Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP)

PLAN

November 14, 2012

RHP#3 Healthy Homes Fall Prevention Initiative

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Narrative for Category 2 Project Title: Healthy Homes Fall Prevention

Project Option - 2.6 Implement Evidence-based Health Promotion Programs

Project Option - 2.6.3 Engage community health workers in an evidence-based program to increase health literacy of a targeted population.

Unique Project ID:0937740-08.2.1
Performing Provider Name/TPI: City of Houston Department of Health and Human Services / 0937740-08,-03,-07

Project Description:

The Healthy Homes Fall Prevention (HHFP) project proposes to utilize community health workers to provide essential education related to fall prevention and safety as critical components to the health and well-being of older adults (60+ years) in the community and prevent unnecessary ER usage for preventable falls in the home.

This initiative will follow a three-pronged approach: education, evaluation/assessment and follow up. This initiative will engage community health workers in an evidence-based program to increase health literacy of a targeted population. One innovative aspect of the initiative is follow-up home visiting for referrals generated by programs that already visit homes of older adults in specific high-risk zip codes that have a disproportionately high number of ER visits for falls.. Through partnerships with other Houston Department of Health and Human Services (HDHHS) programs, at-risk older adults will be identified and enrolled in the HHFP Initiative.

Issues addressed by the Safe and Healthy Homes concept are critical to the ability of seniors to age safely in place and to enjoy improved quality of life. Educating older adults on the principles of healthy homes will promote reduction of hazards in the home environment; reduce emergency room visits and reduce costs of rehabilitation. Additionally, education will be provided for home care givers to help reinforce the principles of healthy homes.

Many older adults seek care at the ER several times a year for fall related injuries. Preventing falls requires a multifactorial approach with assessment and management (CDC, 2012). The HHFP program proposes to utilize an evidence based approach of home hazard assessment and education for reducing the risk of falling. The average cost of emergency room visit for adults (aged 50-85 years) due to unintentional falls in the US, is estimated to be $3323 per visit. This is inclusive of Medical Cost and Work Loss Cost. [1]

The project will target older adults aged 60 and overand provide education on the value of a safe and healthy home by identifying hazards that impair safety and health in the home. Program staff will perform home inspections to evaluate safety in the home, perform needs assessments, conduct periodic follow up inspections, facilitate limited remediation and refer seniors to other support programs to reduce hazards.

1... Centers for Disease Control. Fall Risks in Older Adults. http://www.cdc.gov/features/fallrisks/. Accessed on 11/5/12.

The referrals to HHFP willbe generated through currently existing programs such asHarris County Area Aging Agency (HCAAA), the Houston Fire Department(HFD)/Emergency Medical Team (EMT), Houston Department of Health &Human Services (HDHHS)Tuberculosis (TB) Control and other departmental(Communicable Diseases, etc.) home visiting programs.

Goals and Relationship to Regional Goals:

Project Goals:

The primary goal of this program is to prevent fall related accidents that result in Emergency Room (ER) visits

- Educate older adults on principles of Healthy Homes
- Reduce environmental hazards in the home
- Preventfall related accidents that result in Emergency Room (ER) visits
- Reduce 9-1-1 calls to the Houston Fire Department

This project meets the following regional goal by implementing an education and follow-up model that prevents falls and potential unnecessary emergency room visits for older adults:

Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.[1,2]

Challenges:

Some of the challenges anticipated with implementation of this initiative include difficulty in gaining trust of older adults and convincing them to modify behaviors that lead to poor health outcomes. The project will build upon relationships already established by referring program staff and use evidence based models that will lead to behavior modification.

5-Year Expected Outcome for Provider and Patients:

Reduction in the number of ER visits and calls to EMT for preventable injuries (e.g., falls)

Starting Point/Baseline:

In 2010, the overall rate of nonfatal fall injury episodes for which a health-care professional was contacted was 43 per 1000 persons. Persons aged > 75 years had the highest rate (115 per 1000 persons). Because this is a new initiative, a new baseline for the population that is the target of this project will be established in Year 2 in order to determine improvements and project effectiveness in subsequent years.

1. Stakeholder input from RHP 3Working Group Members throughout the Region (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)

2. The State of Health – Houston and Harris County, 2012.

Rationale:

The average cost of emergency room visit for adults (aged 50-85 years) due to unintentional falls in the US, is estimated to be $3323 per visit. This is inclusive of Medical Cost and Work Loss Cost. With an estimated 350 high risk individuals enrolled by the HHFP program, assuming that the program could prevent even one ER visit per year/person for unintentional falls in our enrolled population, the cost savings to the ER and the Health care system is $1,163,050 per year. Nationally, falls account for 52.4% of unintentional injuries (HCUP, 2012). In Texas, 46.7% of unintentional injuries were due to falls (Healthcare Cost and Utilization Project, 2012)[1].

Risk for suffering a serious fall related injury increases exponentially with advancing age. Nationally, approximately one third of elderly adults experienced a fall (Hausdorff et al., 2001)[2] each year. Older adults comprise a large number of ER visits due to falls. Even more disconcerting is the fact that there has been a sharp year to year increase in the number of fatal falls in older adults in the past 10 years. Many older adults seek care at the ER several times a year for fall related injuries. Preventing falls requires a multifactorial approach with assessment and management (Centers for Disease Control, 2012)[3]. The HHFP program proposes to utilize one such evidence based approach of home hazard assessment and education for reducing the risk of falling.

In 2010, the overall rate of nonfatal fall injury episodes for which a health-care professional was contacted was 43 per 1,000 population. Persons aged ≥75 years had the highest rate (115 per 1000).[3] . The direct medical costs for fall related injuries nationally is about $20 billion annually and is expected to increase substantially over the next decade as the population ages .

Project Components: There are no required project components for the project option.

Unique community need identification numbers the project addresses:

The Healthy Homes Initiative also addresses the issues addressed in the following community needs assessments:

- CN.8 High rates of inappropriate emergency department utilization[1,2]
- CN.23 Lack of patient navigation, patient and family education and information programs.[1,2]

1. Healthcare Cost and Utilization Project (HCUP), 2012. Emergency Department Data Evaluation.Report # 2005-02.US Department of Health and Human Services.Agency for Healthcare Research and Quality.From http://www.hcup.us.ahrq.gov/nedsoverview.jsp.Accessed on 7/29/12.

2. Hausdorff JM, Rios DA, Edelberg, HK. Gait variability and fall risk in community-living older adults: a 1 year prospective study. Arch Phys Med Rehabil; 82: 1050-6.

3. WISQARSTM Web-based Injury Statistics Query and Reporting System).From www.cdc.gov/ncipc/wisqars/, Accessed on 7/29/12.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

The project is a new innovation which provides services in the home to reduce falls and potential ambulance transports and emergency room visits.

Related Category 3 Outcome Measures:

OD- 9 – Right Care, Right Setting

IT-9.4 Milestone: Other Outcome Improvement Target (ED appropriate utilization – Stand-alone measure)

- Reduce ED visits related to falls in home settings(including ACSC)
- Metric: Number of 911 Calls for falls among adults age 60 and older from specific zip codes during measurement period
- Metric: Number of ED visits for falls among adults age 60 and older from specific zip codes during measurement period

Reasons/rational for the selecting the outcome measures:

We chose the "Other Outcome Improvement Measure" as our outcome because of the prevalence of falls among older adults due to structural conditions in the home that are preventable and remediable. According to the United States Preventive Task Force recommendations, decreasing the incidence of falls would also improve the socialization and functioning of older adults who have previously fallen and fear falling again http://www.uspreventiveservicestaskforce.org/uspstf11/fallsprevention/fallsprevrs.htm. The burden of falls on patients and the health care system is large. Decreasing the incidence of falls would also improve the socialization and functioning of older adults who have previously fallen and fear falling again. Many other interventions could potentially be useful to prevent falls, but because of the heterogeneity in the target patient population, multiplicity of predisposing factors, and additive or synergistic nature, their effectiveness is not known. Despite this, a cost effective solution to avoid falls in older adults and the subsequent inappropriate usage of ER, a comprehensive Fall Prevention intervention in high risk communities is relatively easy to implement.

Relationship to other Projects:

Relationship to Other Performing Providers' Project and Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region

that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration, and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Healthy Homes Fall Prevention project received a composite Prioritization score of 5.4 and a Public Health Impact score of 6.

Unique Identifier: 0937740-08.2.1	***RHP PP Reference Number:*** 2.6	***Project Components*** *2.6.3*	***Project Title: Healthy Homes Fall Prevention Initiative***	
Performing Provider Name: City of Houston Department of Health and Human Services				*HDHHS -*
Related Category 3Projects:	*0937740-08,-03,-07.3.5*		*IT-9.4*	Other Outcome Improvement Target
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P –X1]: Complete a planning process for the implementation of a program to educate the elderly in fall prevention, engage partners, identify current capacity and resources needed, and develop a timeline Metric [P-X.1]: Development of a report documenting implementation plans, partnerships and necessary resources, and implementation timeline Goal: Completion of planning process and report Data Source: Completed report that includes information identified above Milestone 1 Estimated Incentive Payment: $ 708,089.33	**Milestone 4 [P-4]:.** Milestone: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. P-4.1. Metric: Document learning and diffusion strategic plan Goal: Develop dissemination tools for evidence based Fall prevention program in target population c. Data Source:Documentation of implementation of Learning and Diffusion materials developed by program Milestone 4Estimated Incentive Payment: $ 1,008,754 **Milestone 5 [P-5.]:**Milestone: Execution of evaluation process		**Milestone 6** I-8. Milestone: Increase access to health promotion programs and activities using innovative project option. I-8.1. Metric: Increase percentage of target population reached. a. Numerator: Number of individuals of target population reached by the innovative project. b. Denominator: Number of individuals in the target population that were referred. Baseline: Establish Baseline c. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 6 Estimated Incentive Payment: $ 1,003,710.50	**Milestone 8** I-8. Milestone: Increase access to health promotion programs and activities using innovative project option. I-8.1. Metric: Increase percentage of target population reached. a. Numerator: Number of individuals of target population reached by the innovative project. b. Denominator: Number of individuals in the target population that were referred. Goal: Increase by 10% over baseline c. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 8 Estimated Incentive Payment: $ 893,980.50

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Performing Provider Name: City of Houston Department of Health and Human Services				*HDHHS -*
Related Category 3Projects:	*0937740-08,-03,-07.3.5*		*IT-9.4*	Other Outcome Improvement Target

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 [P-1.1]. : Conduct a needs assessment to identify the Conduct an assessment of health promotion programs that involve community health workers at local and regional levels. Metric: Provide report documenting target population characteristics, gaps in services, ideal number of patients targeted per year, priority high volume zip codes to target for fall prevention program. Goal: Determine the need and scope of fall prevention program Data Source: Program documentation, needs assessment survey Milestone 2 Estimated Incentive Payment: $ 708,089.33	for project innovation. P-5.1. Metric: Document evaluative process, tools and analytics. a. Data Source: Documentation of implementation TBD by Performing Provider Goal: Initiate evaluation of programs and connections/referrals to care for target population Data Source: Program documentation Milestone 5Estimated Incentive Payment: $ 1,008,754	**Milestone 7 [I-6**.]: Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model. I-6.1. Metric: Proportion of unique patients receiving evidence based intervention Numerator: Total number unique of patients in defined population whoreceived innovative Fall Prevention intervention b. Denominator: Total number of patients in defined population referred to Fall Prevention Program. Baseline: : Number of unique target population served over Yr.3 in Fall Prevention Program Data Source: Program Documentation	**Milestone 9 [I-6]:**Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model. I-6.1. Metric: Proportion of unique patients receiving evidence based intervention Numerator: Total number of unique patients in defined population who received innovative Fall Prevention intervention b. Denominator: Total number of patients in defined population referred to Fall Prevention Program. Goal : Increase by 10% over baseline the Proportion of unique target population served over Yr. 3 in Fall Prevention Program Data Source: Program Documentation

Unique Identifier: 0937740-08.2.1	***RHP PP Reference Number:*** 2.6	***Project Components*** *2.6.3*	***Project Title: Healthy Homes Fall Prevention Initiative***	
Performing Provider Name: City of Houston Department of Health and Human Services				*HDHHS -*
Related Category 3Projects:	*0937740-08,-03,-07.3.5*		*IT-9.4*	Other Outcome Improvement Target
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 3 [P-X1]: Select evidence-based Healthy Homes – Fall Prevention initiative for older adults using best practice guidelines P-2.1. Metric: Document selection of evidence based innovational Fall prevention strategy and plan. Goal: Select appropriate Fall Prevention intervention for target population Data Source: Program Documentation Milestone 3 Estimated Incentive Payment: $ 708,089.34			Milestone 7 Estimated Incentive Payment: $ 1,003,710.50	Milestone 9 Estimated Incentive Payment: $ 893,980.50
Year 2 Estimated Milestone Bundle Amount:$2,124,268	Year 3 Estimated Milestone Bundle Amount:$ 2,017,508		Year 4 Estimated Milestone Bundle Amount:$2,007,421	Year 5 Estimated Milestone Bundle Amount:$1,787,961

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Performing Provider Name: City of Houston Department of Health and Human Services				*HDHHS -*
Related Category 3Projects:	*0937740-08,-03,-07.3.5*		*IT-9.4*	Other Outcome Improvement Target
Year 2	Year 3		Year 4	Year 5
(10/1/2012 – 9/30/2013)	**(10/1/2013 – 9/30/2014)**		**(10/1/2014 – 9/30/2015)**	**(10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):*$ 7,937,159				

Narrative for Category 3 Outcome Measure Associated with Category 2 Project Title:
Healthy Homes Fall Prevention

Title of Outcome Measure (Improvement Target):IT-9.4Other Outcome Improvement Target (ED appropriate utilization)

Unique RHP Outcome Identification Number: 0937740-08.3.5

Outcome Measure Description:
IT-9.4 Milestone: Other Outcome Improvement target (ED appropriate utilization (Stand-alone measure)}

In 2010, the overall rate of nonfatal fall injury episodes for which a health-care professional was contacted was 43 per 1000 persons. Persons aged > 75 years had the highest rate (115 per 1000 persons) of falls. The primary goal of this program is to prevent fall related accidents that result in Emergency Room (ER) visits. Since the primary recruitment source is the EMS database for 911 calls, this program is expected to reduce 911 calls in targeted high risk zip codes for falls in the home setting. This initiative will implement an Evidence-based Health Promotion Program that utilizes community health workers to increase health literacy and provide minor structural changes in homes of a targeted population.

Metric 1: Number of 911 Calls for Falls from specific zip code during measurement period

Metric 2: Number of ED visits for falls from specific zip codes during measurement period

Process Milestones:

- DY 2
  - P-3:: Develop and test Data systems
- DY 3
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
  - P-5: Milestone: Disseminate lessons learned and best practices

Outcome Improvement Targets for each year:

- DY 4
  - IT-9.4 Milestone: Other Outcome Measure (ED appropriate utilization)
  - Reduce Number of 911 Calls for Falls from specific zip code during measurement period
  - Reduce Number of ED visits for falls from specific zip codes during measurement period
- DY 5
  - IT-9.4 Milestone: Other Outcome Measure (ED appropriate utilization)
  - Reduce Number of 911 Calls for Falls from specific zip code during measurement period
  - Reduce Number of ED visits for falls from specific zip codes during measurement period

Rationale:

The "Other Outcome Measure" for Category 3 was chosen for this project because it aligns with the goals of the project. Fall related injury and ensuing visit to the ER is one of the 20 most expensive conditions in community dwelling elderly. Preventable falls among community dwelling elderly result in costly morbidity. According to a new CDC study published in the *Morbidity and Mortality Weekly Report (MMWR),* an estimated 234,000 people ages 15 and older were treated in U.S. emergency departments (ED) in 2008 for injuries that occurred in bathrooms. Four out of 5 of these injuries were caused by falls—which can have especially serious consequences for older adults.Almost one-third (30 percent) of adults aged 65 and above who were injured in bathrooms were diagnosed with fractures. Among adults aged 85 and older, 38 percent were hospitalized as a result of their injuries. Eliminating hazards at home is one of the recommended strategies for fall prevention in older adults. This Fall Prevention intervention will focus on reducing hazards at home for older adults from specific zip codes so that a costly ER visit is averted.

Outcome Measure Valuation:

The Outcome measure was valued at 9.25% of the overall assigned project value for the associated Category 2 project in year 3, 9.25% in Year 4 and 9.25% in Year 5.

Houston Department of Health and Human Services (HDHHS) utilized the following method to determine the Category 2 project value:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health

Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Healthy Homes Fall Prevention project received a composite Prioritization score of 5.4 and a Public Health Impact score of 6.

Unique Cat 3 ID: *0937740-08.3.5*	*Ref Number from RHP PP:* IT-9.4	IT-9.4 Milestone: Other Outcome Improvement Target	
Performing Provider Name: City of Houston Health and Human Services			*HDHHS -*
Related Category 1 or 2 Projects:	*Unique Category 2 identifier - 0937740-08.2.1*		
Starting Point/Baseline:	TBD in DY 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1: [P-3]: Develop and test Data systems Metric 1: Determine and provide documentation of type of system and IT resources needed. Metric 2: Select, install and test data system Goal: Utilize an efficient and effective data system for reporting Data Source:Program records and documentation Estimated Incentive Payment: $ 111,804	**Process Milestone2 [P-4]:** Conduct Plan Do Study Act cycle to continually improve Metric: Document use of PDSA in planning process Goal: Ensure systematic cyclical quality improvement process Data Source: Program Records Process Milestone 2 Estimated Incentive Payment: $112,084 **Process Milestone 3 [P-5]:**Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned Goal: Share lessons learned and best practices	**Outcome Improvement Target 1 [IT-9.4:**Milestone: Other Outcome Improvement Target (ED appropriate utilization) Metric 1: Number of ED visits for falls from specific zip codes during measurement period enrolled in Healthy Homes Fall Prevention Program Metric 2: Number of 911 calls for falls from specific zip codes during measurement period enrolled in Healthy Homes Fall Prevention Program Goal: Reduce by 5% each the number of ED visits among program participants and number of 911 calls made for falls in older adults 60 years and over from specific zip codes over baseline (Baseline TBD in DY 3) Data Source: Program Records, 911	**Outcome Improvement Target 2 [IT-9.4: Other Outcome Improvement target (**ED appropriate utilization) Metric 1: Number of ED visits for falls from specific zip codes during measurement period enrolled in Healthy Homes Fall Prevention Program Metric 2: Number of 911 calls for falls from specific zip codes during measurement period enrolled in Healthy Homes Fall Prevention Program Goal: Reduce by 10% each the number of ED visits among program participants and number of 911 calls made for falls in older adults 60 years and over from specific zip codes over baseline Data Source: Program Records, 911

	Data Source: Program Records Process Milestone 3 Estimated Incentive Payment: $112,084	system Outcome Improvement Target 1 Estimated Incentive Payment: $ 223,047	system Estimated Incentive Payment: $ 446,990
Year 2 Estimated Outcome Amount: $ 111,804	Year 3 Estimated Outcome Amount: $224,168	Year 4 Estimated Outcome Amount: $223,047	Year 5 Estimated Outcome Amount: $446,990
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):*$1,006,008			