FALLS FREE WISCONSIN

wiha
Wisconsin Institute
for Healthy Aging

LOCALIZING EFFORTS TO ADDRESS FALLS (LEAF)

2025-2026 GRANT REPORT

Falls Free® Wisconsin

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BACKGROUND

Since 2021, the Wisconsin Institute for Healthy Aging (WIHA) has served as the convener of the Falls Free Wisconsin Coalition, a statewide collaborative dedicated to helping older adults prevent falls and age with strength, confidence, and independence. In 2022, WIHA received a federal earmark to advance the Falls Free Wisconsin initiative and expand access to resources across the state.

With support from this funding, WIHA, in partnership with the Falls Free Wisconsin Coalition, developed **FallsFreeWI.org**, a centralized online resource that connects older adults, caregivers, and professionals, with falls prevention information, programs, data, and tools.

Recognizing that meaningful change happens at the local level, WIHA launched the first **Localizing Efforts to Address Falls (LEAF)** grant program in 2023. Through this initiative, 10 organizations received a total of $70,000 (up to $10,000 per grantee) to strengthen sustainable falls prevention efforts in their communities. Projects focused on expanding access to evidence-based falls prevention programs, serving those with the greatest social and economic need, and creating or revitalizing local falls prevention coalitions.

Building on this momentum, WIHA received additional funding in 2025 through the National Council on Aging (NCOA) State Falls Prevention Coalition Grant. This support made it possible to award Mini-LEAF grants to six organizations, distributing a total of $30,000 (up to $5,000 per grantee) to further strengthen local fall prevention initiatives across Wisconsin during a 7-month grant project period.

The following pages highlight the accomplishments of the 2025–2026 LEAF grantees. These brief summaries demonstrate the innovative approaches communities are taking to reduce falls, build local partnerships, and improve access to fall prevention resources throughout Wisconsin. WIHA extends its sincere gratitude to each LEAF grantee and their partners for their leadership, collaboration, and commitment to helping Wisconsinites build resilience and age safely, confidently, and independently.

ADRC of Brown County

Medication Awareness for Falls Prevention

Project Goal(s): Educate participants on how to effectively communicate with pharmacists; Raise awareness of medications that increase fall risk; and Provide individualized medication reviews to identify and mitigate fall-related risks.

Outcomes/Lessons Learned

- Successfully increased community awareness of how medications can contribute to fall risk and empowered older adults by participation in pharmacist-led educational presentation and 1:1 medication consultations. Participants reported increased confidence in discussing medication concerns and a better understanding of how specific drug classes may affect balance, dizziness, or mobility.
- Offering multiple consultation dates increased accessibility and allowed more time for in depth reviews.

Activities

- Held a live pharmacist-led presentation (14 participants) and recorded it for future online access to increase reach beyond the initial in-person event. Translated the recording into Hmong and Spanish. View the recordings **here**.
- Hosted 2 days of 1:1 medication consultations (8 participants) and distributed medication management tools (portable pill punchers and travel medication boxes) to participants.

Partners

- Streu's Pharmacy
- Aging & Disability Resource Center (ADRC) of Brown County
- Brown County Library (East Library Branch)

Sustainability/Next Steps

- Continue to promote the recorded presentations.
- Explore opportunities to host additional live presentations or expand the medication consultation model based on demand.
- Use the new technology equipment to record future fall prevention or health education programs.
- Strengthen collaboration with Streu's Pharmacy and other community partners to develop additional medication safety initiatives.

Menomonee Falls Fire Department (MFFD)

Mobile Integrated Health (MIH) Falls Response Program

Project Goal(s): Increase the percentage of patients who receive a follow-up call and visit with an evidence-based comprehensive fall reduction evaluation after experiencing a MFFD 911-triggering event by 75%; Reduce repetitive 911 usage for calls for lifting assistance and falls for patients that have more than one 911 encounter by 20%; and Enhance the number of patients who receive referral to wraparound community services and medical follow-up after a MFFD MIH visit for a fall by 75%.

Outcomes/Lessons Learned

- Identified 54 total patients meeting inclusion criteria. MIH was successful in connecting with 71% of patients and made home visits to 62% of eligible patients. During the home visits, 78% received a general evaluation, 70% received fall-risk assessments, and 63% received fall risk reduction items.
- Patients that received a home visit accounted for a 30% reduction of combined 911 usage when compared to patients that did not receive a visit. Additionally, patients that received a home visit collectively paid $118,000 less in ambulance charges than those who did not, spending an average of $4,300 per person less **(Appendix A)**.

Activities

- Reviewed automated reports generated from 911 run data weekly. The MIH Practitioners attempted to connect with patients meeting inclusion criterion following an eligible 911 call related to a fall.
- Conducted home visits, completed fall risk screenings, and Social Determinants of Health assessments. If a patient screened positive on any fall risk assessment, risk reduction materials were provided to the patient at no-cost.

Partners

- Waukesha County Falls Prevention Coalition, Healthy Aging Action Team
- ADRC of Waukesha County
- Wisconsin Institute for Healthy Aging

Sustainability/Next Steps

- The MIH team will continue to follow-up with older adults experiencing repeated fall-related 911 encounters. The team will constantly evaluate 911 usage to connect with some of the most vulnerable residents and continue to provide fall risk reduction outreach aimed at improving outcomes and reducing healthcare costs.

Milwaukee County AAA

Pharmacist Referrals to Stepping On

Project Goal(s): By December 2025, develop and implement a standardized pharmacist referral process to the Stepping On program; By March 2026, Hayat Pharmacy will integrate fall risk screenings into 100% of CMRs for patients aged 60+, identifying at least 36 older adults at risk for falls; and By February 2026, ensure 10-14 participants enroll in a Stepping On workshop referred through this program.

Outcomes/Lessons Learned

- Developed and integrated a process into the Comprehensive Medication Review (CMR) to identify patients at high risk of falls and introduce the Stepping On program, engage patients in a conversation about their fall risk, and refer interested patients to a local Stepping On workshop.
- Pharmacy staff at 5 Hayat Pharmacy locations were trained on fall risk criteria, referral protocols, and patient engagement strategies.
- This project reinforced the importance of repeated outreach to encourage participation in prevention programs. Many patients initially declined the CMR, highlighting the need for pharmacists to discuss fall risk during prescription pick-up and refill calls.

Activities

- Trained pharmacists at 5 Hayat Pharmacy locations on fall risk criteria, referral protocols, and patient engagement strategies.
- During the CMR, pharmacists discussed medications and fall risk factors, introduced the Stepping On program, provided information about upcoming workshops. The Director of Clinical Services followed up with interested patients.
- Attached postcards promoting upcoming workshops to the medication bags of patients identified as high risk.

Partners

- Hayat Pharmacy
- Greenfield Fire Department
- Greenfield Library

Sustainability/Next Steps

- Hayat will continue incorporating the Fall Risk Screening and Referral Guide **(Appendix B)** into its CMR and continue making referrals.
- Milwaukee County AAA will regularly share information about upcoming Stepping On workshops located near Hayat Pharmacy locations.

Northwest Wisconsin Community Services Agency (NWCSA) | SAIL Forward

Project Goal(s): By April 2026, enroll at least 20 older adults in the Stay Active and Independent for Life (SAIL) program across Ashland, Bayfield, and Douglas Counties; and By April 2026, 50% of participants will show measurable improvement in their strength and balance.

Outcomes/Lessons Learned

- Participants demonstrated improvements in strength, balance, and mobility over the 12-week program. One participant progressed from taking just 4 heel-to-toe steps to walking 20 feet with confidence. Another improved from lifting over a 3-inch obstacle to safely stepping over 8-inch obstacles without losing stability.
- The group setting encouraged consistent attendance, accountability, and mutual encouragement, helping participants build confidence, stay engaged, and increase awareness of fall prevention strategies.
- Learned about the value of addressing individual needs within a group setting, incorporating fun and engaging activities to reduce intimidation around exercise, and providing consistent encouragement.

Activities

- Offered the 12-week SAIL program and extended it beyond the initial 12-weeks.
- Integrated fall prevention education into each session and connected participants to local aging services.

Partners

- AmeriCorps Seniors RSVP through NWCSA
- Bretting Community Center through Ashland Parks & Recreation Dept.
- Senior Connections & its Senior Nutrition Dept.
- Lew Martin Senior Center
- Ashland Aging
- Bayfield County Aging Unit

Sustainability/Next Steps

- Continue offering SAIL classes 2x/week on an ongoing basis, supported through a suggested donation model.
- Will seek new funding opportunities and partnerships to support the SAIL program growth, including training new instructors, and expand access to evidence-based health promotion initiatives. Will integrate fall prevention education into other programs and services whenever possible.

Rebuilding Together Fox Valley (RTFV)

Rural Awareness

Project Goal(s): Increase the awareness of older adults in rural areas of RTFV's free fall prevention initiatives by providing brochures and fliers to locations highly frequented by that population; and Conduct two targeted Facebook campaigns geofenced to RTFV's footprint to increase the awareness of older adults and children of older adults.

Outcomes/Lessons Learned

- Expanded community outreach efforts throughout 6-county service area, but focused efforts on Calumet County and rural Brown County. This outreach is already building interest among homeowners in underserved areas and demonstrating community demand for future grant funding.
- Found that paid social media advertising works best with an established, engaged online presence. As a small nonprofit with limited staff capacity, a greater return on investment was achieved by direct community outreach and trusted referral partners. Word-of-mouth referrals continue to be one of RTFV's strongest sources of new applicants.

Activities

- Developed a suite of professionally printed outreach materials including brochures, postcards, business cards, and rack cards and distributed to partner agencies in Calumet and rural Brown Counties.
- Developed and launched 2 targeted Facebook ad campaigns aimed at reaching older adults and adult children of aging parents.
- Leveraged in-kind support to create homeowner thank you bags containing a RTFV mug, stress ball, cold pack, and 3 referral postcards.
- Increased outreach efforts in rural communities where awareness of RTFV's services has historically been limited.

Partners

- Aging & Disability Resource Centers
- Senior Centers
- Municipalities
- Fire Departments
- Healthcare Providers
- Community-Based Organizations

Sustainability/Next Steps

- The resources developed through this project (printed materials and homeowner thank you bags) will continue to support outreach efforts well beyond the grant period.
- Will continue expanding relationships with partners while strengthening RTFV's organic social media presence.

Safe Communities' Falls Free Dane Coalition
Balance Stamp of Approval (BSOA)

Project Goal(s): Prepare and update Balance Keys Committee materials; Develop a toolkit of resources that can be used to easily replicate the process in other communities by December 31, 2025; Increase awareness of the BSOA via an intentional campaign (news releases, t-shirts, magnets, videos, etc.) by March 31, 2026; and Expand local efforts by hosting a "BSOA Sampler" event in an underserved and/or rural area of Dane County by April 30, 2026.

Outcomes/Lessons Learned

- Developed the **Balance Stamp of Approval (BSOA) Implementation Manual**, which provides clear direction and guidance to any entity hoping to evaluate community-based classes for balance and to promote them as "balance-enhancing", and promotional **video**.
- Increased public awareness of falls and connected people with local falls prevention programs and resources.
- It truly takes a team to make it happen. All that was accomplished with this grant was made possible through collaboration and partnership!

Activities

- Created and verified content for, proofread, and edited BSOA Implementation Manual and accompanying resources.
- Worked with partners to develop and film BSOA video.
- Created BSOA promotional materials (magnets, window clings, t-shirts).
- Held a BSOA Sampler Event to give people in a more rural community in Dane County the opportunity to try a few classes that have been awarded the BSOA. Participants loved trying a variety of classes.

Partners

- Falls Free Dane (FFD) Coalition's Balance Keys and Communications Committees
- BSOA Program Participant & Instructors
- Beyond Words Productions
- Safe Communities
- External Partners/ Reviewers
- Cornerstone Community Center

Sustainability/Next Steps

- Share the BSOA Implementation Manual with other communities in Wisconsin and beyond, and provide technical assistance to those using it.
- Continue programming at the Cornerstone Community Center.
- Use the materials developed with this grant to continue to raise awareness of the BSOA program.

PICTURES

Balance Stamp of Approval Sampler Event

Rebuilding Together Fox Valley Homeowner Thank You Bag & Printed Materials

Stay Active & Independent for Life Workshop Flyer

CONCLUSION

This report offers a snapshot of the impactful fall prevention work happening across Wisconsin. The dedication and innovation of LEAF-grantee organizations demonstrate a shared commitment to reducing fall-related injuries, deaths, and healthcare costs while helping older people age with strength, confidence, and independence. A few common themes from their work are summarized below.

Prioritize accessibility

- Make resources accessible by translating materials, and intentionally reaching rural communities and those of the greatest social and economic need.

Don't reinvent the wheel

- Build on evidence-based programs, existing resources, and community partnerships to maximize impact while using time and funding efficiently.

Collect data to demonstrate impact

- Track outcomes to measure success, identify the most effective strategies, and maximize return on investment.

Continue outreach and strengthen partnerships

- Ongoing education and strong partner networks help connect more people with fall prevention resources, programs, and services.

Leverage peer support and social connection

- Group activities and social connection encourage participation, build confidence, reduce isolation, and support long-term healthy aging and fall resilience.

ACKNOWLEDGEMENTS

The Localizing Efforts to Address Falls (LEAF) grant program would not have been possible without the investment of the many organizations and their partners listed above. Their dedication to falls prevention is evident and will make all the difference moving forward.

If you have any questions about the content of this report please reach out using the contact information below.

We thank you for your continued support in our efforts and contribution to fall prevention in Wisconsin!

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APPENDIX A

VILLAGE OF Menomonee Falls

MOBILE INTEGRATED HEALTH
Menomonee Falls Fire Department
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Menomonee Falls, WI 53051-3140
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Menomonee Falls Calls for Falls
Menomonee Falls Fire Department Mobile Integrated Health
Falls Response Program

Executive Summary

The Menomonee Falls Fire Department Mobile Integrated Health (MIH) Falls Prevention Program was developed to proactively engage older adults at increased risk for falls, reduce repeat 911 utilization, and connect vulnerable residents with fall prevention resources and community support services. Through grant funding and community partnerships, MIH practitioners conducted outreach to residents aged 65 years and older, living independently, and who experienced a fall requiring emergency assistance. Home visits focused on fall risk assessment, chronic disease management, medication review, social determinants of health screening, and the distribution of evidence-based fall prevention resources.

Key Outcomes

- **54 eligible patients** were identified between October 1, 2025 and April 30, 2026.
- **70% of eligible patients (n=38)** were successfully contacted by the MIH team.
- **71% of contacted patients (n=27)** received an in-home MIH visit.
- **78% of visited patients (n=21)** received a comprehensive MIH evaluation.
- **70% of visited patients (n=19)** completed a formal fall-risk assessment.
- **63% of visited patients (n=17)** received fall prevention supplies and education material.
- **78% of visited patients (n=21)** were screened for social determinants of health and potential resource needs.
- **67% of visited patients (n=18)** received fall prevention resources, supplies, or referrals to community-based services.
- Patients receiving an in-home MIH visit demonstrated a **30% reduction in combined 911 utilization** compared with patients who did not receive a visit.
- Participants receiving an in-home visit incurred approximately **$118,000 less in ambulance charges** than those who did not receive a visit.
- Patients receiving an MIH intervention averaged **more than $4,300 less in ambulance charges per person**.
- Eligible patients accounted for **35% of all repeat 911 callers** within the community.
- The MIH team conducted **21 unscheduled home visit attempts**, with **71% successfully resulting in patient engagement**.

Community Partnerships

- Partnered with the **Waukesha County Falls Prevention Coalition**, Healthy Aging Action Team, and Aging and Disability Resource Center.
- Established a new partnership with **Falls Free Wisconsin and the Wisconsin Institute for Healthy Aging**, which provided grant funding for fall prevention supplies.
- Distributed no-cost fall prevention equipment including shower grip mats, shower chairs, motion-activated nightlights, reach extender tools, and educational materials.

The program demonstrated that proactive post-fall outreach by MIH Practitioners can successfully engage high-risk older adults, identify fall hazards and social needs, reduce repeat emergency service utilization, and lower healthcare costs. The Menomonee Falls Fire Department plans to continue and expand these efforts by integrating falls prevention outreach into routine MIH operations and pursuing additional funding opportunities to sustain services for vulnerable residents.

APPENDIX B

Hayat Fall Risk Screening & Referral Guide

For Patients ≥ 60 Years of Age

Purpose

Identify older adults at increased risk of falls during Comprehensive Medication Reviews (CMRs) and refer eligible patients to the Stepping On Program — a community initiative coordinated by ADRC that helps seniors prevent falls, stay independent, and remain healthy.

Who to Flag

Screen every patient ≥ 60 years old during a CMR. Flag if they meet any of the following:

- History of falls (past 12 months, or reports unsteadiness/dizziness)
- Polypharmacy: ≥ 4 prescription drugs
- High-risk medications (see table below)
- Fall-related side effects: sedation, orthostatic hypotension, dizziness, confusion, visual changes

High-Risk Medication Groups

Category	Common Examples	Fall Risk Effects
Sedatives / Hypnotics	Diazepam, lorazepam, temazepam, zolpidem	Drowsiness, impaired balance
Antidepressants	Amitriptyline, doxepin, trazodone, sertraline, duloxetine	Drowsiness, orthostatic hypotension
Antipsychotics	Risperidone, quetiapine, haloperidol	Sedation, slow reflexes
Opiates	Codeine, morphine, tramadol	Sedation, delirium
Anti-epileptics	Phenytoin, carbamazepine, phenobarbital	Unsteadiness, ataxia
Parkinson's drugs	Ropinirole, selegiline	Orthostatic hypotension
Cardiovascular drugs	Tamsulosin, doxazosin, clonidine, nitrates, beta blockers, diuretics, ACE inhibitors	Hypotension, dizziness
Other risk meds	Oxybutynin, tolterodine, diphenhydramine	Confusion, mental fuzziness

How to Engage the Patient

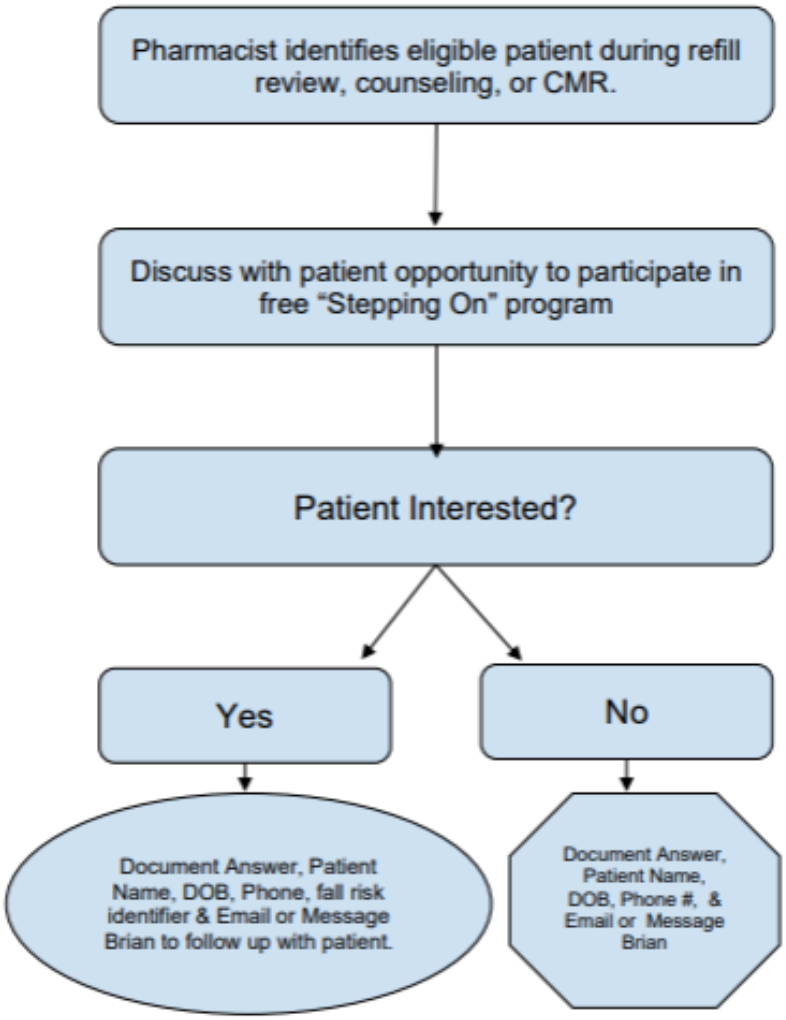
1. Supportively acknowledge their fall risk.
2. Say: "Because some of your medications and health factors may increase your risk of falling, I'd like to share information about a free program called Stepping On. It helps older adults prevent falls and stay independent. Would you like me to refer you?"

APPENDIX B (CONT'D)

Hayat Fall Risk Screening & Referral Guide

For Patients ≥ 60 Years of Age

Referral Process



Key Reminders

- Falls are predictable and preventable
- Mortality risk at age 85 after a fall is ~1% per fall
- Always document patient response (accept / decline referral)
- Reinforce fall-prevention tips: rise slowly, hydrate, avoid alcohol, safe footwear

✅ **Your role as a pharmacist is critical: by screening and referring, you help patients live safer, healthier, more independent lives.**