SITE F

Program Name: VNA Community Healthcare, Guilford, CT

GENERAL PROGRAM DESCRIPTION

1. How long has your program been in operation? greater than 10 years
   a. How many individuals have been served from program inception? approximately 35-65 a year
   b. How many on average do you serve on a monthly basis? 10-15

2. How many Full-time Equivalents (FTEs) are allocated to the program? approximatley 4-6/wk

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: skilled nursing visits-safety assessment performed, physical therapists on staff-safety assessment performed

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: over age 65
      ii. ☐ gender; specify:
      iii. ☒ history of falling,
      iv. ☒ Other: fractures, previous falls
   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: provide appropriate medical equipment/$40 pp
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: see above
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: provide appropriate equipment
Medical History Review	☒ Yes ☐No	1. ☐ Referral to Physician 2. ☒Other: done as part of skilled nursing visit
Medication Review	☒ Yes ☐No	1. ☒ Referral to Physician 2. ☐ Other: not part of the grant, but they do it
Home Safety	☒ Yes ☐No	1. ☒ Suggestions 2. ☒ Doing actual modification(s) 3. ☒ Paying for actual modification(s) 4. ☐ Other
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: nurse/therapists have been instructed in the proper use of all equipment

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: East SHore Health District, state of CT DPH

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? enclosed

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? Pt. is guided on how to obtain the equipment through Medicare, by the nurse/therapist making the visit

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? keeping track of equipment going out to patients and storage of larger items

6. What feedback do you get from the program participants you serve? all have follow-up calls with 100% satisfaction

7. What feedback do you get from the people actually performing the intervention or pieces of the intervention? Feedback is positive except for the increase in paperwork to do assessment

FUNDING REQUIREMENTS

1. How is your program currently funded? ESDHD Block Grant provided by the CT state department of Public Health

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? Administrative, copying, postage, equipment assembly
    b. What is the average cost of a typical intervention? $40 cap

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? Any cost of equipment greater than $40
    b. What is the typical out of pocket cost? $0-$13

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?

$100.00

6. How does this cost breakdown by each component of the intervention?
    a. Internal program staff cost: $24.00
    b. Field staff cost: $44.00
    c. Printed Materials and Mailing: $2.00
    d. Home Modifications: $30.00
    e. Exercise Program: $
    f. Other: cost: $

OUTCOMES MEASUREMENT

1. Do you follow up with the program participants? ☐ No ☒ Yes
    a. If **Yes**, how often? once
    b. What method(s) do you use to follow up? telephone call- 2-4 month f/u but once discharged from skilled, they don't track anymore
    c. What do you find when you follow up? 98-100% no fall rate, satisfaction with equipment

2. Are you measuring program participants' compliance with the recommendations put forth? ☐ No ☒ Yes
    a. If **Yes**, how do you measure this? telephone call, ongoing skilled nursing visit if indicated
    b. What do you find? good compliance

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
    a. If **Yes**, what have you found? Overall, the fall rate decreases after providing/installing the equipment - for 10 years

GENERAL OBSERVATIONS

1. What do you view as the single most important element of your program? Helping financially strapped seniors secure equipment needed to decrease the risk of falls/injuries/hospital admissions.

2. If you could add one element/component to the program to make it more effective, what would it be? Increase funding as we have more seniors in need than we have money for.

3. What is the single most important element to assuring programmatic success? Good safety assessment and f/u to ensure compliance and resolution of fall risk issue.

4. What is the single most important barrier to success? Funding-lack of adequate amount to fulfill all requests

5. Do you have any thing else you would like to share with us? Not at this time

SUGGESTIONS FOR KEY COMPONENTS

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

It would have double the amount of funding as it appears we run out in about 6 months. Stocking items would be easier and more accessible to staff. Paperwork in place works very well with the necessary information and I would use it again.