NACCHO
National Association of County & City Health Officials

Developing the Capacity to Support **Clinical Older Adult Fall Prevention**

Local Health Department Workbook

Why Should Local Health Departments Develop a Clinical Fall Prevention Program?

Subsections:

- Subsection 1: What is a Fall?
- Subsection 2: An Older Adult Falls Every Second of Every Day
- Subsection 3: What are Fall Risk Factors?
- Subsection 4: What Impact Do Falls Have on Older Adults?
- Subsection 5: Why are Falls Among Older Adults an Urgent Public Health Issue?
- Subsection 6: What Role Should Local Health Departments Play in Older Adult Fall Prevention?

SWOT Analysis:

Identify the Strengths, Weaknesses, Opportunities, and Threats of creating a clinical fall prevention program.

STRENGTHS	WEAKNESSES
OPPORTUNITIES	**THREATS**

How Does a LHD Start Planning a Clinical Fall Prevention Program?

Subsections:

- Step 1: Assess community need and context
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- Step 2: Identify a population of focus
- Step 3: Assess existing cycles of care
- Step 4: Set goals and objectives
- Step 5: Begin designing the program

Review Questions:

1. Does your local health department have a Community Health Assessment (CHA), or Community Health Improvement Plan (CHIP) set in place citing older adult falls as a public health issue in your community?
2. What clinical and community fall prevention activities exist in your community?

Data Indicator Selection Tool:

Identify the available data indicators that can be used to illustrate the scope of falls in your community.

S.M.A.R.T.I.E. Goals:

Create a set of S.M.A.R.T.I.E. goals with your local health department with developing a clinical fall prevention program.

Logic Model:

Consider areas of the logic model that can be completed.

Health Indicator (e.g., 911 calls related to falls, ED visits due to fall injury, positive fall risk screen)	**County data available?** Y/N	**Sub-county data available?** Y/N	**State data available?** Y/N	**National data available?** Y/N	**Trend data available for the past 10 years?** Y/N	**Trend data available for the past 5 years?** Y/N	**Sound methodology used** (e.g., adequate sample size, valid measure)? Y/N	**Data can be stratified by demographics** (e.g., age, race/ethnicity)? Y/N	**Comments**

Adapted from: Austin/Travis County Health Department

S.M.A.R.T.I.E. Goals

SPECIFIC Does this objective clearly specify what will be accomplished, by whom, and for whom?	
MEASURABLE Can we easily demonstrate that this goal has been met?	
ATTAINABLE Is this objective realistic, reasonable, and within our control or scope?	
RELEVANT Does this clearly align to the vision and strategic priorities identified?	
TIME-BOUND By when will you have accomplished this objective?	
INCLUSIVE How will you include or involve those most impacted in the process, activities, and decision-making?	
EQUITABLE Does this objective seek to address systemic injustices or inequities?	

Logic Model

Program:

Situation:

Inputs	»	Outputs		»	Outcomes -- Impact		
		Activities	Participation		Short	Medium	Long

Assumptions	External Factors

What Clinical Partners Should LHDs Work With?

Subsections:

- Step 1: Identify Potential Partners
- Step 2: Determine Roles and Responsibilities
- Step 3: Maintain Engagement and Collaboration

Review Questions:

1. As explained in the third section of this guide, partnerships are vital in both the sustainability and ultimate success of a clinical older adult fall prevention program. In considering clinical and community partners, it is important to identify their role as you develop a clinical older adult prevention program. Think of the existing partnerships that you have in the community who support healthy aging and fall prevention you would like to engage in the program planning process. What roles do you foresee each of them taking in the development of this program?
2. This section identifies challenges that may arise for LHDs during the planning process of a clinical older adult fall prevention program. Are there challenges, either identified in this section or not, that you have identified as a barrier to implementation?

Levels of Partnerships:

Consider what partnerships you currently have, and into which category of partnership they fit.

Levels of Partnerships

Networking	Coordinating	Collaborating	Integrating
Make connections to exchange information and ideas	Informal partnership with commitment to reduce older adult falls but little structure or shared resources	Work together toward a shared goal	Strong, structured partnership

What are the Key Activities in a LHD's Clinical Fall Prevention Program?

Subsections:

- Key Activity 1: Establish a Referral-Based System
- Key Activity 2: Identify Older Adults at High Risk for Falls
- Key Activity 3: Assess Fall Risk Factors and Recommend Interventions
- Key Activity 4: Care Coordination and Follow Up

Review Questions:

1. As you read through this section, do you have an idea of the staff you would like for this program?
2. For your current fall prevention programming, how do you currently identify community-dwelling older adults for program outreach, and would you continue this approach for this new program? If you do not currently have fall prevention outreach, how do you anticipate you will identify community-dwelling older adults for program outreach?
3. What fall risk factors do you think your program or partners can assess? Who will perform these assessments?
4. What clinical and/or community-based interventions can older adults be referred to that can effectively address their specific modifiable fall risk factors?

Goal

Objectives

-
-
-

Tasks	Start Date	End Date	Person/Partner(s) Responsible	Resources Required	Desired Output/ Result

Referral-Based System Workflow

A Provider Referral

The referral is made by a healthcare provider.

In this case, healthcare providers may refer older adults who are at risk of falling to clinical and community-based resources to receive assessments to identify their specific fall risk factors or to interventions that address risk factors providers have identified.

B Internal Registry

The referral is made through a registry of patients who have received medial care (e.g., 911 calls, ED visits, hospitalizations) due to falls. This referral would be made for older adults to receive fall risk assessments to identify what factors are increasing their fall risk and interventions to address specific risk factors.

C Self-Referral

The referral is made by a patient who is concerned about their fall risk. In this case, patients would call a hotline number and would be referred to receive a fall risk assessment and interventions to address their specific risk factors.

Referral Process Option	Build A Referral-Based Workflow Based on the three options for a referral-based workflow, start with the option that would best suit your local health department and partners. From there, create the prospective referral-based workflow

Identifying How are potential participants identified and referred into the program (e.g., self-screen/referred, referred by PCP)?	**Assessing** What risk factors will be assessed as part of your program and by who (e.g., home hazards by occupational therapist; gait, strength, and balance by physical therapist)?	**Intervening** What are possible referrals to partners or interventions (e.g., home modifications, referral to PCP, referral to community-based fall program)?

How should LHDs monitor and evaluate their program?

Subsections:

- Subsection 1: Evaluation Process
- Subsection 2: Evaluation Design
- Subsection 3: Types of Key Metrics
- Subsection 4: Use Data for Quality Improvement
- Subsection 5: Assess Impact of Programs and Services
- Subsection 6: Challenges with Program Monitoring and Evaluation

Review Questions:

1. Who are the internal and external stakeholders you envision to be a part of the evaluation process (e.g., local hospitals, primary care providers, EMS, fire & rescue)?
2. What are the existing resources in place for data collection and evaluation at your LHD? If applicable, how much of your research/evaluation budget can be used for this project?
3. What are the barriers that you feel your LHD will face in the data collection and evaluation process? How can you overcome those barriers?

Evaluation Templates:

Review and complete the following templates to help organize your local health department's evaluation plan for the clinical older adult fall prevention program.

Evaluation Plan Templates

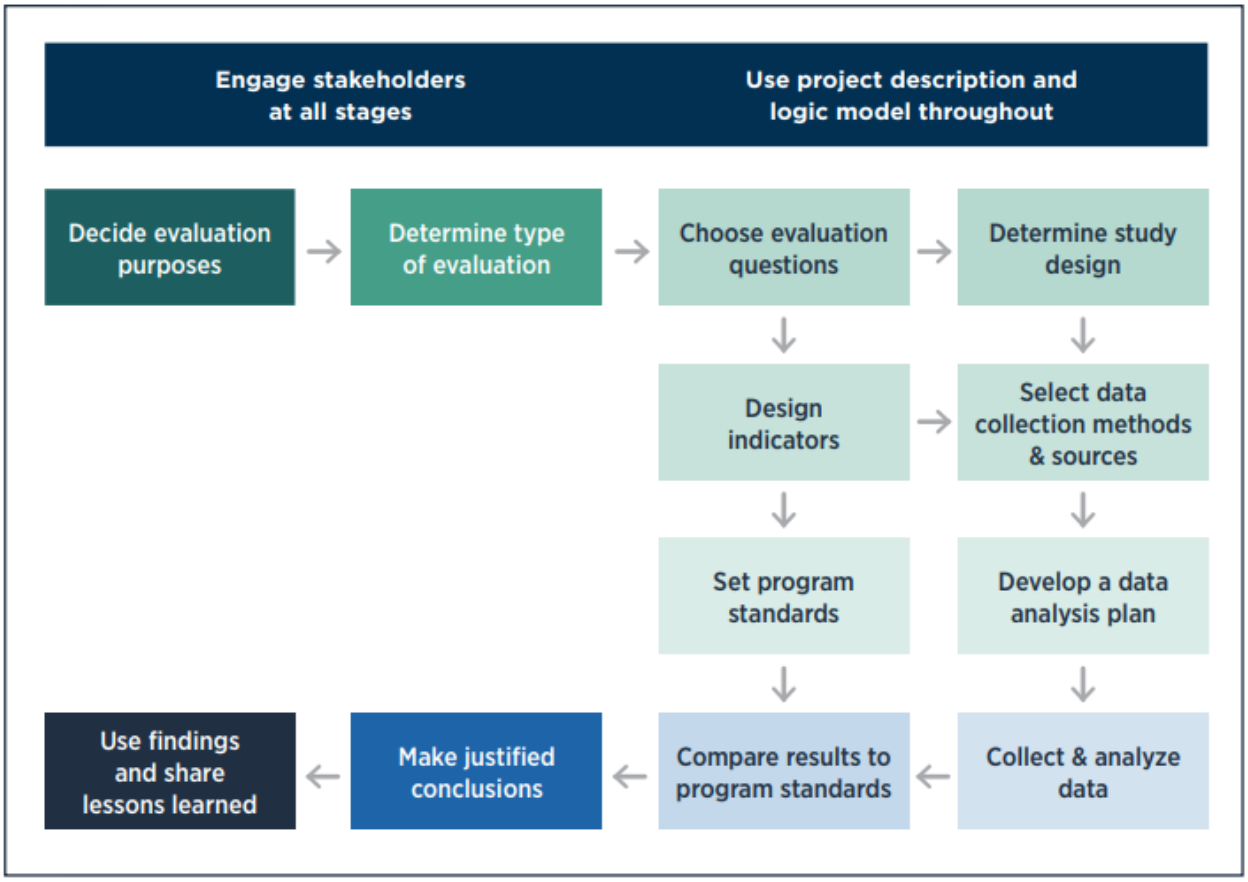

Figure 1: Steps involved in the evaluation process (CDC, 2019)

Evaluation Plan Templates

Table 1: Roles and Responsibilities of the Evaluation Team Members		
Individual	**Title or Role**	**Responsibilities**

Table 2: Stakeholder Assessment and Engagement Plan			
Community Partner Category	**Interest or Perspective**	**Role in the Evaluation**	**How and When to Engage**

Evaluation Plan Templates

Problem Statement:

Inputs	Outputs		Outcomes	
	Activities	Outputs	Short/Mid	Long
▪ ▪ ▪	▪ ▪ ▪	▪ ▪ ▪	▪ ▪ ▪	▪ ▪ ▪

Assumptions
▪ ▪ ▪

Evaluation Plan Templates

Priority Issue:
Goal (Aim):

Objective #1:
Strategy #1:

Key Actions	Lead Role & Community Resources	Target Date for Completion	Status of Progress	Evaluation Measure	Evaluation Results
Action #1:					
Action #2:					
Action #3:					
Action #4:					
Action #5:					

Evaluation Plan Templates

Evaluation Types	When to use	What it shows	Why it is useful
Formative Evaluation Evaluability Assessment Needs Assessment	• During the development of a new program. • When an existing program is being modified or is being used in a new setting or with a new population.	• Whether the proposed program elements are likely to be needed, understood, and accepted by the population you want to reach. • The extent to which an evaluation is possible, based on the goals and objectives.	• It allows for modifications to be made to the plan before full implementation begins. • Maximizes the likelihood that the program will succeed.
Process Evaluation Program Monitoring	• As soon as program implementation begins. • During operation of an existing program.	• How well the program is working. • The extent to which the program is being implemented as designed. • Whether the program is accessible an acceptable to its target population.	• Provides an early warning for any problems that may occur. • Allows programs to monitor how well their program plans and activities are working.
Outcome Evaluation Objectives-Based Evaluation	• After the program has made contact with at least one person or group in the target population.	• The degree to which the program is having an effect on the target population's behaviors.	• Tells whether the program is being effective in meeting it's objectives.
Economic Evaluation: Cost Analysis, Cost-Effectiveness Evaluation, Cost-Benefit Analysis, Cost-Utility Analysis	• At the beginning of a program. • During the operation of an existing program.	• What resources are being used in a program and their costs (direct and indirect) compared to outcomes.	• Provides program managers and funders a way to assess cost relative to effects. "How much bang for your buck."
Impact Evaluation	• During the operation of an existing program at appropriate intervals. • At the end of a program.	• The degree to which the program meets its ultimate goal on an overall rate of STD transmission (how much has program X decreased the morbidity of an STD beyond the study population).	• Provides evidence for use in policy and funding decisions.

Figure 3: Types of Evaluation (CDC, 2007)

Evaluation Plan Templates

Table 3: Indicators and Program Benchmark for Evaluation Questions		
Evaluation Question	**Process and Outcome Indicators**	**Program Benchmark**
1.		
2.		

Table 4: Data Collection Plan				
Indicator	**Data Sources**	**Collection**		
		Who	**When**	**How**

Table 5: Illustrative Timeline for Evaluation Activities				
Evaluation Activities	**Timing of Activities for [Year]**			
	1st Quarter	**2nd Quarter**	**3rd Quarter**	**4th Quarter**

Evaluation Plan Templates

Table 6: Evaluation Plan Methods Grid					
Evaluation Question	Indicator/ Performance Measure	Method	Data Source	Frequency	Responsibility

Table 7: Analysis Plan	
Data Analysis Technique	Responsible Person

Table 8: Dissemination Plan			
Target Audience (Priority)	Dissemination Medium	Responsible Person	Date/Timetable

How can LHDs sustain their older adult fall prevention program?

Subsections:

- Subsection 1: Funding
- Subsection 2: Program Expansion
- Subsection 3: Partnerships
- Subsection 4: Outreach

Review Questions:

1. As indicated in this section of the guide, sustainability of a clinical older adult fall prevention program relies on funding, partnerships, and outreach. With that in mind, what internal partnerships do you anticipate forming within your LHD to maintain sustainability?
2. Is there an opportunity for shared funding or would it require applying for additional funding?
3. How do you currently conduct outreach for public health programs? Would this type of outreach also be used for an older adult fall prevention program?

Logic Model:

Revisit the logic model to see if there is anything you would like to add. What are the short, medium, and long-term outcomes that your local health department would like from a clinical fall prevention program?

Program Sustainability Assessment Tool:

Review the templates within the Washington University at St. Louis's Program Sustainability Assessment Tool.