SITE C

Program Name: York County Fire and Rescue

GENERAL PROGRAM DESCRIPTION

1. How long has your program been in operation? since 1995
   a. How many individuals have been served from program inception? 100 interventions, program now in hiatus
   b. How many on average do you serve on a monthly basis? 4

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: EMS or fire calls to a residence

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:
      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)	☐ Yes ☒ No	1. ☐ Suggestions about finding help to care for yourself 2. ☐ Referral to Physician 3. ☐ Referral to Home Care Agency 4. ☐ Other
Instrumental Activities of Daily Living (IADLs)	☐ Yes ☒ No	1. ☐ Suggestions about finding help to do these tasks 2. ☐ Referral to Physician 3. ☐ Referral to Home Care Agency 4. ☐ Other
Cognitive Status	☐ Yes ☒ No	1. ☐ Referral to Physician 2. ☐ Referral to Home Care Agency 3. ☐ Other
Fear of Falling	☐ Yes ☒ No	1. ☐ Referral to Physician 2. ☐ Referral to Counselor/Therapist 3. ☐ Other
Medical History Review	☐ Yes ☒ No	1. ☐ Referral to Physician 2. ☐ Other
Medication Review	☐ Yes ☒ No	1. ☐ Referral to Physician 2. ☐ Other
Home Safety	☒ Yes ☐ No	1. ☒ Suggestions 2. ☐ Doing actual modification(s) 3. ☐ Paying for actual modification(s) 4. ☒ Other: give referral resource list
Exercise	☐ Yes ☒ No	1. ☐ We make suggestions and encourage exercise 2. ☐ Pamphlets 3. ☐ Video Exercise Programs 4. ☐ Scheduled program in a group setting; Type: Program Duration: ; Frequency of Exercise: 5. ☐ Individualized exercise program; Type: ; Program Duration: ; Frequency of Exercise:
Balance	☐ Yes ☒ No	1. ☐ We make suggestions and encourage balance-related exercises 2. Type of training: 3. Program Duration:

Gait	☐ Yes ☒ No	1. ☐ We make suggestion and encourage gait-related exercises 2. ☐ Training in proper use of ambulatory aides 3. ☐ Other:

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: phone call to MD to refer to home care or other referral

10. Who is involved in the program, either for Assessment or Intervention? (*Check all that apply).*
    i. ☐ Administrative Staff
    ii. ☐ Nurse
    iii. ☐ Social Worker
    iv. ☐ Physical therapist
    v. ☐ Medical Doctor
    vi. ☒ Emergency Response Unit (EMTs)
    vii. ☒ Fire Department
    viii. ☐ Volunteers
    ix. ☐ 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?

3. If you discover that the program participant could benefit from equipment that might be covered by Medicare or Medicaid, how is this handled? call to MD while at the person's home

4. Do you run into any language barriers with the program participants you serve? ☒ No ☐ Yes
   a. If **Yes**, how is it handled?

5. In an operational sense, what do you view as the biggest challenge with implementing your program? people unwilling to change habits-some

6. What feedback do you get from the program participants you serve? Love it, appreciative-like the time spent with them

7. What feedback do you get from the people actually performing the intervention or pieces of the intervention? many of them are uncomfortable doing the assessment-they would rather ID the people and have someone else do the assessment and intervention.

FUNDING REQUIREMENTS

1. How is your program currently funded? cost absorbed by fire department

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:

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, w**hat 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?

   $

6. How does this cost breakdown by each component of the intervention?
   a. Internal program staff cost: $absorbed by fire dept
   b. Field staff cost: $
   a. Printed Materials and Mailing: $75 per person total spent o forms/printing
   b. Home Modifications: $
   c. Exercise Program: $
   d. Other: cost: $

OUTCOMES MEASUREMENT

1. Do you follow up with the program participants? ☐ No ☒ Yes
   a. If **Yes**, how often?2 weeks and 4 weeks
   b. What method(s) do you use to follow up? phone
   c. What do you find when you follow up? followed easy parts of recommendations-harder parts are not accepted or able to be gotten

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? 60% comply, 20% refuse, 20% went to NH due to the fire department notifying MD that they had fallen

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

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 <u>your</u> program? ID of people not "in the system" - no one knows they are falling

2. If you could add one element/component to the program to make it more effective, what would it be? Advertising the program so that people can self-refer before they fall

3. What is the single most important element to assuring programmatic success?
   leadership, continued energy and support

4. What is the single most important barrier to success? Fire Department employees who feel this is not their job

5. Do you have any thing else you would like to share with us? We are initiating new plans, 1) core group of volunteers; 2) kit and 3) advertising.

SUGGESTIONS FOR KEY COMPONENTS

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