APPENDIX F

ACTION PLAN

LOGO

{Date}

{Salutation}{Participant First Name} {Participant Last Name}
{Address}
{City}, {State} {Zip code}

Dear {Salutation}{Participant Last Name},

We would like to thank you for your participation so far in the Independent Living and Mobility Program (ILAMP), an important national Program among older Americans. As you know, ILAMP is being sponsored by the U.S. Department of Health and Human Services and the goal of the program is to learn more about ways to keep people healthy and living independently.

Enclosed you will find your personalized "Action Plan." This Action Plan was developed after careful review of the information provided in your In-Person Assessment. Its purpose is to help you maintain your independence and safety in your home. The Physician you identified as being the person primarily involved in your care will also receive a copy of this Action Plan. We encourage you to contact your Physician and set up an appointment to review the findings of this Action Plan. We will contact you in about two weeks to review your Action Plan and to answer any questions that you may have.

In addition, we are pleased to provide you with a Health Promotion and Fall Prevention Tool Kit. Using the information provided in this Tool Kit will help keep you in shape and maintain your body strength and balance. The kit contains the following helpful items:

- Health and Home Safety Information Handout. This handout includes tips for maintaining safe health habits and increasing home safety and falls awareness.

- Wipe-off medication management planner. The wipe-off medication management planner is designed to help you keep track of your medications. It has 14 spaces to record the name of the medication, dosage, how to take your medication as well as the shape and color of the medication.

- National Institute on Aging exercise video and guide. A state-of-the-art exercise video sponsored by the National Institute on Aging that includes 42 minutes of stretching, balance and strength-building exercises and also comes with an 80-page exercise guide. Of course, one of the best and easiest exercises is walking, and we recommend at least 20 minutes of walking every day. However, if you prefer to exercise to this tape, following this video will help keep you in shape and maintain your body strength and balance.

- Exercise Progress Chart. A booklet of weekly schedules for you to track the progress of your exercise routine. Please keep track of your daily exercise in this exercise progress chart.

- Falls Journal. The falls journal is designed to capture detailed information about any falls you may have over the Program period. If you experience a fall during the Program period, please document the details of the fall in this journal.

- Pedometer. A pedometer is an instrument that records the distance a person walks on foot by responding to the body motion at each step and is worn on the waist. The pedometer will allow you to count how many steps you take in a day. The goal is to increase the number of steps you take.

After our initial phone call in a couple of weeks, we will then be calling you every three months to check on how you are doing. During these calls we will be asking you about your exercise routine and if you have experienced a fall of any kind. You should use the items provided in this Toolkit for tracking your exercise progress and any falls that might occur and reference them during our phone calls. Again, we would like to thank you for your participation in ILAMP. If you have any questions, please do not hesitate to call at 800-525-7279 Ext. XXX.

Sincerely,

ACTION PLAN FOR INDEPENDENT LIVING AND MOBILITY (ILAMP) PROGRAM

Participant Name: **Date of Birth:**

Recently, as part of your participation in the Independent Living and Mobility Program (ILAMP), you had a Telephone Interview and an In-Person Interview. A Clinician reviewed the information from these interviews, ~~,~~and the following Action Plan was prepared for you. In general, we are very pleased with the results. Here are some areas you should focus on to ~~was developed to address the~~help further decrease your chance of a fall ~~specific issues identified~~. We suggest that you contact your Physician to talk about this Action Plan.

ACTION PLAN -- Areas to focus on:

Note: Each participant's customized ILAMP Action Plan will display only the patient-specific identified areas of concern. For illustrative purposes, all options are shown here.

☐ You told us that you do not have a primary care physician. If you need help in locating a Doctor, please contact your health insurance plan for assistance.

☐ An exercise program is strongly suggested to help you gain strength and reduce your risk of falling. Please consult with your Doctor to determine the best program for you.

☐ You told us that you have fallen in the past 6 months ~~Tell your Doctor about any falls~~ (including slips, trips, etc.). Please be sure your Doctor knows about this and any ~~or~~ injuries that happened because of your fall.

☐ Tell your Doctor about any forgetfulness or memory concerns.

☐ You are taking one or more medications that increase your risk of falling. Please take all of your medications to your Doctor's office, and ask your Doctor review them with you.

☐ Discuss with your Doctor the following new medical conditions that you told us about during the interview:

☐ During your interview, you told us that you have been experiencing feelings of {SADNESS} {ANXIETY}. Please discuss your concerns with your Doctor, trusted family member, friend, or clergy person.

☐ During your interview, your blood pressure was checked. Your blood pressure readings show changes from when you are lying down to standing up. This could increase your risk of falling. Please consult with your Doctor about this.

☐ During your interview, you told us that you {have not had your vision checked in the last five years}{have difficulty seeing in certain situations}. Please consult with your Doctor or an ophthalmologist about having an eye examination.

Please see the next page.

ACTION PLAN FOR FALL PREVENTION PROGRAM (continued)

Participant Name: **Date of Birth:**

ACTION PLAN -- Areas to focus on:

☐ Your {LOWER BODY STRENGTH} {BALANCE} {WALKING (gait)} {FEAR OF FALLING} was tested during your interview, and the results show that you have an increased risk of falling. A Physical Therapy evaluation is recommended. Please talk to your Doctor about this.

☐ Your interview showed that ~~P~~Yyou might benefit from the purchase or rental of some equipment to make your home environment ~~more safe~~safer. Please talk with your doctor about an Occupational Therapy evaluation, to look at your home environment and make specific recommendations for improved safety. ~~–~~**All equipment needs to be professionally installed. DO NOT ATTEMPT this yourself.**

Equipment that may be covered by Medicare:

☐ Straight Cane
☐ Multi-pronged Cane
☐ Hospital Bed
☐ Walker
☐ Wheelchair
☐ Commode
☐ Other:

Equipment typically paid for out-of-pocket: ~~**(see below for specific recommendations)**~~

☐ Electric Scooter
☐ Electric Recliner
☐ Stair Lift
☐ Medical Alert System
☐ Tub rail (tub)~~Hospital Bed~~
☐ Bath/shower Stool ~~Tub rail (tub)~~
☐ Shower bench with back ~~Bath/shower Stool~~
☐ Hand Held Shower~~Shower bench with back~~
☐ Raised Toilet Seat
☐ Toilet Safety Frame
☐ Other:

☐ You might benefit from hiring a caregiver (home health aide/personal care attendant) to help you with personal care such as bathing, dressing and other daily living tasks.

Recommended Service	Recommended Frequency	Recommended Duration
☐ Home Health Aide/Personal Care Attendant	___hrs/day ___d/wk	
☐ Other_____		

☐ You might find it helpful to hire one or more services to assist you with cleaning, laundry, meal preparation, transportation and other services not related to personal care.

~~*See below for specific recommendations.*~~

Recommended Service	Recommended Frequency	Recommended Duration
☐ Homemaker/Companion	____hrs/day ____d/wk	
☐ Meals on Wheels/Nutritional Services	____meals/wk	
☐ Transportation		
☐ Alzheimer's Association "Safe Return" program		
☐ Other_____		
☐ Other_____		