May 2015 Public Health Live! Transcript

*Making Fall Prevention Part of Primary Care: Implementing CDC's STEADI Toolkit*

>>> Hello, and welcome to public health live," the Third Thursday Breakfast Broadcast. I'm Rachel Breidster, and I'll be your moderator today. Before we get started, I would like to ask that you please fill out your online evaluation at end of the webcast. Continuing education credits are available after you take our short posttest, and your feedback is helpful in planning future programs. As for today's program, we will be taking your questions throughout the hour by phone. Our number is 1-800-452-0662, or you can e-mail us at phlive.ny@gmail.com. I also want to let you know that the planners and presenters of "Public Health Live" do not have any financial arrangements or affiliations with any commercial entities whose products, research or services may be discussed in this activity and no commercial funding has been accepted for this activity. Today's program is entitled, "Making Prevention Part of Primary Care, Implementing CDC's STEADI Toolkit." Our guests are Dr. Frank Floyd, Associate Medical Director and Champion at United Health Services, and Harrison Moss, Program Director for the New York State Department of Health's Older Adult Fall Prevention Program in the Bureau of Occupational Health and Injury Prevention. Thank you very much for being here today.

>> Thank you.
>> Thank you for having us.

>> Now, in addition to this being a professional situation for both of you, I understand that you both have personal stories about falls in older adults that you'd like to share. And Harrison, I wonder if you would start that for us today?

>> Sure. Well, the slide here shows a picture of my grandmother, who, at age 72, fell down the stairs and broke her hip. As a result, she was left confined to a wheelchair. And less than six months later, she passed away. Just three years after that, my twin brother and I were born. But because of the fall, we never got the opportunity to meet our grandmother, and our grandmother never got the opportunity to meet us, her grandchildren. So, I often think that if the fall was prevented, we'd at least have the opportunity to make that connection.

>> Sure.
>> So, when I think of falls, I think of my grandmother.

>> And did you have a story as well, Dr. Floyd?
>> Yes, actually. As an internal medicine physician, there's many stories I could tell. But like Harrison, the one that really intrigued me the most and helped me to get started and be a champion for this program was my grandmother, too, really. Her life, or functional life, really, ended after she fell and broke her hip and had to be in a nursing home; she was never able to return home again. And that really led

to, ultimately, to her demise.

>> And I think that's something a lot of our viewers can probably relate to as well, having these personal stories, which is why today's program I think is going to be very beneficial. So, can you give us, Harrison, an overview of falls in New York State with older adults?

>> Sure. Falls among older new Yorkers are the leading cause of deaths due to injury. In fact, every year, over 1,000 older new Yorkers die due to fall-related injuries. So, although falls may seemingly be harmless, they can and sometimes are fatal, especially for older adults.

Falls are also the leading cause of hospitalizations and emergency department visits for older new Yorkers. Every year, over 141,000 older New Yorkers are treated at the hospital or emergency department for fall-related injuries. And, to give you a sense of how much that is, that's enough to fill every seat in Yankee stadium nearly three times over.

>> That’s a pretty staggering number that we see visiting the hospital. You say that's visiting the emergency room due to falls? Now, can you tell us about some of the more common injuries that are due to falls?

>> Sure. About 20% to 30% of those who fall suffer a moderate to severe injury. Such injuries include things like head traumas, hip fractures and lacerations. For hip fractures, of those in New York State who are hospitalized for a fall, a little over a quarter suffer a hip fracture. And falls are actually the most common cause of fractures in older adults. And fractures can also cause falls as well.

>> And can you tell us more about the other injuries? You mentioned brain injuries as well?

>> Sure. Falls are the leading cause of traumatic brain injury among older adults. And in New York State, for those hospitalized for fall injuries, about 13% suffer such an injury.

>> Now, when we talk about falls and fall injuries, is this something that's kind of remained stagnant, or has this trend changed much over time?

>>Unfortunately, it has changed, and in the wrong direction. The graph on the slide shows the rate of fall hospitalizations among older residents per 100,000 from 1996 to 2012. And as you can see, the rate has grown by nearly 14%. And, so, notice it's a rate. So, not only have fall injuries increased, but they've increased in tandem with the growing aging population. And this is really significant, because New York State is home to the fourth largest older adult population in the nation. So, although more people are living longer, falls remain a growing and serious threat to lifelong independence, quality of life and well-being.

>> That’s certainly something for concern. I wasn't aware that we were the fourth state in terms of older adult population. That's definitely something for us to be aware of. Now, you talked a bit about the prevalence of falls and related injuries. What about the financial impact? I think people always, you know, in addition to wanting to know the stories, everyone's talking about the bottom line. So, what's the

financial impact of these rates that you're discussing?

>> Sure. Well, falls are increasingly costly to the health care system. In New York State, the direct medical charges related to fall-related injuries for treatment at hospitals and emergency departments totals over $2.3 billion every year, and that's just in New York State. And if you look at that over a year, that's more than $6 million every day. And these are just the direct medical charges. It doesn't account for things like follow-up care, rehabilitation, loss of productivity, loss of quality of life, lifelong disability, as well as the impact on caregivers and families.

>> Sure. So, certainly, it's a pretty tremendous financial burden, just in the direct care numbers, but then when you consider those other things you've stated, we're really looking at a pretty big picture here.
>> Absolutely.

>> Now, what about the individual impact of falls on older adults? I think that's something that we definitely need to explore a little bit.

>> It is, because those who fall often suffer what's called a downward spiral in physical, mental, social and emotional health. And those who suffer the more serious fall injuries I mentioned previously are often discharged to a nursing home or a long-term care facility. And some may never return home. Others will spend months and months of painful, challenging, difficult recovery. And for those who do return home, they're often never the same person again. They can never do the things they once did. And it really is a cause of -- falls are really a cause of loss of independence among older adults.

>> I mean, that certainly sounds like a very dramatic impact, and I think that's something we all hear is when someone falls and breaks their hip and people say, oh, that's the beginning of the end, or the downward spiral, as you said. So, it's certainly a very dramatic situation.

>> It is, and the impact of falls on individuals really reminds me of a quote I heard from a video that was put out by Simon Fraser University Research Lab that interviewed individuals who suffered a serious fall injury and as a result were admitted to a long-term care facility. And one individual's comment really struck me; she said, "You depend on people for things you never would have before." And I think that really captures the impact of falls on one's independence.

>> Sure. And what a staggering impact that can have on somebody's quality of life. Now, something that I think has come up and is a question for people is, okay, so, falls, certainly are a problem financially and a problem for those impacted, individually, but, what can we do about it? Aren't falls a normal part of aging?

>> That's a great question, Rachel, and falls are actually *not* a normal part of aging. It's a common belief but a misconception that falls just happen, they're inevitable, so, there's nothing that can be done to prevent them.

>> And so, would you say that, in fact, that is not the case and we can do something to prevent falls?

>> I would. There is hope. There are a lot of things that both older adults, medical

providers and community organizations can do to prevent falls. There are proven practices, policies and programs that we can adopt to make a difference.

>> And so, now specifically in New York State, how are we working? What are we doing to try to address falls and to make that difference?

>> Well, in 2011, New York State was one of three states to receive a grant from the Centers for Disease Control and Prevention (CDC) to work on fall prevention and address this problem. The other states include Oregon and Colorado.

>> Okay. So, that's certainly a place to start. Can you tell me more about the program?

>> Sure. Well, since then, we've been focusing on three counties across New York State. These include Broome, Chautauqua and Suffolk. And as the slide shows on the map, they're spread pretty far apart geographically and really serve diverse communities. And these counties were selected because they had a high burden of falls, [impacting] a high proportion of older adults compared to the state as a whole. And [they also had] existing infrastructure and partners who were willing, ready and able to deliver these programs. And we're so fortunate to have phenomenal partners at the Suffolk County health department, Broome County Health Department and Chautauqua County Office for Aging.

>> That’s fantastic. So, this program sounds fairly comprehensive. I wonder if you can talk about some of the different components of the program and what the approach is to falls prevention.

>> Sure. Well, the approach is simply to embed evidence-based fall prevention programs in both clinical and community settings. In the community setting, we've hosted a number of instructor trainings to certify instructors to deliver these programs, and our key partners have partnered with community organizations, such as the YMCA, state parks and the retired senior volunteer program. In the clinical setting, we've promoted the integration of fall risk assessment and referral to proven interventions. So, there's both a role for health care providers as well as community organizations.

>> Excellent. Now, can you describe for us in a little bit more detail about some of the community programs that you have been delivering?

>> Mm-hmm. Well, first, we've been delivering two evidence-based Tai Chi programs. These include Tai Chi Moving for Better Balance and Tai Chi for Arthritis. And I just want to point out that for these programs, Tai Chi Moving for Better Balance has been adapted to the YMCA training system and delivery infrastructure and has been rebranded in another version called YMCA: Moving for Better Balance. Tai Chi for Arthritis was formerly known as the Arthritis Foundation Tai Chi Program.

>> Okay.

>> It’s the same thing. So, for those unfamiliar with Tai Chi, it's an ancient Chinese martial art that involves coordination and slow, fluid movements of the upper and lower body. And it's recently been modernized for health promotion. And more and

more research is coming out that Tai Chi is really good at preventing falls, specifically by improving balance, posture, coordination, leg strength, but also reducing the fear of falling and promoting mindfulness. So, Tai Chi not only has physical benefits, but there are also mental benefits as well. And one final benefit of Tai Chi is that it can be learned by anybody and done anywhere. You don't need fancy equipment. You don't need a gym. Older adults can do it in the home, outdoors or in the community.

>> Excellent. So, really accessible to anybody that could benefit from it. Now, to give you an idea of how this program works, we want you to hear from a few Tai Chi participants in Broome County's program to see what they think of the program.

ROLLIN
>> It really has helped. The coordination and just being focused on what you're doing. I hope I can continue it for a long time. I used to could not stand an hour and do this, and now I can. It has changed my life a lot. It really has. I feel like I'm not getting old anymore. I can do things that I used to be able to do. She reaches how to hold your legs and how to walk, and I keep that in my mind, and I haven't fallen since I started.

>> So, Tai Chi sounds like a great activity. And like you said, it's accessible. And we heard from the participants now about the benefits they're experiencing. Are there programs that might be more appropriate for more frail adults?

>> There are, and we've been promoting Stepping On, which is specifically designed for older adults who are at risk of falling, have a fear of falling, or who have fallen one or more times. The program meets for seven weeks and is delivered by a health professional or aging professional, and they educate older adults on ways that they can reduce their fall risk, like keeping the home safe, doing strength and balance exercise and getting medications reviewed. And stepping on is really about building confidence. And I'm often reminded of a quote from one of the participants that really struck me. And they said, "thank you for teaching me how to fly without falling," and I thought, what a beautiful thing. And that's what these programs are about.

>> That's really excellent. That's a great quote to share. Now, are there programs for homebound adults as well?

>> There are. We've been promoting the Otago exercise program that was developed in New Zealand. It's a year-long program where a physical therapist comes into the home and prescribes Individualized strength and balance exercise along with a walking program. And for physical therapists who want to get trained in the program, there's a great online training offered through the University of North Carolina, and the link is posted on the slide for those interested.

>> Excellent. And just as a reminder to our viewers, if you cannot read the slide on the screen, there are handouts that are available on our website for you to download. So, certainly, that will be accessible to you as well. Now, you talked earlier about how the programs you're doing are evidence-based programs. Is there any evidence that suggests that these programs reduce any health care costs?

>> There are. And more and more evidence is coming out that these programs not

only reduce fall risk, but they reduce health care costs. And it makes sense, because due to the costly fall injuries, it makes sense that preventing them can really make a difference when it comes to health care costs. In fact, earlier this year, a study was published in the "Journal of Safety Research," and it looked at Otago, Tai Chi for Better Balance and Stepping On. And the study here shows the net benefit per participant for each of these programs and found that not only were there costs-savings from these programs, the net benefits far exceeded that. So, these programs resulted in positive returns on investment. And this study only looked at the direct medical costs that were averted due to fall injuries. So, they're likely much more cost-effective than this study came to conclude.

>> Sure, because as you mentioned earlier, there's all those indirect care costs that don't necessarily get figured into the calculations. Now, let's shift gears for just a moment and talk about the other strategy you mentioned. You talked about incorporating fall prevention into clinical care settings. Can you talk about why it is important to do this and what role health care providers play in doing this?

>> Well, targeting a clinical setting, particularly primary care, is very important, because although one in every three older adults falls each year, less than half tell their health care provider about the fall. And this can be for many reasons. Falls are stigmatizing. Admitting a fall can perhaps mean admitting that you're getting a little older, a little less independent. But health care providers can play a big role in being protractive and asking patients about falls. More specifically, screening and assessing their fall risk factors and then recommending them to appropriate interventions, whether it's physical therapy, vitamin D or one of the programs that I mentioned earlier.

>> Excellent. I think we've all heard about how busy primary care providers and clinicians are, so are there specific tools or resources that primary care providers can use to screen and refer patients more efficiently?

>> There are. There's an excellent tool that we've been promoting and implementing. It's called the STEADI toolkit. STEADI stands for Stopping Elderly Accidents, Deaths and Injuries. It was developed to help primary care providers, and really any medical provider, incorporate fall screening, assessment, management and referral to interventions into their practice. And the toolkit is available on CDC's website: www.cdc.gov/STEADI.

>> Great, thank you. Now, what role do community programs play in STEADI?

>> Well, community programs provide a place for providers to refer patients to that can empower them and equip them with the knowledge, the confidence and the skills to manage their fall risk and reduce their risk. And STEADI is really the link between the clinical setting, where fall risk assessments are done, and of course, education, and then the community programs. So, there are roles that they all can play in working together to prevent falls.

>> Excellent. Now, let's talk for a minute about the clinical piece of this. How is the toolkit actually developed?

>> The toolkit is based on the clinical practice guideline that was published in 2010 by the American and British Geriatric Societies. And it includes things about fall

screening, risk assessment and then referral to appropriate interventions based on that individual's specific fall risk factors. And CDC also conducted a literature review, focus groups and interviews with health care providers. And they found that most providers were not implementing the guidelines, and this was for two reasons. They either weren't aware of the guidelines, or the guidelines were too costly, time-consuming or complicated to implement. So, through these interviews and focus groups, they also asked providers what tools and resources would make it easier for them to implement the guidelines into their practice. And as a result, the STEADI toolkit was created.

>> That sounds excellent. Really doing the research and trying to figure out [the question], “we've got this toolkit, but how do we make it something that's really meaningful and that people will use?” Now, can you tell us more about what's in the CDC STEADI toolkit?

>> Sure. The toolkit provides three types of resources. [The first is a series of] provider resources, and one of the main ones is an algorithm adapted from the American Geriatric and British Geriatric Societies guidelines. [There are] also training materials for providers and also patient education materials as well.

>> And can you describe a few of these resources in more detail?

>> Sure. For the provider resources, one of the best examples I can think of is a set of three standardized and validated fall risk assessments. One thing that CDC found in their studies and interviews with providers is that a lot of them weren't aware of some fall risk assessments that they could easily implement. And the three of them in the toolkit include instructions and also videos posted on CDCs website. These include the *Timed Up and Go Test*, the *Four-Stage Balance Test* and the *30-Second Stand Test*. And these are all validated and standardized. They're simple, easy to do, and they don't take a lot of time. And they assess gait and balance, which can be important for fall prevention.

>> Are there resources in regards to how to talk to patients?

>> There are. And that's one of the challenges I think not just medical providers face, but also family members and caregivers is having that conversation with an older adult. And there are conversation-starters in CDC’s toolkit that helps providers meet older adults where they're at in terms of their readiness, ability and willingness to make a behavior change and take action to reduce their risk.

>> And are there things in the toolkit that speak to what patients need to know or what they need in order to help reduce their fall risk?

>> There are. There's three brochures that are available for patients in this STEADI toolkit. One of them is called "What you can do to prevent falls." it includes four simple steps that older adults can take to reduce their fall risk. The second is a Home Safety Checklist that walks the older adult through common fall risk hazards in the home and ways that they can address it, things like poor lighting, throw rugs and things like that. And the last piece of patient education is called "Stay Independent," which is a self-risk assessment. It asks the older adult 12 questions about common fall risk factors so they can identify the ones specific to them and how they can address it.

>> Well, it certainly sounds like a very comprehensive toolkit that can be beneficial not only to providers but to individuals and family members or caregivers. So, thank you very much for sharing that. Now, Dr. Floyd, I'm going to turn to you now and talk about the prevention work you've been doing in your county. Can you tell us about your local system?

>> Sure. United Health Services, or UHS, as we know it, is based in Broome County, New York. The Binghamton-metropolitan area has our largest population. But it extends all the way from the western Catskills over to the Finger Lakes area. We serve northern Pennsylvania up to approximately the Cortland area. United Health Services is comprised of four hospitals. It has over 300 clinicians involved. It has a nursing home, an assisted living facility. So, it's a very comprehensive, integrated system.

>> Excellent. Thank you. Now, Dr. Floyd mentioned that UHS serves Broome County. Let's take a moment to hear from Claudia Edwards. She's the director of the Broome County health department who spoke about falls as a pressing public health issue for the STEADI video produced by Harrison's program.

ROLL IN
>> The prevalence of falls in Broome County was very significant because our population here is 16% aged 65 and older. Our rate is about 293 per 10,000, which far exceeds the New York State rate. We did a community health assessment. Our steering committee realized that this was a serious problem for us. We got with New York State Department of Health on this, and they, through a series of discussions, decided to give us some pilot money to roll this out.

>> So, Ms. Edwards kind of really laid out the need to include fall prevention in the county. And it sounds like the numbers are high. And as Harrison pointed out, they're increasing. Can you talk more specifically about how you make STEADI work at United Health Services?

>> We went through a comprehensive review of the excellent materials devised by the CDC and provided to us by the New York State Department of Health in Broome County, and immediately, we recognized the materials are excellent. There's an excellent algorithm for addressing fall risk. But we had to find a way to integrate that into the work flow of the clinician and of the office so it would not really obstruct that work flow. Again, keep in mind what Harrison just pointed out. Most patients don't come in because of their falls, which is why you need a screening program to assess fall risk. That patient may be in that office for any number of reasons. That patient may be there because they think they have pneumonia. They may have just been discharged from the hospital and it may be a post-operative check or they may be there for diabetes. So, you have to make sure you do not make an additional step to an already crowded health care agenda. And also keep in mind that primary care physicians face a lot of other tasks and challenges that they're facing as well. They're expected to screen for depression, alcohol abuse, smoking, domestic violence and multiple other things that also could launch algorithms that they're expected to assess on top of what the patient is actually there for. So what we really had to do was to find a way to avoid and prevent screening overload and to really integrate this into the system.

>> So, can you walk us through how you would go about conducting a risk assessment using the STEADI toolkit or principles when you're faced with a patient who's come in after having fallen?

>> We broke this down into four separate phases where this needed to be integrated into the process. First thing is, is we wanted it directly in the nurse's workflow, not something she had to seek out or remember to do. We want it built right into their workflow. So, what we did, at the time that we started this -- and we started it in my office in 2012 -- we didn't have any screening tool in electronic medical records, so our IT department or technology department built one and put it right in and put it right directly into the nurse's workflow, so as they're doing their intake, they would see it. This is comprised of a series of questions, five simple questions they ask the patient. If the patient answers “no” to all those questions, then that patient is identified as likely not being an increased fall risk. But if they answer “yes” to any of those questions, then additional questions are asked and a Timed Up and Go test that Harrison mentioned is then performed. Then we devised a referral sheet of evidence-based programs that is put right on the clinician's keyboard so that they will an alerted of the need to address this with the patient and be given the tools to make their referrals. The clinician phase then is that the physician will come in, ask the patient or address why they were found to be at increased fall risk. They'll do a targeted assessment, depending on what -- especially what their interview finds that they need to do and then will develop an action plan and make appropriate referrals. And then for sites, and this is something we're still building up in our system -- not all of our sites have care coordinators, but as we're building that up and getting care coordinators, and we have care coordinators aggregate those plans and follow through and work with the patients to try to encourage them to implement what the clinician recommended.

>> So, certainly, there's a lot going on there, but it seems like it's happening in a very efficient manner, like you said, to make it easier, and something that they don't necessarily have to think about. It's just [a matter of] going with the work flow. Now, assuming somebody is determined to be at risk and you have to make a referral, where would you refer patients to?

>> We developed a referral form that has, again, evidence-based programs. What Harrison already mentioned in his questions that he addressed. But what we did, we have an actual checklist form that we devised. And on that checklist, it has really the key components. So, vitamin "D" supplementation and exercise are two evidence-based treatments that the U.S. Preventive Services Task Force recognizes as helping to reduce fall risk. Then, we have the vitamin "D" supplementation on the form, along with physical therapy, the training programs that Harrison mentioned, the tai chi programs and the stepping on programs. We also include additional information, such as that the patient needs to use a cane, walker or assistive device. We also have our own what we call In-balance Program, which is run through our home health agency. And with that program, if the patient qualifies for home care, they will get physical therapy coming to their house, not only to work on whatever caused the fall, but also to do a home safety assessment. All the clinician has to do is check off what he wants to implement, and a copy of that can be given to the patient right at the office visit. It even has the information on there where they can call to find out where the local Tai Chi and Stepping On programs are. So, we stream-lined the process as much as we could.

>> Sounds like you've done a *lot* of work. It sounds like a terrific program. It's really well laid out. Now, can you talk a little bit about how you modified your electronic health and screening records or screening and referrals?

>> Sure. When we started this program in 2012, again, we used an electronic medical record called Nexgen, and the version we were using at that time did not have fall screening in it, and I'm not sure, it probably wasn't even available back then. So, what we needed to do was, looking at the CDC's evidence, we adopted questions that they had recommended that should be asked as part of the screening. We added one or two of our own as part of the intake process. We actually built this right into our electronic medical record directly in the nurse intake component.

>> Excellent. And in addition to the screening and referral, were there other changes that you had to make to customize the electronic records?

>> Right. Like I said, there's two parts of the nurse component. First of all, there's the screening questions, which was just shown on the slide that was just up on the PowerPoint accompanying this. If the patient answers yes to any of those questions, then an additional pop-up comes up that cues the nurse as to the steps that they need to do to complete the process, and it includes the Timed Up and Go test and it includes giving out the educational brochures that Harrison mentioned.

>> So, it certainly seems like these changed would not only benefit the patient, but do so in a way that's helpful to the flow of work in the office. So, with that in mind and with this assessment in hand, can you tell us about the results that you've seen in your program?

>> Sure. Actually, on a personal level, I've been overwhelmed by how well this program has been received. Day one, when I started doing this, I had a patient that came in that just said he felt unsteady and couldn't walk. I asked him to get up and walk. I realized watching him walk that he had Parkinson's disease, which is easier to diagnose when someone has a tremor, but he had no tremor. To this day, I'm just amazed that on the day that we implemented this, this happened. I've had many positive stories on Tai Chi from patients that have been there, and one patient's wife even told me she's going to become a Tai Chi instructor after attending the class with her husband. So, it's just amazing to me. But even other statistics are bearing out the success of the program. We now have had just under 500 participants in the Tai Chi program, just under 200 in Stepping On. And the fall statistics for Broome County that led to us being asked to be the national pilot for the CDC and the state pilot for this program are also improving, too. Prior to going to this program, we were at 291 hospitalizations for falls for patients above age 65 per 10,000. The most recent data, we're down to 221. So, we've already dropped that by about 70.

>> That sounds outstanding. So, with those results in mind, and certainly, those are excellent results to hear, what happens next? How do you go about monitoring assessment and referrals and keeping track of what's going on?

> It's one thing to bring up a program. It's another thing to keep it implemented. As time goes by, people will get tired. They'll want to move on to something else. They've been doing this for a while. So, what we've done at our sites and, actually, for our individual clinicians, we've created drilldown data so that we can tell by site

and by clinician who's doing the screening, who isn't. We have to be very vigilant for new clinicians that are added that haven't been trained on the process and make sure that they get education for it. So, we monitor on a monthly basis the statistics for our sites and our individual clinicians. And even in the last three months, we've gone back out for a number of sites and reinstituted retraining for sites that are scoring below our average.

>> Now, can you talk about who or what sectors, what entities were essential? I mean, I would imagine this isn't something that one person can do single-handedly. So, who is really essential in making this work and the whole system kind of come together?

> Well, this really does take a team. But step number one is you really need to find a champion, really, to lead the process and to guide it. So number one is you have to look internally and do that. But the biggest thing that has to happen with this in my mind is that it is one thing to implement the screening, but you have to have programs, quality programs that you can refer to. Otherwise, you're screening and you're accomplishing nothing.

>> Sure.

>> And the Broome County and New York State health department were absolutely fantastic in terms of helping us to get quality programs that we can refer to. Our nursing administration has spear-headed the ongoing training for sites that need training. They've been fantastic. Our medical administration has been highly supportive of us as well. Information technology, as I mentioned, has been very helpful in terms of helping us to customize our electronic medical record as needed. Community partners. Harrison mentioned the YMCA, and I don't want to leave out the Tai Chi and Stepping On instructors. They've done a fantastic job. And also, the local news media has created excitement about the program as well with their coverage.

>> That's excellent. It's really great to be able to hear about the good things that are happening, you know. Especially when we looked at the data earlier about what a significant problem this is, both personally, financially, and the rates of it. It's really great to hear about the successes and people who are making it happen. So, thank you for sharing that.

ROLL IN
>> Now, to give you a picture of what we're talking about and hear directly from clients and nurses involved in delivering the program, we have another set of clips to show you from the STEADI video.
>> As a result of my visiting Dr. Floyd, he recommended, and he actually had a sign-up sheet there and registered me for a Tai Chi class. I've been more attentive to preventing falls, and it helped in my balance. Just makes you feel more confident to go out and actually do things.
>> Well, we took the information the CDC gave us out of the toolkit. We chose what we thought would work best in the offices. And after we did that, then we went site by site by site by site and spoke to the providers, and then we did speak to the clinical staff. So, everyone was on the same page with what we were trying to roll out.

>> About 89% of our patients over the age of 65 have been screened for a fall risk. And we're able with our EMR to track our program, how many patients we've screened, our care planning and all of the different steps through the process.

>> So, certainly, everything that you've shared and everything we've seen point to what a great program this is, but with anything, we know there's always some challenges in implementing something, getting things up and running. So, can you talk about what were some of the challenges that you faced in implementing the STEADI program?

>> Sure. As you pointed out, there's always going to be challenges. And as expected, a lot of primary care physicians – this is a primary care-based initiative -- already feel overwhelmed by everything that they're asked to be doing and by all the changes that are occurring in health care. So, we expected some pushback, and yes, we got some. But by and large, our clinicians have really been excited about this project as something that can be very beneficial to their patients. As I mentioned, in terms of the electronic medical record, it can be your best friend or your worst enemy, depending on how it's configured or deployed. We made it our best friend in 2012 by putting the screening directly into the intake process, where people don't have to go out of their way to do the screening. So, our customization of the electronic medical record I think was really a key to the success of our program. And then the last issue that we've had is with the data that we're aggregating is we're having trouble just capturing the treatment plans. And the reason for that is any treatment plans that are being recorded by the primary care clinician that's seeing the patient are being generally typed in as part of their assessment and plan and not being put into a structured field, which makes it harder to retrieve and aggregate that data.

>> So, let's look at each of those challenges in a little bit more detail. You mentioned that, you know, the first one was the clinician reluctance, because again, they've got so much going on. How have clinicians responded to this approach and what have you done to make it more successful?

>> By and large, the physician and clinician's acceptance of this program has been very high. Most people were excited about it because it was something that actually has an impact on their patient care that could have a positive benefit for their patient. But yes, there are some that felt that this is just another thing I'm being asked to do on top of everything else. But fortunately, those are clearly in the minority. Among the things that helped with that, I think, number one is having a physician champion. I think physicians often relate better to physicians. So, that helped with getting that out there. And what also helped is that this was piloted at my site before we rolled it out to other sites, which gave me credibility when I went out to other physicians and said I'm not just dropping this on you, I've been doing it, and we've fixed it and this is ready to roll. So, that really helped as well. So, I think those were key aspects.

>> Excellent. Now, you also mentioned the issues with the electronic health records, and I believe you said we made it our best friend in 2012, if those were your words?
>> Right.

>> Can you talk about what some of the challenges were and how did you make it your best friend?

>> Well, what we had to do was, again, put the screening questions in the direct workflow. And again, our electronic medical record is Nexgen, and we're facing this issue right now. We had to customize the electronic medical record to put the questions in there. So, that helps with the screening. The problem that happens with that, though, is when you're create your own templates, that data then is usually not captured for quality monitoring purposes.

>> Okay.
>> So, there's a program called PQRS -physician quality reporting system that captures data from our electronic medical records and then can be reported to the government, if you choose to report that measure. Because we're using customized templates, that information is not presently being captured by nexgen. So, the customization helped in terms of usability, but it's actually hurting in terms of quality monitoring and reporting.

>> Okay. So, still a challenge to keep working on.
>> Right.

>> Now, the third challenge you had mentioned was capturing in the treatment plan. Can you tell us in a little bit more detail about what that challenge was and how are you trying to work with it?

>> What happened with the treatment plans is that if you, for example, checked somebody's blood pressure in your office, and if you just type it into your note that the blood pressure is 180 over 70, that's not going to be captured for quality monitoring because it's not in what's called a structured field. There's a specific template for vital signs. If you put that blood pressure in that specific template, then for quality monitoring, that is captured. That's what we're facing with the problem with capturing plans for this, is someone comes in, they've found a risk to fall, if it's attributed to arthritis, the clinician will usually put that in under arthritis rather than under falls, and it makes it harder to go back and trace and capture the data that way.

>> Okay. So, now you've talked about some of the challenges, and it seems like you're working to address the different challenges. Can you've us a few tips, because it does sound like such a successful program, on how our viewers get started if they wanted to start using STEADI in their practice or in their community? What are some of the steps they would take to really bring this to life, and either, you know, Dr. Floyd or Harrison, if you want to share.

>> Sure. I'll start. Well, again, number one is find a champion. So, you need to have someone who's going to lead it. Number two is you've got to get the teamwork in place that I mentioned. So, form the team that you need. I would strongly encourage bringing in everything that I mentioned there. You're going to have to engage your medical administration, your nursing department, your IT department to implement everything that needs to be done. And number three, I'd say, I think is especially important, is if you're going to have a successful screening program, it has to fit in the work flow of the office.

>> And can you share more information about these tips? You say find a champion. I know one of the things you shared is that for you, you went out and said, I've been

implementing this. Is there anything else you would say about what's the importance of, or how do you select, someone to be the champion for this?

>> The way I would approach [finding] a champion is I would look at your clinicians internally that you have and find somebody who really is committed to providing evidence-based care and that is really interested, has demonstrated interest in improving their health outcomes for their patients. That's going to be a natural champion. And I would approach them with this project. With any champion, you have to recognize there are other commitments, their work schedule, and their personal time. So, again, make it worthwhile. It fit in my particular situation because not only am I a practicing internal medicine physician, but I also do part-time medical administration, so I was able to adapt my administration schedule to really participate in this process.

> Sure. And what about establishing a team? I mean, who would you say are the critical people to get on board? How do you ensure that the systems that you're putting in place make sense across the entire workflow? Who needs to be involved in that?

>> The key people are really the ones that I mentioned. Nursing is integral to this. And Amy and Bridget, who are on the video clip earlier, have just done an outstanding job working with our sites in terms of keeping this program running, monitoring sites whose screening rates are down in falling and retraining those sites and working with the clinicians at those sites. Again, we're a far-flung system, all the way from the Catskills to the Finger Lakes, so that's not an easy job to do that. But nursing is key. Medical administration needs to be committed to it so that not only are they committing the resources initially, but they are maintaining those resources as time goes by. Information technology has to not only make sure that the screening templates are in there, but that the data is being aggregated and tracked. Community partners. You don't want a screening program that leads nowhere. You want a screening program that goes to quality programs. And we have had that in Broome County with Tai Chi and Stepping On with the health department.

>> Excellent. That's a lot to consider, for sure. Harrison, for those out there who are interested in STEADI or a community program, what resources are available to our viewers?

>> There's a lot, and I would recommend the best starting place is to visit the CDC's website: www.CDC.gov/STEADI. And the site is great and it has a lot of resources on data and statistics about the costs of falls, both at an individual level and to the health care system. It also includes all the resources in the STEADI toolkit that are available for download for free as well, for those interested. And it also has great information on evidence-based programs as well.

>> Great. And are there any other resources or best practices that other communities or localities could look into as they're considering their own programs?

>> Mm-hmm. Well, one resource I'd recommend that CDC recently updated is the compendium of fall prevention interventions. This is available for free and downloadable on CDC's website, and it includes almost 30 evidence-based interventions in clinical settings, exercise-based interventions, as well as home-based. So, for those looking for a proven program, this is a great place to start.

>> And are there any resources for, okay, here are the programs, but how do I make this happen, how do I implement these programs?

>> Sure, there is. CDC has a related guide. It's really a how-to guide to develop, implement and evaluate community fall prevention programs. It's also available on the website. It covers everything from conducting a needs assessment, identifying and recruiting community partners, implementing it, sustaining it, promoting and recruiting participants as well as evaluating the success of the program.

>> Excellent. And are there any incentives that are available to providers who decide to implement the STEADI program?

>> There are. For providers in New York State, Colorado and Oregon, they are eligible, if they adopt STEADI, to earn 20 certification part 4 credits through the American Board of Internal and Family Medicine. And for those interested in this, they can visit the link posted on the slides.

>> Excellent. Now, we've got a few minutes to take some questions from our audience. We've got a few that have come in. Let me see. We have Mark Pettis. "Great presentation. Do either of you have experience in Matter of Balance as a community-based fall risk reduction intervention?"

>> That’s a great question. We're very familiar with Matter of Balance. That hasn't been one of the programs we've supported, but another organization that we partner with called the New York State Quality and Technical Assistance Center, which is based in Albany, has done a lot of work with Matter of Balance. And if they're in New York State, a lot of aging offices have implemented that. And that is a program we're considering to expand in the future.

>> Great. And Dr. Floyd, can you address the capacity to code for employing the STEADI tool in a primary care setting that captures quality as woven into the visit?

>> What happens with the coding is the codes are dropped automatically in our electronic medical record as the patient screening is done. So, it's really -- we've automated that process so that, really, the clinician doesn't have to do anything. In fact, when they even get down to the assessment and plan, the history of fall/fall risk code is actually in a pick list that they can choose from to drop right in their assessment. So, we've really automated that process. And in terms of added incentive, what we do -- what happens with this, with the clinicians, is there's no direct incentive for screening, for doing the screening program now. However, for those patients that are identified at increased fall risk, which is going to be the ones that failed the standard questions and that they get the referral form on, as they address and document that, that can affect their evaluation and management code so that there can be some potential for increased reimbursement attached to that visit if they do the evaluation and document it appropriately.

>> Thank you. We have another question. "Who completed the medication review after the nursing screens? Is there a prompt for the doctor?"

>> There is no prompt for the doctor. We have -- the medication reconciliation is part of the nursing intake, so that is done automatically. For those that screen as

being at increased fall risk, part of our training for individual clinicians were to really do three things. Number one, ask the patient why they fell or why they were at increased fall risk. I find in my own practice, about 85% of the time, I either know or the patient tells me, I have arthritis in my knee, my balance is off due to my back pain. That's step one. Step two is to ask the patient to get up and walk and see what happens when the patient walks. And step three, do a targeted medical assessment. And part of that targeted medical assessment is a review of meds with emphasis on looking for meds that increase fall risk. And those are the three steps that we train our clinicians to implement.

>> Thank you. We have another question from someone in New Mexico that says, I am a STEADI toolkit trainer and have gotten pushback from providers because the reimbursement rates are better or higher for services like managing congestive heart failure than they are for screening for falls. Can you address this?"

>> Again, as I mentioned, there is no direct reimbursement for screening for falls. And the question is absolutely correct. It's one of the issues we knew going out to primary care providers. You're asking them to implement more screenings and do more things without reimbursement attached. And not only screenings, but you think of all those reauthorization forms, all the paperwork, all the time documenting electronic medical record, a big complaint in primary care right now is the amount of time it takes to do things, and especially the uncompensated components of it. But again, there is potential for increased revenue if it is affecting the level of evaluations that you are doing. It can affect what we call your E&M, your evaluation and management coding, which can increase the relative value units that are attached to that visit for that clinician and then can potentially increase revenue for those that are found to be at increased fall risk.

>> Okay. Now, we have another question. Are there programs that are geared for home care agencies? I know we saw the one in the review.

>> Sure. There's one, I mentioned the Otago Exercise Program, which is really designed for home-based physical therapists. Another tool in New York State is the Home Safety Self-Assessment Tool, which was developed by Buffalo University for doing home safety checklists and assessments and also referral to resources that older adults can contact in order to address those fall risks. So, those are the two that I'd recommend, but there's many more in the CDC's compendium of fall preventions and interventions.

>> And we have our fall prevention program that applies to patients that qualify under Medicare guidelines, which essentially means a patient has to be homebound. But under that program, our certified health agency, not only with visiting nurse or whatever else they need for home care, they will get home physical therapy. And part of that is not only addressing whatever increases their fall risk, but also doing home safety evaluation.

>> Great. Another question came in. "I the provider assessment conducted at the same visit or a subsequent visit?"

>> Yeah, we expect it all to be done at the same visit. So, it's all part of the assessment and plan at the same visit there. However, there are times when people can need follow-up for that particular -- for a particular issue. So, and certainly, if

something needs to be addressed, if you find that patient has orthostatic hypertension, you're going to need to follow that up to make sure whatever treatment you implement is taking place.

>> Great. Are participants usually charged a fee for the community classes or are they free?

>> There is a small fee attached. Do you know? I'm not sure of it, the price off the top of my head here. But I have not heard that the fee has been an issue for my patients. So, again, the programs have been extremely well received. The YMCA was, when we first started the program, was providing it, I believe, free of charge for a period of time. And they did have it open for nonmembers to participate as well. My understanding is that that has stopped and you can still participate there, but if you're a nonmember, there is a fee.

>> Okay. And are medication screenings implemented into electronic medical records? Do you work with local pharmacists as community partners, and if so, how?

>> We do not work directly with local pharmacists. We have med reconciliation built in as one of the things the nurse has to do at intake, and we do monitor the frequency with which that is being done so that we can tell by individual sites and actually drill down by individual clinician as to how often the med reconciliation process is being done, but it does not involve pharmacists directly.

>> okay. Well, thank you both so much. We're nearing the end of the hour here, but before we leave, you know, we kind of started the show with some stories of how this topic is personally important to you, and then we went into the show and talked about the reasons why professionally this is a concern for everyone in public health. I wonder if there's anything, Dr. Floyd that you'd like to leave the audience with as kind of a parting message.

>> This is a program that works. We went into this and there was a "New England Journal of Medicine" article that came out in 2008 that showed that community-based programs can be successful on reducing fall risk. And this has really led to the impetus for STEADI and I think in Broome County, and this is going to be studied further by the CDC, but I'm thinking we're seeing a repeat of that study that was done in the "New England Journal of Medicine" in 2008. If you accomplish the screening, if you have quality programs to refer your patients to, this is something that really can help improve the health of your community.

>> Excellent. And Harrison, are there any parting thoughts or final messages that you would like to share with the audience?

>> Sure. Just to add on to what dr. Floyd said, by adopting STEADI and these community programs, you cannot just reduce fall risk and save lives, but you can save money. And CDC recently came out with an estimate. If 5,000 health care providers adopted STEADI, how many falls could be prevented? How much money can be saved? And it's really about much more than that, and it reminds me of one of my favorite quotes by Randy Pausch; he said "We beat the reaper not by living longer; we beat the reaper by living well and by living fully." And by adopting STEADI and these programs, viewers can help make that a reality for older adults.

>> Well, thank you both very much for sharing, again, both your personal investment in this public health issue as well as all of your professional expertise and experience. I think this is really valuable for our viewers. So, thank you for being here.

>> My pleasure.
>> Thank you.
>> Thank you for having us.

>> And thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available. To obtain nurse continuing education hours, CME and CHES credits, learners must visit www.phlaw.org and complete an evaluation and posttest for today's offering. Additional offerings on webcasts and health-relevant topics can also be found on our Facebook page. Like us Facebook to stay up to date. This broadcast will be available on our website within two weeks of today's show. Please join us June 18th for the next webcast focused on pediatric CT scans, radiation and risks, having an informed dialogue. I'm Rachel Breidster. Thank you for joining us on "Public Health Live!"