Topic: **Identifying and engaging stakeholders & building momentum**

The Opportunity

Falls are the number one cause of reported adverse events in VA. Among the 620 serious falls reported to the VA Adverse Events Registry in 1999, 60% resulted in hip fractures and 7% resulted in death. Reducing veteran falls and injuries due to falls remains a top priority of VA. In the United States, one of every three adults 65 years old or older falls each year. Falls are the leading cause of injury deaths among people 65 years and older and are the most common cause of injuries and hospital admissions for trauma among the elderly (Centers for Disease Control and Prevention, CDC).

Demographic reports have profiled veterans' aging projections to plan for their health care needs. Due to the increased aging population, prevention of falls and fall related injuries have received national attention with the Veterans Health Administration. According to Doweiko (2000), 7,000 – 12,000 people 65 years and older have lost their lives due to falls in the past few years (p. 38). "Nearly one-third of older Americans fall, costing more than $20 billion in direct health care costs, according to the U.S. Department of Health and Human Services" (Doweiko, p. 38). Falls are a major component of adverse patient events, consistently the largest single category of reported incidents in hospitals (Gaebler, 1993), with estimates of 25% to 84% of all adverse events in health care agencies (DiBella & Harvey, 1998). In 1996, falls accounted for more than 14,000 deaths and 22 million visits to hospitals and physicians' offices (Hoskin, 1998).

A Northeast Veteran Integrated Service Network (VISN) focused-review-team analyzed fiscal year 1996 data and determined that 20.4% of all falls occurred in the Nursing Home Care Unit, 14.8% on the Acute Medical Unit, and 60% were 65 years of age or older (DiBella & Harvey, 1998). Estimates are that 45% to 70% of residents in long-term care settings fall each year, twice the rate of those dwelling in the community (Thapa, et al., 1995). This epidemiological profile is particularly relevant as the VA veteran patient population ages.

Falls are the leading cause of death in the home, taking the lives of 10,700 people in 1998, a 9 percent increase from 9,200 in 1996; and more than 86 percent of these fatal falls are in people 65 years old or older (National Safety Council, 1999). **The U.S. Public Health Service estimates that two thirds of the deaths associated with a fall are preventable.** Adverse outcomes go well beyond the injuries sustained as a result of a fall. An injurious fall increases estimated costs (relative to non-fallers, in 1996 dollars) by $11,042 in hospitals, by $5325 in nursing homes, by $253 in the emergency room, and by $2,820 in a home health setting (Rizzo, et al., 1998). Staffs in hospitals and long term care settings work hard to reduce the number of patient falls and the resultant injury to the patient. These efforts are challenging at a time when facilities are striving to have restraint-free environments in the climate of a nursing shortage.

On July 12-13, 2001, 40 Multidisciplinary Falls Improvement Teams came together with experts on reducing falls and injuries due to falls, for an initial two-day learning session to learn both specific strategies for reducing falls and injuries, and a model for implementing changes. For eight months after the first learning session, the teams were supported through conference calls, e-mail/listserv, and coaching to reduce falls and injuries at their facilities. The teams turn in monthly "Senior Leader" reports on progress and changes made. On March 7-8, 2002 the teams came together again to share their results and create these documents. This document is a synthesis of the teams' work in a specific area. It represents what the teams learned about how to make changes and improve care, and is supported by the actual outcome the teams achieved.

Steps to success & Pitfalls to avoid

I. Identify stakeholders

- Be inclusive

- Top leadership to front line
- Target thought leaders
- Understand the informal organization
- Don't restrict to patient care providers
  - Include anyone who comes into contact with the patient
  - Include anyone who influences the patient's care environment
- Include the patient and family

II. Communicate the importance of the project
- Use multiple methods of communication
  - Communicate the message 8 times, 8 different ways
  - Use high visibility, high leverage areas
    - Communicate to the target population in places where they are likely to see it
      - Bathrooms
      - Near patient beds
      - At eye level
- Ensure bi-directional communication
  - Allow and encourage opportunities for input
  - Provide opportunities to write suggestions/give input on the communication medium
  - Ensure all providers have easy access to team members
    - Photos of members
    - Email and phone numbers
- Communicate through action
  - Enact ideas received
  - Give credit freely and often
  - Have physician be part of the team
- Communicate at every opportunity and through every venue
  - If you are in meeting with leadership, talk about the project
  - Schedule regular meetings with leadership to update
    - Use leadership environmental rounds to show what is happening at front lines
  - Curbside updates on the project are important
  - Use widely distributed written materials (newsletters, etc)
  - Give more formal updates to providers, didactics and lectures
  - Focus groups, soliciting input, are useful
  - Communicate with QM office
    - These projects are frequently quite helpful in JCAHO visits
    - QM office may have data and resources to help
- Communicate appreciation
  - Identify and recognize success
  - Reward success publicly and frequently
  - "Caught you at your best" awards

III. What to communicate
- That all members of the organization, patients, and their families share a common aim
  - To improve the care and safety of the patient

        - We are all in this together and all have an important role to play
        - Use peer pressure, aligning arguments
        - We share ownership in the process
            - It is not "someone else's job"
            - We are responsible for safety
                - This may improve morale
    - Engaging material
        - Communicate fresh ideas
        - Use data in communication materials – to persuade and convince
        - Shape the message to individual and facility priorities
            - To all communicate the single aim
            - To leaders, include cost issues, cost-savings potential
            - To front line, demonstrate the patient care impact
        - Use "dollhouse" for independent living residents, to show what is safe and what isn't
    - Communicate that individuals can make a difference
        - Every level is important
        - Every level can have good ideas
        - The front line is a knowledge reservoir that needs to be tapped
    - Communicate that every day is a new day
        - Patient's risk for falling may change
        - Key to maintain active role in preventing falls

IV. Pitfalls to avoid
    - Don't try to do too much
        - Start small
        - Don't implement before testing
        - Don't let top leadership micromanage
            - Sometimes they want to push to implementation before it is ready
    - Don't ignore the process owner
        - Attempts to circumvent process owners will not work
        - Process owners have good ideas about how to improve the process
    - Don't get discouraged
        - Change is hard and takes time
        - Anticipate, particularly with rare events, occasional spikes
    - Don't forget to identify and communicate relative advantage
        - Identify and communicate what is in it for the front line
            - Better patient care
            - More confidence in doing the right thing for patients
    - Don't make the process change inconvenient
        - Ensure participation of process owners
        - Changes will be adopted much more readily if it is easy to make the change part of work process
    - Don't underestimate culture
        - Understand the formal and the informal organization
            - Engage both
        - Never miss an opportunity to communicate a culture of safety
            - Focus on systems issues

- Don’t forget to orient new team members
    - Understand what you’re trying to do, what you’ve done

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