

Meeting Notes (draft 4/25/07)

Falls Prevention Task Force Meeting

Wednesday, April 25, 2007 7:30 – 9:00 AM

McConnell Hall, Classroom 9

Thanks to Mary Zimmerman and Meriter Hospital for hosting

Attending: Andy Kosseff, Cheryl Wittke, Kathy Andrusz, Pam Bracey, Cal Bruce, Linda Bruck, Mary Jean Eisenga, Amy Elske, Myra Enloe, Kendra Jacobsen, Dottie Krull, Colleen Howes, Marilynn Lawler, Carrie Meier, Linda Mahlberg, Burlie Williams (for Kathy Martinson), Sandy Miskelly, Jean O'Leary, Joyce Pohl, Janie Riebe, Virginia Robbeloth, Frank Salvi, Amy Vieth, Amy Schumacher, Mary Stamstad, Mary Zimmerman, Daryl Sherman (Madison Senior Center and Dudgeon Monroe Neighborhood Association), Carmel Tesmer (St. Mary's OT), Marilyn Howe (RSVP).

Welcome, new member introductions - Andy

Brief updates

- Application submitted to CDC to fund public education campaign development – grant awards to be announced and funds to be released in June (proposal was distributed) - Cheryl.
- Re: MD Visit workgroup: Andy will speak to MPSC seeking full participation of local health care organizations; he is also inviting MPSC to co-host Falls Prevention Symposium this summer (training for clinicians and PTs; CME credits to be provided). We are still seeking participation from UWMF and Group Health Cooperative. Task Force members provided contacts to pursue: Carl Ghetto and medical director of CME at UWMF; Mark Dalebroux, Physician Relations Director at GHC. Andy will contact these folks.
- Evaluation plan – Evaluation consultants will provide draft plan by April 30 which we'll circulate to all workgroups for discussion. Evaluation will measure achievement of "year 1 deliverables" and will include a pre-measure of awareness for public education campaign. No one in the room fainted at the prospect of workgroups being charged with some data collection.

Workgroup updates (minutes were distributed via e-mail prior to meeting)

Home Safety Assessment – Sandy Miskelly, Carrie Meier and friends: Workgroup determined that all assessment tools in use are fine – the question is: how will referrals for home safety assessments funnel to and from 211. Aging network/case managers are the folks best equipped to make referrals for home safety assessments and to ensure that follow-through on recommendations occurs. So, next step is to contact aging network focal points to bring them up to speed on Task Force efforts. Our plan is to set up a meeting with first with focal point directors (Cheryl will do so) and then with case managers at their monthly meeting (down the road). *On topic of flyer and map of focal points to be distributed to EMS districts:* Case managers reviewed flyer developed by Carrie Meier that provides instructions to EMS staff on referring falls risk patients to case management services – revised flyer was distributed at the meeting. Also, Carrie noted that Dr. Steegler, Dane County Emergency Management Medical director, is meeting with medical directors from around the county to solicit feedback and ensure others don't have HIPPA concerns. Case managers in attendance (Amy S. and Amy E.) didn't think the

aging network would be overtaxed accommodating additional contacts that might be generated via EMS.

Exercise Balance Workgroup – Joyce Pohl, Jean O’Leary: Workgroup asked for and received commitment from Task Force for \$100 to fund coordination of training and CME credits for Otaga Method instruction for PTs via Wisconsin Physical Therapy Association. Terry Shea is still pursuing master training classes for Stepping On – this requires clearance from research project that developed the program. Our goal is to train a cadre of “master trainers” in Year 1 who can then train others in Dane County to deliver Stepping On at a variety of venues (churches, senior centers, congregate housing, via wellness programs at hospitals) in Year 2. See Exercise/Balance Workplan for overview of “tiers” (more intensive outpatient clinical intervention is Otaga, next step is Stepping On in community settings, next step is community exercise programs). In terms of training fitness instructors on falls prevention exercises to incorporate into community exercise programs, Jean O’Leary noted that training should include guidance for referring folks to other programs if theirs isn’t appropriate.

Overview of and Feedback on Year 1 Deliverables

After an overview and discussion, there was general group agreement on following:

Medical Side of the House:

- All medical groups (or one or more pilot) have systems in place to accept and effectively manage referrals from Falls Helpline
- Organize, promote and conduct one Otaga Method training for area PTs. All medical groups (or one or more pilot) have PT staff trained in Otaga method (CME credit provided).
- Organize, promote and conduct one Falls Prevention Expert Clinician Training (Bob Przybelski and team). All medical groups have a 2 – 3 clinician trained (CME credit provided). **CLARIFICATION:** hope is that we would have clinicians trained at each site (eg. Associated Physicians, Wildwood, etc.) vs. just a few within each system (eg. Dean Clinics as a whole).

Community Side of the House:

Falls Helpline operational. 211 staff trained, database in place; field test conducted. Included in the Falls Helpline database is up-to-date information about falls prevention services in the community (eg. home safety assessments available through RSVP, Madison Fire Department; contacts at each medical facility)

Falls prevention public education campaign developed and proposals to fund it in circulation. Prior to year end, generate proposals from cause-related marketing staff at media outlets (Morgan Murphy Media; Entrecom) to recruit airtime sponsors.

Disseminate map of aging network with contact information to EMS district staff, along with flyer developed by Dane County Emergency Management that describes procedure for making referrals in the age of HIPPA (see attachment).

Second Community Falls Prevention Summit conducted with following elements - we decided to hold a summit in Year 2. One rationale for delay is to wait until we’re ready to launch community-wide Stepping On training.

- Fitness instructor training: Provide training on how to incorporate effective falls prevention activities into exercise programs for older adults (continuing education credits provided). Open to all certified fitness instructors working in Dane County fitness centers and community programs (charge registration fee to offset costs).
- Senior Center Staff Training: Provide training on how to incorporate falls prevention activities (eg. social dancing opportunities) into senior center activity plans. Share resources available for senior center staff to access.
- Community-by-Community Networking to Prevent Falls: After a briefing from Carrie Meier and Dane County EMS Medical Director on what's acceptable under HIPPA, divide into EMS district, swap cards and make plans to communicate about referring older adults who have fallen to appropriate services.
- Briefing on Falls Prevention Services available: 211 Falls Helpline, Home Safety Assessment services, case management, lead falls prevention staff and contact information within each medical system

Workgroups are asked to consider what other goals could be accomplished at a second summit and to bring ideas to an upcoming task force meeting.

Falls Helpline Report and Discussion on Flow Chart

Cal provided a report and task force members reviewed flow chart that Kendra developed based upon caller scenarios developed by workgroup. Comments and questions from Task Force members:

Question: initially the plan was for the first 211 referral to be to the health care provider. This plan assumes that first referral is to case management. Seemed to be general agreement that case manager is the right place to start given their knowledge of community resources. This assumes that an immediate response isn't required: case managers typically conduct home visits 1 – 2 weeks after receiving a request, which folks thought was entirely reasonable for given that we're talking about people living in a community setting.

Many thought the most important service 211 can provide is to directly connect an older adult caller to case managers (rather than providing phone numbers). Burley thought this is very doable – 211 is willing to do this.

Some expressed concern about the number of decisions 211 staff would need to make – 211 is a referral service, not a case management service. 211 would be the repository of all information about community falls prevention services so that in the event someone has a specific question (eg. I'd like to set up a home safety assessment) they can answer it. But, flow chart should be simplified so 211 only has a few options to act upon:

- 1) I've fallen and am injured = live transfer to 911
- 2) I've fallen before and need some help (or my mother has fallen ...) = live transfer to case manager (needs to be a mechanism to determine outcomes)

- 3) I've never fallen but am interested in avoiding a fall = give person phone number for case management and other community programs listed in database

If case managers are the main referral source to be utilized by 211 staff, does it make sense for them to call 211 (scenario 2)?

What about other concerned community members (meals on wheels, meter checkers, DME staff, postal carriers)? What would their link be to 211, and are there any privacy issues? Amy E. noted that it's not uncommon for these folks to call the Senior Coalitions about a person of concern, and since the same process would be in place for EMS staff she didn't see a problem responding to calls from this group.

Question about function of acute care staff (hospital therapists and discharge planning) – what is their role? Yet to be determined, but hope is to involve them in training and to provide information about referrals if they don't have it already.

Question about capacity of case managers/aging network – given current staffing levels can staff manage additional clients that could result from 211 going on line? To be determined – necessary discussion to have with leaders of focal points.

Question about referrals for people not served by aging network (people under 60 years of age) – hope is that they will also benefit from additional clinician training on preventing falls. We invited Coalition of the Blind to join the Task Force.

NEXT MEETING DATE

Wednesday, May 16, UW Home Health, 2030 Pinehurst Dr. , Middleton.

Proposed agenda items: Draft evaluation plan, plans for mid-year reports to funders, review second draft of Falls Helpline flowchart, other?

Directions to UW Health Home Care Services for our May meeting:

Address: 2030 Pinehurst Dr Middleton

From University Ave in Madison:

Travel west on University Ave through Middleton. Go under the beltline. Pass through several lights after the beltline, with the final light being Pleasant View. The next right (no light) is Pinehurst. Our building is the second building on your left. Park in lot or on the street.

From Beltline West, take Hwy 14 exit toward Lacrosse and Spring Green, and turn right at bottom of exit ramp. Pass through several lights after the beltline, with the final light being Pleasant View. The next right (no light) is Pinehurst. Our building is the second building on your left. Park in lot or on the street