

SITE A

Program Name: ViCAP

GENERAL PROGRAM DESCRIPTION

1. How long has your program been in operation? since 1993
 - a. How many individuals have been served from program inception? 630
 - b. How many on average do you serve on a monthly basis? 3
2. How many Full-time Equivalent (FTEs) are allocated to the program? .025 for coordination, all assessments and modifications are done by volunteers that get training.
3. Who is served by your program? (*Check all that apply*)
 - a. Elders
 - b. Medicare Recipients
 - c. Dually Eligible (Medicare and Medicaid)
 - d. Catchment area population
 - e. Other: Disabled-anyone 18 or older who is living independently and unable to drive
4. How do you target individuals eligible to receive benefits under this program? (*Check all that apply*)
 - a. Self-referred
 - b. Referral from MD
 - c. Outreach by program staff
 - d. Other: Neighbors (clients) already receiving other services (see attached)
5. Is your intervention or program targeted at people with certain characteristics that deem them at "high risk" for falling? No Yes
 - a. If **Yes**, how do you define "high risk?" (*Check all that apply*)
 - i. age; specify: elderly or disabled
 - ii. gender; specify:
 - iii. history of falling,
 - iv. Other: Individual and home care considered for project safe home when home assessment for other services is conducted
 - b. If **No**, then how are program participants identified?
6. Do you use standardized tools or assessment forms in your program? No Yes
7. Are you able to provide us with a copy of these tools/forms? No Yes

8. Does your fall prevention program include one or more of the following Components? (For each Component, specify whether or not it is included as part of your program's Assessment. If Yes, then tell us how it is addressed as an Intervention).

Component	Part of Assessment	Intervention
Activities of Daily Living (ADLs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. <input type="checkbox"/> Suggestions about finding help to care for yourself 2. <input type="checkbox"/> Referral to Physician 3. <input type="checkbox"/> Referral to Home Care Agency 4. <input type="checkbox"/> Other
Instrumental Activities of Daily Living (IADLs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. <input type="checkbox"/> Suggestions about finding help to do these tasks 2. <input type="checkbox"/> Referral to Physician 3. <input type="checkbox"/> Referral to Home Care Agency 4. <input type="checkbox"/> Other
Cognitive Status	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. <input type="checkbox"/> Referral to Physician 2. <input type="checkbox"/> Referral to Home Care Agency 3. <input type="checkbox"/> Other
Fear of Falling	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. <input type="checkbox"/> Referral to Physician 2. <input type="checkbox"/> Referral to Counselor/Therapist 3. <input type="checkbox"/> Other
Medical History Review	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. <input type="checkbox"/> Referral to Physician 2. <input type="checkbox"/> Other
Medication Review	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. <input type="checkbox"/> Referral to Physician 2. <input type="checkbox"/> Other
Home Safety	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1. <input type="checkbox"/> Suggestions 2. <input checked="" type="checkbox"/> Doing actual modification(s) 3. <input checked="" type="checkbox"/> Paying for actual modification(s) 4. <input checked="" type="checkbox"/> Other: referred to utility company for power lines
Exercise	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. <input type="checkbox"/> We make suggestions and encourage exercise 2. <input type="checkbox"/> Pamphlets 3. <input type="checkbox"/> Video Exercise Programs 4. <input type="checkbox"/> Scheduled program in a group setting; Type: _____; Program Duration: _____; Frequency of Exercise: _____ 5. <input type="checkbox"/> Individualized exercise program; Type: _____; Program Duration: _____; Frequency of Exercise: _____
Balance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. <input type="checkbox"/> We make suggestions and encourage balance-related exercises 2. Type of training: 3. Program Duration:

Gait	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. <input type="checkbox"/> We make suggestion and encourage gait-related exercises 2. <input type="checkbox"/> Training in proper use of ambulatory aides 3. <input type="checkbox"/> Other:
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9. Do you send a report of your findings and recommendations after you visit the program participant? No Yes

a. If **Yes**, to whom are findings and recommendations reported?

(Check all that apply).

- i. Program participant
- ii. Participant's Primary Care Physician (PCP)
- iii. Participant's next of kin
- iv. Other: all copies sent to funder during beginning of program

10. Who is involved in the program, either for Assessment or Intervention? (Check all that apply).

- a. Administrative Staff
- b. Nurse
- c. Social Worker
- d. Physical therapist
- e. Medical Doctor
- f. Emergency Response Unit (EMTs)
- g. Fire Department
- h. Volunteers
- i. Other:

OPERATIONAL ISSUES

1. Do you provide educational materials to the program participant? No Yes

a. If **Yes**, what do you provide?

2. Do you supply any sort of "gift" or kit with information, supplies or equipment as part of the program? No Yes

a. If **Yes**, what do you provide? anything involved in safety is paid for. all supplies or equipment needed to make the home safe; grab bars, non-skid mats, night lights, etc.

3. If you discover that the program participant could benefit from equipment that might be covered by Medicare or Medicaid, how is this handled?

4. Do you run into any language barriers with the program participants you serve? No Yes

a. If **Yes**, how is it handled? utilize spanish speaking staff and volunteers

5. In an operational sense, what do you view as the biggest challenge with implementing your program? acceptance by the clients to have the inspection done. They may be suspicious that it truly is free and/or are worried that their house will be condemned. Afraid that independence will be taken away and they will need to go to ALF or NH.
6. What feedback do you get from the program participants you serve? "it's free" They are so grateful; impressed with the thoroughness; feel safer
7. What feedback do you get from the people actually performing the intervention or pieces of the intervention? They realize the importance of this program and feel that they are really helping someone. Feel gratified

FUNDING REQUIREMENTS

1. How is your program currently funded? "Project Safe Home" is funded by Salt River Project (SRP), a local utility company
2. Have you applied for and/or received any additional funding? No Yes
 - a. If **Yes**, from which types of organization(s)?
 - i. Governmental agency or body
 - ii. Private institution
 - iii. Private donations
 - iv. Other: fundraisers
3. Does the program pay for the cost associated with implementing the interventions or recommendations (e.g. home modifications, pill boxes, exercise programs, etc)? No Yes
 - a. If **Yes**, what is paid for under the program? Any purchase/modification to make the home safe from a fall or fire. Grab bars, non-skid mats, shower chairs, etc.
 - b. What is the average cost of a typical intervention? \$50 for 1st time
4. Does the program participant pay for any part of the intervention? No Yes
 - a. If **Yes**, what does the program participant pay for?
 - b. What is the typical out of pocket cost?
5. If you took the total costs associated with the program, including the assessment and intervention costs, what would you say the annual per participant costs would be?

\$44.00

6. How does this cost breakdown by each component of the intervention?
- a. Internal program staff cost: $\$10.80\text{hr} \times 52 \text{ hours} = 562/35 \text{ recipients} = \16 per person
 - b. Field staff cost: \$0
 - c. Printed Materials and Mailing: $\$50/\$35 = \$4$
 - d. Home Modifications: $\$832/35 = \24 (some had modifications that didn't cost anything)
 - e. Exercise Program: \$
 - f. Other: cost: \$

OUTCOMES MEASUREMENT

- a. Do you follow up with the program participants? No Yes
 - a. If **Yes**, how often? 1x year
 - b. What method(s) do you use to follow up? phone call and offer to go to home
 - c. What do you find when you follow up? most would like a follow-up check; usually only need new batteries for smoke detector, etc.

- b. Are you measuring program participants' compliance with the recommendations put forth? No Yes
 - a. If **Yes**, how do you measure this?
 - b. What do you find?

- c. Do you track program outcomes? No Yes
 - a. If **Yes**, what specifically do you track? (*Check all that apply*)
 - i. Changes in number of falls
 - ii. Changes in number of repeat falls
 - iii. Changes in number of injurious falls
 - iv. Change in fear of falling
 - v. Change in Emergency Room visits
 - vi. Change in use of outpatient services (Doctor's visits, physical therapy, etc)
 - vii. Change in use of inpatient services
 - viii. Change in Medications
 - ix. Participation in an Exercise program
 - x. Other

- d. Do you track the program's impact on dollars spent by either the program participant or other funding source like Medicare or Medicaid? No Yes

- e. Do you have a way of measuring whether the investment in the program is justified by the benefits it yields the program participants? No Yes
If **Yes**, what have you found?

GENERAL OBSERVATIONS

1. What do you view as the single most important element of your program?
It is very structured and thorough
2. If you could add one element/component to the program to make it more effective, what would it be?
Promotion of the program, more outreach, reach more people
3. What is the single most important element to assuring programmatic success?
Completion of repairs/modifications/purchases to eliminate potential hazards.
4. What is the single most important barrier to success?
Acceptance of the program-allowing people to come in.
5. Do you have any thing else you would like to share with us?
We use our "Hazard House" in conjunction with Project Safe Home. See attached brochures and picture. It is utilized in safety fairs, presentations and often checked out by the public.

SUGGESTIONS FOR KEY COMPONENTS

If you were designing a new Fall Prevention program from “scratch” what would it look like?

Our program is so comprehensive that I can't think of any additions. I'm including our entire manual for your use.