

Quick Shot Presentation

# Fall Prevention in the Aging Adult Population

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Tulsa, OK

ACS Level II



# Identifying Need

- ▶ # 1 MOI for St. John Trauma. 35% are readmitted
- ▶ Trauma Registry
- ▶ Number of people >60 years

Falls are and continue to be the leading cause of morbidity and mortality within our region. A third of people over 65 and half of people over 80, fall at least once per year. At an individual level, falls are the number one precipitating factor for a person losing independence and going into long term care.

# Intervention Design

- ▶ New/Integrated program → based on the Colorado Springs Fire Department CARES program integrating EMS into the broader healthcare system by developing a collaborative care model.
- ▶ Target population → patients that are increased fall risk with an appropriate discharge process with possible follow-up and home inspection. Greater Tulsa area
- ▶ Type of intervention → education, early detection, safety measures, assessment (construction/remodel)
- ▶ Program objectives → : Identify community residents with unmet service needs. Assist frequent utilizers of emergency services with navigation into appropriate, community care. Seek community healthcare partnerships in order to form a collaborative network

# Program Implementation

- ▶ Summary of program → In 2014, Tulsa Fire evaluated the role of the department in response to the changing healthcare needs of the community. In response, the Community, Referral & Education Services program was researched and developed.
  - ▶ Collaborative efforts between St. John and Tulsa Fire with its proposed role as the "bridge organization" to assist persons with resource utilization, improving social determinants of health and decreasing the readmissions with the MOI of falls.
- ▶ Staffing → Tulsa Fire, master of social work students, Injury Prevention RN
- ▶ Budget and funding sources → operating without dedicated funding and with short term grants
- ▶ Implementation timeline → 2 years
- ▶ Community stakeholders → Tulsa Fire, master of social work students, Injury Prevention RN, Mental Health Association, Family & Children's services, local hospitals

# Program Evaluation

- ▶ Types of evaluation →
  - ▶ hospital side: identified patients with identified interventions with decreased readmissions, follow-up with patients where intervention was completed and overall satisfaction when family was involved. (Cannot evaluate if prevention was key and no detrimental outcome occurred);
  - ▶ fire side: decrease in the number of 911 calls, follow-up with patients in his/her home
- ▶ Data collected → high utilizer patients r/t falls, patients visited readmit rate
- ▶ Other measures of program success → decreased the high utilizer list by 3%. Focused on fall risk and readmission r/t falls.

# Program Outcomes

- ▶ Impact→ increased safety awareness, bridging healthcare gap in geriatrics
- ▶ Outcome→ lower readmission rate, decrease fall risk potential
- ▶ Dissemination of findings→ quarterly pre hospital meetings
- ▶ Successes and/or barriers→ shortcomings: a physical file created on each person, became to big and therefore computer database was created.
- ▶ How other programs can adapt→ Develop a closer relationship with local health and social care partners. Communicate clearly with partners outlining the benefits that would realistically suit your community. This may include a shared risk profile and opportunities presented by focused referral pathways and delivering joint improvements in premises where the most vulnerable are at risk and in need of prevention activity.
  - ▶ IVP would identify the needs based upon the MOI in his/her hospital and in turn identify the patients based upon those specific targets. A consent would need to be formulated hospital specific and the patient and/or family would sign if they are willing or needing services. IVP could adopt fall discharge education or tai chi classes for in-patient fall risk patients, or home safety visits if time allows.
  - ▶ IVP would identify local team entities to carry on the follow-up should the patient need it, or services outside the scope of what the IVP is working toward.
  - ▶ At any time, the patient can render "inactive" once the need is addressed and/or met and no follow up would be needed.



**Consent to Provide Personal and Protected Health Information (PHI) to the Community Response Team (CRT) and/or Community Assistance, Referral and Education Services (CARES) Programs**

**(Bolded information below must be completed.)**

I understand that numerous public safety organizations, health care providers and social services entities are members of and participate in the CRT and/or CARES programs as a means to provide services and support to low income in-need citizens within the greater Tulsa metropolitan area.

As I wish to participate in the CRT and/or CARES programs, I hereby authorize the CRT and/or CARES programs to obtain, share and exchange my personal information (name, address, date of birth, social security number, telephone number, e-mail address,) as listed below, among its members and participants so that they may verify my eligibility for assistance and contact me regarding the available services and support that I may need. Additional information regarding the CRT and/or CARES programs and participating/affiliated members may be obtained by calling 918-596-9405 or by email at [ftdcares@cityoftulsa.org](mailto:ftdcares@cityoftulsa.org).

**Participant's/Patient's Full Legal Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Home Telephone:** \_\_\_\_\_ **Cellular Telephone:** \_\_\_\_\_

Optional:<sup>1</sup>

As part of the CRT and/or CARES program services and support may relate to medical treatment, I further authorize \_\_\_\_\_ (entity) as a participant of the CRT and/or CARES programs to receive on my behalf, as my personal representative, my medical information and records, often referred to as "protected health information" or (PHI), and to release and share my medical information among its participants and affiliated health care providers as necessary to provide or facilitate health care to be provided to me as part of or through the CRT and/or CARES programs. Receipt and/or release of my PHI may be in written, verbal, facsimile or electronic mail form.

I hereby authorize \_\_\_\_\_

and any other health care provider who has provided services to me to release the following information to my personal representative as identified above.

<sup>1</sup> The following language regarding the release of PHI is consistent with the Oklahoma State Department of Health, Community and Family Health Services/ Administration Form OCH 206, entitled "Oklahoma Standard Authorization to Use or Share Protected Health Information (PHI)," (August 2014).

Psychotherapy Notes (if checking this box, no other boxes may be checked)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ (if separate pages are used)

Entire Medical Record

Billing Information for \_\_\_\_\_

Mental Health Records

Substance Abuse Records

Medical information compiled between \_\_\_\_\_ and \_\_\_\_\_

Other: \_\_\_\_\_

The above information may be disclosed in support of my participation in the CRT and/or CARES programs and for the following purpose(s) only:

Insurance  Continued Treatment  Legal  At my or my representative's request

Other: \_\_\_\_\_

I understand that by voluntarily signing this authorization:

I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.

- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Legal Representative's Authority

\_\_\_\_\_  
Expiration date (if longer than one year from date of signature or no event is indicated.)