the state partners identify what should be accomplished, over what timeframe and how to track and leverage results.

## How to use this Toolkit:

This toolkit covers a broad spectrum of goals, policy options relevant to National Falls Free goals, supportive strategies and examples that may seem daunting. Each state and its coalition will need to identify manageable policy options that fit its distinctive culture, current activities, economic situation, partners and unique opportunities. Partners will need to reach a consensus on what service areas, institutions, and clinical practices should be targeted and what will best serve the state needs. Although the eight goals and legislative options are offered as separate sections, they are not discrete entities; the user should appreciate they are inter-related.

An equally important aspect of this work is an assessment of what financial and ongoing resources can be leveraged that will foster and sustain a statewide fall prevention initiative. The three NCIPC grant-funded states will collaborate with the national evaluation team's effort to identify delivery costs as well as assess costs associated with increased awareness, education and training of providers and infrastructure building across the state.

All states should consider the range of current and potential resources and how to leverage them. States not grant funded can leverage the learning's and/or adopt the tools and processes developed to support the three funded states. While this toolkit enfold aspects of the grant funding not available to all states, the policy recommendations presented in this toolkit can be adopted by any state with a strong coalition and committed partnership with the Department of Public Health (DPH) and the State Unit on Aging (SUA). These are offered to evoke greater clarity in the long range planning and discussion among partners.

Under each of the eight goals (not ranked in any order of priority), the reader will find a list of relevant policy change options that can be employed to advance the goal. Policy change options are phrased as action statements or the intended outcome of that policy change. Suggested supportive strategies and salient examples where available are included for consideration.

While this toolkits ends with suggested legislative options, most of the policy suggestions do not target legislative activity. If undertaken, no more than one or two legislative targets should be selected. Consensus should include an agreement on the social, political, and economic climates that prevail in the state and what opportunities and challenges are anticipated. Finally, this effort requires a consensus that effectively addressing fall prevention should include a broad-based effort enfold the continuum of care to achieve a collective social impact.

Appendix B offers the users a number of additional resources that serve to provide further understanding of the power of policy change and potential opportunities for engagement. Appendix C provides an overview of the process of discovery and research that undergirds this toolkit. A companion **State Policy Toolkit for Advancing Fall Prevention: Suggested Indicators** document offers suggested indicators for some of the higher priority goals and policy changes offered in this toolkit that a state may select to advance. Indicators are provided over a five year implementation period that coincides with the CDC grant funded activities in CO, NY and OR (NCIPC Core Violence and Injury Prevention Program, 2011). The companion **State Policy Toolkit for Advancing Fall Prevention: Select Resources** offers the users an array of marketing tools noted within the Toolkit.

At the national level, the Falls Free<sup>®</sup> Advocacy Plan will be revised to reflect strategies and activities in direct support of those state and local policy change concepts introduced in this plan. This is not intended to be a static document—please send any additional suggestions or examples you may wish to include to [fallsfree@ncoa.org](mailto:fallsfree@ncoa.org)

## **Goal: Increase awareness of the issue and effective prevention strategies among stakeholders**

To achieve lasting change, it is important to bring greater awareness to the issue as it affects the elderly with the state – making it relevant to older adults; emphasizing the preventable nature of falls; and promoting access to effective, practical strategies and local programs and services.

Policy Change: The DPH, in collaboration with the SUA, will appoint and coordinate a broad-based, state Fall Prevention Advisory Group (for the three CDC grant funded states this function is met by the requisite Implementation Team) to advise on how to facilitate targeted activities and to expand statewide; leverage members' current investments and level of interest; address barriers to broader implementation; and promote fall prevention awareness and awareness of the overall initiative. In some states with strong coalitions, the coalition leadership committee may serve this function. Members can also advise on the use of expanding technology.

Strategy: Develop and activate a strategy for identifying and engaging key stakeholders, their organizations, networks, resources and commitment to fall prevention activities. Key stakeholders include those who may influence outcomes. Identify the needs of stakeholders and strategies for meaningful engagement to promote commitment.

Examples: For the Administration on Community Living (ACL) Chronic Disease Self-Management Program (CDSMP) grants, states were required to field an advisory committee of diverse interests that yielded tremendous access to networks, providers, funding opportunities and other resources that helped to build statewide systems change and sustainable practices at little or no cost.

Minnesota formed the Minnesota Health Improvement Partnership, a group of individuals representing a broad sector of both public and private organizations, including members from local departments of health. This group was charged with the responsibility to develop Healthy Minnesotans: Public Health Improvement Goals for 2004. (from *Healthy People 2020*, <http://healthypeople.gov/2020/implementing/mobilize.aspx>)

Refer back to the NCIPC Core Violence and Injury Prevention Program, 2011, in which key stakeholders include: representatives from the state health department; state and local falls prevention coalitions; the ACL's State Unit on Aging (SUA) and Area Agencies on Aging (AAA); relevant community-based organizations; leaders in physical activity promotion; health care providers; insurers; and businesses.

Strategy: Use the [CDC Implementation Team guidelines](#) (targeting the 3 funded states) as guidance for the Advisory Group membership. At a minimum, CDC guidelines suggested representatives include the SUA and Area Agencies on Aging, the exercise community, Health Maintenance Organizations (HMOs), hospitals, Emergency Medical Services (EMS), consumers/patients, state or local chapters of professional organizations such as American Physical Therapists Association (APTA) and American Occupational Therapists Association (AOTA), as well as practitioners including primary care providers, nurses, retired health care providers, and pharmacists. Additionally, representation from state agencies such as Medicaid is requisite. Representation from the State Fall Prevention Coalition is also considered essential.

Policy Change: DPH and SUA in partnership with other state level departments and the State Coalition will co-lead the effort to launch a statewide awareness campaign.

Strategy: Leverage the resources and networks of Advisory Group members and other potential resources to develop effective messaging and statewide awareness campaign. Look to the [CDC Framing Guide](#) and the [NCOA Falls Prevention Awareness: Findings and Lessons Learned From State Coalitions on Fall Prevention](#) for guidance.

Strategy: Leverage relevant [Healthy People 2020 Objectives](#) (US DHHS, 2012):

- **OA-1** Increase the proportion of older adults who use the Welcome to Medicare Benefit (includes a falls risk assessment)
- **OA-6** Increase the proportion of older adults with reduced physical or cognitive function who engage in light, moderate, or vigorous leisure-time physical activities
- **OA-11** Reduce the rate of emergency department visits due to falls among older adults

Strategy: Identify state or local osteoporosis awareness initiatives, and incorporate state osteoporosis activities, other chronic conditions initiatives and appropriate coalitions in the awareness campaign. Consider co-branding this effort and including a representative on the Advisory Group.

Strategy: Develop and maintain current fall prevention information on an accessible web page to enhance communications with stakeholders.

Strategy: DPH/Epidemiologist in collaboration with the Department of Communications/Media, SUA, the State Coalition on Fall Prevention and other relevant stakeholders develop an easy-to-read and use format for portraying data and impact of injury and cost to a variety of stakeholders and gather feedback on appropriate modifications and needs by stakeholders.

Strategy: Plan and activate a media plan and awareness campaign in collaboration with the coalition members, the Advisory Group/Implementation Team and the state communications department. Plan should include timely, targeted follow-up with testimonials and ongoing success stories to keep awareness level high throughout the year. The news media is a powerful mechanism to educate and inform the public about the importance of injury issues, and can be an effective venue to inform policy makers.

Strategy: Activate a strategy to collect and leverage fall prevention testimonials from a broad constituency, including older adults, family members, organizational leads, program deliverers, and health providers.

Strategy: Identify and follow up with potential funding sources and sponsors, for support to underwrite the development of PSAs, videos, brochures, presentations, flyers with unified messaging.

Strategy: Participate in Falls Prevention Awareness Day; obtain the Governor's and local community leaders' Proclamation. Explore collaborating with contiguous states and regions to leverage resources.

Example: Look to the resources, tools and state strategies gathered by the National Council on Aging and available for your use: [www.ncoa.org/FPAD](http://www.ncoa.org/FPAD)

Strategy: Work with local businesses, healthcare facilities and group providers, faith-based organizations, retirement homes and Naturally Occurring Retirement Communities (NORCs), to promote organizational commitment and to host events, distribute educational materials, and promote local programming.

Strategy: Target older adults, family members and caregivers to engage in dialogues with each other and providers on maintaining independence through the implementation of effective fall prevention strategies.

**Policy Change:** DPH will activate an internal policy for developing testimony; reviewing, and informing legislative actions and imminent regulatory or policy changes that would affect older adult falls risk; and providing timely information to organizations, state and local leaders to help inform regulations, policies and legislations.

Strategy: Leverage key policy resources, such as:

[Falls Free National© Action Plan](#)

[NCIPC Compendium of Evidence-based Fall Prevention Programs](#)

[National Prevention Strategy](#)

[Safe States State of the States 2009 Report](#)

[Using the Evidence-Based Public Health Framework to Move Policy Forward](#)

Strategy: Leverage local stakeholders and consumer testimonials, including providers as well as older adults and their family members.

Strategy: Leverage the CDC/NCIPC recommendation that states adopt a comprehensive injury prevention program which can serve to provide consistent, reliable and comprehensive data for policymakers; ensure that high-risk populations are identified and reached with programs and services; integrate state efforts among programs with varied injury prevention goals; and provide continuity amid changing administrations and budget priorities.

Strategy: Engage stakeholders to promote the need for senior falls prevention awareness, systems change and policy opportunities via newsletters, timely e-mail blasts, and social media.

## Goal: Increase provider participation in fall prevention practices

The recent Agency for Healthcare Research and Quality (AHRQ) report, [The Number of Practicing Primary Care Physicians in the U.S.](#) (AHRQ, 2011a), noted that, of the 624,434 physicians who spend the majority of their time in direct patient care, slightly less than one-third are in primary care. In a companion report---[The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the U.S.](#) (AHRQ, 2011b)—it was estimated that, in 2010, approximately 56,000 nurse practitioners and 30,000 physician assistants were practicing primary care. Thus, reaching out to individual providers will not achieve an appreciable increase in provider participation in fall prevention practices. The target for organizational policy change should therefore be provider networks, health plans, large group practices and those associations that affect practice.

Policy change: Provider networks and health plans require providers to enfold fall prevention screening within the annual wellness visits and welcome to Medicare experiences, and adopt routine screening protocols for all adults > age 65.

Strategy: Leverage [Healthy People 2020 objectives](#): OA-7 to increase the proportion of the health care workforce with geriatric certification (specifically physicians, registered nurses, and physical therapists)

Strategy: Identify and target key stakeholders and readily available champions or strategies to engage target provider practices. Identify and leverage organizational incentives for them to participate.

Strategy: Develop and activate engagement of key stakeholders; approach state American Physical Therapy Association (APTA) chapters with a two page marketing brief on the Otago Exercise Programme opportunities and reimbursement strategies found within the accompanying Toolkit Resources; similarly approach state American Occupational Therapy Association (AOTA) chapters with a two page marketing brief on opportunities and reimbursement strategies. (See accompanying Toolkit Resources)

Policy change: State and local health departments will collaborate with targeted clinical delivery systems to promote appropriate, high quality and effective fall prevention services and referrals.

Strategy: Older adults who present to the emergency room for fall-related injuries but are not admitted will be scheduled for a home visit by an appropriate health care provider or home care agency.

Example: MaineHealth is implementing such a program and monitoring outcomes, including cost effectiveness and additional falls related issues, while tracking repeat falls.

Strategy: Educate providers about available reimbursement for fall prevention assessment and intervention, the CDC/NCIPC Stopping Elderly Accidents, Deaths and Injuries (STEADI) tool and the availability of community programs.

Example of physician/provider referral: Olympic Area Agency on Aging (O3A) has produced and distributed 50 stamps (attractive stickers) to all local community partners, hospitals, and local medical and health care providers throughout the service region with the contact information for fall prevention workshop registration. In response to the demand from providers, O3A has ordered additional stamps for clinicians to use in their offices and clinics.

Strategy: Enhance referral process for accessing community programs through easily accessible resources including: web portal, trained and knowledgeable Area Agency on Aging (AAA) intake staff/Aging and Disability Resource Centers (ADRCs)/ State Health Insurance Counseling and Assistance Programs (SHIPs).

Strategy: Develop and present appropriate education and training of staff to ensure a smooth recruitment and referral process. Monitor outcomes and modify training as warranted.

Strategy: Identify and promote the implementation of available training programs for care managers and Home Care Agencies.

Strategy: When partnering with Advantage Care Health Plans, leverage the [CMS quality bonus payment initiative](#) for plan holder survey questions including query: *Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?*

Example: Congress mandated that CMS use its Star Ratings to reward higher rated plans with quality bonus payments. The CMS star rating system is based on more than 40 Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, including preventive screenings, managing chronic conditions, and customer service; starting in 2012, plans with 4 or more stars will receive bonuses and higher rebates including bonuses of 1.5% in 2012, 3.0% in 2013, and 5.0% in 2014 and later years. For more information refer to the [HHS National Medicare Training Program](#).

Strategy: Leverage the [CMS Professional Quality Reporting System \(PQRS\)](#) bonus payments for select providers. The PQRS incentivizes certain providers to assess fall risk and to create a fall prevention plan if a risk is identified. Eligible professionals, including physicians, nurse practitioners, physician assistants, occupational and physical therapists in independent practice, and other practitioners providing services that are paid under the Medicare Physician Fee Schedule, may voluntarily report on a set of quality measures through the Medicare claims they submit. Professionals who successfully report on measures are eligible for incentive payments. For more information, visit [www.cms.hhs.gov/PQRS](http://www.cms.hhs.gov/PQRS). Falls PQRS measures are described as follows:

- **Falls: Risk Assessment**
  - Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months
- **Falls: Plan of Care**
  - Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

Strategy: Empower consumers and their caregivers through awareness and education to engage in a meaningful dialogue with providers about fall prevention strategies. Bring awareness to older adults, caregivers and family members, and direct care work force on practical steps they can take to promote fall prevention; link back to the awareness campaign and messaging

Policy Change: Select professional associations will recognize and promote fall prevention intervention as a priority of professional practice.

Strategy: Target state professional associations, chapters, and affiliates such as the APTA, AOTA, American Medical Association, State Geriatrician Association, Geriatric Nurse Practitioners, EMS/State Trauma Advisory Boards and Councils, National Association of Professional Geriatric Care Managers, and others relevant to the state needs.

Strategy: [Eighteen States' Geriatric Education Centers \(GEC\)](#) are currently funded by the Health Resources and Services Administration (HRSA) to address fall prevention through health care provider training. Identify a GEC contact affiliated with the state coalition to enhance collaboration and leverage their efforts in training.

Strategy: Identify and champion fall prevention awareness with the Area Health Education Centers (AHEC). In many states, the AHECs are already actively participating in the education and training and

dissemination of evidence-based healthy aging programs. Find local AHECs through the [National Area Health Education Center Organization interactive member map](#).

Policy change: Appropriate state regulatory boards and councils will require fall prevention continuing education for professional license or certification renewal.

Strategy: Leverage [Healthy People 2020](#) Objective OA-7: Increase the proportion of the health care workforce with geriatric certification.

Strategy: Make the case for fall prevention with state professional associations, chapters or affiliates and leverage champions and members of the state coalitions. Consider state chapters of the American Medical Association; American Physical Therapy Association; American Occupational Therapy Association, Geriatric Nurse Practitioners, and others; enlist the collaboration of national Falls Free© partners where appropriate such as the APTA and AOTA.

Strategy: Seek out home health agency opportunities to bring greater awareness and training to home care providers (using the [Otago Exercise Programme](#), the APTA/NCOA marketing materials found in the resources section and the [NCOA-Paraprofessional Healthcare Institute Direct Care Worker Training Program](#)).

Strategy: Leverage the state's Advisory Group/Implementation Team members and their respective organizations. Team members will commit to influencing their own organizations and professional associations.

Strategy: Develop a state targeted PowerPoint presentation for delivery at professional conferences, medical meetings, and other venues; link to national and professional association's continuing education offerings and conferences.

Examples: The state coalitions in Arizona, North Carolina, and New Mexico launched a speakers' bureau with a generic PPT, enfolding DPH data to support speakers

Strategy: Educate providers about available reimbursement for fall prevention assessments and activities. (See above)

Strategy: State and local DPH provides technical assistance and state or local data to professional associations to affect education and training opportunities for providers (could use a state developed/targeted PPT with relevant data as noted above).

Strategy: Leverage multiple quality initiatives fostered under the Affordable Care Act.

Examples: The core principles of the Patient-Centered Medical Home (PCMH) include wide-ranging team-based care; patient-centered orientation toward the whole person; care that is coordinated across all elements of the health care system and the patient's community; enhanced access to care that utilizes alternative methods of communication; and a systems-based approach to quality and safety. The goal is to improve the care of patients across the continuum of chronic and acute illness, while potentially improving both patient and provider experiences with the health care system. An example of a systems-based approach to improving quality and safety includes a care planning process, evidence-based medicine/clinical guidelines, point-of-care resources, electronic prescribing, test-tracking, performance measurement, self-management support, accountability, and shared decision-making. <http://www.ahrq.gov/clinic/tp/gapcmh.htm>

Strategy: Leverage public-private [Partnership for Patients](#) linking hospitals, employers, health plans, providers and stakeholders with state and federal government in funding support of initiatives to reduce hospital related injuries (by 40% in 2013) and readmissions (by 20% in 2013).

Examples: The Florida Hospital Association Board of Trustees adopted a policy on June 13, 2008, that encourages all Florida hospitals to adopt standardized colors for patient alert wristbands.

<http://www.fha.org/wristband/background.html>. On a national level additional information is found at <http://www.aha.org/advocacy-issues/tools-resources/advisory/2008/080904-quality-adv.pdf>.

Massachusetts focused fall prevention efforts in the hospital venue resulted in a decline over time in the number of falls precipitated by a DPH regulation identifying falls as a “serious reportable events,”

<http://www.mass.gov/eohhs/provider/reporting-to-state/reporting-entities/hospital/serious-reportable-events.html> PatientCareLink was developed by the Massachusetts’ Hospital Association and Massachusetts Falls Prevention Coalition to support the effort. Learn more at <http://www.patientcarelink.org/>

A number of state examples are found in the Flex Monitoring Team Policy Brief #24: Evidence-based Falls Prevention in Critical Access Hospitals <http://www.flexmonitoring.org/allpubs.php>

Nearly half of the patients admitted to Advocate South Suburban Hospital (Hazel Crest, Illinois) are 65 years of age or older. In order to meet the specialized needs of older adults, the hospital has joined the Nurses Improving Care for Healthsystem Elders (NICHE) Program. The Geriatric Resource Nurse (GRN) Model is the NICHE foundation for improving geriatric care. Advocate South Suburban Hospital GRN’s are trained by geriatric advanced practice nurses to identify and address specific geriatric syndromes such as falls and confusion, and to implement care strategies that discourage the use of restrictive devices and promote patient mobility.

<http://hartforddign.org/>

Maryland House Bill 665, Section 2 would have required on or before January 1, 2013, the Secretary of Aging and the Secretary of Health and Mental Hygiene to develop a statewide protocol for home safety inspections for senior citizens who are discharged from the hospital following a fall, with the aim of reducing future fall-related readmissions. Although it did not pass into law, the Department of Health and Mental Hygiene is nonetheless proceeding with this initiative, enrolling members of the state coalition in working group to develop the protocol.

#### Other initiatives that can be leveraged include:

[Partnership for Patients Hospital Engagement Networks](#): Launched in April 2011 as a nationwide public-private partnership that offers support to physicians, nurses and other clinicians working in and out of hospitals to make patient care safer and to support effective transitions of patients from hospitals to other settings. Periods of transition can increase the risk of falling.

The [Community-based Care Transitions Program \(CCTP\)](#), sponsored by the Centers for Medicare & Medicaid Services (CMS), the CCTP enrolls Aging and Disability Resource Centers (ADRCs) and community resources. The Community-based Care Transitions Program tests models for improving care transitions to reduce hospital readmissions. CMS is required to give funding preference to Administration on Community Living (ACL) grantees that provide care transition interventions in conjunction with multiple hospitals and practitioners serving medically underserved populations, as well as small communities and rural areas. In addition to the CCTP, ACL, through its ADRCs, has focused efforts on disseminating effective care transition models for older people and people with disabilities. Leverage any CCTP grants or activities undertaken by your State Unit on Aging.

Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days, which equates to approximately 2.6 million seniors at a cost of over \$26 billion every year ([www.healthcare.gov/center/programs/partnership](http://www.healthcare.gov/center/programs/partnership)). The Patient Protection and Affordable Care Act (PPACA) of 2010 included a provision to reduce Medicare payments to hospitals that have “excessive readmissions.” A [2010 survey](#) by the National Association of Public Hospitals and Health Systems (NAPH) found that most of the hospitals surveyed had made reducing readmissions a priority within the past 18 months.

The Agency for Healthcare Quality and Research has released a new toolkit to guide hospitals through the process of using the AHRQ Inpatient Quality Indicators (IQIs) and Patient Safety Indicators (PSIs) to improve care. A toolkit for Hospitals is now available at <http://www.ahrq.gov/qual/qitoolkit/>

**Policy Change:** Medical schools and institutions require falls prevention training for medical students and other appropriate health care professionals, including entry level PT, OT, Nursing, Emergency Medical Technicians (EMT), and care managers.

**Strategy:** Make the case for Fall Prevention with state professional associations, chapters and affiliates; leverage champions and member organizations of the state coalition. Seek university training program stakeholders and champions. Employ best practice strategies used by other states; enlist the collaboration of national Falls Free© partners where appropriate such as the APTA, AOTA and NAGEC.

**Example:** The University of North Carolina at Chapel Hill's School of Medicine requires that all medical students complete a unit on falls prevention.

**Strategy:** Leverage the coalition and state Advisory Group/Implementation Team members and their respective organizations. Members should make a commitment to influencing their own organizational priorities and networks.

**Example:** East Carolina University physical therapy and occupational therapy students perform supervised screening assessments during the annual East Carolina Falls Prevention Awareness Fair. Several students have also become A [Matter of Balance](#) coaches.

**Policy change:** DPH requires EMT and other emergency medical services providers to report data to a state registry.

**Strategy:** Identify and activate EMT/Trauma champions. Begin partnership engagement at the association level and trauma associations; use current data to make the case for better data collection to develop appropriate solutions.

**Strategy:** DPH will identify/develop/activate a falls data repository for emergency medical data that provides timely and user-friendly data and trends analysis to make the case for EMT participation.

**Example:** The New York State Department of Health, Bureau of Emergency Medical Services is responsible, pursuant to Article 30 of the Public Health Law (PHL), for the collection of pre-hospital patient documentation data. Prehospital Care Report (PCR) has been the primary instrument used for patient care and EMS event documentation. Its primary purpose is to document all prehospital care and pertinent patient information for medical and legal purposes, as well as serving as a data collection tool for local and statewide quality improvement, protocol development and when approved, research. PHL Article 30 requires that all ambulance and advanced life support first response services (ALS-FR) must submit all call reporting documentation to the Department, in a format approved by the Department. The NY State EMS Code, 10NYCRR Part 800.15, requires that every person certified as an EMS provider, at any level, must complete a PCR for each request for EMS response received by his/her agency, in accordance with the Department's established policy.

**Policy Change:** Health care systems, hospitals and fire departments require EMT and other emergency medical services to link in-home fallers (uninjured/not transported) to community services for timely follow-up.

**Strategy:** Make the case for fall prevention with state EMS associations. Through the NCOA State Coalitions on Fall Prevention Workgroup, link to other state initiatives and share resources.

**Examples:** The NJ Department of Health and Senior Services Office on Aging and Community Services created falls prevention content for a EMS newsletter that was distributed to over 27, 000 EMTs and paramedics in the state. Ninety-seven people completed a post-test included in the [newsletter](#) to receive CEUs. NJ has also trained several EMTs to become coaches or master trainers in [A Matter of Balance](#).

Southern Maine Agency on Aging developed a 4 part fall prevention training webinar with continuing education units for the area EMT. <http://connect.maine.edu/p9q7szccea/>

Policy Change: State contracted health clinics conduct fall prevention screening and appropriate referral on all patients 65 yrs of age and older. [Community Health Centers](#) serve the primary health care needs of more than 20 million patients in over 8,000 locations across the United States, employing an innovative emphasis on comprehensive preventative care. Requirements include training in evidence-based practice.

Strategy: Identify and partner with the state oversight office for the health clinics and the state contracting agencies.

Strategy: Leverage national initiatives with Federally Qualified Health Centers (See NCOA Tip Sheet: <http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/NCOA-AoA-Flyer-FQHC.pdf>)

Example: New Hampshire DPH influenced the renewal of contracts with their Federally Qualified Health Centers to require all adults aged 65+ be screened for fall risks with appropriate assessment and follow up as indicated. Providers were required to undergo continuing education training in support of this requirement. Compliance will be monitored by a retrospective audit.

Policy Change: All state funded health clinics disseminate culturally and literacy level appropriate fall prevention materials.

Policy Change: Medicaid requires providers to screen, assess and intervene as appropriate and refer patients at risk to community programs.

Strategy: Federal funds for state-run Medicaid programs are provided through the Federal Medical Assistance Percentage, or FMAP, providing funding to state Medicaid offices for expanded coverage and eligibility for prevention and chronic care for older adults. More information on Medicaid funding and support can be found by visiting the [Centers for Medicare & Medicaid Services](#) (CMS) website. There may be different offices within your state's Medicaid Agency (chronic care, disabilities, community mental health) as well as separate offices that manage waiver programs. State Leads and partners should identify key agency contacts and make the case for fall prevention.

Strategy: Leverage Return on Investment resource provided with this toolkit.

## Goal: Increase funding opportunities and investments for fall prevention

Even in times of economic hardship, there are existing Federal, state and local funding opportunities that can be thoughtfully leveraged to include or reinforce fall prevention activities. Falls occur in all ages and all settings; in older adults the risks of falling are well known but other associated risks includes the presence of one or more chronic conditions that now affect over 90% of older adults. A case can be made for all funding activities to consider the impact on or relevance to fall prevention activities being undertaken across the state.

“Many of the strongest predictors of health and well-being fall outside of the health care setting. When all sectors (e.g., housing, transportation, labor, education, defense) promote prevention-oriented environments and policies, they all contribute to health.”

-National Prevention Strategy (National Prevention Council, 2011

<http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>

Policy Change: All State Departments’ budget requests for aging services will incorporate fall prevention activities.

Strategy: State Unit on Aging will require Area Agencies on Aging budgets to include fall prevention programs and activities; and to include budget requests for Title III D funds to support evidence-based falls prevention programs.

Strategy: State Public Health Departments will require local PH departments budgets include fall prevention programs and activities, and to link to Area Agencies on Aging and other community-based organizations reaching older adults.

Example: The Maryland Department of Health and Mental Hygiene (DHMH) invested its CDC Core Violence and Injury Prevention grant in two local health departments (Cecil and Washington) and one local area agency on aging (MAC, Incorporated which covers Dorchester, Somerset, Worcester, and Wicomico Counties) to implement the CDC approved evidence-based intervention programs [Tai Chi: Moving for Better Balance](#) and [Stepping On](#).

Example: Several states, including North Carolina and Wisconsin, are supporting the expanded implementation of programs such as [A Matter of Balance](#) and [Stepping On](#) with Title III D funds.

Policy Change: All state and local grant proposals will commit to exploring funding or leveraging fall prevention opportunities in all grant proposals or block grants.

Strategy: Employ state and professional champions to make the case with state grant overseers and other state level departments, including transportation, education, public works, etc.

Strategy: Leverage the [National Action Plan](#), the [National Prevention Strategy](#), [NCIPC Compendium of Evidence-based Fall Prevention Programs](#), and the [Healthy People 2020 objectives](#), all of which offer evidence-based strategies and a call for greater collaboration across key sectors including transportation and education, governmental agencies, private sector partners and others.

Strategy: Develop a communications strategy and accompanying PowerPoint presentation to reach potential funding organizations including foundations, community boards, health care institutions, health plans, and others.

Strategy: Develop a business plan for sustaining fall prevention investment.

Strategy: Educate stakeholders on cost savings and return on investment for the evidence-based programs (see Return on Investment resource provided with this toolkit); include the state Advisory Group/Implementation Team members.

Strategy: Explore the [Use of Civil Money Penalty \(CMP\) Funds by States](#) to incorporate specific provisions pertaining to the imposition and collection of CMPs when nursing homes do not meet Medicare and Medicaid requirements for Long Term Care Facilities. A portion of collected Federal CMP funds may be used to support activities that promote quality care and the well-being of nursing home residents in certified nursing homes. **Direct Improvements to Quality of Care or Resident Protection:** CMP funds may be used for any project that is designed to directly improve care processes or protections for nursing home residents of multiple nursing homes.

Examples: include New York that has used CMP funds to promote:

- A user-friendly electronic care documentation system for use by nurse aides that simplifies documentation and helps caregivers follow resident conditions and progress of treatment;
- A project to improve resident balance and mobility and decrease falls using innovative exercise and balance programs that include Tai Chi and Yoga.

Strategy: Explore the emerging opportunities within the Affordable Care Act, including but not limited to the State Balancing Incentive Payments Program to increase access by low income seniors to long term services and supports; and increased funding is available to Aging and Disability Resource Centers to enhance access to both institutional and community programs ([Kaiser Brief – Medicaid and the uninsured, Feb 2011](#)).

Policy Change: Throughout the five year grant and beyond, the Advisory Group/Implementation Team provides input to the assessment of potential funding sources and strategies for pursuing that support. This includes but is not limited to:

- State block grants
- Federal/state community transformation grants
- CDC Core Injury Prevention Grants
- ACL Evidence-based and disease prevention program
- Older Americans Act
- State aging funding opportunities
- Local government: city, county, special tax and others
- Medicaid: State plans, HCBS Waiver plan
- Medicare: Transitions grants and demonstrations, ACOs, Medical Homes
- Philanthropic and charitable organizations: Foundations and United Way
- Health Care organizations such as Federally Qualified Health Centers and State Funded Health Clinics; these HRSA funded clinics are charged with treating low income patients. They can harness the expertise and resources of the aging services network to enable older patients' access to beneficial supportive services, which can result in cost savings for HRSA grantees through shared resources.
- Community health benefit funds

## Goal: Enhance data surveillance collection, analysis and system linkages

"No one strategy will ensure adequate support for (injury) prevention programs. But without data to demonstrate the severity of the problem there is no hope of gaining local, state, or national support. And without demonstrating results, we will be asking decision makers to back our efforts without evidence they are working. Finally, without influential partners, including enlightened leadership, prevention programs will ultimately suffer because there is no natural advocacy and priorities will very likely be skewed toward emergency response capabilities. Those are critical as well, but we can and must do a more effective job of building the support necessary to maintain effective (injury) prevention efforts."

- Jim Crawford, Retired Deputy Chief and Fire Marshall, Vancouver, WA Fire Department (Institution of Fire Engineers, n.d.)

*Building Blocks of Advocacy* <http://www.strategicfire.org/advocacytoolkit/demonstrate-the-need.html>

Policy Change: The DPH will identify key data resources within state level departments and partner with relevant data managers to improve the capture and quality of those data deemed important to fall prevention. DPH will leverage the available fall module within the BRFSS or consider using recommended state specific questions now in use by three states. Survey questions can be found in the [Falls Free© Evaluation Guidelines](#).

Policy Change: The DPH will give priority to epidemiological and surveillance services that can identify and address barriers, gaps and needs in fall data to produce annual (or more frequent) user-friendly profiles of the impact and cost of falls among older adults. Areas of high injury rates, EMT use, hospitalization rates and deaths will be analyzed; timely, useful data and an analysis of trends will be provided to all key stakeholders. Data output should be useful for key stakeholders who can educate and inform state and local decision makers.

Example: Massachusetts regulation under Chapter 305/Acts of 2008, Section 9 requires the Department of Public Health to collect hospital-specific data on adverse medical events and medical errors (includes falls within the facilities).

Example: Florida Department of Public Health publishes an informative, user friendly report displaying epidemiologic data: [Florida Injury Facts: Unintentional Falls: Seniors](#).

Policy Change: Critical Access Hospitals report data on falls voluntarily to the [Database for Nursing Quality Indicators](#) which provides benchmarking reports for hospitals with fewer than 100 beds. The National Database of Nursing Quality Indicators® (NDNQI®) is a proprietary database of the American Nurses Association. The database collects and evaluates unit-specific nurse-sensitive data from hospitals in the United States. Participating facilities receive unit-level comparative data reports to use for quality improvement purposes.

Policy change: As initiated by the American Hospital Association, standardize color-coded wristbands to identify patients at high risk of falling ([http://www.aha.org/search?q=yellow+wrist+bands&site=redesign\\_aha\\_org](http://www.aha.org/search?q=yellow+wrist+bands&site=redesign_aha_org)). Promote staff educational requirements for the color-coded wristband system.

Policy Change: The state hospital association and trauma associations will require accurate and timely coding of external cause of injury codes (E-Codes) to better monitor data injury rates and follow up. A majority of states mandate E-Codes in their electronic statewide hospital ED data system (HEDDS) or hospital discharge data system (HDDS); however the quality of those data vary and E-coding in the majority of state databases is incomplete. (CDC, 2008) Look to the CDC [Strategies to Improve External Cause-of-Injury Coding in State-Based Hospital Discharge and Emergency Department Data Systems](#) for proven strategies:

Example: Since 1990, NYS has mandated reporting etiology from hospitalization data in the form of external cause-of-injury codes (E-codes); any injury record lacking an E-code is rejected and returned for revision. Thus,

nearly 100 percent of injury hospitalizations in NYS are E-coded. Starting in 2005 NYS mandated emergency department data was to be submitted to the state data registry.

Policy Change: Accurate, timely Emergency Medical Services data for older adult falls will be captured at a central state repository and analyzed for trends and gaps in services. Emergency data systems will be linked to provide more accurate reporting of fall-related injuries and deaths.

Strategy: Develop and activate data collection and accountability system.

Strategy: Update falls-related data (injury, hospitalization, EMS, death) on a timely basis; create useful benchmarks and post to an accessible web site.

Strategy: Monitor trends, quality of data, identify and pursue opportunities for data linkages, identify data gaps, strengthen e-code use, and promote accessible and user-friendly data systems and formats.

Strategy: Partner with state hospital associations, state trauma associations, and state EMT associations to promote accurate and timely data collection, and more accurate reporting of fall-related incidents.

Examples: New York State PHL Article 30 requires that all ambulance and advanced life support first response services (ALS-FR) must submit all call reporting documentation to a state Trauma Registry for analysis, in a format approved by the Department. The NY State EMS Code, 10NYCRR Part 800.15, requires that every person certified as an EMS provider, at any level, must complete a Prehospital Care Report for each request for EMS response received by his/her agency, in accordance with the Department's established policy.

Through Massachusetts law (chapter 305 of the Acts of 2008), hospitals and ambulatory surgery centers are required to report Serious Reportable Events (SREs) to the Massachusetts Department of Public Health (DPH). National Quality Forum's serious reportable events are adverse events that are of concern to the public, healthcare professionals and providers; clearly identifiable and measurable, and thus feasible to include in a reporting system; and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare facility. The law also prohibits hospitals from charging for these events or seeking reimbursement for SRE-related services. Through regulation, the Department has defined SREs to meet the National Quality Forum's definitions of twenty-eight such events. From <http://www.mass.gov/eohhs/provider/reporting-to-state/reporting-entities/hospital/serious-reportable-event-sres.html>

Policy Change: State Medicaid services will promote the capture of utilization data and require the linkage of external cause of injury codes to hospital transfer records to more accurately assess the cost and impact of falls among low income older adults.

Policy Change: An easy to read, annual report will be submitted and/or used as an educational strategy to the legislature portraying the impact and cost of falls within the state, including Medicaid share of the costs.

Strategy: DPH will assess available data sets and develop a template for an annual report to the State Medical Officer, state legislature and other key stakeholders.

Example: Florida Department of Public Health publishes an informative, user friendly report displaying epidemiologic data: [Florida Injury Facts: Unintentional Falls: Seniors](#).

Strategy: Encourage state legislators to set an annual reporting requirement of the impact and cost of falls within the state, including Medicaid costs.

Policy Change: Align data collection among states to allow for more consistent reporting of falls prevention data. Recommendations have been put forth by the CDC/NCIPC and within the Safe States Alliance Working Group and should be implemented and monitored through the Regional Injury Prevention Networks.

## **Goal: Increase the availability and accessibility of community programs and services**

Programs and services that promote and sustain fall prevention must be accessible to those at risk and available across the county, region or state to reach large numbers of older adults; beyond geographical location, other participation barriers may include cost, time of program offering, transportation, cultural and educational level of the program and the outreach strategies, relevance to need, and reinforcement of importance from providers and family/friends. The policies and strategies suggested in this section are also tied to previous sections on awareness and infrastructure building, provider participation and data collection.

Policy change: State leadership in public health and aging will identify the array of essential fall prevention programs, services and resources that each community or county should have in place.

Strategy: Leverage CDC Core Injury Grant investments

Example: The Maryland Department of Health and Mental Hygiene (DHMH) invested its Centers for Disease Control and Prevention (CDC) Core Violence and Injury Prevention grant in two local health departments (Cecil and Washington) and one local area agency on aging (MAC, Incorporated which covers Dorchester, Somerset, Worcester, and Wicomico Counties) to implement the CDC approved evidence-based intervention programs [Tai Chi for Better Balance](#) and [Stepping On](#).

Example: The Washington Injury and Violence Prevention program, with funding from the Centers for Disease Control and Prevention, developed the “Stay Active and Independent for Life” campaign, which provides risk assessments and exercise classes for older adults. A 2007 evaluation of the campaign reported more than 90 percent of participants improved their strength or balance and were able to more easily complete daily activities.

Strategy: Partnering with the DPH, identify and geo-map areas of high fall concentration and leverage state aging and public health guidance for giving priority to fall prevention services.

Strategy: Identify and catalog current community fall prevention resources, programs and services.

Strategy: Promote and champion local and regional coalitions and working groups’ development to extend the reach of the state coalition.

Strategy: Employ state-level and professional association champions to make the case with other state-level departments, including transportation.

Example: The Northern VA Fall Prevention Coalition has been building momentum, community engagement and most recently reached out to partner with researchers in balance and gait assessment. They have been successful in also engaging champion legislators: A state senator collaborating with the Secretary Department of Health and Human Resources introduced a budget amendment directing the Department to examine current fall prevention strategies and potential budget savings if the state were to implement some of activities being offered in Northern Virginia.

Strategy: Partner with community transportation planners to ensure safe and accessible transportation services; offer training of transportation operators.

Strategy: Develop a partnership engagement strategy and accompanying PowerPoint presentation to reach potential funding organizations including foundations, community boards, health care institutions, health plans, and others to target gaps in programs and services.

Strategy: Target fall prevention efforts with culturally relevant programming to reach concentrations of high risk fallers (identified through DPH efforts); partners in this effort could include local PH departments, in collaboration with AAA and local coalitions.

Strategy: Leverage the Hospital Community Health Benefits Program that is required to maintain the nonprofit status. Participating hospitals are required to:

- Determine and address broad community interests and health needs through community input and collaboration with public health;
- Promote public education;
- Develop and implement community health plans that can inform federal policies.

Strategy: Recognize the contributions of a healthy life style as promoted through other evidence-based programs and promote fall prevention by offering a menu of programs and services.

Example: Physical inactivity, chronic disease manifestations, depression and fear of falling are all risk factors for falling that can be exacerbated by having multiple chronic diseases and the medications prescribed to treat them. Encouraging older adults to become more physical active, to better manage their chronic condition(s), and to enhance their self efficacy re falls through the array of evidence-based health promotion programs offered within the aging services network and other community providers can make a significant contribution to reducing falls risk. Moreover programs are designed to empower older adults to make appropriate choices and behavior changes which can be reinforced through additional program participation. Initiatives include linking Matter of Balance graduates to EnhanceFitness or Tai Chi: Moving for Better Balance.

Strategy: Consider cross state initiatives to share training costs.

Examples: A collaborative partnership with the Veterans Administration included aging staff and VA staff from NM, AZ and TX to jointly fund course leader training and pairing of veteran leaders with new community leaders. Similarly NM, UT, AZ and CO are collaborating to fund training for course leaders to access rural and Tribal Nations elders in the four corners area.

Recently NV and UT discussed cross state initiatives in [Stepping On](#). VT and NH are jointly training Tai Chi: Moving for Better Balance instructors to meet states' needs for implementation.

Policy Change: In accordance with State Unit on Aging guidance, the Area Aging Service Plans enfold fall prevention into program offerings and the delivery of Home and Community Based Services.

Strategy: Develop and offer a menu of programs to promote healthy aging and support ongoing behavior change strategies; link programs and services.

Example: In Colorado, representatives from CDPHE and SUA participate in the state falls coalition to link falls prevention initiatives with the aging network and existing evidence-based programs. They also work closely with Consortium for Older Adult Wellness, a non-profit institute offering training programs and fidelity monitoring to community based, aging organizations.

Example: The Wisconsin Institute for Healthy Aging (WIHA) was formed to advance the spread of evidence-based prevention programs that encourage and support healthy living among older people through [partnerships](#) with public and private organizations. Key founding organizations include DPH, SUA and University of WI-Madison.

Strategy: Develop a tracking system for ensuring delivery of quality programs and services.

Strategy: Develop a web accessible program and service directory for use by consumers, family members and providers.

Policy change: Community planners, local city managers and others will consider environmental impacts on falls of funding and infrastructure decisions.

Strategy: Activate partner networks and volunteers to conduct [walkability audits](#). Walkability audits, also called walkability workshops or walking classrooms, are powerful planning and teaching tools that help turn blocks, streets, corridors, downtowns, waterfronts and neighborhoods into walkable and livable places. A walking audit allows all people to see conditions and opportunities for enhancing the safety of their communities

Example: The California Community Fall Prevention Coalition conducted an environmental scan and walkability audit to address community safety. [Additional Helpful Resources on Walkability and on Fall Prevention's Relationship to the Environment](#) is posted on the Stop Falls site.

Strategy: Link walkability activities and volunteers to local media resources to broaden reach.

Strategy: DPH produces an annual report of community activities and infrastructure modification to to inform local policy makers, health care sectors and the public about the impact of falls in older adults.

## **Goal: Build and leverage an integrated, sustainable fall prevention network**

There is an obligation to plan for sustainability from the beginning of the state's effort to affect falls and fall related injuries and deaths in older adults. Building a creative and effective partnership for action across the state can be sustainable and self-perpetuating if given appropriate planning and attention.

Policy Change: The State Coalition leadership will set a priority to leverage and advance the grant activities to build and sustain a statewide fall prevention network.

Strategy: The State Coalition seeks out opportunities to partner with other coalitions such as chronic disease, (including osteoporosis), healthy aging initiatives, safe community and activity community efforts, disability; professional associations, health care facilities, the Veterans Administration Hospitals and Clinics, and others.

Strategy: The State Coalition develops a targeted partnership and stakeholder engagement working group and a network of fall prevention stakeholders.

Strategy: The State Coalition encourages the development of local and regional coalitions and working groups, and provides technical assistance and nurturing.

Policy Change: State Coalitions reach out to new partners and venues where older adults are served.

Strategy: Encourage local and regional coalitions to align their efforts with the state coalition goals.

Strategy: Promote the consideration of environmental impacts of falls on funding and infrastructure decisions by enrolling city planners, transportation officials and others.

Strategy: Identify and activate champions within faith-based communities, parks and recreations, other congregation and meeting sites; offer technical assistance and speakers to bring greater awareness to the issue and prevention strategies.

Strategy: Empower consumers and caregivers through awareness and education to dialogue with providers about fall prevention strategies; encourage them to take advantage of the annual Wellness Visit.

Policy Change: Fall prevention interventions will be incorporated in appropriate state agency plans and budget requests, particularly Public Health and the State Unit on Aging.

Policy Change: Department of Public Health will commit to promoting new partnerships across the division and other state departments and will work with communities/counties to identify the array of resources for essential fall prevention.

Policy change: Communities will consider the environmental impacts of falls on funding and infrastructure decisions on falls. The public health implications of decisions made by policymakers, public health officials, community planners, transportation directors and other officials often are substantial.

Example: Legislators in California, Connecticut, Maryland, Massachusetts, Minnesota, Missouri, Tennessee, Washington and Wyoming have begun to consider the issues and are seeking to link the health effects to funding appropriated or decisions made by state officials. This objective analysis—a health impact assessment—can provide information about the effects of a project on public health (Farquha, 2008).

Strategy: In collaboration with local public works officials, activate partnership networks and volunteers to conduct walkability audits. To be effective, action must be based on findings or included in planning considerations.

Strategy: Leverage the Hospital Community Health Benefits Program. In order to maintain their nonprofit tax status, community hospitals invest “profits” into the communities served seeking to:

- Determine and address broad community interests and health needs through community input/collaboration with public health
- Promote public education
- Develop and implement community health plans that can inform federal policies

“Integrating health policy efforts with those related to education, housing, business, transportation, agriculture, media, and other areas outside of the health sector will ultimately improve the health, safety, and prosperity of the Nation.”

-

- Leading Health Indicators for Healthy People 2020 (Institute of Medicine, 2011)

## **Goal: Improve fall prevention activities in places where older adults reside**

In support of a long range systems change that enfold all older adults residing within the state, leaders should look beyond the immediate implementation sites to reach those organizations serving older adults no matter where they reside. Although outside of the CDC grant requirements, given that a growing number of older adults are residing in a variety of long term care (LTC) facilities and settings, leadership should consider appointing a working advisory group to help lead this extension of fall prevention. Settings should include but not be limited to: LTC facilities, hospitals, nursing homes, assisted living facilities and Naturally Occurring Retirement Communities (NORCs). The 2010 National Survey of Residential Care Facilities estimated there were over 31,000 residential care facilities, providing 177 beds/1000 persons aged 85 and over; clearly a population at risk of falling. For more information, see <http://www.cdc.gov/nchs/data/databriefs/db78.htm>.

**Policy Change:** Fall prevention is viewed as a priority across the continuum of care and in all transitions activities.

Strategy: Partner with the state affiliate of the National Association of Professional Geriatric Care Managers, the state hospital association, the state nursing home association and others long term care associations.

**Policy Change:** Nursing homes under state license or accepting State Funding will routinely include Vitamin D supplements for residents.

Strategy: Leverage U.S. Preventive Services Task Force (USPSTF) report on the efficacy of Vitamin D in fall prevention. <http://www.uspreventiveservicestaskforce.org/uspstf11/fallsprevention/fallsprevart.htm>

Leverage the CMS Quality Assurance and Performance Improvement Program mandated under the Affordable Care Act, which will begin regulating quality of nursing homes in 2012-2013.

[http://www.cms.gov/SurveyCertificationGenInfo/05\\_QAPI.asp](http://www.cms.gov/SurveyCertificationGenInfo/05_QAPI.asp)

**Policy Change:** Long term care facilities under state license and/or receiving state funds will show evidence of a fall prevention program subject to ongoing internal evaluation and quality improvement strategies.

Strategy: Communicate with the state nursing home and long term care associations to bring awareness to the issue and cost-effective, implementable prevention strategies.

Strategy: Partner with local businesses, faith-based organizations, retirement homes and NORCs, to promote organizational commitment and to host informational and educational events, distribute educational materials, and promote local programming.

Strategy: Develop and offer culturally competent and appropriate technical assistance, and education and training for staff.

Strategy: Promote the adoption of Quality Improvement Organization and Advancing Excellence Campaign fall prevention goals in nursing homes. Leverage strategies in the AHRQ falls management program available for long term care: <http://www.ahrq.gov/research/ltc/fallspx/fallspxman2.htm>

Strategy: Review the expected revision of long term care quality indicators and quality measures reportable through the Long-Term Care Minimum Data Set (MDS). MDS is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in a Medicare and/or Medicaid-certified long-term care facility. Currently, a fall history is required for admission to long term care facilities. Revisions underway may include quality indicators for injurious falls.

Strategy: Encourage facilities to adopt validated falls risk assessment tools.

## Goal: Institute ongoing evaluation of state efforts and outcomes

The three CDC funded states are actively engaged in the national evaluation effort and tracking a variety of outcomes as measures of the effectiveness of state activities. All states should adopt an evaluation process that can provide outcomes data to funding organizations and stakeholders; it can also provide the leadership with progress indicators that can be used to improve leverage or revise those activities.

Policy Change: Department of Public Health/Injury Prevention Section develops, implements and monitors an evaluation of the state's overall efforts as an expanded function of its epidemiological activities.

Strategy: Link to the CDC National Evaluation Strategy. Expand efforts to include data monitoring of program implementation sites, key partnerships, and activation of policy changes offered in this toolkit.

Strategy: In partnership with the state Advisory Group/Implementation Team, establish goals and benchmarks for a broader, statewide initiative and develop and implement a monitoring system.

Strategy: Collaborate with the State Coalition's Evaluation Initiative to measure impact; look to the Evaluation Guidelines for additional information. [www.ncoa.org/fallsevaluation](http://www.ncoa.org/fallsevaluation)

Strategy: Develop and activate a communications strategy to keep stakeholders routinely apprised of progress and shortfalls.

Policy Change: Department of Public Health has the opportunity to brief the state legislation or the appropriate Senate Finance or House Appropriations Committees on an annual basis.

Strategy: Target coalition partners and activities to identify a legislator or staff to champion the issue.

Example: Northern VA Coalition successfully advocated with a local congressman to champion investment in fall prevention. The congressman introduced an amendment requiring the VA Secretary of Health and Human Resources to examine the efficacy of implementing fall prevention strategies and programs statewide. Under this amendment the Secretary would be required to include in the review potential state budget savings that might be achieved from developing fall prevention strategies and programs in the Commonwealth, and report his findings to the Senate Finance and House Appropriations. Although this amendment was not enacted, it served to increase awareness by the legislature and the Secretary of Health.

Example: in support of Fall Prevention Awareness Day, MA hosted its second annual event on the steps of the State House in Boston. After a full day of events packets of information about falls prevention were dropped off at all legislators' offices (total of 200) by coalition members and older adults.

Additionally, look for new opportunities tied to the evolving implementation of the Affordable Care Act, especially focusing on care transitions. Risk of falling is heightened in periods of transition.

Examples: As it becomes available, collaborate with the Institute on HealthCare Improvement Initiative which is now in four states (Massachusetts, Michigan, Ohio, and Washington): State Action on Avoidable Rehospitalizations (STAAR) initiative is a multi-state, multi-stakeholder approach to improve the delivery of effective care and reduce rehospitalizations by working across organizational boundaries and by engaging payers, stakeholders at the state, regional and national level, patients and families, and caregivers at multiple care sites and clinical interfaces. IHI partners with STAAR states to provide strategic guidance, support and technical assistance to hospitals and cross-continuum teams to improve transitions in care and reduce avoidable rehospitalizations. <http://www.ih.org/offerings/Initiatives/STAAR/Pages/default.aspx>

In November 2011 CMS awarded funds to seven organizations in six states as part of the Community-Based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act. The CCTP provides funding

for contracts to test models for improving care transitions for Medicare patients who are at high risk for readmission. For more information and to learn of organizations selected for the first round of awards, see <http://www.cgsmedicare.com/hhh/pubs/news/2011/1111/cope17131.html>

Evaluation research methods offer credible and reliable tools and processes to support your case, as well as develop a deep understanding about what is working and what might need to be considered in the area of advocacy and public policy change. To help states, NCIPC recently posted an **Injury Policy Evaluation Guide** to support its efforts to evaluate federal and state injury prevention and control policies. It provides a basic understanding of policy evaluation and includes a number of select resources.

But one of the key challenges in evaluation of advocacy and policy work is the identification and definition of short- and intermediate-term outcomes that might occur on the way to longer-term change. These changes could be described either as performance measures for a grantee or as incremental achievements or conditions that indicate progress toward a long term policy change goal. The Annie E Casey Foundation developed [A Guide to Measuring Advocacy and Policy](#) for use by foundations to measure impact and investment in community activities that are relevant to coalition efforts. They noted six fairly standardized and widely accepted outcome categories in the service delivery arena that is relevant to the fall prevention efforts:

### **1. SHIFT IN SOCIAL NORMS**

Description: the knowledge, attitudes, values and behaviors that compose the normative structure of culture and society.

### **2. STRENGTHENED ORGANIZATIONAL CAPACITY**

Description: the skill set, staffing and leadership, organizational structure and systems, finances and strategic planning among non-profit organizations and formal coalitions that plan and carry out advocacy and policy work.

### **3. STRENGTHENED ALLIANCES**

Description: the level of coordination, collaboration and mission alignment among community and system partners, including nontraditional alliances, e.g., bipartisan alliances, unlikely allies.

### **4. STRENGTHENED BASE OF SUPPORT**

Description: the grassroots, leadership and institutional support for particular policy changes.

### **5. IMPROVED POLICIES**

Description: the **stages of policy change in the public policy including** policy development, policy proposal, demonstration of support (e.g., co-sponsorship) adoption, funding and implementation.

### **6. CHANGES IN IMPACT**

Description: long term outcomes and goals that **ultimately changes social and physical lives and conditions.**

## Legislative Options:

Public health laws direct the responsibility of the government and can give broad authority to the health department. Policymakers are responsible for developing public health policy interventions, including policies that address injury. However, their efforts are not always informed by the best available research. In turn, Departments of Public Health charged with implementing those policies and laws can enhance specificity through regulations. Healthcare laws direct the organization, financing, and provisioning of personal medical services and the relationships among providers, health care insurers, and regulators.

Strategy: Policy makers may be seeking signature issues or have a personal interest in fall prevention.

Example: In Maryland: the Dept of Aging and Dept of Health and Mental Hygiene met with State Delegates and the Montgomery County AAA Director. Delegate Arora voiced an interest in what he heard about senior fall prevention and the Maryland Fall Prevention Advisory Group activities. Delegate Arora asked what we could do if we had more funds for senior fall prevention, and the Maryland Advisory Group provided him with a draft plan for investing more into evidence-based fall prevention programs and leveraging existing programs. A bill was subsequently submitted for this legislative session.

As reported by the Conference of State Legislatures, member legislatures are playing an increasingly visible role by establishing programs and appropriating funds to address fall prevention. Laws in seven states support further research and development; promote statewide fall prevention planning; or empower seniors, community members and health care providers to take proactive steps to reduce falls.

The following mix of public health and healthcare laws can significantly advance a statewide approach to fall prevention; additional information may be found through the National Conference of State Legislatures where fall prevention and osteoporosis legislative initiatives and their eventual outcomes are listed.

<http://www.ncsl.org/issues-research/health/elderly-falls-prevention-legislation-and-statutes.aspx>.

1. Codify the State Coalition or Advisory Group as a state fall prevention and early detection task force to develop a statewide approach to reduce falling among older adults.

Examples: [HI HCR 23](#) would establish a Hawaii state fall prevention and early detection task force to develop a statewide approach to reduce falling among older adults.

[ME Chapter 149 Resolve of the Second 122nd Regular Session](#) requires the Commissioner of Health and Human Services to appoint a statewide Falls Prevention Coalition to review the effects of falls of older adults on health care costs, the potential for reducing the number of falls of older adults, and the most effective strategies for reducing falls and health care costs associated with falls.

In Virginia, a fall prevention champion Senator introduced a 2013 budget amendment: Page 206, after line 43, insert: "D. The Secretary of Health and Human Resources shall examine the efficacy of implementing fall prevention strategies and programs statewide. The Secretary shall include in the review potential state budget savings that might be achieved from developing fall prevention strategies and programs in the Commonwealth. The Secretary shall report his findings to the Senate Finance and House Appropriations Committees by October 1, 2012." **Explanation:** This language amendment requires the Secretary of Health and Human Resources to examine the effectiveness and potential cost savings of developing a fall prevention strategy statewide. With the aging of Virginia's citizens, the strategy would be designed to prevent future health and long-term care costs.

2. Require hospitals to provide complete and accurate reporting of external cause of injury code.

Example: Since 1990, NYS has mandated state reporting of etiology from hospitalization data in the form of external cause-of-injury codes (E-codes); any injury record lacking an E-code is rejected and returned for revision. Thus, nearly 100 percent of injury hospitalizations in NYS are E-coded. Emergency Department data was

mandated to be submitted in 2005.

### 3. Declare/Proclaim Fall Prevention Awareness Day/Week

Examples: The State of California recognized the importance of fall prevention with the introduction of a legislative resolution promoting Fall Prevention Awareness in California. Senate Concurrent Resolution 77, authored by Senator Alan Lowenthal (D-Long Beach), establishes an annual Fall Prevention Week recognition in the state and urges all state and local agencies to incorporate fall prevention considerations in their planning documents affecting housing, transportation, parks and recreational facilities. Co-sponsored by the Fall Prevention Center of Excellence and the California Commission Aging, the resolution also urges state and local aging programs to incorporate fall prevention in their master plans, and recommends the development of standardized definitions and reporting methods to approve the information available on falls. Local fall prevention coalitions celebrate Fall Prevention Awareness Week to raise awareness among older persons and their families about the seriousness of falls and how they can be prevented.

Maryland House Bill 665: Subtitle 6. Commemorative Weeks 13–601: In recognition of the need for increased awareness of the effect that falls have on the Senior Citizens of Maryland, the Governor each year shall proclaim the week that begins on the first Sunday that falls after the Autumnal Equinox as Fall Prevention Awareness Week.

### 4. Require long term care workers to meet basic core competencies in fall prevention. The Affordable Care Act (ACA) of 2010 included the first ever federal initiative to improve training for home care and personal assistance workers, and to assess the future capacity needed in the personal care workforce.

Examples: Arizona's Direct Care Workforce Initiative has overseen the development of a model training curriculum for PCAs, "Principles of Caregiving." From this curriculum, the AZ Direct Care Workforce Committee and other stake-holders drafted competencies and standards for direct care workers as well as a standardized competency evaluation. Throughout 2011, Arizona's Medicaid department has implemented the new training and testing requirements for Direct Care Workers (DCW) who work in home care settings under DES or AHCCCS Medicaid Programs. Full roll-out will be completed by October 2012.

Following recommendations of the Wisconsin Home and Community Based Long Term Care Workforce Development Workgroup, SEIU initiative 1029 passed in 2008; in November 2011, initiative 1163 passed moving the implementation to 2012. The training must be conducted using the DSHS curriculum or approved comparable curricula, and very few workers will be exempted.

### 5. Require submission of EMT/ED data to a statewide database.

Examples: The New York State Department of Health, Bureau of Emergency Medical Services is responsible, pursuant to Article 30 of the Public Health Law (PHL) for the collection of pre-hospital patient documentation data. The paper Prehospital Care Report (PCR) has been the primary instrument used for patient care and EMS event documentation. The primary purpose of the PCR is to document all prehospital care and pertinent patient information for medical and legal purposes, as well as serving as a data collection tool for local and statewide quality improvement, protocol development and when approved, research. PHL Article 30 requires that all ambulance and advanced life support first response services (ALS-FR) must submit all call reporting documentation to the Department, in a format approved by the Department. The NY State EMS Code, 10NYCRR Part 800.15, requires that every person certified as an EMS provider, at any level, must complete a PCR for each request for EMS response received by his/her agency, in accordance with the Department's established policy.

Through Massachusetts law (chapter 305 of the Acts of 2008), hospitals and ambulatory surgery centers are required to report Serious Reportable Events (SREs) to the Massachusetts Department of Public Health (DPH). The National Quality Forum (NQF) defines serious reportable events as adverse events that are of concern to both the public and healthcare professionals and providers; clearly identifiable and measurable, and thus feasible to include in a reporting system; and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare facility. The law also prohibits hospitals from charging for these events

or seeking reimbursement for SRE-related services. Through regulation, the Department has defined SREs to meet the National Quality Forum's definitions of twenty-eight such events. From <http://www.mass.gov/eohhs/provider/reporting-to-state/reporting-entities/hospital/serious-reportable-event-sres.html>

6. Establish a statewide consumer education and training program for falls and osteoporosis. At least **thirty-four** states and **Puerto Rico** have enacted laws relating to osteoporosis, the majority of which establish statewide education, public awareness and prevention programs; most already enfold injurious falls and could be expanded to include fall prevention strategies.

Examples:

- [CA Health and Safety Code § 125704](#) (California Osteoporosis Prevention and Education Act) requires the Department of Health Services to develop effective protocols for the prevention of falls and fractures and establish these protocols in community practice to improve the prevention and management of osteoporosis.
- G.A. Code Ann. § 31-42.1 et seq. (1995) enacted the Osteoporosis Prevention and Treatment Education Act to create a multigenerational, statewide program to promote awareness and knowledge about osteoporosis, risk factors, prevention, detection and treatment options.
- [N.H. Rev. Stat. Ann. § 126:I-1 et seq.](#) (1997) requires the Department of Health and Human Services to establish, promote and maintain an osteoporosis prevention and education program. The program shall promote public awareness about the causes of osteoporosis options for prevention, and the value of early detection and possible treatments, including the benefits and risks of those treatments. The law also provides for the establishment of an advisory council.
- TN. Code Ann. § 68-1-1501 et seq. (1995) was intended to create the Osteoporosis Prevention and Treatment Education Act. The law establishes a statewide program to promote public awareness and knowledge about osteoporosis within the Department of Health.

7. Require long term care hospitals to report falls data in accordance with the FP protocol of the national database of Nursing Quality Indicators.

Example: [P.A. 96-1130, 2010 Ill. Laws](#): Requires long-term care hospitals to report data on elderly falls to the Department of Healthcare and Family Services as part of the Long-Term Care Hospital Quality Improvement Transfer Program. Participating hospitals must report the number of falls with injury per 1,000 patient days in accordance with guidelines established by the Fall Prevention Protocol of the National Database of Nursing Quality Indicators (NDNQI) and the number of falls among discharged long-term care hospital patients whose fall during the hospital stay necessitated an ancillary or surgical procedure.

8. Require Medicaid services to report to the state legislature the cost of falls related health care and nursing home expenses on an annual basis.

9. Increase investment in evidence-based interventions.

Examples: [CN Gen. Stat. §14b-33](#): Establishes a fall prevention program within the Department of Social Services that 1) supports research, development and evaluation of risk identification and intervention strategies; 2) establishes a professional education program in fall prevention; 3) oversees and supports demonstration and research projects.

Maryland is leveraging its investment of Core Injury Prevention Grant funding in two local health departments (Cecil and Washington) and one local area agency on aging (MAC, Incorporated which covers Dorchester, Somerset, Worcester, and Wicomico Counties) to implement the CDC recognized evidence-based intervention programs [Tai Chi: Moving for Better Balance](#) and [Stepping On](#). Efforts included demonstrating successful implementation against the backdrop of growing numbers and costs of fall-related injuries. MD emphasized the potential return on investment (requesting training funds for program leaders): Based on MD data, for every one fall-related admission/re-admission to the hospital that is prevented, \$14,446 in cost could potentially be saved, and \$625 for each emergency visit averted. MD also noted the efficient use of use of Federal Public Health and Health Services (PHHS) Block Grant in fall prevention which is being eliminated in the 2012 budget.

In Hawaii companion House and Senate bills in 2011 [HI HB 507/SB 939](#) and [HI HCR 23](#) were intended to establish the position of statewide fall prevention (or task force) and early detection coordinator to investigate the immediate and long-term dangers of fall injuries on the elderly population and make recommendations for measures that will promote early detection of falls.

In 2008, the Washington Legislature appropriated funds to support the falls prevention program. One goal was to identify service gaps and help professionals identify and reduce fall risks. The funds also were used to make affordable exercise programs more widely available to older adults.

10. Require long term care workers to meet basic core competencies or continuing education requirements (including fall prevention) as a basic requirement for renewal of nursing home licenses/certifications.

Example: District of Columbia passed DC B 481 (Health Care Facilities Improvement) that required the Mayor to create continuing education requirements for nursing home administrators as a condition for renewal of licenses, registrations or certifications; fall prevention is mentioned as a suggested topic.

11. Leverage the 2009 "Call to Action to Promote Healthy Housing" as part of the national Healthy Homes Initiative led by the U.S. Department of Health and Human Services' Centers for Disease Control and Prevention (CDC) and the U.S. Department of Housing and Urban Development (HUD). HUD, CDC and other partners highlight the public health importance of promoting healthy homes, including the prevention of falls across the lifespan. Related legislative and regulatory initiatives that have been considered though not successfully enacted include:

- Income tax credits for primary residence modifications to accommodate aging and/or disability safety and access through the installation of hand rails, grab bars and other safety devices.
- New York City Council considered a Grab Bar bill that would create a tax credit for landlords to install bathroom grab bars to accommodate aging and/or disability safety.

## References

- Agency for Health Care Policy and Research (AHRQ). (2011a). Primary care workforce facts and stats No. 1: The number of practicing primary care physicians in the United States. AHRQ Publication No. 12-P001-2-EF. Rockville, MD: AHRQ. Retrieved from <http://www.ahrq.gov/research/pcwork1.htm>
- Agency for Health Care Policy and Research (AHRQ). (2011b). Primary care workforce facts and stats No. 2: The number of nurse practitioners and physician assistants practicing primary care in the United States. AHRQ Publication No. 12-P001-3-EF. Rockville, MD: AHRQ. Retrieved from <http://www.ahrq.gov/research/pcwork2.htm>
- Centers for Disease Control. (2009). CDC Injury Framing Initiative, *Adding Power to Our Voices*. Retrieved from <http://www.cdc.gov/injury/framing/index.html>
- Centers for Disease Control. (2008) Strategies to improve external cause-of-injury coding in state-based hospital discharge and emergency department data systems: Recommendations of the CDC workgroup for improvement of external cause-of-injury coding. (MMWR 57 No. RR-1). Atlanta, GA: Coordinating Center for Health Information and Service, CDC. Retrieved from <http://www.cdc.gov/mmwr/PDF/rr/rr5701.pdf>
- Centers for Disease Control. (2010). The National Survey of Residential Care Facilities. <http://www.cdc.gov/nchs/nsrcf.htm>
- Crawford, James (n.d.). A guide to fire prevention advocacy: Implementing your advocacy program. Retrieved from <http://www.strategicfire.org/advocacytoolkit/demonstrate-the-need.html>
- Reisman J., Gienapp, A. and Stachowiak, S. (2007). A Guide to measuring advocacy and policy. Annie E. Casey Foundation. Baltimore, MD Retrieved from <http://www.aecf.org/upload/PublicationFiles/DA3622H5000.pdf>
- Farquha, D (2008) Health impact assessments: A tool to assess and mitigate the effects of policy decisions on public health. National Conference of State Legislatures. Retrieved from <http://www.ncsl.org/default.aspx?tabid=13210>
- Institute of Medicine. (2011). *Leading health indicators for Healthy People 2020: letter report*. Washington, DC: National Academies Press. Retrieved from [http://books.nap.edu/openbook.php?record\\_id=13088&page=R1](http://books.nap.edu/openbook.php?record_id=13088&page=R1)
- National Association of County and City Health Officials and [Safe States Alliance](#). (2011). Standards and indicators for local health department injury and violence prevention programs. Retrieved from <http://www.naccho.org/topics/HPDP/injuryprevention/standards.cfm>
- National Center for Injury Prevention and Control. (2012). Injury policy evaluation guide. Centers for Disease Control.
- National Conference of State Legislatures. (2009). Legisbrief: Preventable injuries burden state budgets. Vol 17. Washington, DC.
- National Conference of State Legislatures. (2010). Legisbrief: Preventing falls among older Americans. Vol 18. Washington, DC.
- National Council on Aging (NCOA). (n.d.) Falls Prevention Awareness Day. Retrieved from <http://www.ncoa.org/improve-health/center-for-healthy-aging/falls-prevention/falls-prevention-awareness.html>

National Council on Aging. (2012). Falls Free© logic model. Retrieved from <http://www.ncoa.org/improve-health/center-for-healthy-aging/falls-prevention/evaluation-guidelines/why-use-a-logic-model.html>

National Prevention Council. (2011). *National Prevention Strategy*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. Retrieved from <http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>

National Prevention Council. (2010). *2010 Annual status report: National Prevention, Health Promotion and Public Health Council*. Retrieved from <http://www.hhs.gov/news/reports/nationalprevention2010report.pdf>

[Safe States Alliance](#). (2011). Making the case for injury and violence prevention: A conversation starter for state injury and violence prevention directors to use with state health officials and other leaders. Retrieved from <http://www.safestates.org/associations/5805/files/Safe%20States%20Making%20the%20Case.pdf>

National Council on Aging, (2009). *Falls Prevention Awareness: Findings and Lessons Learned from State Coalitions on Fall Prevention*. Washington, DC: Schneider, E.C. Retrieved from <http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/falls-prevention-awareness-2.html>

Songer, T., Stephens-Stidham, S., Peek-Asa, C, et. Al. (2009, April). *Core Competencies for Injury and Violence Prevention*. *Am J Public Health*, 99(4), 600–606. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661480/pdf/600.pdf>

U.S. Department of Health and Human Services (DHHS). (2011). Healthy People 2020 objectives: Older adults. Retrieved from <http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=31>

U. S. Department of Health and Human Services and Centers for Disease Control and Prevention. (2011). Core Violence and Injury Prevention Program (Core VIPP) Funding Opportunity Number: CDC-RFA-CE11-1101 Retrieved from <http://www07.grants.gov/search/search.do?oppId=58714&mode=VIEW>

## Appendix A

### Resources to develop effective advocacy skills

Systemic advocacy seeks to introduce, influence or produce positive long-term changes to attitudes, systems, policies and procedures, to remove barriers, address discriminatory practices and to ensure the collective rights and interests of health consumers are attained and upheld. It is primarily concerned with encouraging changes to the law, government, policies and community attitudes. It also seeks to influence...the social and political structures that promote and sustain injustice and inequality. Health Consumers Queensland. Health Advocacy Framework: Strengthening health advocacy in Queensland. March 2011. Pg 15 Accessed online, November 29, 2011 [http://www.health.qld.gov.au/hcq/publications/hcq\\_framework\\_may11.pdf](http://www.health.qld.gov.au/hcq/publications/hcq_framework_may11.pdf)

Fall Prevention Center of Excellence Fall Prevention Advocacy Toolkit: This resource serves as a guide for those interested in becoming a more effective advocate for fall prevention; providing ideas, tools and resources to get you started. <http://www.stopfalls.org/advocacy/need.shtml> Accessed 12/12/2011

Hardman, S. (2012, August 21). *Law as a Path to Health and Safety*. A webinar is designed to help participants understand core concepts of public health law so that they can more effectively protect the public from intentional and unintentional injury – and avoid legal trouble. Webinar retrieved from [http://www.safestates.org/associations/5805/files/Law as a Path to Health and Safety 8.21.12.pdf](http://www.safestates.org/associations/5805/files/Law%20as%20a%20Path%20to%20Health%20and%20Safety%208.21.12.pdf)

Mental Health America (2011). Advocacy 101: Getting started. Mission Kit Series. This guide offers the reader a particular emphasis on strengthening coalition advocacy skill level. Retrieved from [http://www.mentalhealthamerica.net/action/Advocacy\\_Guide.pdf](http://www.mentalhealthamerica.net/action/Advocacy_Guide.pdf).

National Association of County and City Health Officials. (2011). Public Health Communications Resources. This communications toolkit was created by the National Association of County and City Health Officials (NACCHO) to help local health departments (LHDs) effectively communicate about local public health Retrieved from <http://www.naccho.org/advocacy/marketing/toolkit/index.cfm>

National Council on Aging. Policy Toolkits: The Advocacy Toolkit offers the reader strategies to build relationships with your lawmakers in your community and how to tell the story of your organization and the people you serve. Retrieved from <http://www.ncoa.org/public-policy-action/advocacy-toolkit/> There are also toolkits focused on for long term services and supports, health care and seniors programs:

- [Advocacy Toolkit: Long-Term Services & Supports;](#)
- [Advocacy Toolkit: Health Care;](#) and
- [Advocacy Toolkit: Federal Funding for Seniors Programs](#)

Research!America. (2011). Public Health Advocacy Toolkit. This [public health advocacy toolkit](#) and series of print ads highlights the day-to-day benefits that prevention and public health research delivers to Americans' health. These ads, spotlighting chronic diseases and unintentional injuries, emphasize the leadership role that the Centers for Disease Control and Prevention plays in protecting Americans from needless suffering. Retrieved from <http://www.researchamerica.org/toolkits>

University of Kansas. (2012). The Community Toolbox. This online resource has 46 Chapters and nearly 300 different sections that provide practical, step-by-step guidance in community-building skills. Refer to Chapter 25. Changing Policies is particularly useful. Retrieved from [http://ctb.ku.edu/en/tablecontents/chapter\\_1025.aspx](http://ctb.ku.edu/en/tablecontents/chapter_1025.aspx)

## Appendix B

### Additional Suggested Resources

Agency for Health Care Policy and Research. (2010). Closing the quality gap: Revisiting the state of the science "The Patient-Centered Medical Home." Retrieved from <http://www.ahrq.gov/clinic/tp/gappcmh.htm> This review examines the results of studies focusing on changing care for all or most patients serviced by a health care organization certified as a patient-centered medical home.

Agency for Health Care Policy and Research. (2011). Consumer materials: Be More Involved in Your Health Care: Tips for Patients. <http://www.ahrq.gov/consumer/beinvolved.htm>, and Your Medicine: Be Smart. Be Safe: <http://www.ahrq.gov/consumer/safemeds/yourmeds.htm>

Agency for Healthcare Research and Quality (AHRQ). (2012). Hospital Quality Indicators toolkit. <http://www.ahrq.gov/qual/qitoolkit/>

American Hospital Association. (2008). Implementing standardized colors for patient alert wristbands. Quality Advisory. Retrieved from <http://www.aha.org/advocacy-issues/tools-resources/advisory/2008/080904-quality-adv.pdf>

CDC Assessment Initiative. Retrieved from <http://www.cdc.gov/ai/> supported the development of innovative systems and methods that improve access to health data and the way data are used to inform and guide leaders involved in planning, developing, and evaluating health policies and interventions. CDC currently funds the participation of nine states.

Centers for Disease Control. (2011). 2010 National Survey of Residential Care Facilities. In 2010, the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) conducted a new study of residential care communities. The National Survey of Residential Care Facilities (NSRCF) is a first ever survey of residential care providers Retrieved from <http://www.cdc.gov/nchs/nsrcf.htm>

Centers for Disease Control. State program evaluation guides: Developing an evaluation plan. Retrieved from [http://www.cdc.gov/dhdSP/programs/nhdsp\\_program/evaluation\\_guides/evaluation\\_plan.htm](http://www.cdc.gov/dhdSP/programs/nhdsp_program/evaluation_guides/evaluation_plan.htm)

Centers for Disease Control. Stopping Elderly Accidents, Deaths and Injuries (STEADI) tool: to be posted on Retrieved from [www.PhConnect.org](http://www.PhConnect.org)

Hooker, S., Cirill, L. & Wicks, L. (2007). Walkable neighborhoods for seniors: The Alameda County experience *Journal of Applied Gerontology* 26; 157-182.

MaineHealth. (2009). Fall Prevention resource manual for healthcare providers Adapted from the American Geriatrics Society Falls Tool Kit – under revision. Retrieved from [http://www.mainehealth.org/workfiles/mh\\_PFHA/FallsInfoProviders.pdf](http://www.mainehealth.org/workfiles/mh_PFHA/FallsInfoProviders.pdf).

Southern Maine Area Agency on Aging. Frequent Fallers Series: a four part educational program for Emergency Medical Technicians. <http://connect.maine.edu/p9q7szccea/>

National Association of Public Hospitals and Health Systems. (2011). Reducing readmissions in safety net hospitals & health systems. NAPH conducted an online survey of 51 member facilities, followed by in-depth interviews with eight respondents, to gather information about the strategies to reduce readmissions being implemented by safety net facilities; findings emphasized readmissions are a priority for NAPH. Retrieved from

<http://www.naph.org/Main-Menu-Category/Publications/Reducing-Readmissions-in-Safety-Net-Hospitals-Health-Systems.aspx?FT=.pdf>

National Council on Aging. (2008). A practical guide to state coalition building that addresses a growing public health issue. Retrieved from <http://www.coalitions.fallsfree.org/>

National Council on Aging. (2012). Evaluation guidelines for state coalitions' on fall prevention. Retrieved from [www.ncoa.org/fallevaluation](http://www.ncoa.org/fallevaluation)

National Council on Aging. (2009). Advancing and sustaining a fall prevention agenda: The role of legislation, policy and regulation. This document is offered as a resource for state and local advocacy efforts. It provides a menu of strategies and initiatives for advancing and sustaining a state fall prevention agenda through legislative, policy, and regulatory initiatives. It also outlines a number of considerations that should be weighed when planning strategies. The initiatives and strategies described in this document are intended primarily to provoke dialogue within coalitions. Retrieved from <http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/advancing-and-sustaining-a.html>.

National Health Policy Forum. (2011, October 28). Preventing hospital readmissions: How can care transitions for Medicare beneficiaries be improved? FORUM SESSION. [http://www.nhpf.org/library/forum-sessions/FS\\_10-28-11\\_PreventingReadmission.pdf](http://www.nhpf.org/library/forum-sessions/FS_10-28-11_PreventingReadmission.pdf)

National Prevention Council. (2010). 2010 Annual Status Report: National Prevention, Health Promotion and Public Health Council. <http://www.hhs.gov/news/reports/nationalprevention2010report.pdf>

O'Shaughnessy, C.V. (2010). Aging and Disability Resource Centers, federal and state efforts to guide consumers through the long-term services and supports maze. National Health Policy Forum, Background Paper No. 81. Retrieved from [www.nhpf.org/library/details.cfm/2835](http://www.nhpf.org/library/details.cfm/2835) .

Pearson, KB & Coburn, AF. (2011). Evidence-based falls prevention in critical access hospitals. Policy Brief #24. . Retrieved from [http://flexmonitoring.org/documents/PolicyBrief24\\_Falls-Prevention.pdf](http://flexmonitoring.org/documents/PolicyBrief24_Falls-Prevention.pdf)

Reimbursement overview – see companion **State Policy Toolkit: Select Resources**

Schneider, E.C. (2009). Falls prevention awareness: Findings and lessons learned from state coalitions on fall prevention. National Council on Aging, Washington, D.C.

Retrieved from [www.healthyagingprograms.org](http://www.healthyagingprograms.org). <http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/falls-prevention-awareness-2.html>

State profiles, fact sheets: contact NCOA for individual state profiles designed to enhance advocacy and awareness by enfolding data and state coalition efforts in a compelling two page issue brief. Retrieved from <http://www.ncoa.org/improve-health/center-for-healthy-aging/falls-prevention-state.html>

Trust for America's Health. (2011). [Prevention and The Affordable Care Act: Benefits to Seniors](#) This brief provides an overview of the benefits for older adults under the Affordable Care Act including the annual wellness visit, clinical services, immunizations and community transformation to promote prevention.

Yvonne L. Michael, Y.L., Whitlock, E.P., Lin, J.S., et. al. (2010). Primary Care–relevant interventions to prevent falling in older adults: A systematic evidence review for the U.S. Preventive Services Task Force. Retrieved from <http://www.uspreventiveservicestaskforce.org/uspstf11/fallsprevention/fallsprevart.htm>

## APPENDIX C

### Process of discovery and development:

This section provides an overview of the process of discovery and development that undergirds this toolkit. Policy is a broad concept, defined by CDC as “a law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions”. Policies that promote effective environmental and systems change can influence behavior and healthy choices of consumers, clinical practitioners, organizations and whole communities. As demonstrated in the model below, policies can evolve from current practices and investments as a strategy of sustainability as well as be used to drive change, a consideration included in this toolkit.



In this work we took a holistic view. The authors sought to keep in mind the need to think and act broadly, and to integrate other perspectives, leverage scarce resources, and employ strategies at multiple levels including the organization, the community, regionally and across the state.

NCOA conducted an extensive review and considered a variety of frameworks, taking from the literature a number of strategies for putting this information into a usable document. Among them was [RE-AIM for Program Planning: Overview and Applications](#), the Socioecological Model, the [World Health Organization Fall Prevention Model](#), the model of the [National Prevention Strategy](#), the [CDC Multi-component Falls Prevention Program Logic Model](#), the [Public Health Institute Dialogue 4 Health Model](#) and finally the [Falls Free© Logic Model](#).

Ultimately the Falls Free© Logic Model was selected as the working framework, however while populating the framework, the authors were careful to ensure elements of those alternate models were considered, especially the levels of effect and effort found within the Socioecological Model. Within this document we have included Policy Changes covering the scope of regulatory, legislative, institutional practice, clinical practice, reimbursement practice, and expanded resources/investment. Finally, we also considered linkages to the National Evaluation Strategy and the concurrent efforts in the dissemination of evidence-based health promotion programs. Policy evaluation should ideally be conducted both before and after enactment looking at potential costs, cost savings, impact and unintended consequences.

Suggestions and comments were sought from partnering professional associations and select state coalitions.