M-DASH South Portland -- Falls Intervention Work Group
January 26, 2021
By Zoom

Attending: Josh Reny, Jess Maurer, Gabe Martinez, Anne Schroth, Sue Henderson, Ann Tucker, Effie Rorke

Meeting Notes

I. The Question

a. What do we do when someone falls in South Portland so that we are intervening in some way to address the cause of the fall?
    i. Understand why and how often people fall
    ii. Create referral systems to reduce falls

II. Falls Data

a. See New Falls dashboard (distributed with these notes).
b. 56% of all falls are in 70-89 range. Helps to think about targeting
c. Causes of the falls in EMS data suggest opportunities for in-home assessments, home modifications, and in-home falls reduction measures (e.g. throw rugs, etc.). Data suggests there is real ground to make up to reduce additional falls.

III. Discussion

a. EMS Calls
    i. How to think about intervention in 2 EMS scenarios:
        1. No transport and healthcare not involved
        2. Transport and healthcare involved
        3. Every fall should get a referral – not just those that do or don't get transported.

    ii. EMS are responders in the field who are the most informed about situations where there could be more help.
        1. They currently do what they should within their scope of work but there isn't connection to community-based organizations to prevent another fall.
        2. Can we develop a referral mechanism?

    iii. How do we get uniformity in classifying every fall so we get better data as we move forward?
        1. We don't know if any of those data are for the same person. If EMS could check on that internally, would indicate need for intervention.
        2. Is there a way to make "cause" more uniform? If we understood better, e.g., what "slip, trip, stumble" means? That could go a long way to intervention side.

    iv. Question for EMS: What is the maximum inconvenience/additional job duties that would be reasonable to ask?

1. Could be as simple as a HIPAA compliant card to consent to share info with others (with some talking points to address reluctance piece)
2. Seems like a little bit of training and a little bit of procedure
    a. For each shift there is a shift commander; EMS coordinator on top.
    b. Could we go up the chain to shift commander or straight to EMS coordinator that "this happened and likely requires some follow up and the EMS coordinator would follow up?
    c. If we can do something to impact the number of calls for falls, it would free up resources to use in different ways.
    d. Need to bring the Fire Chief in – he has a very good knowledge up and down the chain. Would know about their capacity.

b. <u>Home Repair</u>
    i. How to engage Housing Authority and Habitat?
        1. We don't want EMS to have to figure out who is the right person to call.
        2. Maybe we need to formalize these relationships and workflow in some way:
            a. E.g., Housing Authority, could be the primary contact to do a home assessment and perhaps do the work
            b. If they don't have the capacity, they refer to Habitat or OA to get next level of support in.
    ii. We need a huddle with SPHA, Age-Friendly SP, Josh and MCOA to talk through this.

c. <u>Healthcare Role</u>
    i. Is there a way for provider to assess whether a fall risk and then provider (or Community Health Worker) could put referral in the system so their home could be assessed?
    ii. Greater Portland Health has Sunshine Fund to support uninsured.
        1. Remember Concord VNA model: uses Medicare for something like 90% of cases.
    iii. Maybe we could create a pilot: FQHC generates the medical order to allow for CHW to go in and do assessment and take navigation from there.
        1. FQHC just added CHW in SP; a pilot might be useful to help CHW learn what options are and do the paperwork…so if someone has SP patient, how they could refer them back in to get help from system
    iv. We need to develop a flow process: focus on intervention and then layer in prevention for people who have not fallen but are at risk.
    v. Want to solve this problem for all people so that we don't have to ask who is your insurance provider. How do we work that out?
    vi. From intervention standpoint, if we map process of resources available to those over 60 and here's how it works if you have a fall. And here's all the paperwork.
        1. What we do know is that there needs to be a warm handoff. That's why Concord model is so good.

d. <u>Available resources</u>
    i. If someone needs modifications, repairs or durable medical goods, is there a funding mechanism for that?
    ii. There are some sources for home modifications (Opportunity Alliance, South Portland Housing Authority, Community Development Block Grants, Habitat, etc.)

iii. Question is how to link people to apply for the programs.
iv. A lot of health insurance coverage will cover for durable medical equipment but a lot of people don't want to admit that they need help like walkers, wheelchairs, etc.
v. How do we motivate people to take advantage of what is available?
    1. As soon as someone falls, they start limiting activities…esp. if injuries.
    2. How do we get people out of fear and denial to get the help they are eligible for?
        a. Messaging campaign could happen in the simplest way… e.g. on the card they sign for referral, could say something empowering.

IV. Next Steps

a. Interviews with healthcare providers
    i. Interview with Ann Tucker at FQHC, with Kat/Anna at SMAAA, Mike Hulsey, MaineHealth; Martin's Point, Northern Light, Gabe to understand the universe of things available.
        1. Maybe a targeted survey to all provider types that serve SP to answer the same questions to understand what is current flow, what resources they have, etc. so we understand how systems are supposed to work re: falls or falls risk?

b. Conversations re: work flow ideas
    i. With fire, EMS coordinator, health officer to look at what a pilot would look like.
    ii. Housing Authority to discuss formalizing referral flow, then including Habitat and Opportunity Alliance.
    iii. SMAAA re: what they can do in the process. They would be a perfect resource as point navigator if we could figure out how to pay for it.