

SITE D

Program Name: Foundations for Rural Housing, Inc.

GENERAL PROGRAM DESCRIPTION

1. How long has your program been in operation? since 1995
 - a. How many individuals have been served from program inception?
 - b. How many on average do you serve on a monthly basis?
2. How many Full-time Equivalents (FTEs) are allocated to the program? 0
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:
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:
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: 62
 - ii. gender; specify:
 - iii. history of falling,
 - iv. Other:
 - 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 checked="" 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: volunteer does labor
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:

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: coordinator, retired hanypersons, etc.

OPERATIONAL ISSUES

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

a. If **Yes**, what do you provide? brochures on safety

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? door knob and faucet

3. If you discover that the program participant could benefit from equipment that might be covered by Medicare or Medicaid, how is this handled? within aging office usually, coordinator refers to aging office

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

a. If **Yes**, how is it handled? neighbor translates

5. In an operational sense, what do you view as the biggest challenge with implementing your program?

6. What feedback do you get from the program participants you serve? very very positive
7. What feedback do you get from the people actually performing the intervention or pieces of the intervention? very positive, volunteers enjoy interaction

FUNDING REQUIREMENTS

1. How is your program currently funded? Retirement and Research foundation for 17 counties
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: quilt raffle
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?
 - b. What is the average cost of a typical intervention?
4. Does the program participant pay for any part of the intervention? No Yes
 - a. If **Yes**, what does the program participant pay for? materials
 - b. What is the typical out of pocket cost? under \$200
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?

\$270
6. How does this cost breakdown by each component of the intervention?
 - a. Internal program staff cost: \$RH reports, etc. spread over \$50
 - b. Field staff cost: \$coordinators time +/- \$60
 - c. Printed Materials and Mailing: \$
 - d. Home Modifications: \$usually under \$200, avg +/- \$80 materials-seniors pay
 - e. Exercise Program: \$
 - f. Other: volunteer cost: \$value of labor +/- \$80 avg

OUTCOMES MEASUREMENT

1. Do you follow up with the program participants? No Yes
 - a. If **Yes**, how often? depends on country and client
 - b. What method(s) do you use to follow up? some use one page evaluation form some call clients
 - c. What do you find when you follow up? many thank yous

2. 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?

3. 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: job/repair completed satisfactory

4. 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

5. 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? The local volunteer coordinator

2. If you could add one element/component to the program to make it more effective, what would it be? long term financial support for coordinator so she/he can be "on job" consistently

3. What is the single most important element to assuring programmatic success? flexibility

4. What is the single most important barrier to success? Keeping the word out there for seniors so they will be comfortable asking for assistance
5. Do you have any thing else you would like to share with us? small things (especially grab bars) seem to make a big difference for seniors

SUGGESTIONS FOR KEY COMPONENTS

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