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The National Association of Rehabilitation Providers and Agencies

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CEU Certificate Access Instructions

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- Registered for the course
- Participate marked by Zoom for the live or virtual version of the webinar
- Completion of the Medbridge event – attestation and assessment

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1. Log into Medbridge (use the email address you received your notification at to access Medbridge): https://www.medbridgeeducation.com/
2. From the Dashboard, look under Events in the middle of your screen (you may have to click **View All** in order to see the appropriate Conference event)
3. Until the event has occurred it will say REGISTERED in Green
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If you did not attend the live event, you will need to email NARA to confirm you have watched the recording so you can be marked as attended. Without this marking you will not have the course 100% complete.

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You will not be able to complete these events until the end date of the event has occurred.

Questions?

Contact Christie Covington at christie.covington@naranet.org

HealthPro HERITAGE

Continuing Education Webinar

From Evidence to Outcomes: Patient-Centered Falls Care Across the Continuum

A practical framework for falls prevention, recovery, and safe transitions of care

Presenters:
Erin Merklinger MS, OTR/L
Julie Gala MA-CCC, SLP, RAC-CT
Sara Turnbull PT, DPT, RAC-CT

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Housekeeping Reminders

- All attendees are on mute
- **Handouts** are available on the NARA website: Resources>Quick Links Page
- **Questions for Speakers:** submit them using the Q&A button on the attendee control panel
- **Technical Questions:** submit them using the Chat button on the attendee control panel
- **Recording:** will be available on the NARA member portal and in the Medbridge event – Monday, August 31
- **CEUs:** approved through state of IL for PT/PTA, AOTA for OT/OTA, and ASHA for SLP. Must complete all requirements through Medbridge (email with the event access will be sent on Monday, August 31.

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Disclaimer

The information shared in today's presentation is shared in good faith and for general information purposes only. It is accurate as of the date and time of this presentation. Providers should seek further guidance and assistance from CMS and their Medicare Administrative Contractor (MAC), commercial payers, state and national associations, and continue to watch for new developments and information regarding the topics discussed today.

Objectives

By the end of this session, participants will be able to:

Define & Identify	Define a fall and describe common clinical, environmental, and behavioral contributors to falls risk across patient populations.
Apply Strategies	Identify evidence-informed falls prevention strategies that support safety, function, and patient-centered outcomes.
Address Cognition	Incorporate cognitive status, executive function, fear of falling, and patient engagement into falls-related assessment, intervention, and discharge planning.
Align with VBC	Explain how falls programming supports value-based care goals, including reduced utilization, improved transitions of care, and sustainable outcomes.

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Falls & Risk Factors

CDC definition: "An unexpected event in which a person comes to rest on the ground, floor, or lower level."

Intrinsic (Patient-Specific)

Change in medical status, co-morbidities, medication side effects

Impaired mobility, balance, gait deviations, decreased strength

Fear of falling, pain, altered/low vision, cognitive deficits

Extrinsic (Environmental)

Wet floors, clutter, unsecured rugs, uneven surfaces

Inappropriate lighting, excessive noise, weather conditions

Ill-fitting clothing or footwear

Action Items

Clearly document ALL risk factors and tie the IDT to a plan for each one.

Every treatment plan should address both categories

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The CDC STEADI Framework: Screen, Assess, Intervene

CDC's evidence-based, cyclical model for identifying and reducing fall risk across the continuum of care

Building the Cycle

Program Foundation — establish the interdisciplinary infrastructure

Screen — proactively identify residents at risk

Assess — complete a comprehensive rehabilitation evaluation

Intervene — deliver targeted, individualized interventions

Sustaining the Cycle

Intervene: *Respond* — assess immediately after a fall and update the plan

Intervene: *Educate* — engage residents and families as safety partners

Intervene: *Transition* — hand off to structured wellness and maintenance

Monitor & Re-Screen — track outcomes and re-enter the cycle as risk changes

How STEADI Applies Here

Each element of Screen, Assess, and Intervene is explored in detail throughout this session and translated into practical actions your interdisciplinary team can implement immediately.

Endorsed by the AGS/BGS Clinical Practice Guideline for Fall Prevention.

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Program Foundation & Screening

CDC STEADI Framework • Foundation + Screen

Program Foundation

Create a multidisciplinary falls committee to oversee strategy and drive accountability

Provide ongoing in-service education for all professionals involved in resident care

Standardize policies, workflows, and communication across nursing, therapy, and support staff

Screen: Proactively Identify Residents at Risk

Screen all residents using evidence-based tools and clinical observation

Use interdisciplinary assessments to identify intrinsic and extrinsic risk factors

Flag high-risk individuals clearly (EMR alerts, door symbols, care plan indicators)

Why It Matters

A strong foundation plus early identification are the two highest-leverage steps in preventing a first fall.

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Falls Are Not Just a Therapy Initiative: Interdisciplinary Success Model

01

Therapy

Identifies how and why a resident is at risk

Detects early functional changes and gait instability

Implements targeted interventions and reassesses progress

02

Nursing & Ancillary Services

Provides 24/7 surveillance and clinical continuity

Monitors condition changes and post-fall status

Communicates observations back to therapy

03

Life Enrichment & Wellness

Reinforces recommendations between therapy sessions

Provides daily opportunities for safe movement

Reports concerns to nursing and therapy

04

Leadership

Establishes expectations for IDT collaboration

Ensures data is reviewed and acted upon

Holds teams accountable for execution

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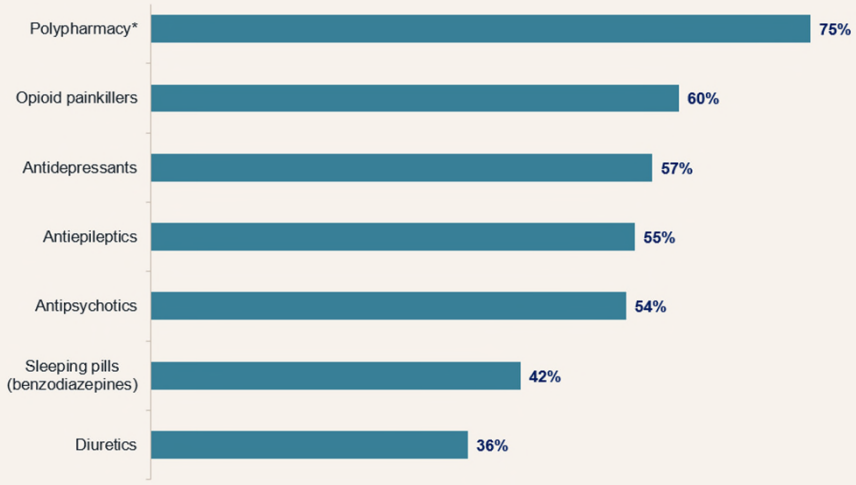
Pharmacy + Therapy Collaboration

Our prescription to help: an interdisciplinary approach to medication management



Sources: de Vries et al. 2018; Seppala et al. 2018

Proactive ID

Leverage therapy to help screen residents at risk for falls tied to medication effects.

Polypharmacy (4+ medications) creates a 75% increased risk of falls — the highest of any category.

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Identifying & Monitoring At-Risk Residents

Different settings, complementary approaches to catching risk early

SNF

Clinical Grand Rounds, Therapy communication cards, and clinical meetings for formalized monthly IDT rounding

Senior Living & CCRC

At-Risk Meetings, Education Series, Therapy communication cards, and Standardized screens

Why Grand Rounds Work

In-depth probing identifies subtle changes early, preventing accidents and improving quality measures

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Assess: Comprehensive Rehabilitation Evaluation

CDC STEADI Framework • Assess Phase

Assess the Resident

Strength/balance deficits, gait abnormalities, orthostatic hypotension

Medication effects, cognitive impairments, environmental hazards

Vision, hearing, vestibular, and lower-extremity joint function

Individualize the Plan

Determine each resident's specific contributing risk factors

Apply standardized tests (Berg Balance, TUG, Gait Speed) and reassess as appropriate

Enroll in focused clinical programs or balance/mobility initiatives

Why It Matters

A thorough evaluation is the bridge between risk identification and effective, individualized intervention.

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Recommended Fall Risk Tests & Measures by Discipline

01

Physical Therapy (PT)

- **Balance**: Berg Balance Scale, Timed Up & Go (TUG)
- **Gait**: 10-Meter Walk Test (gait speed), Dynamic Gait Index
- **Strength/Mobility**: 30-Second Chair Stand, Four Square Step Test

02

Occupational Therapy (OT)

- **ADLs/IADLs:** Katz Index, Lawton IADL Scale, Modified Barthel
- **Home Safety:** Home Safety Self-Assessment Tool (HSSAT)
- **Vision & Cognition**: Vision screening (e.g., Snellen), MoCA

03

Speech-Language Pathology (ST)

- **Cognitive Screening**: Montreal Cognitive Assessment (MoCA), Allen Cognitive, GDS
- **Attention & Executive Function**: Trail Making Test (A & B)
- **Dual-Task Performance:** walking paired with a cognitive/verbal task

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Intervene: Implement Targeted Interventions

CDC STEADI Framework • Intervene Phase

Deliver Focused Therapy

Strengthening and balance training, vestibular treatment

Assistive device training and environmental modification

Dual task training and functional exercise progressions

Integrate & Follow Up

Include health literacy and caregiver education/teach-back

Integrate strategies into nursing, restorative activities, and wellness programming

Provide regular follow-up to confirm falls are reduced and function improves

Why It Matters

Targeted interventions turn risk data into measurable improvements in resident safety and function.

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Core Concept of Balance & the Otago Program

The vast majority of older adults present with balance impairments

Core Balance Factors

Control center of gravity over base of support, achieve postural control, and maintain adequate strength and flexibility

Otago Program

Evidence-based muscle strength and balance retraining program, individualized to strength, flexibility, and reaction time

Proven Impact

35% reduction in falls-related injuries when applied appropriately; continues as an ongoing wellness offering

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Mindful Movement: Training the Brain-Body System

Efficient movement requires integration of motor and cognitive systems — and dual-task training builds that integration

Why Attention Divides Risk

Walking while conversing, carrying items, navigating crowded spaces

Gait speed decreases, stride variability increases — this is "Dual Task Cost" and is strongly associated with fall risk

Dual Task Training Progression

1. Stable posture + cognitive task
2. Simple gait + cognitive task
3. Complex gait + environmental navigation

The Evidence

"Walking while performing a secondary cognitive task significantly increases fall risk in older adults."

— Journal of the American Geriatrics Society

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Cognition and Fall Risk

Cognitive impairment increases fall risk 2–3x higher and must be addressed explicitly

Why Cognition Matters

Executive function, attention, and dual-task ability are the cognitive domains most strongly linked to falls

Residents with cognitive impairment often require modified assessment and intervention approaches

Multifactorial Interventions

Combining education, environment, exercise, and medication review reduces fall risk most effectively

Why It Matters

Addressing cognition explicitly, not as an afterthought, is what makes a falls program truly multifactorial.

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Memory Care Matters

01

Why It's Different

- Impaired judgment & dual-task difficulty
- Gait variability & visual-spatial deficits
- Increased wandering risk

02

What Works

- Objective risk identification via technology
- Therapy-led, short-burst interventions
- Environmental & cue-based strategies
- IDT carryover

03

Results

- Fewer falls & accidents resulting in injury
- Improved functional mobility and confidence
- Better documentation integrity supporting MDS accuracy

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Intervene: Respond After a Fall

CDC STEADI Framework • Intervene Phase (Post-Fall Response)

Assess Immediately

Conduct a prompt post-fall assessment: injury status, root cause, contributing factors

Evaluate changes in function or cognition since the fall

Update the Plan

Determine the need for therapy re-evaluation

Update the care plan and implement corrective actions based on findings

Why It Matters

A fast, structured response prevents a single fall from becoming a pattern of repeat falls.

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Resident with Repeat Falls Need a Different Strategy

Start with the WHY: a coordinated, sequential root-cause response

- Consider all causes: physical, cognitive, medical, behavioral, environmental, timing
- Environmental set up: call light access, walker in reach, optimal bed height, lighting, footwear

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Intervene: Transition to Wellness & Maintenance

CDC STEADI Framework • Intervene Phase (Sustaining the Gains)

Plan & Sustain

At the conclusion of therapy, develop an interdisciplinary transition plan with home exercise and self-management strategies

Reinforce that discharge is a transition to sustained health, not the end of intervention

The Hand-Off to Wellness

Without ongoing engagement, residents often lose strength, balance confidence, and coordination

Transitioning to structured wellness and group exercise programs helps maintain therapeutic gains

Why It Matters

Therapeutic gains fade quickly without a structured hand-off to ongoing wellness support.

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Monitor & Re-Screen: Outcomes and Transitions of Care

CDC STEADI Framework • Closing the Loop

Monitor & Re-Engage

Continue monitoring residents for new falls, functional decline, or cognitive/medical changes

Refer residents back to therapy whenever risk factors re-emerge

A Smooth, SAFE Transition

Unified IDT approach with a consistent, individualized aftercare plan (HEP, restorative program, health literacy)

Personalized, teach-back supports with ongoing oversight through Grand Rounds and follow-up

Why It Matters

Falls prevention is a continuous feedback loop — not a one-time event — across the resident's entire stay.

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Intervene: Educate Residents and Families

CDC STEADI FRAMEWORK • INTERVENE PHASE (EDUCATION)

Ongoing Education

Educate on the causes of falls and prevention strategies
Teach safe mobility and home/environmental safety

Tailored, Teach-Back Approach

Plain-language education tailored to cognitive status
Teach-back confirms real comprehension, not assumed

Partner for Safety

Address fear of falling and build confidence
Engage families and caregivers as safety partners

Interdisciplinary Consistency

Aligned provider communication improves adherence
Reduces confusion at every care transition

Why It Matters

Educated residents and families are active partners in preventing the next fall.

Education only changes behavior when it's understood, reinforced, and consistent across every member of the care team.

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Care Transition Planning: It Starts on Day One

CMS REQUIRES DISCHARGE PLANNING TO BEGIN AT ADMISSION AND CONTINUE THROUGHOUT THE STAY (42 CFR 483.21)

Day 1 (within 48 hrs) — Baseline assessment

Ongoing — Reassess & update

Discharge — Coordinated hand-off

Day 1: Baseline Assessment

Screen for cognition, mobility, and fall risk in 48 hours

Identify the likely discharge destination early

Throughout the Stay: Plan Around Cognition

Tailor environment, mobility, and meds to cognitive status

Re-evaluate and update the plan as status changes

At Discharge: Coordinate the Hand-Off

Communicate risk factors and equipment needs clearly

Engage residents and families in the transition

Source: 42 CFR 483.21, CMS Requirements for Long Term Care Facilities

Why It Matters

A well-coordinated discharge plan is the bridge between clinical gains in therapy and sustained safety in the next setting.

Starting on day one gives the team time to close gaps in equipment, caregiver training, and follow-up care, and reduces the risk of a preventable readmission.

The CMS Standard

Baseline care plan within 48 hours of admission. Comprehensive care plan within 7 days. Interdisciplinary re-evaluation continues for the length of the stay.

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Value-Based Care Impact & Rehospitalization Prevention

Falls are a direct, measurable driver of cost, quality performance, and readmissions

- Direct Tie to CMS, ACO, SNP, VBP
- Falls Are High-Cost, Preventable Events
- Reduces Utilization & Readmissions
- The First 30–90 Days Post-Discharge Are Critical
- Home Hazard & Medication Review Lowers Risk

12–20% reduction in fall-related readmissions with improved care coordination

Interdisciplinary follow-up (therapy, nursing, pharmacy, primary care) improves CMS Star Ratings and outcomes — Hoffman et al., 2023

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Advocacy Spotlight: The SAFE Act

H.R. 1171 / S. 2612 • SUPPORTING POLICY THAT EXPANDS ACCESS TO FALLS PREVENTION SERVICES

What the Bill Would Do

Adds a no-cost falls risk assessment and PT/OT referral to the Medicare Annual Wellness Visit

Refers beneficiaries who fell in the past year to a PT during their Welcome to Medicare exam

Bipartisan Momentum

Introduced by Reps. Carol Miller (R-WV) and Melanie Stansbury (D-NM)

H.R. 1171 has 50 House cosponsors; S. 2612 is before the Senate Finance Committee

The Cost Case

Falls send 3M older adults to the ER and cost Medicare an estimated $50B+ a year

Post-fall PT is linked to 39% lower opioid use and roughly $2,100 saved per episode of care

Source: CDC; APTA/APTQI cost-benefit analysis; Congress.gov (119th Congress)

Why It Matters for Patients

Ensures beneficiaries who've fallen are referred for evaluation, even outside the annual wellness visit.

Early PT after a fall lowers repeat-fall risk and reduces reliance on opioids for pain management, at no added cost to the patient.

Take Action

Ask your Representative and Senators to cosponsor H.R. 1171 and S. 2612.

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Key Takeaways

Falls prevention drives measurable, patient-centered value across the continuum of care

Interdisciplinary Approach

Interdisciplinary approach: falls prevention works best as a system-level, coordinated effort

Cognition & education: health literacy helps patients understand risk and follow prevention strategies

Critical Discharge Transition

Communication gaps at discharge increase fall risk and adverse events

Why It Matters

Coordinated, cognition-aware care at every transition is what turns falls prevention into measurable value-based outcomes: fewer readmissions, better function, lower cost.

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Questions & Answers

From Evidence to Outcomes

Open floor for discussion

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Thank You!

From Evidence to Outcomes

Patient-Centered Falls Care Across the Continuum

Sources

- **Falls framework: CDC STEADI Initiative (Screen, Assess, Intervene), operationalizing the AGS/BGS Clinical Practice Guideline for Fall Prevention — cdc.gov/steadi**
- Readmissions reduction (HRRP) — cochrane.org
- Cost per fall (~$62K); national cost burden (~$80B); multifactorial intervention effectiveness — academic.oup.com
- Education impact on falls — uspreventiveservicestaskforce.org
- Post-discharge fall risk (up to 40%) — journals.rcni.com
- Home modification effectiveness — ncbi.nlm.nih.gov
- CDC STEADI discharge model — pmc.ncbi.nlm.nih.gov
- Medication-related fall risk data — de Vries M et al. 2018; Seppala LJ et al. 2018
- H.R.1171 - SAFE Act, 119th Congress
- S.2612 - SAFE Act, 119th Congress
- SAFE Act Reaches 50 Cosponsors in the U.S. House - APTQI
- Analysis: Increased Use of PT Among Medicare Patients Prone to Falls Could Reduce Spending by $10 Billion - APTQI
- The Stopping Addiction and Falls for the Elderly (SAFE) Act - APTA Geriatrics
- 42 CFR § 483.21 - Comprehensive person-centered care planning
- eCFR: 42 CFR Part 483 - Requirements for Long Term Care Facilities

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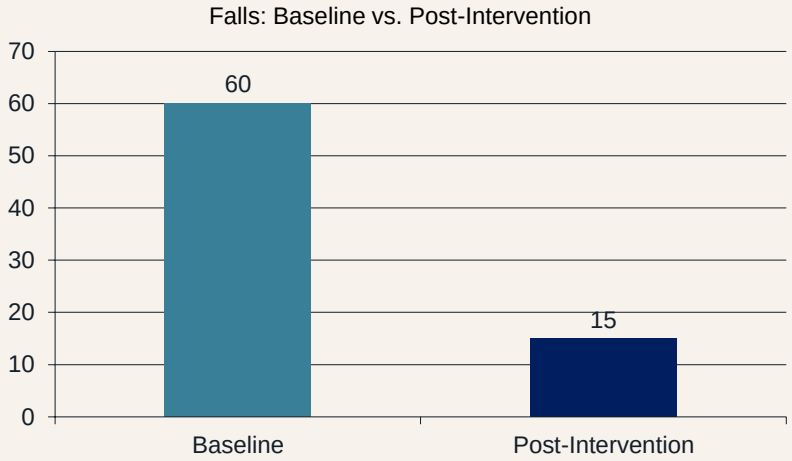
Fall Prevention Case Study Results

Shifting to a functional care model drove measurable, patient-centered outcomes



75%

reduction in falls, from 60 to 15

50% improvement in functional outcomes; reduced hospitalizations, ED visits, and improved community discharge.

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