

Keeping Patients SAFE from FALLS Initiative

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Session Objectives

- Discuss why a Falls Initiative is important to Maryland
- Provide an overview of the MPSC SAFE from FALLS Pilot and Associated analytical findings
- Describe the Statewide Keeping Patients SAFE from FALLS initiative

Basic National Figures - Falls

- Second leading cause of unintentional injury deaths (medication errors ranks #1)
- Most common cause of injuries and hospital admissions for trauma
- Account for an estimated 783,000 hospitalizations and 11.5 million non-hospitalized injury cases each year
- Incidence rates in hospitals and nursing homes are almost three times the rates for persons living at home
- An estimated 350,000 hip fractures occur annually in the United States

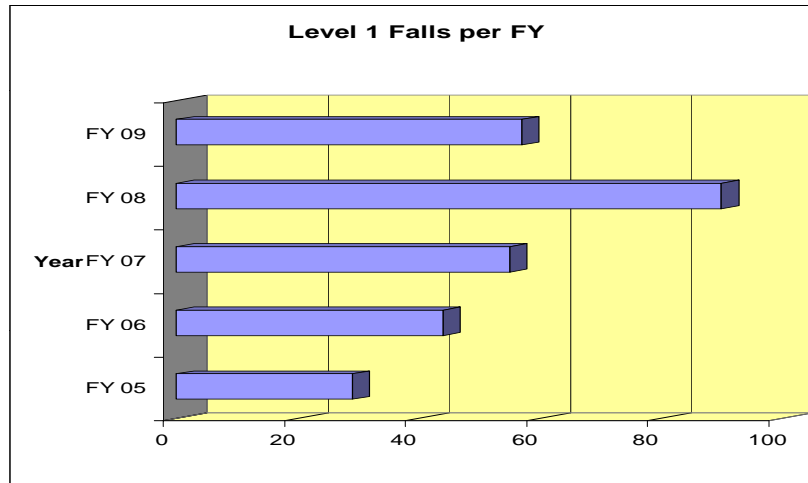
Profile of Fall-Related Injuries in Oklahoma, 2003, Ruth Azeredo, Dr. PH, Epidemiologist, Oklahoma State Department of Health, October 2006

National Cost Estimates - Falls

- Cost of care for patients post-fall is nearly \$6 billion annually, exclusive of physician charges (\$12.6 billion inclusive)
- National length of stay after a fall averages 10.4 days, median stay of 7 to 8 days
- Inpatient hospital only - mean charges currently at \$27,000 based on 7 day stay
- Average cost of all services provided following patient fall for 7 day stay \$69,389
 - (Includes inpatient care, carrier costs, skilled nursing facility, hospice, home health durable medical equipment and outpatient services)

US Dept. of VA Affairs, "Hip Fractures: in VA/Medicare-Eligible Veterans: Mortality and Costs", E. Bass, D. French, D. Bradham, L. Rubenstein 7/25/2007

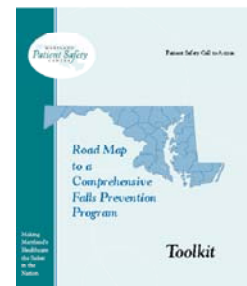
Level 1 Falls in Maryland Hospitals



Data Source: MD Department of Health and Mental Hygiene Office of Healthcare Quality

Possible Solution – SAFE from FALLS Roadmap and Toolkit

- Aims to provide a non-prescriptive guide for a comprehensive Fall Management Program in all healthcare settings
- Implementation requires two main components
 - Fall Management Program
 - Infrastructure
 - Patient/Resident Care “Bundles”



The SAFE Comprehensive Fall Management Infrastructure

- **S**- Safety coordination
- **A**- Accurate and concurrent reporting
- **F**- Facility expectations, staff education, and accountability
- **E**- Education for patients and families

The FALLS Patient/Resident Care Bundle

- **F**- Falls risk screening
- **A**- Assessment of risk factors
- **L**- Linked interventions
- **L**- Learn from events
- **S**- Safe environment

Pilot

- 5 Phases
 - Roadmap and Toolkit Development (July '08 – Sept. '08)
 - Recruitment (Oct. '08)
 - Implementation (Nov.'08 – May '09)
 - Lessons Learned at Outcomes Congress (June '09)
 - Beyond the Pilot - Statewide Rollout begins (Now!)

Pilot Design

- Quality Improvement Program: Rapid cycle implementation of roadmap components with personal coaching/technical assistance from Delmarva
- Learning Network: Monthly sharing calls, conference call sessions and “virtual community” provided learning and knowledge transfer opportunities

Pilot Goals

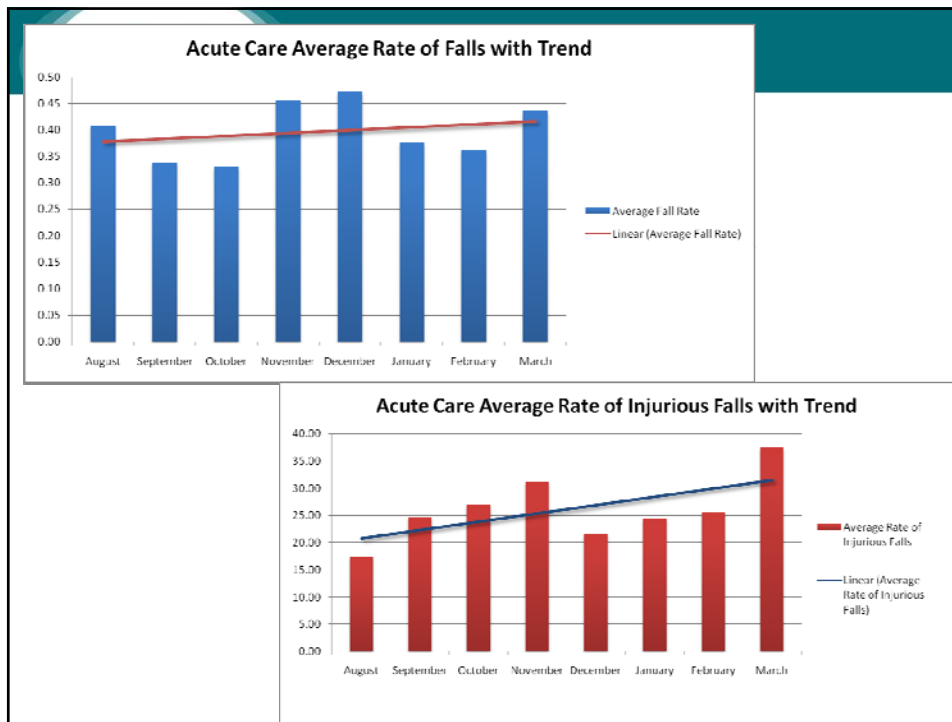
- Collect standardized process and outcome measures across multiple settings (Acute Care, Nursing Homes and Home Care) related to Falls
- Attribute the implementation of the SAFE FALLS Roadmap components (including cross-cutting tools) to the reduction of Falls in pilot sites
- Provide a uniform infrastructure for a comprehensive Fall Management Program in the State of Maryland

Pilot Results

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Acute Care Hospital Aggregate Analysis Report: August 2008-March 2009

- Units reporting include Orthopedic, Neuro/Head Trauma, Oncology and Pulmonology
- March process measures not collected therefore no change reflected from February 2009
- Pilot hospitals reported an average of 80.8% compliance with the roadmap/guidelines, up 12.2% from the baseline rate of 72%

Acute Care Hospital Aggregate Analysis Report: August 2008-March 2009

- Most improved areas: safe environment, facility expectations, staff education/accountability, and accurate and concurrent reporting
- Areas in need of improvement: assessment of risk factors and linking interventions and learning from events
- Overall increase in the rate of falls from February to March 2009* (from 0.36 to 0.44)

*Possible association with overall increase in the Average Daily Census for the month of March but significance unclear.

Acute Care Hospital Aggregate Analysis Report: August 2008-March 2009

- Several hospitals reported no falls for two consecutive months yet there is still an overall increase in the rate of falls with injury (from 25.64 in February to 37.50 in March).
- With no process measure data for March, it is not possible to determine an association between the increase in fall rates (both generally as well as with injury) and a particular area or section of the roadmap.
- One hospital reported no injuries for the entire pilot phase. Will continue to monitor and evaluate once.

Lessons Taught vs. Lessons Learned

- Lessons taught by the pilot
 - Adherence to better practices (roadmap, learning from peers) uncovers structures and processes of patient care that may influence the risk of falls.
 - Data collection is sometimes burdensome, especially if the data definitions are different from what the organization is already used to collecting.
 - The “discovery effect” is a good thing. But being too hasty in linking the rates to “quality” is a hazardous endeavor.
 - Strategies proceed along two paths: “Absolutist” and “Relativist.”

Lessons Taught vs. Lessons Learned

- Lessons learned by the pilot
 - Attribution analysis is difficult. That is, structure and process of care/caring do not always linearly translate in increase of good things or decrease of bad things.
 - Data collection has to be uniform, continuously evaluated, and should reflect generic processes of care applicable to all health care settings.
 - Learning from peers is part of the model. Data alone do not build “tribal comfort.”
 - Patients fall because of many enablers. A systematic understanding of the “ecosystem” of care is required, rather than focusing on a “tree” or even a “forest.”
 - Patient falls can be decreased, and the interval between falls extended significantly.

Maryland Statewide Keeping Patient SAFE from FALLS Initiative

Purpose and Objectives

- *Aim: Statewide implementation of the SAFE from FALLS roadmap by all providers in the acute care, long term care and home health settings to:*
 - *Reduce Statewide incidence of patient/residence falls by 5% and,*
 - *Decrease the severity of all patient/resident falls.*

Key Strategies

- **Coordinated Communication and Outreach Efforts**
 - Provide Roadmap and Toolkit (available for download on www.marylandpatientsafety.org)
 - Disseminate Campaign materials and notices to stakeholder organizations and providers
 - Secure Stakeholder and Senior Leader Support
 - Recruit Committed Providers
 - Build Consumer Awareness
 - Provide technical content and success stories for statewide use
 - Coordinate initiative goals and events with key stakeholders for maximum impact and participation

Participation Requirements

- Participation agreement signed by CEO/Executive Leader
- Identify Senior Leader Champion
- Implement the SAFE from FALLS Roadmap elements
- Submit Process Measures semi-annually
- Submit Falls Outcome Data monthly via established secure portal

Outcome Measures (monthly)

- Total Number of Falls
- Total Number of Falls w/ Injury
- Severity of Falls (0-3 VHA Severity Scale)
- Time of Fall (frequency)
- Location of Fall (frequency)

What's in it for Your Organization?

Program Benefits:

- Access to national subject matter experts and networking with your peers via:
 - * Monthly Sharing Calls
 - * Conference Calls
 - * Webinars and,
 - * Other face-to-face opportunities.
- Formal recognition for your organization from the Maryland Patient Safety Center
- Participation in a *Statewide effort* to reduce the incidence and severity of patient falls

What's in it for Your Patient/Resident?

- Demonstrated Organizational Commitment to Patient/Resident Safety
- Opportunity to establish Patient/Resident Partnership with Care Provider
- Improved Patient/Resident Outcomes
- Fewer Patient/Resident Injuries
- Reduced Care Costs

For Further Information or,
to Register for the Initiative Contact:

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Questions?