The Interactive Work Groups

Six interactive work groups were composed of an average of 20 Summit participants to allow for maximum dialogue and debate. The groups met on each Summit day to revise and develop draft policy recommendations.

The five key areas were:

1. Community Programs (the largest topic area divided into two groups (A and B) to permit maximum participation);
2. Education and Training;
3. Healthy Lifestyles and Recreation;
4. Health Care; and
5. Safe Housing and Communities.

Initially, work groups both revised recommendations and selected their top three priorities before focusing on developing feasible action steps, determining realistic time lines as well as identifying potential collaborating organizations and agencies.

Work groups were facilitated by experts familiar with each topic area. Discussion recorders kept detailed group meeting minutes while recommendation recorders noted changes to draft recommendations. Revised recommendations were shown on screens via computer and projector technology in each session. This setup provided an environment conducive to brainstorming and strategizing.

In the following section each work group’s efforts are highlighted along with the final recommendations. The policy recommendations receiving the most votes in each work group are listed in order as Recommendation 1 through 3. Throughout this document they are described as the “top three” recommendations; they are reported using the exact language as created at the Summit.

Following each recommendation is a list of proposed action steps. Each action step identifies (in parentheses) potential collaborating organizations and agencies that are – or could be – key for implementation. When provided in the Summit source document (i.e. the reports of discussion and recommendation recorders), we also include the suggested timeframe for completion of a particular action step. A list of acronyms included in recommendations can be found under “Resources” (Appendix 7).
Community Programs

The Older American Act (OAA), reauthorized and amended numerous times since it was signed into law more than 40 years ago, provides the legislative foundation for programs, services, and benefits supporting older adults, many of which could address fall prevention.

OAA Title III, Part D (Disease Prevention and Health Promotion Services), is the most relevant section related to community programs. This part of the OAA includes such services as health risk assessments, health promotion and physical fitness programs, home injury control services as well as medication management screening and education. In California, the Department of Aging (CDA) contracts with the network of AAAs who manage various federal and state-funded services for older adults. Specifically, AAAs contract with agencies that operate the Multipurpose Senior Services Program (MSSP) and authorize services that promote healthy aging and help individuals live as independently as possible in their community.

Additionally, the California Department of Public Health (CDPH), and educational institutions as well as public, private, and community-based organizations at the local, state, and national level play crucial roles in delivering services that promote healthy lifestyles and prevent disease and disability among the older population. The common goal is to develop and implement public health interventions and best practices - such as fall prevention - supporting individual and community health. Thus, Summit participants in the Community Programs work groups deliberated ways in which available Title III-D and other funds could further statewide fall prevention efforts through evidence-based fall prevention programs implemented at senior centers, nursing homes, hospitals, and other community settings.

Due to the interest and large number of participants in this topic area, Community Programs was divided into two smaller work groups (A and B) to provide best possible opportunity for discussion and engagement among group members. The major difference among recommendations developed by the two groups was the intensity of language used, such as “strongly recommend” in Recommendation A-1 versus “encourage” in Recommendation B-1.

Listed here are the work groups’ high priority policy recommendations, associated action steps, and (in parentheses) possible collaborating organizations and agencies:

“We should be looking at fall prevention because it is the wisest way to use the limited resources we have.”

-- Senator Alan Lowenthal, PhD
California Legislature

Additionally, the California Department of Public Health (CDPH), and educational institutions as well as public, private, and community-based organizations at the local, state, and national level play crucial roles in delivering services that promote healthy lifestyles and prevent disease and disability among the older population. The common goal is to develop and implement public health interventions and best practices - such as fall prevention - supporting individual and community health. Thus, Summit participants in the Community Programs work groups deliberated ways in which available Title III-D and other funds could further statewide fall prevention efforts through evidence-based fall prevention programs implemented at senior centers, nursing homes, hospitals, and other community settings.

Due to the interest and large number of participants in this topic area, Community Programs was divided into two smaller work groups (A and B) to provide best possible opportunity for discussion and engagement among group members. The major difference among recommendations developed by the two groups was the intensity of language used, such as “strongly recommend” in Recommendation A-1 versus “encourage” in Recommendation B-1.

Listed here are the work groups’ high priority policy recommendations, associated action steps, and (in parentheses) possible collaborating organizations and agencies:
STATEWIDE STRATEGY FOR ACTION

Community Programs: Group A

RECOMMENDATION 1

Strongly recommend that local Departments of Public Health and Area Agencies on Aging assign a staff member as the point person for senior injury prevention. Engage that point person in collaboration in fall prevention activities, services and advocacy efforts

Action Steps

1. Identify existing active senior injury prevention contacts at local public health departments and AAAs as point persons for fall prevention efforts (StopFalls Network membership roster, Archstone Foundation fall prevention coalitions, AAAs, Department of Public Health (DPH)).

2. For those agencies without an existing senior injury prevention contact, identify point people through survey research (EPIC survey, AAA survey, California Department of Public Health (CPH), Fall Prevention Center of Excellence (FPCE), California Department of Aging (CDA).

3. Seek support from California Association of Area Agencies on Aging (C4A) and California Conference of Local Health Officers (CCLHO) to ensure that a point person is identified in each agency (CPH, CDA, DPH, C4A, CCLHO, StopFalls Network, FPCE, community advisory councils).

4. Compile a senior injury prevention roster to facilitate contact with and discussion among DPH and AAA contacts (DPH, AAAs, and FPCE).

RECOMMENDATION 2

Encourage local public health and aging agencies, in partnership with other community organizations, to develop an inventory of local fall prevention programs and resources as a foundation for information and referral networks

Action Steps

1. Develop template/examples of what constitutes fall prevention resources (Veterans Administration-VA).

2. Utilize fall prevention resource list currently being developed by “Information and Assistance” programs (AAA, CDA).


4. Have “Information and Assistance” include fall prevention resources and keep them up to date (C4A, AAA, CDA, FPCE).

5. Inventories of local programs need to be developed and serve as a foundation for further actions (AAA, FPCE, C4A, CDA).
RECOMMENDATION 3
Recommend that the California Department of Aging and Area Agencies on Aging incorporate fall prevention in their upcoming master state and local area plans

Action Steps

1. Encourage all Title III-D funded programs to include fall prevention as part of their activities (CDA, C4A, local AAA steering committees, and organizations that contract with AAAs such as senior centers, service providers, and transport agencies, fire departments, senior advocates such as Senior Legislature, United Seniors of Alameda County, healthy aging initiative (e.g., Napa Healthy Aging Planning Initiative - HAPI) and collaborations).

2. Suggest model language developed by Area 4 Area Agency on Aging for use in other Service Provision Area (SPA) needs assessments.

Community Programs: Group B

RECOMMENDATION 1
Encourage California’s 33 Area Agencies on Aging (AAAs) to A) adopt fall prevention as part of their mission, B) incorporate fall prevention in their upcoming needs assessments and area plans, and C) encourage and support Title III contractors to include evidence-based fall prevention programs as part of their activities

Action Steps

1. Request that the Department of Aging (CDA) send a letter to all 33 AAAs asking them to consider this recommendation.

2. FPCE sponsor/present a fall prevention seminar for AAAs at C4A annual meeting.

3. FPCE sponsor/present at the Triple-A Council of California (TACC) statewide monthly meeting.

4. Each AAA Advisory Group should attend/participate in a presentation concerning fall prevention.

5. Discuss/meet with Directors/Planners of 33 AAAs to discuss ways to implement this recommendation.
STATEWIDE STRATEGY FOR ACTION

RECOMMENDATION 2
Encourage educational institutions such as community college districts and professional and paraprofessional caregiver training programs to incorporate into their curriculum evidence-based fall prevention programs for older adults

Action Steps

1. Convene a meeting with community college districts that teach professional, paraprofessional, and lay persons to explore how they can include fall prevention as part of required curriculum (Community College Districts).

2. Convene a meeting with state licensing bodies and professional organizations that represent these professions to encourage/require fall prevention education as part of certification requirement (Community College and School Districts, CA Statewide Nutrition Network, Certified Nurses Aides (CNAs), Home Health Aides Certification Training Requirements).

3. Convene a meeting with community college districts to identify ways to offer evidence-based fall prevention programs to older adults (Community College and School Districts, CA Statewide Nutrition Network, CNAs, Home Health Aides Certification Training Requirements).

RECOMMENDATION 3
Ensure that local Departments of Public Health take a leadership role by appointing a staff member as the point person for senior injury prevention and coordinating county-level fall prevention activities, services, and advocacy efforts

Action Steps

1. Consult with the California Department of Public Health (CDPH) to discuss ways to implement this recommendation in local county health departments (DPH, local public health departments).

2. Consult with the FPCE to present information on implementing recommendation #3 to the Conferences of Local Health Officers and Local Directors of Health Education (CCLHO), California Conference of Local Directors of Health Education (CCLDHE), CDA, AAAs.

3. Urge attendees of the Summit to go back to their local health departments to encourage implementation of this Recommendation (#3) and report back to the FPCE concerning process.

4. Urge Summit attendees to identify and join local task forces for fall prevention (fall prevention coalitions).
Education and Training

This work group stressed the significance of culturally appropriate curricula on fall prevention for universities and community colleges, as well as institutions offering continuing and adult education. Participants emphasized that future education and training about fall prevention had to reach and educate the entire health care community. Group consensus was that since medication management is an identified risk factor for falling, this message has to be broadcast to primary care physicians and psychiatrists who may lack awareness of falls as a public health issue.

Work group participants included professionals working in universities, community based organizations and health care and service provider organizations as well as AAAs, and consumer advocacy associations. They viewed fall prevention efforts as the information link between the individuals who suffer a fall, the physicians who treat them, the families who care for them, the community social network that fallers interact with, and the businesses who serve the individuals who suffer a fall.

Participants identified difficulties with transportation and insufficient respite care for caregivers that would allow time for continuing education as key barriers to better education about fall prevention for older adults and their caregivers. They agreed that a fall prevention summit held every three years will support education and training efforts and further strengthen California's fall prevention infrastructure.

RECOMMENDATION 1

Educate older consumers and their family caregivers about their crucial role in fall prevention and management through the statewide network of Caregiver Resource Centers and Public Authorities

Action Steps

1. Partner with organizations that have been identified and get buy-in (CAPA, IHSS, senior centers, adult day care centers, health care organizations, AARP, adult education centers and community colleges).

2. Link with partnered organizations’ website and maintain reciprocal links (AAAs, AARP, Alzheimer’s Association (AA), American Society on Aging (ASA), California Welfare Directors Association (CWDA).

3. Get advice from partners such as the Translational Medicine Partnership Forum (TMPF).

4. Partner with the media (public radio stations, public TV stations).

*Timeframe for completion: 12-18 months*
RECOMMENDATION 2
Train physicians, nurse practitioners, and physician assistants on evidence-based practice guidelines (e.g., American Geriatrics Society, ACOVE) for fall risk assessment and management to ensure their incorporation into all primary care settings serving older adults

Action Steps

1. Link with leadership in medical associations (American Physical Therapy Association (APTA), Community Emergency Response Team (CERT), California Medical Association (CMA), Emergency Nurses Association (ENA), National Conference of Gerontological Nurse Practitioners (NCGNP), HMOs, hospitals, Neighborhood Emergency Response Team (NERTs).

2. Fold falls prevention into American Academy of Family Physicians (AAFP) Continued Medical Education (CME) requirements; research pain and end of life mandates for CMEs as a possible model for future inclusion of fall prevention in CMEs (CMA, VA, academic institutions such as UC Davis, UCLA, UCSF, Stanford Medical Center, California State University, community colleges, Medical Board, ACCME).

   Timeframe for completion: 2 years

3. Define the curriculum and the delivery vehicles (academic institutions, CMA, VA, statewide community health clinics, long-term care (LTC) facilities, Aging Services of California (ASC)).

   Timeframe for completion: long-term and ongoing

4. Conduct evaluation efforts to target groups reached, inclusion of fall prevention material, and increased knowledge of participants.

RECOMMENDATION 3
Empower state-level advocacy and professional organizations (e.g., AARP, Older Women’s League, State Independent Living Council, Aging Services of California) to educate their members about their stake in fall risk, prevention, and management

Action Steps

1. Convene a statewide summit to get commitments from all partner agencies and organizations to make fall prevention a priority (California Council of the Blind (CCB), California Welfare Directors Association (CWDWA), C4A, National PACE Association, California Council on Gerontology and Geriatrics (CCGG)).
2. Links with lobbyists and representatives of these organizations (CCB, CWDA, C4A, National PACE Association, CCGG).

3. Disseminate tools and incorporate tools into organizational efforts (CCB, CWDA, C4A, National PACE Association, and CCGG).

4. Reciprocal website links as a cross-cutting strategy (CWDA, C4A, PACE, CCGG).

Timeframe for completion: 18 to 36 months
Health Care

Our fragmented health care system is not exclusively medical; rather, it consists of health care organizations such as HMOs, clinics and hospitals, as well as assisted living, skilled nursing and adult day health care facilities. This fragmentation presents challenges because education on fall prevention is not the sole responsibility of traditional education systems but includes places where health and allied health care professionals work. Many health care providers still know too little about fall prevention or underestimate their role in such efforts.

This group called for more preventive measures including improved medical, medication, and physical activity assessments and intake procedures that incorporate fall history questions. Additionally, data collection about falls often emanates from health care sites but participants pointed out that falls data surveillance is far from being sufficient and satisfactory. The group identified in-home risk assessments as a shared (but unmet) challenge for home builders, contractors/remodelers and health care providers. Group participants suggested that future changes could include case managers as “point of entry” persons who perform initial home assessments.

Action Steps

1. Establish a committee to oversee and identify resources to carry out action steps (HMOs, clinics, hospitals, home health agencies, emergency room departments, adult day health care, assisted living facilities, skilled nursing facilities).

2. Identify or establish a standardized quick fall history/risk screening instrument that can be used by health care organizations (academic institutions, HMOs, hospitals, emergency room departments).

3. Identify or establish a system for more in depth assessment of those persons identified with high fall risk (academic institutions, HMOs, hospitals).

RECOMMENDATION 1

Encourage health care organizations to include standardized fall history/risk screening questions in initial and periodic (i.e., change in condition or annual) follow-up visits to facilitate and initiate in depth assessment, risk management and interventions.

“Falls are often just a marker of serious health problems for older people. By paying attention to falls, we are paying better attention to good geriatric care.”

-- Vicky Scott, PhD
Senior Advisor, Ministry of Health, British Columbia
4. Assist health care organizations in designing and implementing tailored intervention plans based on the assessment, such as developing written physical activity prescription templates for patients reporting little or no physical activity (academic institutions, HMOs, hospitals, home health agencies).

5. Establish priority issues and those responsible for enacting them, such as pharmacists responsible for medication monitoring (chain and community pharmacies, physician group practices).

6. Identify or establish standardized program evaluation criteria. Mobilize healthcare/social service provider organizations, such as California Hospital Association (CHA), ASC, California Association for Adult Day Services (CAADS), and California Chapter of the American Geriatrics Society (AGS) to adopt the recommendation; identify champions.

Timeframe for completion: 1 year

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**RECOMMENDATION 2**

Improve California’s ability to gather accurate information on falls from multiple data sets by developing a standard definition and set of reporting methods for falls from relevant sources at state and local levels

**Action Steps**

1. Identify and review existing data sets and definitions, defining strengths and weaknesses (academic institutions, DPH).

2. Establish a standard core definition of a fall (government, academic institutions, state and local human service agencies, CDA).

3. Identify and review current linkages between data sets (academic institutions).

4. Develop methodology for linking data sets (academic institutions).

5. Develop a system to disseminate findings in a timely manner to those working in prevention (academic institutions, state and local human service agencies).


Timeframe for completion: Data inventory – 1 year, Continuation – long term
RECOMMENDATION 3

Encourage professional associations that interface with seniors to establish fall prevention education and intervention programs for their members. Identify champions

Action Steps

1. Develop an inventory of relevant professional associations and their current activities in fall prevention and education; identify champion (CMA, Board of Registered Nurses (BRN), California Association of Nurses (CAN), California Pharmacy Association (CPA), CPTA, California Chapter of AGS).

2. Identify a list of needed fall prevention education programs (AGS, CMA).

3. Assist organizations to disseminate education materials, such as professional and consumer materials (AARP, CMA, BRN, CAN).

4. Mobilize professional organizations, such as California Chapter of AGS, California Pharmacy Associations, California Nurses Association and California Physical Therapy to infuse fall prevention education among members through continuing education and/or exportable education material.

_Timeframe for completion: 2 years_
Healthy Lifestyles & Recreation

Media and health professionals have always recommended regular exercise for young and middle-aged people, but a growing body of evidence now indicates that physical activity programs can prevent loss of independence, reduce disability and improve overall quality of life for older persons. This understanding informed the efforts of the Healthy Lifestyles & Recreation work group. Participants suggested that we have not reached the objective (i.e., community programs that encourage older adults to lead physically active lifestyles that prevent or minimize the impact of acute and chronic disease on function).

Work group participants discussed interventions as simple as identifying walking trails in the community and as comprehensive as multifactorial fall prevention programs implemented throughout California. They realized that it may take significant culture shifts or more widespread redesign of our communities to help older adults improve their health and quality of life by emphasizing the benefits of an active lifestyle.

To this end, participants identified possible partnerships and advocacy to promote fall prevention in industry, organizations and disciplines. Possible collaborating agencies included commercial fitness companies incorporating physical activity programs for older adults; special advocacy groups emphasizing diet and physical activity; parks and recreation departments, and senior centers throughout California sponsoring fall prevention programs.

Participants emphasize that one size does not fit all in fall prevention programming, meaning that not all older adults have the same level of fall risk. As such, programs need to be developed that address the continuum of fall risk (e.g., low, moderate, and high). Additionally, more cooperation is needed between health care and other service providers to effectively promote preventive and post-fall measures including dietary and medication recommendations.

Community-based programs incorporating exercises to improve muscle strength and endurance, balance, mobility, and flexibility were identified as the most critical agents towards achieving healthier lifestyles and recreation. Maintaining current and accurate information about such programs and the need to create awareness of impact of existing and new physical activity programs were named key barriers.
STATEWIDE STRATEGY FOR ACTION

RECOMMENDATION 1

Develop and publicize a list/directory of well-rounded local community-based exercise programs and classes for older adults (from healthy to frail) that incorporate exercises to improve muscle strength and endurance, balance, mobility, and flexibility for fall prevention.

Action Steps

1. Develop updated web-based database (CDPH - co-lead agency, CDA – co-lead agency, California Parks and Recreation Society (CPRS), AAAs, California Caregiver Coalition, International Council on Active Aging (ICAA), Independent Living Centers, ASC, hospitals and medical services providers, faith-based organizations).

2. Set guidelines for what should be incorporated (CDPH – co-lead agency, CDA – co-lead agency, CPRS, AAAs, California Caregiver Coalition, ICAA, Independent Living Centers, ASC, hospitals and medical services providers, faith-based organizations).

RECOMMENDATION 2

Expand the number of Active Living By Design™ community partnerships in California that promote healthy lifestyles of older adults by addressing community issues (e.g., trails, parks) to increase physical activity levels.

Action Steps

1. Motivate Active Living By Design™ cities to target older adults (city planning departments, local chambers of commerce, California Parks and Recreation Society, faith-based organizations, social interest groups (see San Diego model, League of Cities and Counties, cities currently implementing the Active Living By Design™).

2. Encourage other cities to adopt Active Living by Design™ (City Planning departments, local chambers of commerce, California Parks and Recreation Society, faith-based organizations, social “interest” groups (see San Diego model, League of Cities and Counties, cities currently implementing the Active Living By Design™).

3. Expand the Active Living Everyday (Robert Wood Johnson Foundation) initiative.

4. State should encourage the inclusion of “housing” elements in city/county general plans that define the cities’ policies, programs, and priorities related to housing (city planning departments).
STATEWIDE STRATEGY FOR ACTION

RECOMMENDATION 3

Develop media outreach campaign (e.g., radio, television, internet, public service announcements, and other programming) on balance and mobility fitness promoting healthy lifestyle issues (e.g., physical activity, nutrition, and vision) particularly related to fall prevention for ethnically, educationally, and geographically diverse older adults.

Action Steps

1. Develop speakers bureau targeting service/social clubs and chambers of commerce (DPH, CDA, FPCE, CDC, university communications, AARP).

2. “De-stigmatize” fall prevention; emphasize positive messages (media, speakers bureau, FPCE, pro bono public relations group, state chapter of New America Media, AARP).

3. Create connections with professionals conducting wellness programs (FPCE, hospitals, managed care organizations, CDC).

4. Engage PBS or sponsors (e.g., philanthropic organizations that fund programs) to support fall prevention efforts in the community.
Safe Housing & Communities

The Safe Housing and Communities work group addressed physical design and policy issues related to the built environment and falls. In order to improve the design and maintenance of housing and neighborhoods, the group identified changes needed in local, state, and federal policies, plans, and funding to reduce hazards and add supportive elements to the environment.

Participants in the Safe Housing and Communities group included professionals working in housing, rehabilitation, state government, philanthropy, the media, and local programming. The work group originally developed six recommendations and of those selected the top three priority recommendations. Work group participants identified transportation, lack of public awareness regarding Mixed Use District (MUD), affordable housing, and costs to consumer as the key barriers to implementing action steps.

Action Steps

1. Create an inventory of jurisdictions that have fall prevention-related policies in their current plans. Use best practices examples. (FPCE, CDPH, SLIC).
   
   Timeframe for completion: 12 months

2. Encourage AAAs to participate in planning fall prevention with other local agencies. (CDA, CCoA).

3. Develop planning recommendation language that cities and counties can incorporate into their general plans, housing elements, and other planning documents. Create a guidebook with suggested language that jurisdictions and other stakeholders can use to incorporate fall prevention policies into their specific and general plans. (FPCE, OPR).
   
   Timeframe for completion: 12 – 18 months

4. Develop public understanding and media campaigns to raise awareness of issues and advocate for change with public and policymakers. (ASC).
   
   Timeframe for completion: 12 months and ongoing

5. Advocate for C4A and N4A to place fall prevention on the agenda of annual meetings and develop online training sessions for C4A planners. (C4A, N4A, ASC, AARP Livable Communities Initiative).
   
   Timeframe for completion: 12 months
RECOMMENDATION 2

Provide incentives for local communities and developers to adopt California’s voluntary Model Universal Design Ordinance that includes fall prevention features, such as a “zero step” entrance and an accessible bathroom on the first floor in new and remodeled single family housing.

Action Steps

1. Create fact sheets for professionals and consumers that include Universal Design (UD) minimum standards, listing of possible incentives, best practices, and links to resources for advocating for UD. (FPCE, AIA, APA, California Foundation for Independent Living Centers (CFILC), DOR, Habitat for Humanity, Rebuilding Together, C4A, HCD).
   Timeframe for completion: 12 months

2. Advocate for housing developers and local planning departments to include UD in building affordable and senior housing. (CCAPA, HUD, CRA, city planners and managers, city council, Community Development Block Grant Programs (CDBGs).
   Timeframe for completion: 36 months

3. Create recognition system such as awards for those localities that are providing UD incentives in housing rehabilitation and development. (50+ Housing Council, CDPR, Community Redevelopment Agency (CRA), city planners and managers, CDBGs, redevelopment agencies).
   Timeframe for completion: ongoing and annually
RECOMMENDATION 3

Develop new and more reliable sources of funding for home assessments by professionals (e.g., occupational and physical therapists) and for home modifications.

Action Steps

1. Analyze costs of fall injuries at county levels. (EPICenter).

2. Advocate for expansion of existing resources from such sources as the Department of Rehabilitation (DOR), MSSP, OAA programs, Linkages, CDBG-funded housing rehabilitation programs, and other public/private resources. (California Senior Legislature (CSL), CCoA, DOR, MSSP).

3. Encourage Rebuilding Together and Habitat for Humanity to expand efforts in home modifications, universal design and fall prevention. (CSL, the FPCE’s StopFalls Network, Rebuilding Together, Habitat for Humanity).

4. Develop and/or publicize resource databases for home modification agencies, providers, programs, and consumers (Rebuilding Together, FPCE).

5. Raise awareness about features in homes that can help people age in place. (CSL, AARP, PACE, AOTA, APTA, OTAC, CPTA).

*Timeframe for completion of recommendation 3: ongoing*
Cross-Cutting Recommendations

Some issues relating to fall prevention cut across multiple subject areas and/or all work groups. Summit participants addressed such issues explicitly and generated several separate cross-cutting recommendations rather than assigning them to any individual work group topic.

The cross-cutting recommendations listed here demonstrate the complexity of fall prevention as a joint and coordinated effort by a multitude of organizations, agencies, fields, and disciplines. These recommendations underscore that a commitment to long-term planning, sharing of resources, and dissemination of information on fall prevention is necessary to avoid duplication of efforts, overlap in programs, and a confounded stream of information about fall prevention. Enhancing cooperation and coordination will help providers respond to the needs of older adults at risk of falling, thus making fall prevention a key public health priority.

Action Steps

1. Develop fall-prevention media outreach campaign (e.g., radio, television, internet, Public Service Announcements, and other programming) promoting healthy lifestyle issues (e.g., physical activity, nutrition, and vision issues) appropriate for ethnically, educationally, and geographically diverse older adults.

2. Educate older consumers and their family caregivers about their crucial role in fall prevention and management through the statewide network of Caregiver Resource Centers and Public Authorities.

3. Encourage professional associations that interface with seniors to establish fall prevention education and intervention programs for their members.

Action Steps

1. Encourage the Departments on Aging and Public Health to raise fall prevention to a level of priority for the state and to work collaboratively in achieving a reduction in falls and fall related injuries.
2. Empower state-level advocacy and professional organizations (e.g., AARP, Older Women’s League, State Independent Living Council, Aging Services of California) to educate their members about their stake in fall risk, prevention, and management.

**RECOMMENDATION 3**

**Convene a statewide fall prevention Summit every 3 years**

**Action Steps**

1. Encourage members of professional associations that interface with seniors to establish fall prevention education and intervention programs for their members.
2. In advance, assess progress since the prior Summit.
3. Secure funds from foundations, government and other sources for Summit-related activities.

**RECOMMENDATION 4**

**Develop and widely disseminate culturally appropriate fall prevention information to all community organizations serving older adults (e.g., hospitals, senior and community centers, libraries, recreation and parks, bookstores, religious entities)**

**Action Steps**

1. Encourage local public health and aging agencies in partnership with other community organizations to develop an inventory of local fall prevention programs and resources as a foundation for information and referral networks.
2. Identify and disseminate best practice interventions linking health care and aging organizations.
3. Encourage educational institutions such as community college districts and professional and paraprofessional caregiver training programs to incorporate into their curriculum evidence-based fall prevention programs for older adults.
4. Work with ethnic and cultural groups to develop materials appropriate to a diverse aging population and their caregivers.