

# Remembering When™ **PLUS**

PARTNERS LINKING YOU TO SERVICES



**Establishing a Community-Engaged  
Network to Refer Older Adults to  
Falls Prevention Programming**



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# IOWA

College of  
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**IPRC** INJURY  
PREVENTION  
RESEARCH  
CENTER

This toolkit was prepared for community organizations interested in developing an infrastructure to actively refer older adults to falls prevention programs in their communities. We present a background about the importance of addressing falls prevention for independent older adults and resources for accessing falls prevention programs that work (Section I). We further provide findings of research conducted by the University of Iowa Injury Prevention Research Center and National Fire Protection Association that informed the development of a community-engaged referral infrastructure for older adult falls prevention in two Iowa communities (one urban and one micropolitan) (Section II). Finally, we provide step-by-step guidance, with examples, of how community organizations can develop and sustain a referral infrastructure that engages and supports independent older adults in falls prevention programming in their communities (Sections III and IV).

**Questions and comments about this toolkit can be addressed to the University of Iowa Injury Prevention Research Center by calling (319) 467-4504 or emailing [iprc@uiowa.edu](mailto:iprc@uiowa.edu).**

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### **Why is falls prevention important?**

Falls are the leading cause of unintentional death and injury among adults at least 65 years of age in the United States (NCIPC, 2019). More than one-fourth of older adults fall each year, and many of these falls result in injury, decreased or permanent loss of functioning, loss of independence and a fear of falling (CDC, 2018). Emergency departments in the U.S. report about three million fall injuries annually among older adults, and more than 800,000 are hospitalized each year due to a fall. Much is known about how to reduce falls among older adults, yet rates of fall-related deaths and injuries among older adults continue to increase (NCIPC, 2019).

### **What types of falls prevention programs that work are available in communities?**

Programs to reduce falls among independent older adults have been identified and extensively researched. Exercise programs are consistently found to be effective in reducing the risk of falls. Interventions that are tailored to each older adult and include multiple components (e.g., physical therapy or an exercise program, medication management and home safety practices) are also effective (Gillespie et al., 2012; Stubbs et al., 2015). Examples of falls prevention programs that work which are endorsed by the Centers for Disease Control and Prevention include: Tai Chi Moving for Better Balance, Stepping On, Otago Falls Prevention Exercise Program, and STopping Elderly Accidents, Deaths and Injuries (STeADI) (Stevens and Burns, 2015).

Although these and other effective programs exist, engaging community-based organizations in falls prevention has been a challenge (Markle-Reid et al., 2015). Organizations have competing demands and priorities and are oftentimes too under-staffed and under-funded to focus specifically on falls prevention.

### Why is it difficult to reach older adults with falls prevention?

Some reasons older adults are hard to reach with falls prevention programs include that they (Jansen et al., 2015; Bunn et al., 2008; Calhoun et al., 2011; Child et al., 2012):

- tend not to prioritize falling as a significant health concern,
- are not aware of their risk for falling and the need to participate in programs,
- have beliefs that falls are just part of aging,
- have low expectations that programs can actually prevent a fall.

Participation in programs can be improved if older adults feel they are meaningful to their desired outcomes—whether these outcomes are a reduction in falls, improved daily functioning, or the ability to maintain their independence (Bunn et al., 2008; Child et al., 2012). In addition, older adults report being more likely to participate in falls prevention programs if they are (Bunn et al., 2008; Calhoun et al., 2011; Siegler et al., 2015; Yardley et al., 2006):

- easy to access and affordable,
- include continued social support from peers, family members, healthcare professionals and other caregivers,
- referred and/or delivered by organizations and individuals that are trusted and influential to them.

### Who do older adults trust?

Healthcare providers are consistently identified by older adults as trusted sources of health and falls prevention information (Calhoun et al., 2011; MacMahon et al., 2011; Bunn et al., 2008), including primary care providers, home healthcare providers and physical therapists.

**Religious institutions** are often well-trusted among older adults, especially ethnic minorities who can have some mistrust of medical institutions. About 60% of adults 65+ years of age are likely to be affiliated with a religious organization and attend services on a regular basis (Stiegler et al., 2015). In addition, most religious institutions have some form of senior outreach, including home visitations.

**Aging services network organizations** provide social and health-related services in both in-home and congregate environments. The network consists of State Units on Aging, such as the Department on Aging and Area Agencies on Aging, as well as local service providers who provide:

- Information and Referral Services (e.g., transportation, case management),
- In-Home Services (e.g., homemaker, personal care, home health, adult day services, caregiver programs),
- Elder Rights Services (e.g., legal assistance, Ombudsman, elder abuse prevention, financial assistance), and
- Other Community Services (e.g., senior centers, Meals on Wheels programs, congregate meal programs).

# Remembering When™: A Fire and Fall Prevention Program for Older Adults

## Program background

Remembering When™: A Fire and Fall Prevention Program for Older Adults was developed by the National Fire Protection Association (NFPA) and Centers for Disease Control and Prevention (CDC) to help older adults live safely at home for as long as possible. Remembering When™ is centered around eight fire safety messages and eight falls prevention messages (**Table 1**).

The program can be delivered in both group and home visit formats by teams of fire service personnel and organizations that serve older adults. Organizations have included Councils on Aging, falls coalitions, home visiting organizations, senior centers, meal delivery programs and social and religious organizations.

Materials are publicly available and can be downloaded from the NFPA website: <https://www.nfpa.org/Public-Education/Teaching-tools/Remembering-When>.

## Program effectiveness

In a study conducted by the University of Iowa Injury Prevention Research Center, in collaboration with the NFPA and Fire Protection Research Foundation, Remembering When™ showed improvements in the following falls prevention behaviors (Casteel et al., 2020):

- clearing paths of travel,
- using non-slip mats, and
- installing grab bars on the walls next to the bathtub, shower and/or toilet

Following the Remembering When™ program, older adults also:

- believed they were better able to perform falls prevention behaviors and prevent a fall, and
- felt they had control over falling

**TABLE 1. REMEMBERING WHEN™ FALLS AND FIRE SAFETY MESSAGES**

### FALLS PREVENTION MESSAGES

1. **Exercise** at least 3 times a week
2. **Take your time** sitting up or from lying down
3. **Keep stairs and walking areas clear** of electrical cords, shoes, clothing, books, magazines and other items
4. **Keep well-lit paths** both inside and outside of your home
5. **Use non-slip mats** in the bathtub and on shower floors; **Have grab bars** installed on the wall next to the bathtub, shower and/or toilet
6. **Remove throw rugs** that do not have rubber, non-skid pads
7. **Keep stairways well-lit; Have sturdy handrails** on both sides of the stairs
8. Wear sturdy, **well-fitting shoes**

### FIRE SAFETY MESSAGES

1. If you smoke, **smoke outside**
2. Keep **space heaters** at least 3 feet away from anything that can burn; Turn off space heaters when you leave your home or go to bed
3. **Stay in the kitchen** when cooking
4. If your clothes catch fire: **Stop, Drop and Roll**
5. **Have smoke alarms installed** on every level of your home, inside each bedroom and outside each sleeping area; Test alarms monthly
6. **Plan and practice your home escape** from fire and smoke
7. Know your **local emergency number**
8. **Plan your home escape** around your abilities; Have a telephone near your bed

The Remembering When™ program also had important outcomes for fire safety. Older adults in the study:

- better understood how to use stop, drop and roll procedures to accommodate their abilities,
- believed in their ability to do fire safety behaviors and prevent a house fire,
- felt they had control in preventing a house fire, and
- understood how susceptible they were to a house fire and how severe the fire could be

Furthermore, during home visits, fire service personnel ensured there were functioning smoke alarms on every level of the home and inside each bedroom.

### Reaching high-risk older adults through fire service personnel

The study also showed that fire service personnel are effective in reaching older adults at high-risk for a fall, and older adults viewed them as compassionate, credible and knowledgeable sources of safety information. One firefighter noted, *“... they were a little bit skeptical at first about us coming into their homes and trying to tell them what to do, but we went there and said, ‘Today we’re not here to judge you... We’re just here to help you try to make things better... Keep you in your home as long as we can.’ They realized that so were good with it.”*

Fire service personnel felt that the Remembering When™ program gave them a “way into” the lives of older adults that opened up the possibility for further interaction and support, with one firefighter stating, *“We don’t do visits like we should ... There really isn’t a very good mechanism to reach seniors, and I think*

*this program does that.”* Older adults appreciated their visit stating they *“felt like [the firefighters] were really interested in you.”*

### Connecting older adults to falls prevention programs that work

Fire service personnel are not traditional deliverers of falls prevention information, and delivering comprehensive evidence-based programs—such as those endorsed by the CDC (Steven and Burns, 2015)—is traditionally outside of the scope of their training. However, fire service personnel felt that the Remembering When™ program was an opportunity to connect high-risk older adults to evidence-based falls prevention programs in their community. One firefighter stated, *“Should I reach out to other community services and then direct them to these people? ... Is there training in that area? ... Shouldn’t I do that? How do I work that in?”*

Similarly, older adult participants expressed interest in having more local resources available to implement Remembering When™ program recommendations, stating *“it might be good to have local resources that you could call upon ... like lists for local area fall and fire safety.”* When asked how the program can be improved, older adult participants expressed interest in having additional information about falls prevention, stating *“[Program] didn’t cover specifics about balance or fall prevention exercises”, “Need balance and reaction time exercises”, “More specific information about how to prevent falls.”*

*“... they were a little bit skeptical at first about us coming into their homes and trying to tell them what to do, but we went there and said, ‘Today we’re not here to judge you... We’re just here to help you try to make things better... Keep you in your home as long as we can.’ They realized that so were good with it.”*


FIREFIGHTER

# Remembering When™ PLUS: Partners Linking you to Services (RW™-PLUS)


As discussed above, reaching older adults with falls prevention programs that work has been challenging, and current dissemination and implementation efforts have had limited success (Goodwin et al., 2011; Lovarini et al., 2013). Multiple stakeholders exist in communities and are working to promote the health of older adults, including falls prevention. However, these stakeholders tend to work in silos and are not aware of, or do not utilize, resources available from other community organizations.

This toolkit describes a community-engaged approach to bring together stakeholders who are already working with older adults in communities. By doing the five steps described below, stakeholders can develop a streamlined referral system that fits within their existing service provision infrastructure to encourage older adults to participate in evidence-based programs in their communities. A participatory approach is recommended by the CDC (Noonan et al., 2011) and has shown to be successful in developing programs that are acceptable by community organizations. The five community-engaged steps and materials that can be used within each of these steps are described in the next section.


## THE FIVE STEPS ARE:

-  **Step 1** Identify falls prevention efforts and resources available at the national-, state-, and local-levels


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-  **Step 2** Establish a local Stakeholder Advisory Board and jointly identify community needs, strengths, and key players


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-  **Step 3** Establish a core group of organizations to take part in the referral network: develop referral structure, implementation plans, and staff training

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-  **Step 4** Develop evaluation plans in consultation with the Stakeholder Advisory Board (SAB)

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-  **Step 5** Train staff, implement referral network, and develop sustainability plans

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 **Step 1**

## Identify falls prevention efforts and resources available at the national-, state-, and local-levels

The first step in developing a referral infrastructure is to review the resources on older adult falls prevention available through national, state and local organizations. National organizations are important to review to understand current falls prevention programs available for older adults. Then, check to see what programs your state and local organizations offer. You may find that there are falls prevention programs that can be added and offered through state and local agencies. Below are some resources you can look into to start.

### National organizations and agencies:

- CDC: <https://www.cdc.gov/homeandrecreationalsafety/falls/programs.html>
  - Guide for implementing community based falls prevention programs: <https://www.cdc.gov/homeandrecreationalsafety/pdf/falls/fallpreventionguide-2015-a.pdf>
- National Council On Aging (NCOA): <https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-programs-for-older-adults-2/>
  - Find falls prevention programs that work in your area: <https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-awareness-week/how-to-get-involved/find-evidence-based-falls-program-area/>

### State and local agencies:

- Check and see if your state or local public health departments and your State Department of Aging have falls prevention specialists and/or programs.
- Other organizations include Area Agencies on Aging, Aging network providers, YMCA, local gyms, and health care systems.

## Step 1



**Informant interviews:** In addition to looking at the data, conducting interviews with key stakeholders is very important to gain a comprehensive understanding about the community, its resources, culture, and how best to approach falls prevention in your specific community. They can also help you identify the key stakeholders and potential members of your Stakeholder Advisory Board

(SAB). Below are some sample questions for local fire departments and other organizations to understand their involvement in falls prevention efforts. Interviews with representatives from state departments can help you identify local falls prevention programs and trained program deliverers in your area. Those you interview can also help you find more stakeholders to interview.

## COMMUNITY ORGANIZATION SURVEY

1. How big of a problem are older adult falls in your region, on a scale from 1 to 10 where 1=Not at all a problem and 10=A significant problem?

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2. What is your organization currently doing in falls prevention for older adults?
  - a. If doing something: What has worked well to sustain these efforts? What have been some barriers to achieving the goals?
  - b. If there were past efforts: Why was the programming discontinued?

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3. What other organizations or coalitions do you know of in your region that are involved in older adult falls prevention efforts?
  - a. Which of these organizations/coalitions would be strong partners in helping to support a referral system for older adults accessing falls prevention programming in their communities? And how would they be strong partners?
    - i. How likely is it that <organization/coalition name> would participate in a referral system on a scale from 1 to 5, where 1=not at all likely and 5=extremely likely?
    - ii. How likely would <organization/coalition name> support older adult participation in these programs on a scale from 1 to 5, where 1=not at all likely and 5=extremely likely?
    - iii. How important would it be for us to include this partner?
  - b. If fire department was not listed: This project involves the fire department as a partner in referring older adults to falls prevention programming. What do you know about the relationship of the <city/town> fire department with its community residents? And older adults specifically?

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4. Is there anything we should be aware of about the risk of older adult falls in this community? (e.g., culture/norms/attitudes surrounding falls prevention among older adults, awareness)

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5. Who else should we talk to in order to learn more about older adult health and wellbeing in your region?

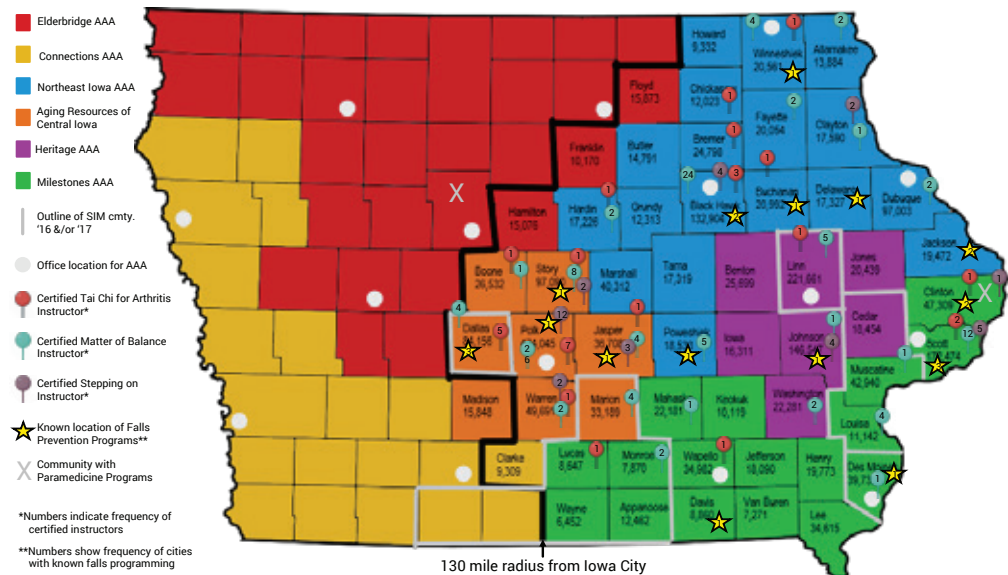
## Step 1

## FIRE DEPARTMENT INTERVIEW SAMPLE QUESTIONS

1. How do you work with older adults in your community?
  - a. What are your experiences with older adult populations in your community?
  - b. What is your department's relationship with older residents in your jurisdiction?
2. What challenges do older adults in your community face?
3. How big of a problem are older adult falls in your community?
4. Do you have a focus on falls prevention? How does your department address older adult falls?
5. What do you see as potential falls prevention interventions for older adults?
6. Do you work with other organizations in your community to support older adults?
  - a. Which organizations?
  - b. How do you collaborate with them?

**Making sense of the data:** Data gathered through the above steps can be summarized to gain a better understanding of the community needs and resource availability.

This map shows the jurisdiction of various organizations, number of evidence-based falls prevention programs, and number of trained program deliverers for various areas in the state of Iowa. This type of map can be used to decide which area(s) to focus on initially and how referral systems need to be structured, for example, for areas without local programs.



You can also present the information in a table or as a PowerPoint presentation.

### EXAMPLE: TABLE PRESENTING THE CHARACTERISTICS OF THE COMMUNITY

City/Town	Resident Population	Older Adult Population	Fire Department Type	Falls Program Trainers	5-Year County Hospitalization Falls Rate per 1,000 Adults 65+ years	1-Year County EMS Calls for Falls among Adults 65+ years	NFPA Material Purchased	Nearby Resources
Cedar Rapids	131,127	17,178	Career/ Part-time (training/ education division)	5 (6 county)	17.9	1,723	Yes	Iowa City
Independence	6,018	1,125	Part-time paid	1	18.8	137	No	Cedar Falls/ Waterloo
Pleasantville	1,694	264	Volunteer	0 (5 county)	12.2	423	No	Indianola
Anamosa	5,553	955	Volunteer	0	13.5	237	No	Cedar Rapids
Burlington	25,663	4,465	Career/EMS partnership	6	23.8	480	Yes	Great River Medical Center

### EXAMPLE: PRESENTING COMMUNITY INFORMATION ON A POWERPOINT SLIDE

Step 1

## BURLINGTON, IA (RE-CAP)

- Des Moines County
- Population 25,663 (65+ population 4,465)
- Fire Department (Career)
  - Partner with EMS and has Educational Component
- 5 MOB; 1 Tai Chi
- Milestones AAA
- NFPA program purchased
- Resources:
  - Great River Medical Center
  - Southeastern Community College
  - Rotary Club and Kiwanis
  - Steamboat Senior Center
  - Public Library and Parks and Rec (senior events)
  - YMCA

## EXAMPLE: SUMMARIZING THE INTERVIEW DATA

**Facilitators to falls prevention**

- Perception that older adult falls are a significant problem in the region
- Fire department looking to engage older adults
- Area Agency on Aging offers evidence-based falls prevention programs
- County health department uses STEADI
  - Referral to community falls prevention programs a barrier
- Interest in building community care model for falls prevention
- Unique transportation model
- Stakeholders: Public Health, Senior Center, home health, meal sites

*"We (fire department) support older adults by working with public health, hospitals, civic groups, charity organizations, Boy Scouts and colleges."*

**Barriers to falls prevention**

- Older adult participation in evidence-based programs can be low
  - RW+ viewed as important pipeline to participation
- Difficult to identify and retain program trainers (e.g., training an add-on to already full workload)
- Difficult to balance training with offering, coordinating and marketing programs
- Difficult to establish connections with hospitals (e.g., if not seen as having "credentials")

*"Evidence-based programs are a real juggling act because we need to have coaches/coaches) and need to have the participants."*

**Present data to activate community engagement:** Data collected from internet searches and informant interviews can be presented to the key stakeholders you interviewed to get additional feedback and information. Convening a community meeting to present data can help facilitate discussions among stakeholders and yield important insights critical for planning next steps. Those you interviewed can help identify stakeholders who should be invited to join the project and be a part of future meetings. Such a meeting is an important first step in identifying formal members of your Stakeholder Advisory Board (Step 2).

### Step 2

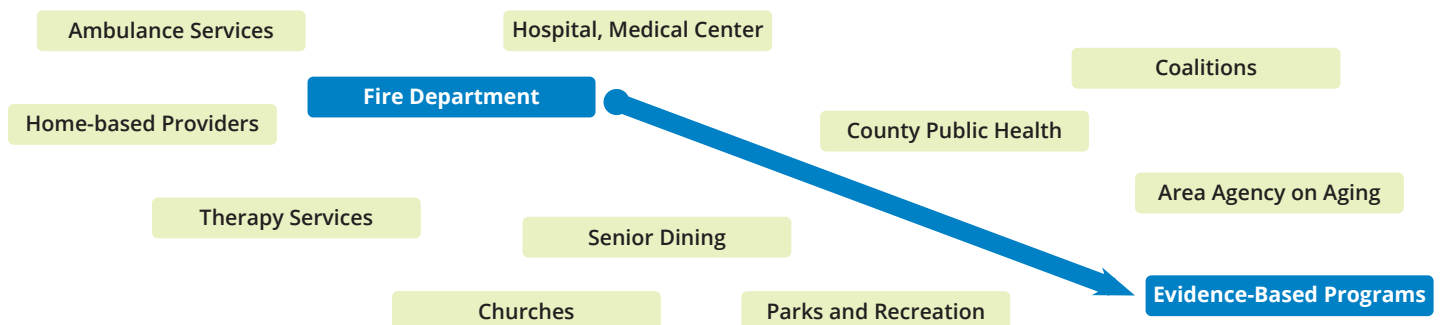
### Establish a local Stakeholder Advisory Board and jointly identify community needs, strengths, and key players

**Establishing a Stakeholder Advisory Board (SAB):** Through Step 1, you have interviewed and talked to key players in your community who work with older adults- in general and falls prevention specifically- and who could be important in providing resources needed to develop a referral infrastructure. Think about those who were most enthusiastic during the interviews and who may have already expressed interest in partnering with you.

- The two key players in the RW™-PLUS network are local fire departments (FD) and agencies that deliver evidence-based falls prevention programs such as your local Area Agency on Aging (AAA).
- In addition, think about partners who: (1) can reach a large number of older adults in the community, (2) provide falls prevention resources and information, (3) have space or a location where older adults can gather, and (4) are trusted in the community. For example, you may choose to reach out to AAAs, county public health departments, senior

and community centers, churches, senior residential locations, home health and other home-based service providers, local health care systems, ambulance services, associations for physical and occupational therapists, social services, and transportation services. The figure below was developed for our project to identify key stakeholders to consider.

- Reach out to formally invite the organization: If the organization participated in the interview or initial community meeting, indicate what you hope that organization would bring to the project. If you have no previous contact with the organization, provide an overview of progress to date (e.g., identified community resources and collected information about community falls prevention and older adult health, interviewed key stakeholders, held a community meeting) and why you are contacting them (e.g., recommendation from another stakeholder, organization provides key missing piece of the infrastructure such as transportation needs of older adults).



### Tip

Let the group know that the goal is to develop guidelines that everyone feels comfortable with to help facilitate the best possible group processes. Frequently ask for suggestions for changes rather than presenting these as given rules. Different organizations have varying priorities which may not always align with the purpose of this project. Therefore, it may be helpful to remind stakeholders of the reason for gathering together to prevent falls and fall-related injury in older adults in your community. This mission should drive the discussion.

**Stakeholder kick-off meeting:** After establishing a SAB, it is important to have an open conversation about how the SAB will operate by understanding the expectations among all parties involved.

- You can start by presenting your expectations and asking the members whether such expectations are doable and acceptable. For example, you may propose how often you meet, what you expect the members to do, and ask what changes are needed so all organizations feel they are able to contribute and can benefit.
- The board members may decide to develop a formal Memorandum of Understanding (MOU) that states expectations for all members. The MOU is not a legal document, rather, it documents good will on the part of all parties and clarifies the terms of the collaborative agreement. Many organizations prefer to have a written and signed document like the one in Appendix 2 to formalize participation.

- Establishing consensus on how to carry out discussions and make decisions during the meeting is important. For example, our SABs discussed such topics as: whether to have a chair person, meeting length, rotating meeting locations, how to handle when someone dominates the conversation, and how to send e-mails to each other (e.g., what to put in the subject line, indicating “response required” as opposed to “information only”).

#### Appendix 2 SECTION IV- STEP 2 STEP 2: MEMORANDUM OF UNDERSTANDING (MOU)

##### MEMORANDUM OF UNDERSTANDING (MOU)

Between  
University of Iowa College of Public Health  
And  
[Partnering Organization]  
For Application To  
RW<sup>TM</sup>-PLUS Program

This Memorandum of Understanding (MOU), while not a legally binding document, does indicate a voluntary agreement to assist in the development of the Remembering When<sup>TM</sup> PLUS program and implementation plans for 2 Iowa communities. The project is funded by the University of Iowa Injury Research Prevention Center and the Centers for Disease Control and Prevention and will be implemented at the University of Iowa College of Public Health. The project is expected to be completed over the course of approximately two years.

##### I. MISSION

The long-term goal of this research is to develop an infrastructure and protocols for maximizing the reach and adoption of evidence-based falls prevention programs by older adults and the community organizations who serve them. This goal will be sought through achieving four objectives stated below:

1. Organize a Stakeholder Advisory Board (SAB) and collaboratively develop a referral infrastructure for the RW<sup>TM</sup> program, called RW<sup>TM</sup>-PLUS.
2. Pilot the implementation and impact of RW<sup>TM</sup>-PLUS in two Iowa communities.
3. Evaluate the reach, adoption, implementation, and maintenance of the RW<sup>TM</sup>-PLUS program.
4. Evaluate the impact of the RW<sup>TM</sup>-PLUS program on behaviors, perceptions and utilization of evidence-based programs.

Together, the parties enter into this Memorandum of Understanding to mutually promote the health and well-being of older adults living in Iowa communities through connecting them to evidence-based programs. Accordingly, the University of Iowa College of Public Health and [partnering organization] will operate under this MOU as follows:

##### II. RESPONSIBILITIES

The research team will:

- Coordinate and participate in meetings of the Stakeholder Advisory Board (SAB)
- Research existing literature on referral programs for older adults and use SAB input to design the RW<sup>TM</sup>-PLUS program
- Develop implementation protocols to pilot test the program
- Schedule and oversee the trainings for the deliverers of the program
- Recruit older adult participants, conduct interviews, provide incentives
- Conduct exit interviews with stakeholders
- Analyze collected data and provide a final report to the funder and SAB members
- Provide an annual stipend of \$1200 (\$600 to be provided at 6-months and at 12-months after the beginning of the project each year)

## POTENTIAL MOU POINTS

### Engage in meetings

### Contribute to project activities

- Review materials & give feedback
- Support community assessments
- Recruit key stakeholders

### Support our initiatives

- Refer clients/organizations
- Facilitate networking
- Publicity

### Evaluation: Yearly interview

**Collaboratively develop referral infrastructure** by identifying community needs, strengths, and active players

- Present project objective to build a referral infrastructure within the community, and discuss data from Step 1 to identify additional information that may be needed to develop the infrastructure.
- Working with the SAB, identify the community's current service delivery infrastructure and key partners. In addition to talking to implementers and coaches of falls prevention programs, talk with the administrators of these agencies to gauge the feasibility of developing and sustaining a referral infrastructure that engages multiple organizations and agencies in the community. Ask the SAB to identify additional partners that should be included.
- Identify facilitators and barriers to collaboration among organizations of aging services within the community. The goal is to not create new resources but work with existing resources.
- **Identifying core partners of the infrastructure:** There are two components in the Remembering When™-PLUS program: Referral and Program Delivery. Think about what roles need to be filled in each of the two components. For example, in the referral component, you will need partners who can reach older adults, receive referrals, help with falls prevention program scheduling, provide transportation support, and determine how to sustain the referral

network. In the program delivery component, you will need partners who provide falls prevention programs, have space for delivering the programs, have funding decision-making authority, and can ensure the quality and continuity of programming. Sample discussion aids are provided on page 20.

**Evaluating the SAB functioning:** It is important to check in with the SAB members periodically to assess how the SAB processes and interactions are going. You can conduct assessments to ask their perceptions about how well the group is functioning. Tools to assess the functioning of community advisory boards are available (Israel et al., 2012). Present the results to the SAB members to get feedback and start a discussion that can help improve the group processes and functioning. This will promote sustainability of the SAB and keep SAB members engaged. Sample survey questions (Appendix 3) along with a report summarizing survey responses (Appendix 4) from the Iowa project are included in this toolkit. Note that you do not need to prepare extensive surveys—just something to check in periodically with your SAB members.

## Step 2

**Appendix 3 SECTION IV: STEP 2**  
**STEP 2: REMEMBERING WHEN™ SAB SURVEY**

**Remembering When™ SAB Survey**

Thank you for supporting the RW™-PLUS project being conducted by the University of Iowa. As we discussed at the beginning of the project, we would like to conduct an annual survey in which we ask you to answer questions regarding how our project went during the first year (December 2017-August 2018). The responses to these questions will remain confidential and will not be reflected back to the respondent.

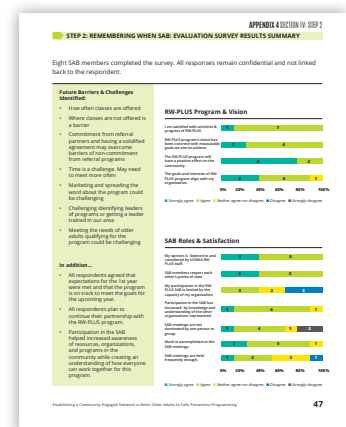
The questions are about the current progress and work completed to begin developing the referral network for the Remembering When™-PLUS program. We would like to understand how the information you provide will be used to help improve the SAB partnership process. Results of this evaluation will be presented to the SAB as a team.

Please select the response option that best corresponds to what you think or feel using the scale provided. If you are not comfortable answering a question, please leave it blank.

**For the following series of statements, please select how much you agree with the statement:**

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I am personally involved with the activities and programs of the RW™-PLUS program during the past 6 months.					
2. The RW™-PLUS program has been successful in meeting the needs of the community.					
3. The RW™-PLUS program will have a positive effect on the community.					
4. I discuss SAB meeting results.					
5. I find SAB meetings to be well organized.					
6. SAB meetings are well attended by participants.					
7. SAB meetings are well attended by participants.					
8. SAB meetings are well attended by participants.					
9. SAB meetings are well attended by participants.					
10. SAB meetings are well attended by participants.					
11. When the SAB makes a decision, implementation follows up.					

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## Step 2

### DEVELOPMENT OF THE REFERRAL COMPONENT

Community	Town A	Town B	Town C
Who has access to older adults who can benefit from this program (who can motivate/recruit and who can refer older adults)?			
Who will receive referrals and schedule older adults to participate in programs?			
Who can help older adults get to the programs (i.e. transportation)?			
Who will follow-up to make sure that the referral is carried out (coordinator/guide the program)?			
Who can ensure the continuation of the referral system?			
For continuation, what does the person/organization in charge need to do to continue the program (i.e. incentives)?			

### DEVELOPMENT OF THE DELIVERY COMPONENT

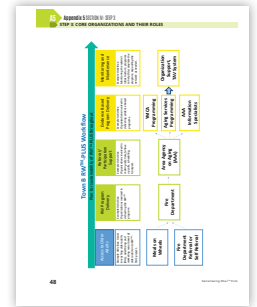
Community	Town A	Town B	Town C
Who provides falls prevention programs?			
Who else can implement falls prevention programs (new deliverers—who makes decisions on program offerings)?			
Who will make resources available to implement the program (space and scheduling and advertising)?			
What other resources are needed to implement the program?			
Who can ensure the continuation of the referral program and what do they need to do?			
Why would they do it (continue the program)—i.e. determinants/incentives?			
What can we do to help this individual continue the program?			

## Step 3

### Establish a core group of organizations to take part in the referral network: develop referral structure, implementation plans, and staff training

Through the procedures in Step 2, identify a small group of organizations that will participate in the initial referral infrastructure and meet more frequently to establish the details of the infrastructure. Keep this core group small to ensure feasibility, for example, by identifying: (1) one organization that

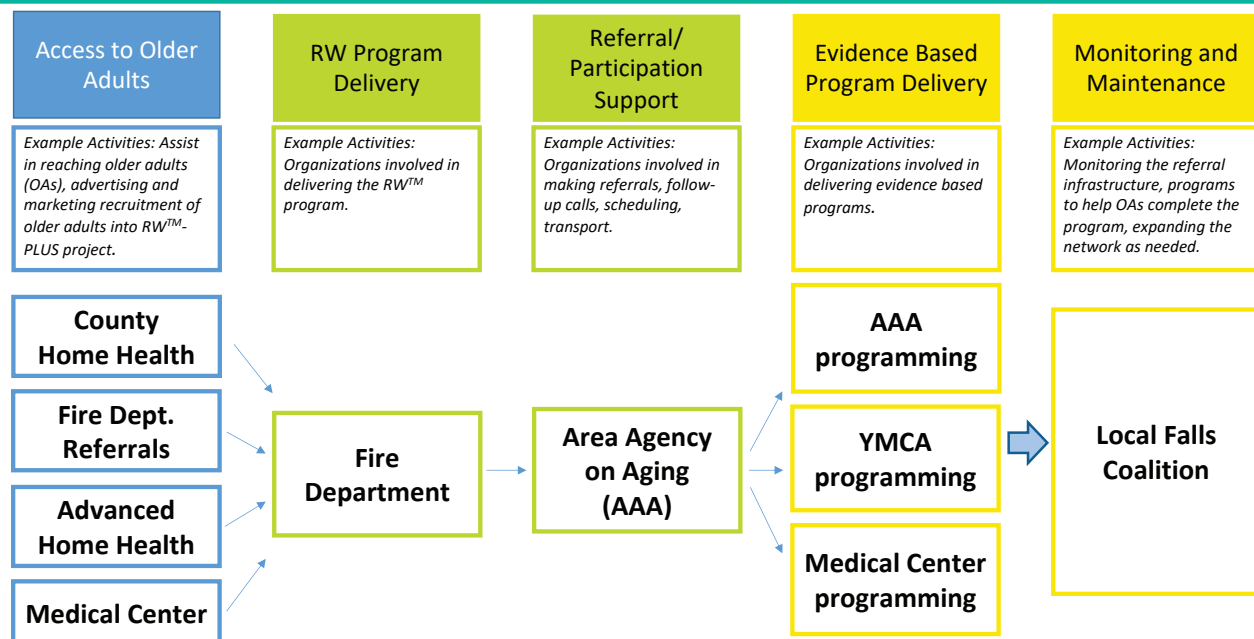
will reach out to older adults, (2) a fire department to deliver RW™, (3) at least one organization that provides falls prevention programs that work, and (4) one organization that connects older adults from the fire department to the program deliverers.



#### CORE ORGANIZATIONS AND THEIR ROLES

##### Town C RW™-PLUS Workflow

Plan for sustainability of RW™-PLUS throughout



Once the representatives of these core organizations (identified from the SAB) agree to their organization's role within the referral infrastructure, identify a contact person at each organization who will be responsible for completing the tasks such as intake, outreach, referral, and program delivery.

Convene a series of meetings to establish a preliminary workflow.

- Learn each organization's current client workflow and discuss how RW™-PLUS procedures can be embedded with minimal disruption in the flow. Note that this is subject to change based on organizations' resources, and that organizations may fit into multiple roles. Below is what we did in two Iowa communities.

- **Outreach:** In one community, the group decided to reach older adults through the Meals on Wheels program by having drivers conduct a three-question screening to identify older adults at high risk for a fall (Chang et al., 2004; Tinetti and Kumar, 2010). In another community, home health nurses conducted the screening with their patients as part of their routine health assessments.

- **Remembering When™ delivery:** In one community, the fire department had an education and outreach department that could receive referrals and deliver the Remembering When™ program. In another community, a battalion chief became a point person to receive referrals and deliver or designate other staff to deliver the program.
- **Information and referral:** In one community, a falls prevention specialist at a local Area Agency on Aging (AAA) became the direct receiver of the referrals from the fire department. In another community, an information and referral staff member at the AAA received referrals from the fire department and contacted older adults to help them sign up for a falls prevention program that fit their specific needs, abilities and interests.

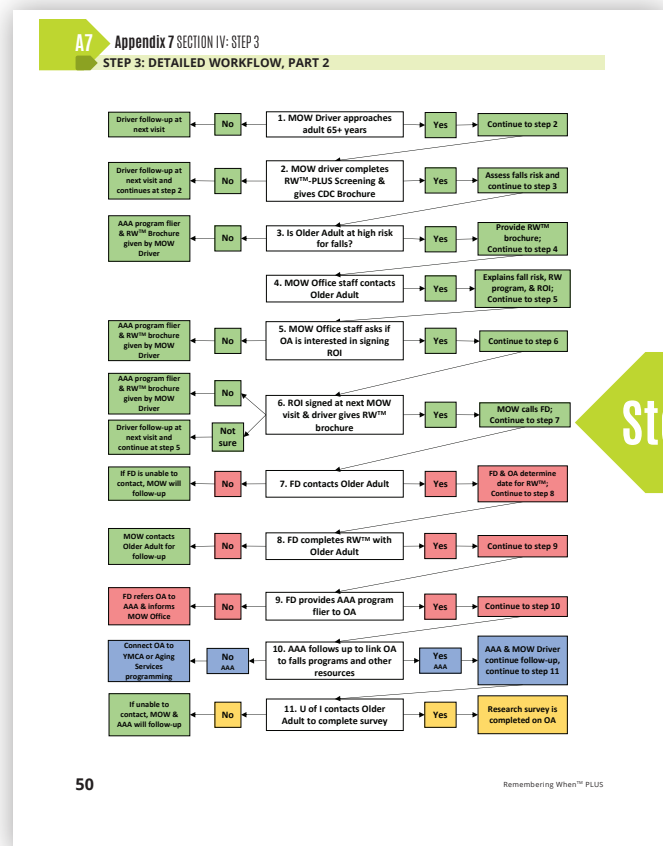
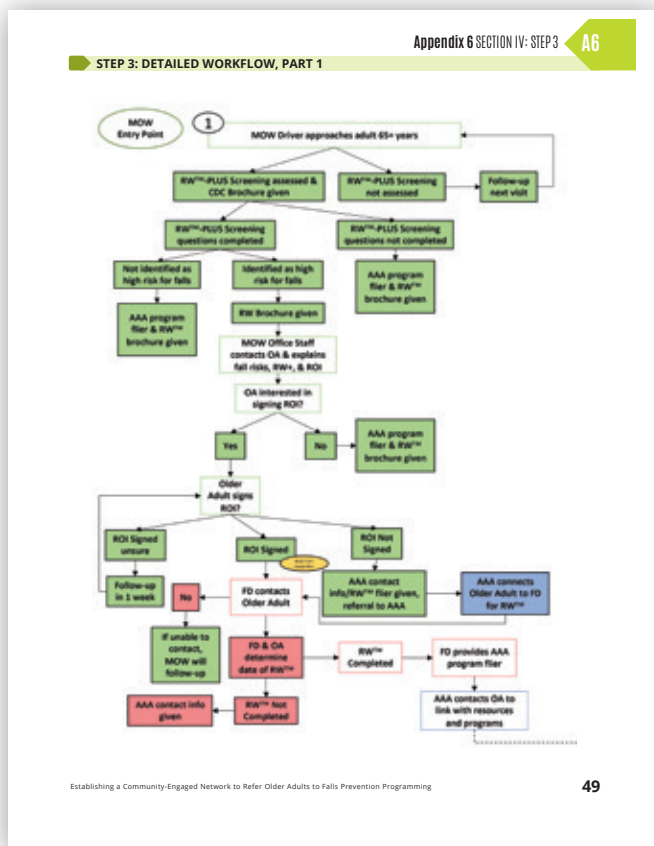
### Three questions to assess falls risk:

- Have you fallen in the past year?
- Do you feel unsteady when standing or walking?
- Do you worry about falling?

- **Develop a detailed workflow:**

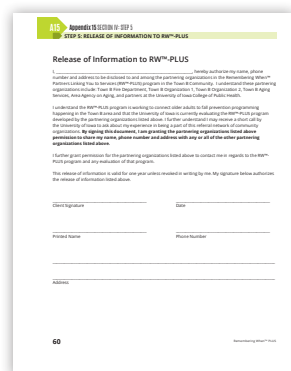
Two examples are provided below and available in Appendices 6 and 7. These diagrams visually show the same workflow in two different ways. The triage diagram on the left and the flowchart on the right show what occurs at each step of the process for each possible option. The workflow follows an “If this, then this” logic. Boxes within the diagram are color coded to show which organization completes each step along the referral infrastructure. This

allows stakeholders to visualize the order each organization appears in the referral infrastructure and how they fit together. It is important to understand your stakeholders and their knowledge and skills in order to develop materials that make sense to everyone. It may be necessary to create multiple versions of the same workflow, including written descriptions, diagrams, or other visuals, in order for everyone within the referral network to understand the process.



**AAA**=Area Agency on Aging  
**CDC**=Centers for Disease Control and Prevention  
**FD**=Fire Department  
**MOW**=Meals on Wheels  
**OA**=older adult  
**ROI**=Release of Information

Identify existing electronic communication systems or discuss preferred ways to communicate to refer and support older adults throughout the referral infrastructure. Some organizations may prefer standard tools like using telephone and fax, but the group may desire to develop a new communication system that will better protect personal information about the older adult (e.g., name, home address, phone number). Note that some organizations may want the older adult to sign a document, which would allow all organizations in the referral network access to this personal information (example in Appendix 16).



## Database needs:

- Easy access for all organizations in the referral network
- Data security to keep personal information confidential
- Automated e-mail notification that alerts organizations in the referral network that they need to provide a RW™-PLUS service to the older adult
- Easy data entry interface



## TAV system – using an existing referral tool

TAVConnect is an electronic referral system that allows community organizations to share demographic, medical and social information electronically with other local health and service providers in order to help clients and patients receive assistance with social services and support.

## Strengths and weaknesses

- **Strengths:** Easy connection to other organizations, formal training available from TAV system vendor, purpose is to serve as a case management system to provide continuity of services across multiple community organizations
- **Weakness:** Costs money to join/ utilize



## Developing a tool just for this referral network

If you partner with an academic institution, you may have access to research databases such as REDCap and Qualtrics:

- **REDCap** (Research Electronic Data Capture) is a secure web application for building and managing online surveys and databases. It allows users to create separate data collection forms that prompt referrals via email to the next organization in the referral network.
- **Qualtrics** is an online survey tool that allows you to build and distribute surveys, then analyze responses.

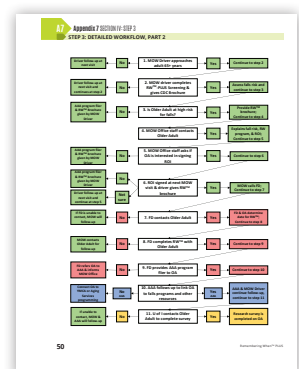
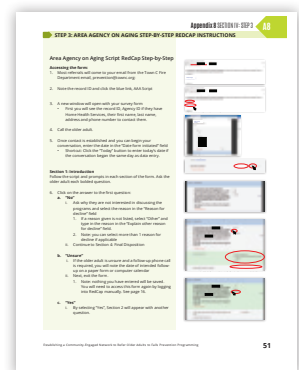
## Strengths and weaknesses

- **Strengths:** Data security to protect personal information and any sensitive data collected
- **Weakness:** REDCap is not user-friendly, both systems require purchase of licenses to use

Develop materials for the referral network and scripts for organizations

- **Intake scripts:** These forms are used to collect the necessary data such as the answers to the three falls screening questions and the contact information for the participant. It should also include scripting that staff can follow while talking with the older adult to ensure no data elements are missed.
- **Step-by-step guides for data entry:** Prepare an instruction manual with pictures and diagrams for staff to follow when logging into and entering data into a database, as well as where to view or send a referral. A partial example is provided in Appendix 8.
- **Training presentations:** Provide members of the referral infrastructure with the instructions necessary to complete their portion of the referral network (see Step 5 for more details).
- **Folder of handouts for older adults:** (see Step 5 for a list of documents)

Convene the core referral network organizations to run-through the workflow, test communication strategies and tools, and review materials including when to disseminate materials and what to do when departures from the workflow occur. (Appendix 7)



 **Step 4**

**Develop evaluation plans in consultation with the Stakeholder Advisory Board (SAB)**

It is important to have a clear idea of what you want to see as outcomes of the RW™-PLUS program and how you can document progress and success before implementation. Before starting program implementation (Step 5), discuss the following with the SAB:

- Program goals and desired outcomes
- What data should be and can be collected
- How the data will be used to further refine and improve the program

Discuss and identify short-term, medium-term, and long-term goals that the group wants to see achieved (and that should be measured). Some examples of short-, medium-, and long-term goals are provided in the table below.

**SHORT-TERM, MEDIUM-TERM, AND LONG-TERM GOALS**

<b>Short-term goals</b>	<ul style="list-style-type: none"><li>• Bring together a group of organizations that may want to participate in RW™-PLUS;</li><li>• Formalize commitments (e.g., by using the MOU or other documentation)</li><li>•</li></ul>
<b>Medium-term goals</b>	<ul style="list-style-type: none"><li>• Develop and implement the referral communication system, including the use of electronic system if chosen</li><li>•</li></ul>
<b>Long-term goals</b>	<ul style="list-style-type: none"><li>• Develop a sustainability plan that includes input and roles (e.g., lead organization) from each organization involved in the network</li><li>•</li></ul>
<b>If we accomplish these goals, we expect...</b>	<ul style="list-style-type: none"><li>• Falls in older adults to decrease</li><li>• Participation in falls prevention programs to increase</li></ul>

**Evaluation methods:** With the Stakeholder Advisory Board, identify measures of success and areas needing improvement that can be collected and analyzed before, during and after implementation of RW™-PLUS. For example, our project collected data through the following methods.

- **Interviews:** It is important to obtain multiple perspectives of how the infrastructure worked:
  - Older adults who participated in the program: What were their experiences like participating in this program? What were their general reactions? Were there suggestions for improvement?
  - Organization staff who were directly involved (e.g., outreach, program delivery, provision of information and assistance): How feasible is this program? What helped implementation of the program? What were barriers to its success? What do you think the impact of the program was? Do you think this program is suitable for older adults in your community? What feedback did you receive from older adults who participated?
  - Administrators of the involved organizations: How did the program align with the organizational values and mission? How did the program fit in with the infrastructure of the organization? How did the program work with the daily service delivery routine of the organization?
- Others who were not part of the core infrastructure but who helped or were involved: There may have been volunteers or other organizations that supported the implementation (e.g., volunteers, transportation services, public library or residential facilities that provided space) who can provide you feedback and insights helpful for sustaining or expanding the program.
- Larger group of organizations that participated in Step 2. Those organizations may see ways to participate to expand the core referral infrastructure initially developed by the smaller group.
- **Program data:** recruitment/outreach log (e.g., number of older adults screened using the three questions in Section 3, screening outcome [e.g., at high risk for a fall/not at high risk for a fall; lives in fire department jurisdiction/does not live in fire department jurisdiction]), referral communication log (e.g., tracking of older adult progress in the referral network), number of older adults who completed each step of RW™-PLUS (e.g., RW™ program, referral to evidence-based falls prevention program, initial participation in falls prevention program), program attendance and completion, feedback and comments made to the staff about program.
- **Community indicators:** 911 calls for falls assistance, ER visits for falls, hospitalizations for falls, fall-related deaths.

## Tip

It is important to consult and discuss an evaluation plan with your SAB members prior to program implementation in order to identify and decide which measures will be collected, how they will be collected and who will collect them. This will help ensure the feasibility of data collection, organizational buy-in for maximum compliance/ support/ participation, and efforts toward short-, medium- and long-term goals.

## Step 4

## SAMPLE QUESTIONS TO EVALUATE YOUR RW<sup>TM</sup>-PLUS PROGRAM

Measure	Sample Questions	Data source
Reach	<ul style="list-style-type: none"> <li>What are the characteristics of older adults who were approached and participated vs. those who declined (e.g., gender, race, falls risk, type of residence [e.g., single-dwelling, apartment, mobile home]).</li> <li>How likely is it that we can reach high-risk older adults from under-represented locations (e.g., rural, low income) using the proposed strategies/plans?</li> <li>What were the motivators/barriers to older adult participation in RW<sup>TM</sup>-PLUS?</li> </ul>	<ul style="list-style-type: none"> <li>Delivery team recruitment log</li> <li>SAB, delivery team interviews</li> <li>Older adult interviews</li> </ul>
Effectiveness	<ul style="list-style-type: none"> <li>Health impacts: participation in evidence-based falls prevention programs, number of falls, changes in perceptions related to falls (e.g., knowledge/skills, self-efficacy, perceived benefits, perceived barriers, falls risks/fear).</li> </ul> <p><b>Additional questions for in-depth inquiry:</b></p> <ul style="list-style-type: none"> <li>What were the positive/negative outcomes identified by older adults, RW<sup>TM</sup>-PLUS delivery teams and providers of community-based falls prevention programs?</li> <li>What unintended consequences or unexpected outcomes occurred?</li> <li>How did behaviors, risk factors and perceptions associated with falls change due to RW<sup>TM</sup>-PLUS participation?</li> </ul>	<ul style="list-style-type: none"> <li>Delivery team, falls program provider, older adult interviews</li> </ul>
Adoption	<p><b>Older adults</b></p> <ul style="list-style-type: none"> <li>What were the facilitators/barriers to participation in RW<sup>TM</sup>-PLUS including the community-based falls prevention program?</li> </ul> <p><b>Delivery team and falls prevention program providers</b></p> <ul style="list-style-type: none"> <li>What were the facilitators/barriers to program delivery?</li> <li>What challenges occurred and how were they addressed?</li> </ul> <p><b>Organization administrators</b></p> <ul style="list-style-type: none"> <li>What motivated your organization to participate? What challenges occurred?</li> </ul>	<ul style="list-style-type: none"> <li>Older adult interviews</li> <li>Delivery team, falls program provider interviews</li> <li>Administrator survey</li> </ul>
Implementation	<ul style="list-style-type: none"> <li>What adjustments were made during RW<sup>TM</sup>-PLUS program delivery and why?</li> <li>To what extent were program delivery protocols followed as intended?</li> </ul>	<ul style="list-style-type: none"> <li>Delivery team interviews</li> <li>Program delivery log</li> </ul>
Maintenance	<p><b>Older adults</b></p> <ul style="list-style-type: none"> <li>How likely is it that you will continue to...               <ul style="list-style-type: none"> <li>participate in the falls prevention program that you were referred to?</li> <li>use falls prevention program knowledge and materials following program participation?</li> </ul> </li> </ul> <p><b>Delivery team/administrators</b></p> <ul style="list-style-type: none"> <li>How likely is it that...               <ul style="list-style-type: none"> <li>program recipients will continue to use knowledge provided in RW<sup>TM</sup>?</li> <li>those receiving referrals to falls prevention programs will participate?</li> <li>you/your organization will continue to deliver the RW<sup>TM</sup>-PLUS program?</li> <li>RW<sup>TM</sup>-PLUS will be integrated into the practice of your organization? community?</li> </ul> </li> <li>What are the challenges associated with continuing this program and how will you address them?</li> </ul> <p><b>Administrators/SAB members</b></p> <ul style="list-style-type: none"> <li>What are the costs associated with implementing RW<sup>TM</sup>-PLUS? (financial, human resources, time, electronic tools)</li> <li>How likely is it that resources needed for RW<sup>TM</sup>-PLUS will continue in your community?</li> <li>What are the challenges in continuing this program and how will you address then?</li> <li>What additional organizations could participate in RW<sup>TM</sup>-PLUS in the future and what would their role(s) be?</li> </ul>	<ul style="list-style-type: none"> <li>Older adult interviews</li> <li>Delivery team and administrator interviews</li> <li>Delivery team organization, SAB surveys</li> </ul>

Using an existing evaluation framework, such as RE-AIM (Reach, Effectiveness, Adoption, Implementation and Maintenance), can help assess the impact of the program. For example, key evaluation questions recommended within this framework can assess whether the RW™-PLUS program is accessible to high-risk older adults from diverse areas (reach); identify positive and negative outcomes of the RW™-PLUS program (effectiveness); identify barriers and facilitators associated with implementation of RW™-PLUS by organizations (adoption); assess the extent to which the RW™-PLUS program was delivered as planned (implementation) and; assess the extent to which RW-PLUS can be sustained to bring long-lasting benefits in the community (maintenance). By assessing these factors, RW™-PLUS can be developed to maximize its reach, effectiveness, adoption, implementation, and maintenance. RE-AIM resources are available at <http://www.re-aim.org/resources-and-tools/>.

The table on the previous page provides sample questions that you can use to evaluate your RW™-PLUS program.

**Other evaluation models:** Many models of program evaluations and tools are available. The Centers for Disease Control and Prevention provide various evaluation resources and tools at: <https://www.cdc.gov/eval/resources/index.htm>.

Partnering with an outside evaluator can help reduce the burden on organizations that are delivering the program. Many researchers at academic institutions are interested in learning how public health programs like RW™-PLUS work in practice. Outside evaluators can help oversee and consolidate data from various sources, analyze the data, and present program findings to different audiences (e.g., community members, program recipients, funding agencies, policy makers, academic community). The outside evaluator can work with the SAB to develop evaluation plans. For academic evaluators, look for Colleges or Schools of Public Health and browse the websites for potential partners. Also look for Centers that can support evaluation, such as the CDC-funded Injury Control Research Centers (<https://www.cdc.gov/injury/erpo/icrc/index.html>) and Prevention Research Centers (<https://www.cdc.gov/prc/index.htm>).

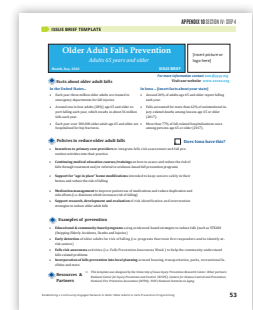
## Step 4

## Step 4

**Dissemination plan:** Using/presenting the evaluation data:

The goal of the dissemination plan is to broadly engage stakeholder audiences involved in the project in the interpretation of program findings and to inform larger audiences of the findings and implications for practice. The audiences for dissemination will include organizations and older adults who collaborated or participated in the research, state agencies, organizations that can use the study findings to inform their own practices such as aging network providers, program funders, policy makers and researchers.

- Convene periodic SAB retreats to share and discuss RW™-PLUS reach, effectiveness, adoption, implementation, and maintenance to review and adjust strategic plans.
- Present program findings to units/agencies that may have funding and resources to support maintenance and future expansion.
- Convene a community forum to present information about RW™-PLUS development and impacts to increase interest and participation from organizations, older adult residents and their caregivers, and other stakeholders who can be influential in supporting the referral network. These stakeholders may come from nontraditional falls prevention partners, but from places where older adults can be reached (e.g., religious institutions, Meals on Wheels programs). Seek input on data interpretation and what it means to the community, as well as recommendations for practice.
- Develop dissemination products tailored to the audiences you want to reach.
- **Stakeholder Advisory Board members:** full report with summary study findings and a fact sheet that can be disseminated to the larger community. A sample newsletter is provided in Appendix 9.
- **Communities:** report briefly summarizing the study and its findings, with succinct and specific recommendations about the implications of the study in practice. Community audiences may include older adult residents, families supporting older adults, agencies that provide support to older adults, and other social units such as community centers and religious institutions.
- **Scientific audience:** research publications and presentations that inform how RW™-PLUS can be successfully implemented by community organizations.
- **Policy makers:** policy brief describing the burden of older adult falls in your community, key findings of your program, and next steps (see Appendix 10 for a policy brief template).




**Step 5**
**Train staff, implement referral network,  
and develop sustainability plans**

Through the previous steps, you now have detailed referral procedures outlined. At the end of Step 3, you held a meeting with the core referral network organizations to run through the overall workflow, decided on a communication system, and decided what materials and information would be provided to the organizations and older adult participants. You are now ready to provide hands-on training to the staff members who will be implementing the procedures. Training will be tailored to their specific roles- for example,

- those reaching out and recruiting older adults
- personnel scheduling and delivering the RW™ program
- staff providing information and referral about community-based falls prevention programs
- those supporting older adults to sign up and attend classes

**Fine tuning the procedures:** Training provides an opportunity for final refining of the implementation procedures.

By going through the procedures in detail with the actual delivery staff, you can maximize the fit of the RW™-PLUS procedures with the daily operations and responsibilities of the staff and organizations. The goal is to identify the most optimal procedures and test these procedures as a team.

- Fitting the new procedures into an existing workflow requires assistance from delivery staff. For example, asking falls risk screening questions may easily be integrated into other regularly conducted assessment visits, eliminating the need to involve additional staff or conduct additional visits. In the Iowa project, for example, we added falls risk questions to an existing 6-month health assessment given by public health county home health nurses.
- Ask about the daily workflows and tools the delivery staff routinely use. For example, do outreach staff use a computer or tablet with internet access where the referral can be submitted directly, or will another staff person at the office submit referrals in bulk?

**Step 5**

What should the training achieve? All staff should understand the goals of the RW™-PLUS network, feel comfortable with their role and have confidence in completing the assigned tasks (e.g., completing intake, data entry, conducting referrals). Invite organizational administrators and supervisors to attend the trainings so they can help integrate the RW™-PLUS procedures into the current workflow and troubleshoot issues that may arise. Depending on the needs of the organization, some training may occur in a group setting whereas other trainings may occur at the individual-level.

### [SAMPLE TRAINING AGENDA]

1. Background and Overview: Remembering When™ Program & PLUS network
2. Staff Roles and Tasks
3. Data Collection and Documentation
4. Use of Electronic Tool for Communication
5. Practice and Test with An Example Client
6. Q&A

## Training Contents and Materials

### 1. Background and overview:

- **Background of the RememberingWhen™ program:** Purpose of the program, program development processes, program materials and delivery, and program effectiveness. Details about the RememberingWhen™ program can be found at <https://www.nfpa.org/Public-Education/Teaching-tools/Remembering-When>.
- **Overview of the RW™-PLUS referral network:** Overview of how it was originally developed and implemented as described in this toolkit, and overview of the roles and responsibilities of organizations by key tasks in the referral network: Outreach and Recruitment, RW™ Deliverers, Information and Referral to Evidence-Based Falls Prevention Programs, Falls Prevention Program Deliverers.

**2. Staff roles and tasks:** Introduce roles and expectations specific to the staff and organization. Provide detailed steps to follow for each role. Some steps may require detailed explanations. A “cheat sheet” or condensed versions can be developed for staff to keep with them during training and implementation.

**3. Data collection and documentation:**

- i. **Outreach and recruitment:** Identify eligible participants, describe the RW™-PLUS program, complete older adult consent (ROI if needed) and complete the intake form (sample intake forms in Appendices 11 and 12).
- ii. **Making and receiving referrals:** This is a core element of RW™-PLUS. Have staff members practice and streamline the procedures previously agreed upon using examples and role-playing. It is important to outline detailed steps of how to make and receive the referral whether it be by a database with automated notifications, a secured email, or direct phone call or fax. Follow-up protocols to check on whether the referrals were successful should also be in place. Referral processes should fit each individual organization and could vary within the referral network. Periodically check in with staff to adjust and improve the referral procedures to strengthen the network. An example flow chart with contact persons/information for implementation and delivery staff is available in Appendix 13.
- iii. **Describing programs and services:** It is important to provide informational materials to participants about the referral network and related programs. Review these handouts and materials with staff during the training. Be sure to explain what the handout is, why it is necessary to provide them to the participant, when it should be provided, and what the staff member will tell the participant about it.

**Tip**

Provide a tutorial with role-playing using the screening questions, consenting older adults (so that participants' information can be shared with other organizations in the network), and completing the intake form. Have each person practice using the tool and form -going through one question at a time- to make sure that the screening tool and intake form are completed consistently. This is also an opportunity to refine any questions and/or scripting for better clarity. Bring a printed version of all electronic forms so that staff can record data regardless of internet access or comfort with the technology.

Appendix 11: Remembering When PLUS Fire Department Intake. This form includes sections for participant information, screening questions, and a consent section.

Appendix 12: Remembering When PLUS Home Health Intake. This form includes sections for participant information, screening questions, and a consent section.

Appendix 13: Remembering When PLUS Intake. This form includes sections for participant information, screening questions, and a consent section.

**INFORMATIONAL HANDOUTS MAY INCLUDE:**

- RW™-PLUS information flier
- RW™ Fire Department Brochure
- Contact list of organizations participating in the RW™-PLUS network
- CDC Falls Prevention Brochure
- Release of information form (2 copies: one for the participant and one for the staff/agency)
- List of falls prevention programs and contact information in the local area
- Local Area Agency on Aging Brochure, including information on services
- Other resources from organizations within referral network (e.g., nutrition, transportation, hoarding, social support programs)

**Step 5**

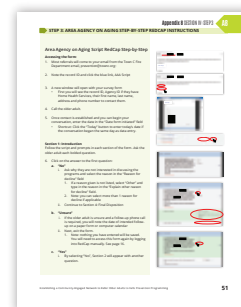
## Step 5

### iv. Record keeping and documentation:

Explain what data will be collected and for what purposes throughout the process. The detailed workflow presented above in Step 3 can indicate when staff should provide which materials to the participants. Identify a person who checks the collected data periodically to ensure it is complete. If you are working with an external evaluator, they may be able to do this. Hold periodic group check-in meetings to review the data, discuss progress and impacts, and troubleshoot issues.

### 4. Use of Electronic Tool for Communication:

If you are using an electronic communication tool, it will be important to provide hands-on training to walkthrough how to access and use the systems (see sample instructions in Appendix 8). Use test data as many times as necessary for staff to practice and feel comfortable using the systems. Training materials for sending and receiving referrals will be specific to your community and organizations.



## MATERIALS AVAILABLE IN THE APPENDICES

	Overview & background	Consent, intake & documentation	Introducing programs & services
Outreach & recruitment	Appendix 1, 5–7, 13	Appendix 12, 15–17, 21, 23	
RW™ delivering organization	Appendix 5–7, 13–14	Appendix 11, 18–19, 22	Appendix 26
Information and referral	Appendix 5–7, 13	Appendix 8, 20	Appendix 24–25
Deliverers of falls programs	Appendix 5–7, 13		

## Tip

Identify a technology point person for each organization, involve them in the training, and connect that technology point person across the organizations. This way, the technology support person can assist the program delivery staff and also communicate with each other to troubleshoot system issues if needed. Having an identified technology point person can help answer questions promptly and identify common issues occurring across multiple organizations.

### 5. Practice and test with an example client:

Start with the organization that is first in line in the referral network (i.e., the organization recruiting older adults into the referral network). That way, you can go through the procedures in the order they occur in the actual implementation. For example, staff at the first organization can create a profile of a new participant (test case) as part of their training and send this person's information to the next organization in line. The training team can then go to the next organization in the referral network that will conduct the RW™ training, showing how to receive referral of this test person and then referring the test person to the organization that will identify appropriate evidence-based falls prevention programs and support participation in a program. This allows the person to practice communicating with the staff from other organizations in the network using the actual communication tool, with the support of the trainers. Special protocols at each referral segment (between two relevant organizations) can be established through this process based on feedback and discussions. You can use the flow charts as described in Appendix 6 as guidance.

**Pilot run-through:** When staff members recruit and refer actual participants and move them through the referral network organizations, trainers and technology support staff should work closely with the staff to ensure smooth steps. This way, system errors can be addressed in a timely manner to reduce staff stress and to provide seamless service to the participants.

### Rolling out the program

After a pilot run-through of the referral network with actual participants and refining the procedures, materials, and tools, it is finally time to put the referral network into action! Work together to select a date when all organizations feel comfortable to begin.



#### Hold a short Tai-Chi program at a congregate meal site to introduce the RW™-PLUS program

- **Introduction:** Short overview of the RW™-PLUS network. Introduce representatives of the organizations involved in the network.
- **Overview of RememberingWhen™:** Fire service personnel provide a short presentation about the program and encourage individuals to sign up for a home visit. (Note: this is not a full RW™ group program.)
- **Try a falls prevention program:** Demonstrate a falls prevention program, such as Tai Chi, to show what a class is like and what older adults would be learning. Provide an opportunity to interact with the instructor of the class.
- **Understand falls risks and get involved:** Older adults complete the falls screening questions and release of information (ROI) so that the fire department can contact them.

## Tip

Tip: Holding a kick-off event is a good way to start the program. This can provide a clear target date for the staff and organizations, and help publicize the program to the community members. It may be helpful to plan around a specific day or event such as:

National Falls Prevention Awareness Day

• Fire safety event

• Local community or organization event

## Step 5

### Sustainability Plans

Sustainability is the most important and the most difficult part of implementing a community-based program like RW™-PLUS. Once you know the referral procedures work, you will need to have a process in place to continue them long-term. Academic institutions supporting the development and evaluation of the program may not be involved long-term especially if they are not physically located in or near the community. Thus, it will be important to:

- Identify a lead organization or person that will keep the referral network functioning and moving forward (if this is a paid position, even better). Establish regular check-ins with the referral network organizations. These can be in-person meetings or sending newsletters- whatever keeps the conversation and momentum going.
- Communicate each organization's capacity to contribute to the referral network (e.g., How many referrals can each organization handle?)

As noted by an organization staff member in the Iowa project: *"It's hard to get everybody in the room at the same time. It's hard to get everybody on the same page... everybody's at different levels of capacity and engagement."*

- Ensure an ongoing funding stream, technical support, and staff training

As noted by an organization administrator in the Iowa project:

*"We sought out and wrote a grant in order to fund a limited number of bus passes so that we could offer those to participants."*

- Periodically identify how each organization is benefiting from participation in the referral network and modify procedures on an as needed basis

As noted by an organization administrator in the Iowa project: *"... it's about identifying key partners that have similar interests in mission and helping older adults remain safely in their homes." "It really provides not only falls prevention, but education and safety for all of our older adults."*

- Gain staff buy-in by creating incentives for staff who will take on additional tasks. *"What really motivated our group was the data... I think it was something like 60% of [our clients] fall... when you look at the data, it really opens up the opportunity."*

- Build local buy-in and engage individuals enthusiastic about the program; activate community resources

As noted by an organization staff member in the Iowa project: *“I think that if we could get just a few more different resources throughout the community involved we would have a larger impact because we would have a larger pool to draw from.”*

- Get information from focus groups or interviews (e.g., participants, deliverers, administrators) to understand how implementation of the referral network may need to be modified or enhanced

As noted by organization administrators in the Iowa project: *“I think being malleable with the model would allow it to address different types of communities... So you can’t have a one size model that would fit all... maybe the messages stay pretty consistent, but how they’re delivered, how they’re communicated, that could be really changed.” “I think the program here could have benefited with more coordination with the health system... taking into account not just outpatient but inpatient work.”*

- Communicate, communicate, communicate! Many of your partners will want to continue after the initial project period, but may lose excitement if they are unsure if other partners are willing to stick with the program for the long-run.

*“Whenever a new community comes on board to try to implement the program... have an initial discussion about the challenges faced by previous implementation so that they can learn from the mistakes...lessons learned becomes a part of what new communities... need to know to be efficient in creating the program.”*

## Step 5

# Conclusion

"I think that it should be a universal standard in the way that falls and fire prevention is provided to every community in the United States."

Organization Administrator

The material in this toolkit provided information, resources and examples for community organizations to develop an infrastructure to actively refer older adults to falls prevention programs in their communities. We presented a background about the importance of falls prevention among independent older adults and resources for accessing falls prevention programs that work (Section I). We further provided findings of research conducted by the University of Iowa Injury Prevention Research Center and National Fire Protection Association that informed the development and implementation of community-engaged referral infrastructures for older adult falls prevention in two Iowa communities (Section II). Finally, we provided step-by-step guidance, with examples, of how community organizations can develop and sustain a referral infrastructure that engages and supports independent older adults in falls prevention programming in their communities (Sections III and IV).

"I would love to see how, or encourage the University team and Remembering When folks to make this available, especially in rural communities.... to develop a tool kit or whatever it takes to offer it as a model or a project that communities could embed and undertake so there are more people helping get falls prevention education and messaging out to our citizens in our communities."

(Organization Administrator)

## CONTRIBUTORS TO RW<sup>TM</sup>-PLUS AND THIS TOOLKIT

AbbeHealth / Aging Services

Advanced Home Health

Age-U-Cate Training Institute, LLC

Benson & Hepker Design

Burlington Fire Department

Cedar Rapids Fire Department

Des Moines County Public Health

Family Caregivers Center of Mercy

Great River Health System

Heritage Area Agency on Aging

Horizons: A Family Service Alliance

Iowa Association of Area Agencies on Aging

Iowa Department of Public Health

Iowa Department on Aging

Johnson County Social Services

Linn County Public Health

Milestones Area Agency on Aging

National Fire Protection Association

University of Iowa College of Public Health

University of Iowa Injury Prevention Research Center

YMCA of the Cedar Rapids Metropolitan Area

**NOW IT'S YOUR TURN!**

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## STEP 1: LOCAL-LEVEL DATA ABOUT TARGET COMMUNITY

Criteria	Information & Notes	Criteria	Information & Notes
Population: Age distribution & number 65+ years of age <sup>a</sup>		Other Aging Programs/Initiatives in Community	
Falls & Fall-Related Injury Rates; EMS Falls Data (local data to identify high need areas)		Transportation Available	
Diversity (include language)		Local Resources Available (e.g., senior or community centers, religious institutions, Area Agencies on Aging, library)	
Fire Department Type		Community-based Programs (e.g., education, meals, companions)	
Fire Department Contact Information		Medical Resources, including physical/occupational therapy and homecare services	
EMS Contact Information		Housing Information (e.g., retirement and senior living communities)	
Other Key Stakeholders		Long-term Care/Assisted Living/Nursing Homes	
NFPA Resources Used		Major Employers	
Evidence-Based Falls Prevention Program Providers			

# MEMORANDUM OF UNDERSTANDING (MOU)

Between  
University of Iowa College of Public Health  
And  
[Partnering Organization]  
For Application To  
RW™-PLUS Program

This Memorandum of Understanding (MOU), while not a legally binding document, does indicate a voluntary agreement to assist in the development of the Remembering When™ PLUS program and implementation plans for 2 Iowa communities. The project is funded by the University of Iowa Injury Research Prevention Center and the Centers for Disease Control and Prevention and will be implemented at the University of Iowa College of Public Health. The project is expected to be completed over the course of approximately two years.

## I. MISSION

The long-term goal of this research is to develop an infrastructure and protocols for maximizing the reach and adoption of evidence-based falls prevention programs by older adults and the community organizations who serve them. This goal will be sought through achieving four objectives stated below:

1. Organize a Stakeholder Advisory Board (SAB) and collaboratively develop a referral infrastructure for the RW™ program, called RW™-PLUS.
2. Pilot the implementation and impact of RW™-PLUS in two Iowa communities.
3. Evaluate the reach, adoption, implementation, and maintenance of the RW™-PLUS program.
4. Evaluate the impact of the RW™-PLUS program on behaviors, perceptions and utilization of evidence-based programs.

Together, the parties enter into this Memorandum of Understanding to mutually promote the health and well-being of older adults living in Iowa communities through connecting them to evidence-based programs. Accordingly, the University of Iowa College of Public Health and [partnering organization] will operate under this MOU as follows:

## II. RESPONSIBILITIES

The research team will:

- Coordinate and participate in meetings of the Stakeholder Advisory Board (SAB)
- Research existing literature on referral programs for older adults and use SAB input to design the RW™-PLUS program
- Develop implementation protocols to pilot test the program
- Schedule and oversee the trainings for the deliverers of the program
- Recruit older adult participants, conduct interviews, provide incentives
- Conduct exit interviews with stakeholders
- Analyze collected data and provide a final report to the funder and SAB members
- Provide an annual stipend of \$1200 (\$600 to be provided at 6-months and at 12-months after the beginning of the project each year)

## STEP 2: MEMORANDUM OF UNDERSTANDING (MOU) CONTINUED

The partnering organization will:

- Participate in the SAB meetings (approximately 12 each year, each lasting about an hour)
- Provide feedback on the RW™-PLUS program throughout development
- Contribute to the development of the RW™-PLUS implementation protocols
- Support research team in identifying and connecting with local stakeholders
- Help identify intervention deliverers and older adult participants
- Provide feedback to results of the RW™-PLUS program
- Help disseminate study findings to key community stakeholders

### III. TERMS OF UNDERSTANDING

The term of this MOU is for a period of approximately two years from the effective date of this agreement and may be extended upon written mutual agreement. It shall be reviewed quarterly to ensure that it is fulfilling its purpose and to make any necessary revisions.

Either organization may terminate this MOU upon thirty days written notice without penalties or liabilities.

### Authorization

The signing of this MOU is not a formal undertaking. It implies that the signatories will strive to reach, to the best of their ability, the objectives stated in the MOU.

On behalf of the organization I represent, I wish to sign this MOU.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## Remembering When™ SAB Survey

Thank you for supporting the RW™-PLUS project being conducted by the University of Iowa. As we discussed at the beginning of the project, we would like to conduct an annual survey in which we ask you to answer questions regarding how our project went during the first year (November 2017-August 2018). The responses to these questions will remain confidential and will not be linked back to the respondent.

The questions are about the current progress and work completed to begin developing the referral network for the Remembering When PLUS programming in selected Iowa communities. The information you provide will be used to help improve the SAB partnership process. Results of this evaluation will be presented to the SAB at a later date.

Please select the response option that best corresponds to what you think or feel using the scale provided. If you are not comfortable answering a question, please leave it blank.

**For the following series of statements, please select how much you agree with the statement:**

Question	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
<b>1</b> I am generally satisfied with the activities and progress of the RW™-PLUS program during the past 9 months.					
<b>2</b> The RW™-PLUS program's vision has been translated into concrete, measurable goals that we aim to achieve.					
<b>3</b> The RW™-PLUS program will have a positive effect on the community it will serve.					
<b>4</b> I find the SAB meetings useful.					
<b>5</b> I find SAB meetings to be well organized.					
<b>5a</b> What worked well and what should be improved (open ended)?					
<b>6</b> Background materials (agendas, minutes, etc.) needed for meetings are prepared and distributed well enough in advance of meetings.					
<b>7</b> One person or group dominates at the SAB meetings.					
<b>8</b> We do not accomplish very much at the SAB meetings.					
<b>9</b> SAB meetings are not held frequently enough.					
<b>10</b> I am satisfied with the overall way in which the RW-PLUS SAB makes decisions.					
<b>11</b> When the SAB makes a decision, appropriate follow-up action is taken by the UIOWA RW™-PLUS staff.					

## STEP 2: REMEMBERING WHEN™ SAB SURVEY (CONTINUED)

For the following series of statements, please select how much you agree with the statement:

Question	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
<b>12</b> Participation in the RW™-PLUS SAB has increased my knowledge and understanding of the other organizations represented.					
<b>13</b> My organization uses knowledge generated by the UIOWA staff and SAB conversations.					
<b>14</b> Membership in the RW™-PLUS partnership requires a considerable time commitment.					
<b>15</b> I am satisfied with my level of participation in the RW™-PLUS SAB.					
<b>16</b> I devote time outside of board meetings to RW™-PLUS activities or projects.					
<b>17</b> My participation in the RW™-PLUS board is limited by the capacity of my organization.					
<b>18</b> The goals and interests of the RW™-PLUS program align with the goals and interests of my organization.					
<b>19</b> I am comfortable expressing my point of view at the SAB meetings.					
<b>20</b> Communication between RW™-PLUS staff and board members is effective.					
<b>21</b> I am comfortable discussing problems and issues with the Research Manager and/or other RW™-PLUS staff.					
<b>22</b> My opinion is listened to and considered by UIOWA staff and investigators.					
<b>23</b> SAB members respect each other's points of views even if they might disagree.					

For the following series of statements, please provide a brief description of your answer in the space following the question:

**24** How has your organization's affiliation with the RW™-PLUS SAB provided benefits to you if any?

## STEP 2: REMEMBERING WHEN™ SAB SURVEY (CONTINUED)

- 25** What does your organization hope to accomplish by its affiliation with the RW™-PLUS program?
- 26** From your organization's perspective, do the benefits of participation in the RW™-PLUS SAB appear to outweigh the costs at this point?
- 27** I have considered having my organization sever its relationship with the SAB. ☐ Yes ☐ No  
If yes, please explain:
- 28** How has the RW™-PLUS program met your expectations for the first year?  
☐ Has not met expectations ☐ Met expectations ☐ Exceeded expectations  
Please explain your answer:
- 29** What sort of challenges or barriers do you foresee for the RW™-PLUS program over the next year? Do you have any recommendations of how the RW™-PLUS program can overcome these challenges or reduce these barriers?
- 30** Please provide any other comments you may have about the progress of the RW-PLUS program, the RW-PLUS SAB, or the University of Iowa team members associated with this program.

## STEP 2: REMEMBERING WHEN™ SAB: EVALUATION SURVEY RESULTS SUMMARY

Eight SAB members completed the survey. All responses remain confidential and not linked back to the respondent.

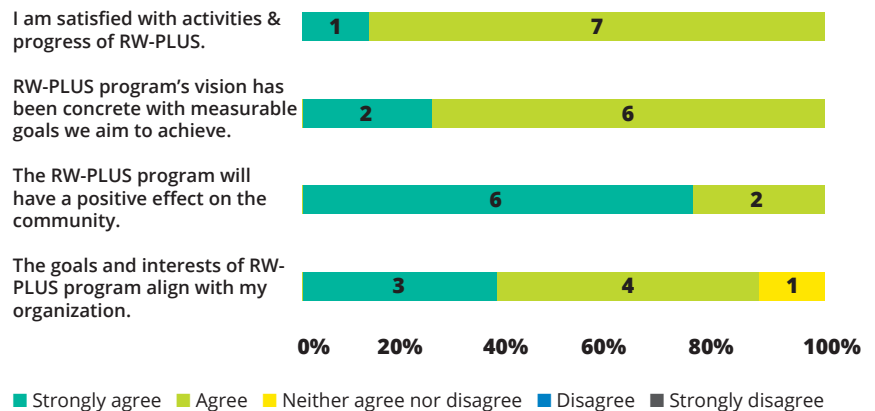
### Future Barriers & Challenges Identified:

- How often classes are offered
- Where classes are not offered is a barrier
- Commitment from referral partners and having a solidified agreement may overcome barriers of non-commitment from referral programs
- Time is a challenge. May need to meet more often
- Marketing and spreading the word about the program could be challenging
- Challenging identifying leaders of programs or getting a leader trained in our area
- Meeting the needs of older adults qualifying for the program could be challenging

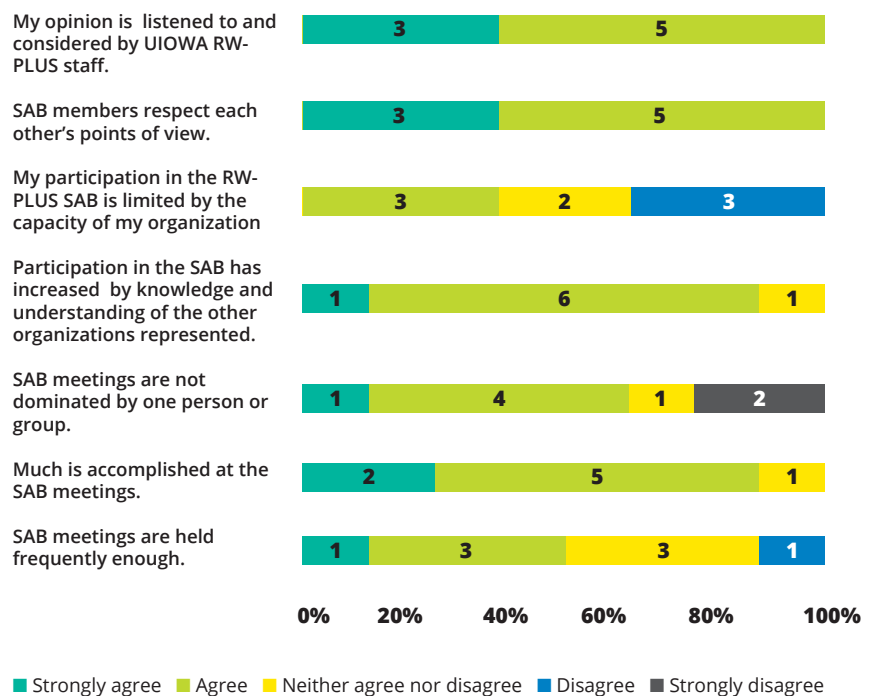
### In addition...

- All respondents agreed that expectations for the 1st year were met and that the program is on track to meet the goals for the upcoming year.
- All respondents plan to continue their partnership with the RW-PLUS program.
- Participation in the SAB helped increased awareness of resources, organizations, and programs in the community while creating an understanding of how everyone can work together for this program.

### RW-PLUS Program & Vision

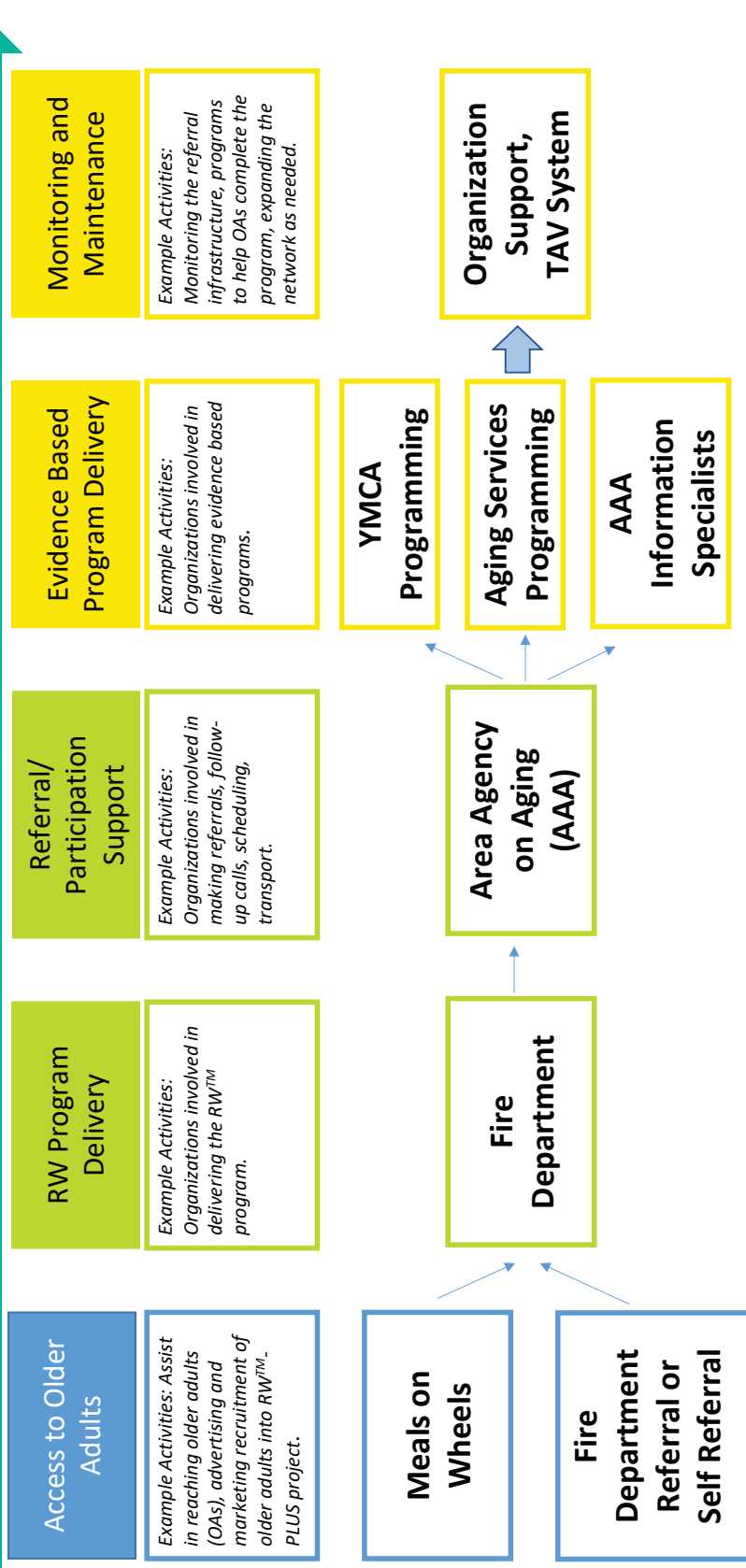


### SAB Roles & Satisfaction

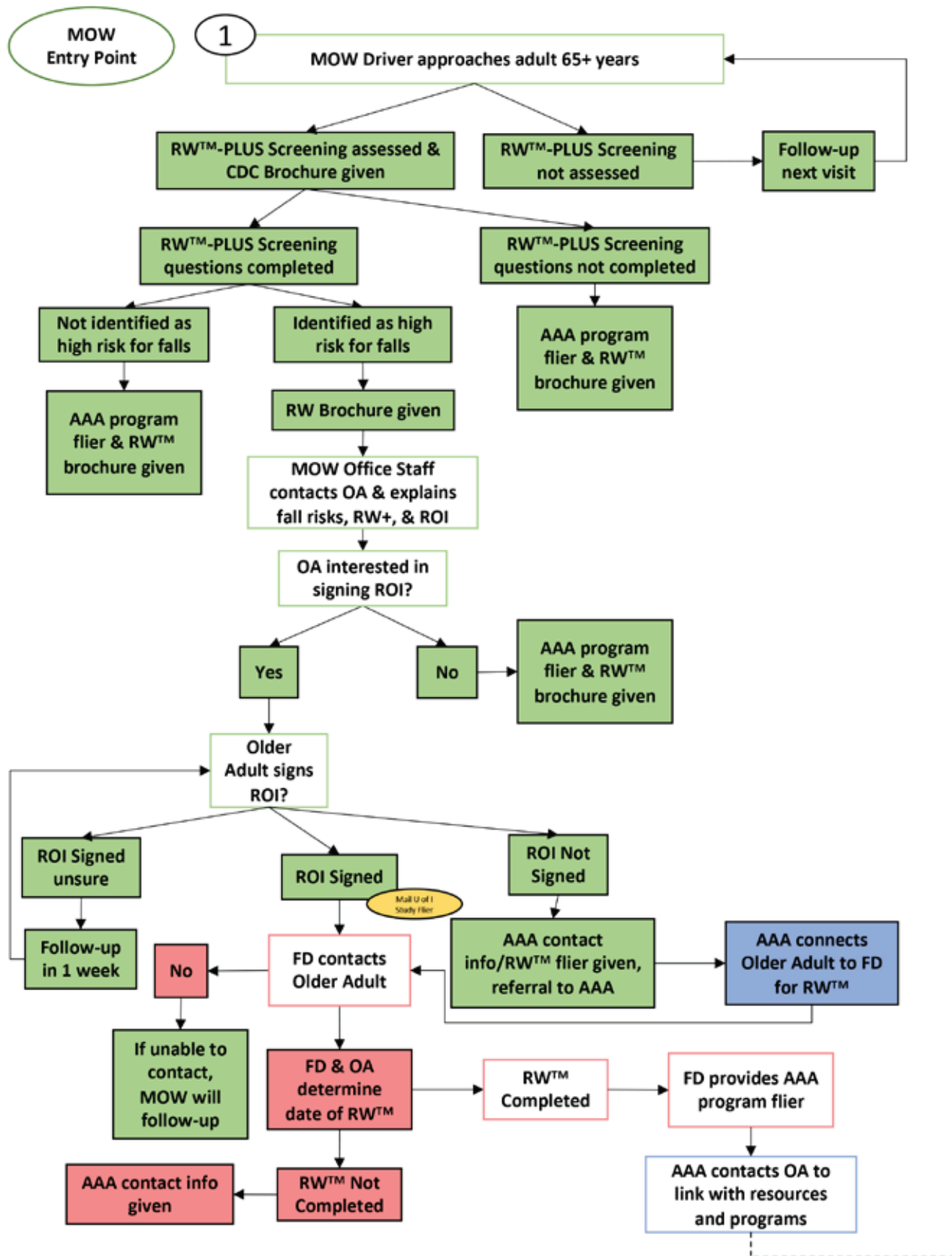


## Town B RW™-PLUS Workflow

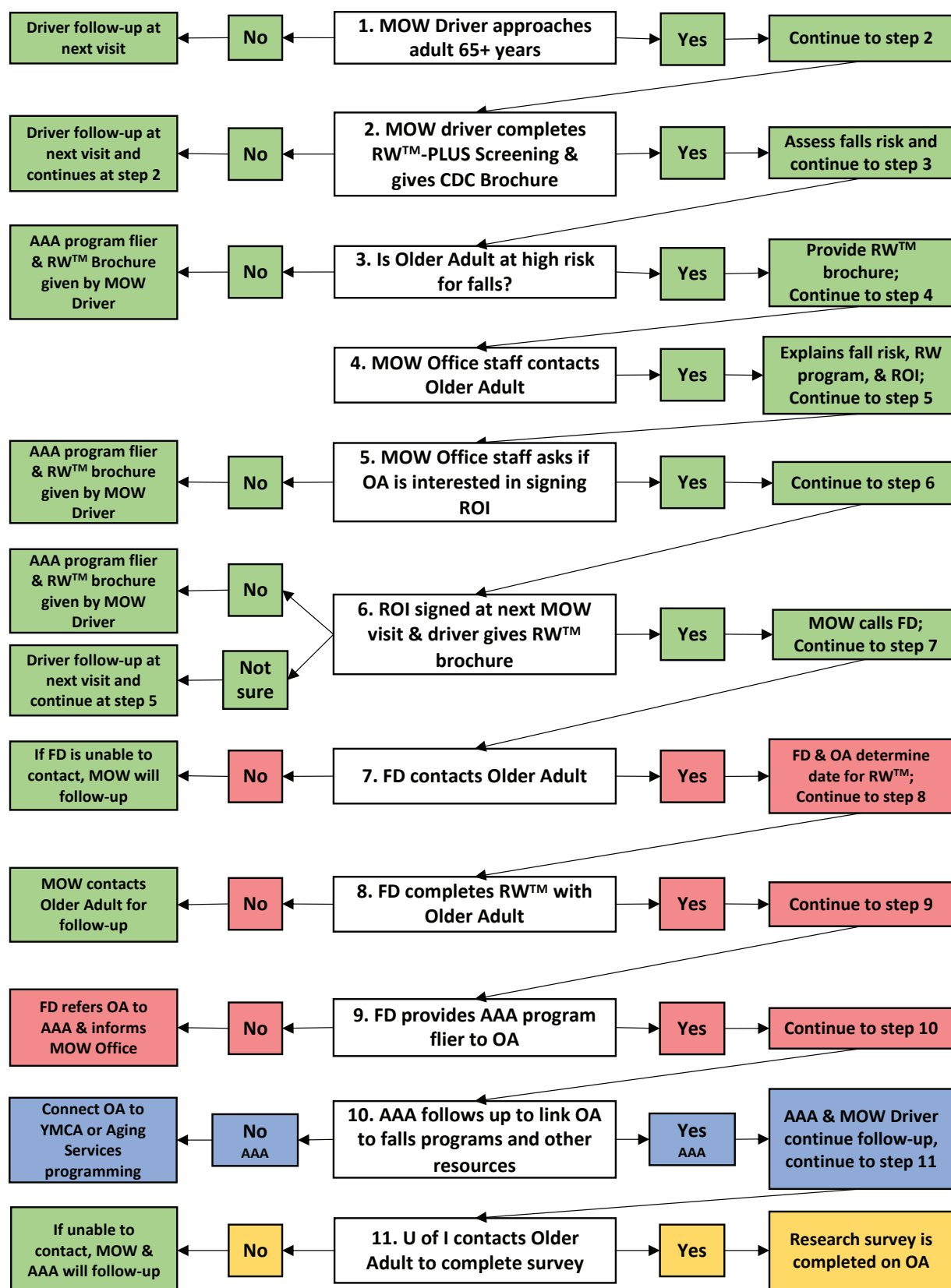
Plan for sustainability of RW™-PLUS throughout



## STEP 3: DETAILED WORKFLOW, PART 1



## STEP 3: DETAILED WORKFLOW, PART 2



## STEP 3: AREA AGENCY ON AGING STEP-BY-STEP REDCAP INSTRUCTIONS

## Area Agency on Aging Script RedCap Step-by-Step

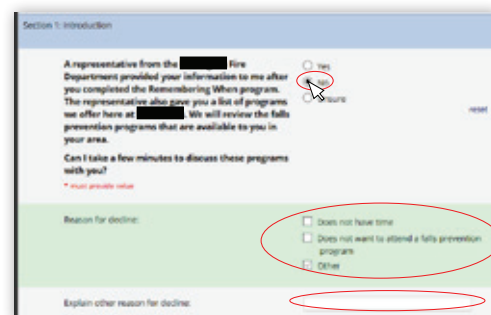
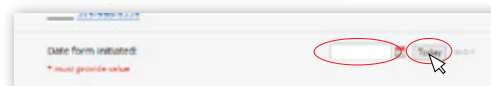
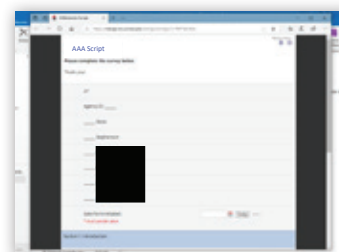
## Accessing the form:

1. Most referrals will come to your email from the Town C Fire Department email, prevention@townc.org:
2. Note the record ID and click the blue link, AAA Script
3. A new window will open with your survey form
  - First you will see the record ID, Agency ID if they have Home Health Services, their first name, last name, address and phone number to contact them.
4. Call the older adult.
5. Once contact is established and you can begin your conversation, enter the date in the "Date form initiated" field
  - Shortcut: Click the "Today" button to enter today's date if the conversation began the same day as data entry.

## Section 1: Introduction

Follow the script and prompts in each section of the form. Ask the older adult each bolded question.

6. Click on the answer to the first question:
  - a. "No"
    - i. Ask why they are not interested in discussing the programs and select the reason in the "Reason for decline" field
      1. If a reason given is not listed, select "Other" and type in the reason in the "Explain other reason for decline" field.
      2. Note: you can select more than 1 reason for decline if applicable
    - ii. Continue to Section 4: Final Disposition
  - b. "Unsure"
    - i. If the older adult is unsure and a follow-up phone call is required, you will note the date of intended follow-up on a paper form or computer calendar
    - ii. Next, exit the form.
      1. Note: nothing you have entered will be saved. You will need to access this form again by logging into RedCap manually. See page 16.
  - c. "Yes"
    - i. By selecting "Yes", Section 2 will appear with another question.





## SAB Newsletter Update

### May 2019






**NFPA Training in Town C in March**

- We had 2 days of Remembering When™ training on March 29th & 30th. The Town C Fire Department hosted a training at the Town C Police Department. Andrea Vastis from NFPA and Firefighter B from the Town B Fire Department led this training.
- Attendance on Friday March 29 included 37 attendees, representing 9 different communities. The Saturday training, aimed at volunteer firefighters, included 16 attendees, representing 4 communities.
- Attendees included fire department personnel, local community organization partners, and health care professionals. The communities represented include Burlington, Cedar Rapids, Davenport, Dubuque, Marion, Mediapolis, Middletown, New London, Sperry, Urbandale, and Wever.

### Community Updates

**Town C:**

The Town C team has had 3 community meetings to identify and narrow down key organizational roles within their developing referral infrastructure. Workflows for the referral process have been drafted and reviewed by the community members. NFPA SAB representatives, Andrea Vastis and Firefighter P, worked together to deliver a Remembering When™ training to many members of the Town C Fire Department. The community's AAA director trained two staff at the County Public Health department in Matter of Balance. We are working on finalizing handoffs and participant support in this community.

**Town B:**

The Town B team has had 4 large community meetings and 2 small group meetings to narrow down the appropriate organizations to fulfill roles within the developing infrastructure. Workflows have been created and approved by organizations. Currently, discussions about communication and procedures for each referral network organization continue and roles of participation support are being finalized.

**Plan for sustainability of RW™-PLUS throughout**

Access to Older Adults	RW Program Delivery	Referral/ Participation Support	Evidence Based Program Delivery	Monitoring and Maintenance
Example Activities: Assist in reaching older adults (OHAP) advertising and marketing recruitment of older adults into the RW™-PLUS program.	Example Activities: Organizations involved in delivering the RW™-PLUS program.	Example Activities: Organizations involved in making referrals, follow-up calls, scheduling, transport.	Example Activities: Organizations involved in delivering evidence based programs.	Example Activities: Monitoring the referral infrastructure programs to help data complete the program, expanding the network as needed.

**County Home Health**

**Fire Dept. Referrals**

**Advanced Home Health**

**Medical Center**

**Fire Department** → **Area Agency on Aging (AAA)**

**AAA programming**

**YMCA programming**

**Medical Center programming**

→ **Local Falls Coalition**

**Meals on Wheels**

**Fire Department Referral or Self Referral**

**Fire Department** → **Area Agency on Aging (AAA)**

**YMCA Programming**

**Aging Services Programming**

**AAA Information Specialists**

→ **Organization Support, TAV System**

Each community has identified organizations with access to older adults, who will deliver the Remembering When™ program, a variety of organizations that can provide referral support/offer evidence based falls prevention programs. Communication strategies and specific roles and responsibilities are being finalized with agreeing referral organizations.

## STEP 4: ISSUE BRIEF TEMPLATE

## Older Adult Falls Prevention

*Adults 65 years and older*

Month, Day, 2020

ISSUE BRIEF

[insert picture or  
logo here]For more information contact [xxxx@yyyy.org](mailto:xxxx@yyyy.org)Visit our website [www.xxxxxx.org](http://www.xxxxxx.org)

## ◆ Facts about older adult falls

## In the United States...

- Each year three million older adults are treated in emergency departments for fall injuries.
- Around one in four adults (28%) age 65 and older report falling each year, which results in about 36 million falls each year.
- Each year over 300,000 older adult age 65 and older are hospitalized for hip fractures.

## In Iowa... [insert facts about your state]

- Around 26% of adults age 65 and older report falling each year.
- Falls accounted for more than 62% of unintentional injury-related deaths among Iowans age 65 or older (2017).
- More than 77% of fall-related hospitalizations were among persons age 65 or older (2017).

## ◆ Policies to reduce older adult falls



## Does Iowa have this?

- **Incentives to primary care providers** to integrate falls risk assessment and fall prevention activities into their practice.
- **Continuing medical education courses/trainings** on how to assess and reduce the risk of falls through treatment and/or referral to evidence-based fall prevention programs
- **Support for “age in place” home modifications** intended to keep seniors safely in their homes and reduce the risk of falling
- **Medication management** to improve patient use of medications and reduce duplication and side effects (i.e. dizziness which increases risk of falling)
- **Support research, development and evaluation** of risk identification and intervention strategies to reduce older adult falls

## ◆ Examples of prevention

- **Educational & community-based programs** using evidenced-based strategies to reduce falls (such as STEADI (Stopping Elderly Accidents, Deaths and Injuries))
- **Early detection** of older adults for risk of falling (i.e. programs that train first responders and to identify at-risk seniors)
- **Falls risk awareness** activities (i.e. Falls Prevention Awareness Week ) to help the community understand falls-related problems
- **Incorporation of falls prevention into local planning** around housing, transportation, parks, recreational facilities and more

## ◆ Resources &amp; Partners

⇒ This template was designed by the University of Iowa Injury Prevention Research Center. Other partners: National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention; National Fire Protection Association (NFPA); NIH's National Institute on Aging

Initials of Staff Completing Form \_\_\_\_\_

Date Form Initiated \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Remembering When PLUS Fire Department Intake

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### SECTION 1: Introduction

I am calling with the Town C Fire Department. Your name was given to me from one of our fire chiefs. The Town C Fire Department offers a free falls prevention and fire safety program called Remembering When. We believe that you may be a good candidate to participate in this program. There is no obligation to participate in the Remembering When program, but we recommend that you allow the opportunity to learn more about falls and fire prevention.

#### Are you interested in receiving the Remembering When program from the Fire Department?

☐ Yes   ☐ No   ☐ Unsure

[If the older adult says Yes, continue to the next question.]

[If the older adult says No, ask why, provide materials listed and then continue to Section 2.]

Reason for Decline:

☐ Does not have time☐ Not interested in learning more about falls prevention☐ Does not want individuals visiting their home from the fire department☐ Other: \_\_\_\_\_

{Provide Area Agency on Aging (AAA) Flier and RW Brochure}

[If the older adult is Unsure, set a follow-up date.]

Intended Week of Follow-up \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date follow-up call was made \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Outcome of follow-up call:

☐ Interested in Remembering When [Continue to Section 2]☐ Not interested in Remembering When [Continue to Section 2]☐ Other: \_\_\_\_\_

#### Next, I have three questions to ask you about your falls risk.

First, have you fallen in the past year?

☐ Yes☐ No

Do you feel unsteady when standing or walking?

☐ Yes☐ No

Do you worry about falling?

☐ Yes☐ No

[Collect the answers then continue to the section 2.]

### SECTION 2: Final Disposition

☐ FD Intake script completed. Date Completed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_☐ FD Intake script not completed. Reason not completed: \_\_\_\_\_

#### Additional Notes:

**STEP 5: REMEMBERING WHEN™ PLUS HOME HEALTH INTAKE**

Agency ID \_\_\_\_\_

Initials of Staff Completing Form \_\_\_\_\_

Date Form Initiated \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Remembering When PLUS Home Health Intake

**SECTION 1: Introduction**

County Public Health Home Health is working with local organizations to link adults at least 65 years of age to community resources around home fire safety and falls prevention. These agencies include the Town C Fire Department, Area Agency on Aging and Town C Medical Center. There is absolutely no obligation on your part to participate in these opportunities, but I would like to ask you three questions about whether you are at risk for a fall when moving around your home.

**May I ask you the questions?**
☐ Yes   ☐ No   ☐ Unsure

[If the older adult says Yes, continue to Section 2.]

[If the older adult says No, ask why, provide materials listed and then continue to Section 4.]

Reason for Decline:

☐ Does not have time

☐ Not interested in learning more about falls prevention

☐ Does not want individuals visiting their home from the fire department

☐ Other: \_\_\_\_\_

{Provide Area Agency on Aging (AAA) Program Flier and RW Brochure}

[If the older adult is Unsure, follow-up at the next Comprehensive Assessment date.]

Intended Week of Follow-up \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date follow-up call was made \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Outcome of follow-up call:

☐ Interested in completing the screening [Continue to Section 2]

☐ Not interested in completing the screening [Continue to Section 4]

☐ Other: \_\_\_\_\_
**SECTION 2: Falls Risk Screening**

Have you fallen in the past year?

☐ Yes

☐ No

☐ Unsure

Do you feel unsteady when standing or walking?

☐ Yes

☐ No

☐ Unsure

Do you worry about falling?

☐ Yes

☐ No

☐ Unsure

[If the older adult did not answer YES to at least one of the three questions, provide RW brochure, CDC Brochure, and AAA Program Flier. Continue to Section 4.]

[If the older adult did not respond to the three questions, follow-up at next visit.]

Intended Week of Follow-up \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date follow-up call was made \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Outcome of follow-up call:

☐ Completed Screening

☐ At high risk for falls [Continue to Section 3]

☐ Not high risk for falls [Continue to Section 4]

☐ Did not complete screening [Continue to Section 4]

☐ Other: \_\_\_\_\_

**SECTION 3: Release of Information**

Based on your responses to the previous questions, you may be interested in participating in a free falls prevention program and fire safety program with the Town C Fire Department, called Remembering When. County Public Health Home Health is working with the Town C Fire Department to help older adults stay safe in their homes, specifically about how to reduce the chances of a fire and a fall. You can refer to the Remembering When brochure for more information. A representative from the fire department would like to contact you about the program if you are interested in hearing more. Again, there's absolutely no obligation that you try the program, but we recommend that you allow the Town C Fire Department to call you to hear more about it.

**Can I provide your name and phone number to the Town C Fire Department?**

☐ Yes   ☐ No   ☐ Unsure

[If the older adult says Yes, continue to next question about ROI.]

[If the older adult says No, ask why.

Reason for Decline:

- ☐ Does not have time  
☐ Not interested in learning more about falls prevention  
☐ Does not want individuals visiting their home from the fire department  
☐ Other: \_\_\_\_\_

[Provide AAA Program Flier and RW Brochure and state, **You should feel free to reach out to the Town C Fire Department directly if you would like to hear about the RW program.** Continue to Section 4.]

[If the older adult is Unsure, follow-up at next visit.]

Intended Week of Follow-up \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date follow-up call was made \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Outcome of follow-up call:

- ☐ Interested in Remembering When [Continue to next question]  
☐ Not interested in Remembering When [Continue to Section 4]  
☐ Other: \_\_\_\_\_

Before the fire department can contact you, I need you to sign a document allowing County Public Health Home Health Care to give them your name and phone number. We do this so we can connect you with falls prevention and fire safety resources in the Town C community. These resources include the Town C Fire Department but also the Area Agency on Aging, and University of Iowa College of Public Health. Signing this form will connect you with resources from all of these organizations.

**Can I get your signature to authorize these community groups to contact you?**

☐ Yes   ☐ No   ☐ Unsure

[If the older adult says Yes, state: **Someone from the Town C Fire Department will call you about the Remembering When program.**

Date ROI signed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ . Continue to Older Adult Information then Section 4.]

[If the older adult says No, ask why.

Reason for Decline:

- ☐ Does not have time  
☐ Not interested in learning more about falls prevention  
☐ Does not want individuals visiting their home from the fire department  
☐ Does not want their contact information shared with other organizations  
☐ Other: \_\_\_\_\_

{Provide AAA Program Flier and RW Brochure and state: **I'm leaving you with information to contact the Area Agency on Aging should you be interested in falls prevention and fire safety in the future.** Continue to Section 4.}]

## STEP 5: REMEMBERING WHEN™ PLUS HOME HEALTH INTAKE (CONTINUED)

[If the older adult is Unsure, follow-up at the next visit.]

Intended Week of Follow-up \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date follow-up call was made \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Outcome of follow-up call:

☐ Agrees to sign ROI [Enter date signed and Continue to next question]

☐ Does not agree to sign ROI [Continue to Section 4]

☐ Other \_\_\_\_\_

### Older Adult Information:

Client First Name \_\_\_\_\_ Client Last Name \_\_\_\_\_

Client Street Address \_\_\_\_\_

Client City \_\_\_\_\_ Client Zip Code \_\_\_\_\_

Client Phone Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

### SECTION 4: Final Disposition

☐ RW screening script completed. Date Completed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

☐ RW screening script not completed. Reason not completed: \_\_\_\_\_

### Additional Notes:

## STEP 5: RW-PLUS TOWN B CONTACTS FOR OLDER ADULTS

Step in RW™-PLUS	Organization	Contact Name	Contact Phone	Contact Email
<b>Step 1</b> Contacted by Meals on Wheels Client Service Manager to sign ROI	Human Services Organization			
<b>Step 2</b> Contacted by Town B Fire Department Education Specialist to participate in Remembering When™	City Fire Department			
<b>Step 3</b> Contacted by AAA Health & Wellness Services Coordinator to connect you to a falls program counselor.	Agency on Aging (Program Coordinator)			
<b>Step 4(option a)</b> Contacted by AAA Options Counselor to discuss falls programming options and support	Agency on Aging (Options Counselor)			
<b>Step 4(option b)</b> Contacted by Aging Services Counselor to discuss falls programming options and support	Aging Services (Counselor)			
<b>Step 4(option c)</b> Contacted by YMCA Director of Healthy Living to discuss falls programming options and support	YMCA			
<b>Step 5</b> Participate in Falls programming	Aging Services (Falls programming instructor)			

## STEP 5: BROCHURE RESOURCE



Fall-related deaths in older Iowans are higher than the national average and continue to be the leading cause of injury deaths among older adults in our state.

Remembering When™ is a fire and falls prevention program designed to help older adults live safely at home as long as possible by encouraging falls and fire safety behaviors.

The Town A Fire Department has offered this program to **548** adults and here is what participants have said about the program:

*"I really enjoyed the visit from the fireman... I thought it was very useful and he's a lot of fun, too."*

*"it really reminded us of some things that we need to do in our home."*

### To Participate in the Remembering When™ Program:

Contact Firefighter Name with the Town A Fire Department at 319-XXX-XXXX or firefighter.name@towna.org



**Injury Prevention  
Research Center**  
Creating knowledge  
to keep you safe

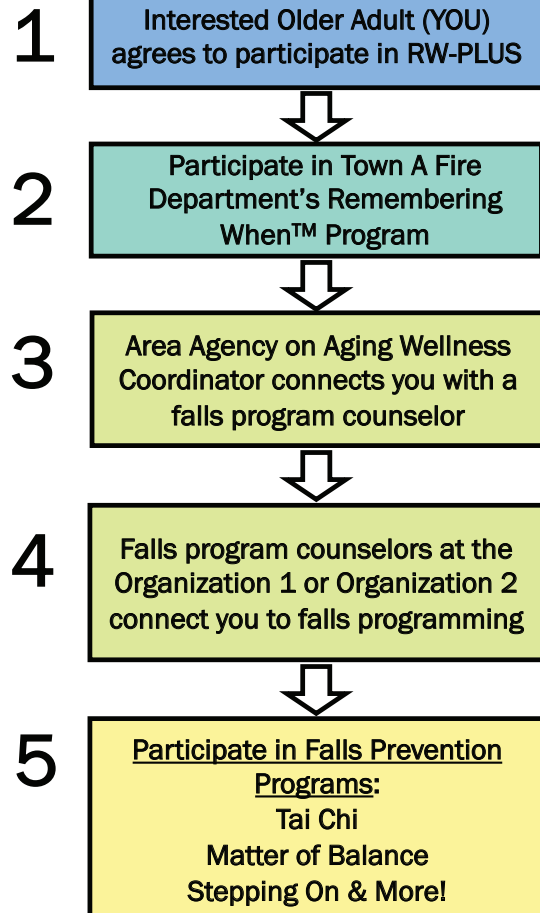
Town A Fire  
Department  
Emblem/Logo

Credits: National Center for Injury Prevention and Control (NCIPC), National Fire Protection Association, Town A Fire Department, Town A Organization 1, Area Agency on Aging, and Town A Organization 2

## PLUS

### Partners Linking yoU to Services

Partners in your community have teamed up to help you prevent falls with programs that best fit you!



The falls and fire prevention network includes The University of Iowa Injury Prevention Research Center, Town A Fire Department, Town A Organization 1, Area Agency on Aging, Town A Aging Services, and Town A Organization 2.



## Release of Information to RW™-PLUS

I, \_\_\_\_\_, hereby authorize my name, phone number and address to be disclosed to and among the partnering organizations in the Remembering When™ Partners Linking You to Services (RW™-PLUS) program in the Town B Community. I understand these partnering organizations include: Town B Fire Department, Town B Organization 1, Town B Organization 2, Town B Aging Services, Area Agency on Aging, and partners at the University of Iowa College of Public Health.

I understand the RW™-PLUS program is working to connect older adults to fall prevention programming happening in the Town B area and that the University of Iowa is currently evaluating the RW™-PLUS program developed by the partnering organizations listed above. I further understand I may receive a short call by the University of Iowa to ask about my experience in being a part of this referral network of community organizations. **By signing this document, I am granting the partnering organizations listed above permission to share my name, phone number and address with any or all of the other partnering organizations listed above.**

I further grant permission for the partnering organizations listed above to contact me in regards to the RW™-PLUS program and any evaluation of that program.

This release of information is valid for one year unless revoked in writing by me. My signature below authorizes the release of information listed above.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

## STEP 5: ROI POWERPOINT INSTRUCTION SLIDE

## Release of information

- 6 Older Adult Signs ROI. (If the Older Adult does not wish to sign, hand out the Milestones contact sheet and the Remembering When™ flier instead. If they are unsure tell them you will follow up at your next visit.)
- 7 Give Older Adult a copy of the ROI and RW-PLUS folder
- 8 Return other copy of the ROI to office staff to file

**Release of Information to RW™-PLUS**

I, \_\_\_\_\_, hereby authorize my name, phone number and address to be disclosed to and among the partnering organizations in the Remembering When™ program serving the Town B Community. I understand these partnering organizations include Town B Fire Department, Town B Organization 1, Town B Organization 2, Town B Aging Services, Area Agency on Aging, and partners at the University of Iowa College of Public Health.

I understand the RW™-PLUS program is working to connect older adults to fall prevention programming happening in the Town B area and that the University of Iowa is currently evaluating the RW™-PLUS program developed by the partnering organizations listed above. I further understand I may receive a short call by the University of Iowa to ask about my experience in being a part of this informal network of community organizations. By signing this document, I am granting the partnering organizations listed above permission to share my name, phone number and address with any or all of the other partnering organizations listed above.

I further grant permission for the partnering organizations listed above to contact me as regards to the RW™-PLUS program and any evaluation of that program.

This release of information is valid for one year unless revoked in writing by me. My signature below authorizes the release of information listed above.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Phone Number \_\_\_\_\_

## STEP 5: INTAKE POWERPOINT PRESENTATION RESOURCE

## Intake Steps



- 1 Ask supervisor/office staff for list of older adults due for Comprehensive Assessment and note if eligible for RW-PLUS
- 2 Approach eligible older adults on the list for Comprehensive Assessment
- 3 Hand out CDC falls brochure
- 4 Complete REDCap Home Health Intake Survey with older adult  
Includes:
  - Fall Screening Questions
  - Complete ROI with signature
- 5 Hand out Remembering When™ PLUS Folder to the older adult

## Falls Screening Questions

## Step 4

1. Have you fallen in the past year?
2. Do you feel unsteady when standing or walking?
3. Do you worry about falling?

- If the person answers YES to any of the three questions, they are considered at risk for a fall.
- Continue survey and provide information about the release of information.

## Release of information

- 6 Older Adult Signs ROI. (If the Older Adult does not wish to sign, hand out the Milestones contact sheet and the Remembering When™ flier instead. If they are unsure tell them you will follow up at your next visit.)
- 7 Give Older Adult a copy of the ROI and RW-PLUS folder
- 8 Return other copy of the ROI to office staff to file



## Falls Screening Questions

## Step 4

1. Have you fallen in the past year?
2. Do you feel unsteady when standing or walking?
3. Do you worry about falling?

- If the person answers YES to any of the three questions, continue survey questions and complete ROI.

- If the person answers No to all three questions, follow survey prompts and provide resources. No ROI will be signed.

## CDC Falls Brochure

- Step 3 Hand out CDC falls brochure to introduce the topic of falls



## Falls Screening Questions

## Step 5

1. Have you fallen in the past year?
2. Do you feel unsteady when standing or walking?
3. Do you worry about falling?

- If the person answers No to all three questions, they will not continue through the referral network.
- Hand out the Area Agency on Aging contact information sheet and the Remembering When™ flyer.

## Falls Screening Questions

## Step 4

1. Have you fallen in the past year?
2. Do you feel unsteady when standing or walking?
3. Do you worry about falling?



If the person does not answer the questions, or does not want to answer the questions at this time, let them know that you will follow up with them on your next visit.

Agency ID \_\_\_\_\_

Initials of Staff collecting data \_\_\_\_\_

Date Form Initiated \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Remembering When PLUS Fire Department Referral to Area Agency on Aging

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### SECTION 1: Introduction

Is the older adult interested in having the Area Agency on Aging (AAA) contact them directly to discuss falls prevention programs?

☐ Yes ☐ No

Date ROI Signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### SECTION 2:

☐ RW completed with Older Adult

Date RW Completed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

☐ RW NOT completed with Older Adult

Reason RW not completed \_\_\_\_\_

Date AAA contacted if contact is permitted (date of data entry \_\_\_\_ / \_\_\_\_ / \_\_\_\_)

### SECTION 3: Final Disposition

☐ Referral to AAA script completed. Date Completed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

☐ Referral to AAA script not completed.

Reason not completed \_\_\_\_\_

### Additional Notes:

Initials of Staff Completing Form \_\_\_\_\_

Date Form Initiated \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Remembering When PLUS Fire Department Schedule Script

RedCap Record ID \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date initial phone contact made with older adult \_\_\_\_ / \_\_\_\_ / \_\_\_\_

OR

Reason contact could not be made \_\_\_\_\_

### Interested in participating in the Remembering When program?

☐ Yes   ☐ No

#### If NO: Reason for decline:

- ☐ Does not have time  
☐ Is not interested in learning more about falls prevention  
☐ Does not want individuals from the fire department visiting their home

☐ Other \_\_\_\_\_

#### If YES: Delivery type(s)

☐ Group Presentation

Intended Date and Time \_\_\_\_ / \_\_\_\_ / \_\_\_\_ at \_\_\_\_

Location \_\_\_\_\_

☐ Home Visit

Intended Date and Time \_\_\_\_ / \_\_\_\_ / \_\_\_\_ at \_\_\_\_

### Final Disposition:

Date Script Completed \_\_\_\_ / \_\_\_\_ / \_\_\_\_ OR

Reason script not completed \_\_\_\_\_

### Additional Notes:

## STEP 5: REMEMBERING WHEN™ PLUS AREA AGENCY ON AGING SCRIPT

# Remembering When PLUS Area Agency on Aging Script

RedCap Record ID \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### SECTION 1: Introduction

The Town A Fire Department provided your information to me. They spoke with you about the Remembering When™ program and gave you a list of falls prevention programs we offer in Town A.

Can I take a few minutes to discuss these programs with you?

☐ Yes ☐ No ☐ Unsure

[If the older adult answers Yes, continue to Section 2.]

[If the older adult answers No, ask why and continue to Section 4.

Reason for Decline:

☐ Does not have time

☐ Not interested in learning more about falls prevention programs

☐ Other \_\_\_\_\_

[If the older adult is Unsure, ask when you can call back and record the response.

Intended Time to Call \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of follow-up call \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Outcome of follow-up:

☐ Interested in discussing programs

☐ Not interested in discussing programs

☐ Other \_\_\_\_\_

### SECTION 2: Review of Falls Prevention Programs

There are several different programs depending on your ability level. We want to help you find the best program that fits you. [Review programs and recommended ability levels]. Let's discuss your interests in any of these programs.

Are you interested in participating in any of the programs?

☐ Yes ☐ No ☐ Unsure

If Yes, list which programs the older adult is interested and why

\_\_\_\_\_  
Continue to Section 3

If No, ask why:

☐ Does not have time

☐ Not interested in attending falls prevention program

☐ Other: \_\_\_\_\_

Continue to section 4.

If Unsure, follow-up another day with the older adult to confirm interest in a falls prevention program.

Intended Date of Follow-up \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## STEP 5: REMEMBERING WHEN™ PLUS AREA AGENCY ON AGING SCRIPT (CONTINUED)

Date of follow-up \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Outcome of follow-up:

- ☐ Interested in falls prevention programs (Continue to Section 3)  
☐ Not interested in falls prevention programs (Continue to Section 4)

☐ Other \_\_\_\_\_

### SECTION 3: Resource Assistance

Do you need assistance to get to this program, such as transportation?

- ☐ Yes ☐ No ☐ Unsure

[If the older adult answers Yes, document the resources needed and continue to Section 4.

Resources needed to attend program \_\_\_\_\_

[If the older adult answers No, continue to Section 4.]

[If the older adult is Unsure, ask when you can call back to help with resources if needed.

Intended Time to Call

Date of follow-up call \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Outcome of follow-up \_\_\_\_\_

- ☐ Needs assistance participating in programs (List resources above & continue to section 4)  
☐ Does not need assistance participating in programs (Continue to Section 4)

☐ Other \_\_\_\_\_

Are you a caregiver?

- ☐ Yes ☐ No

[If the older adult answers Yes, ask the following question:

Would you need any assistance with care-giving in order to attend a program?

- ☐ Yes ☐ No

If Yes, state: I will refer you to Town A Aging Services to connect you with caregiver resources such as adult day care services. Continue to section 4 and indicate a referral to Town A Aging Services with a note for care-giver services.]

[If the older adult answers No, continue to section 4.]

### SECTION 4: Final Disposition

- ☐ Falls Prevention Program to be attended

Referral to:

- ☐ Area Agency on Aging Information Specialist  
☐ Town A Organization 2  
☐ Town A Aging Services

If known, list:

Program Name \_\_\_\_\_

Start Date \_\_\_\_\_

Location \_\_\_\_\_

Other Resources \_\_\_\_\_

- ☐ Falls Prevention Program will not be attended

Additional Comments:

## STEP 5: REMEMBERING WHEN™ PLUS TOWN A ORGANIZATION 1 SCRIPT TO SIGN ROI

Staff Initials \_\_\_\_\_

Date Form Initiated \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Remembering When™ PLUS Town A Organization 1 Script to Sign ROI

RedCap Record ID \_\_\_\_\_

Town A Organization 1's Client First Name \_\_\_\_\_

Town A Organization 1's Client Last Name \_\_\_\_\_

Town A Organization 1's Client Street Address \_\_\_\_\_

Town A Organization 1's Client City \_\_\_\_\_ Town A Organization 1's Client Zip Code \_\_\_\_\_

Town A Organization 1's Client Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### SECTION 1: Introduction

\_\_\_\_\_ at Town A Organization 1's office indicated that you wanted to be connected to falls prevention and fire safety resources in Town A. He/She also explained that in order for Town A Organization 1 to do this, you would need to sign a Release of Information form. I've brought that form with me. As a reminder, it allows the Town A Fire Department, Area Agency on Aging, Town A Organization 2 and University of Iowa College of Public Health to connect you to falls prevention and fire safety resources.

Can I get your signature to authorize these community groups to contact you?

☐ Yes ☐ No ☐ Unsure

[If the older adult says Yes, state **The Town A Fire Department will call you about the Remembering When™ program.**

Date ROI signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_. Continue to Section 2.]

[If the older adult says No, ask why.

Reason for Decline:

- ☐ Does not have time
- ☐ Is not interested in learning more about falls prevention
- ☐ Does not want individuals visiting their home from the fire department
- ☐ Does not want to share their contact information with other organizations

☐ Other \_\_\_\_\_

Provide Area Agency on Aging Program Flyer and RWTM Brochure and explain I'm leaving you with information to contact the Area Agency on Aging should you be interested in falls prevention and fire safety in the future in addition to information about the Remembering When™ program offered by the fire department. Continue to Section 2.]

[If the older adult is Unsure, follow-up at another visit with the older adult to sign the ROI.

Intended Date of Follow-up \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Follow-up \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Outcome of Follow-up:

- ☐ Agrees to sign ROI. Date ROI signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- ☐ Does not agree to sign ROI

☐ Other \_\_\_\_\_

### SECTION 2: Final Disposition

☐ ROI script completed. Date Completed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

☐ ROI script not completed. Reason not completed: \_\_\_\_\_

**Additional Notes:**

Staff Initials \_\_\_\_\_

Date Form Initiated \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Remembering When™ PLUS Fire Department Post-RW™ Script

RedCap Record ID \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### SECTION 1:

Date Remembering When™ was completed with the older adult \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date ROI was signed (with Fire Department \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Is the older adult interested in contact from Area Agency on Aging?

☐ Yes ☐ No

### SECTION 2: Final Disposition

Date script complete \_\_\_\_ / \_\_\_\_ / \_\_\_\_ OR

Reason script not complete: \_\_\_\_\_

### Additional Notes:



## Data Entry Steps

## Data Entry Steps

## Data Entry Steps

Export Results

Completed?

Completed

Uncompleted

Completed

Save & Load Record

Cancel

- Save as 'Complete' if all questions are answered and no follow-up is required. Referral to Fire Department will send after saving as 'Complete' if ROI is signed
- Save as 'Incomplete' if follow-up is required. You will not be able to access and edit a form again after saving as 'Complete'.
- Form Status is only available through RedCap data entry after logging in to your profile. Survey Links that don't require login will always save the form as 'Completed'.



## Practice

## STEP 5: TOWN A FALLS PREVENTION RESOURCES

**Matter of Balance**

Matter of Balance is an 8 session program is held 2 times a week for 4 weeks for those who experience concerns about falling, which cause them to restrict their activities. Individuals who attend this class will learn how to view falls as controllable, set goals for increasing activity, make changes to reduce fall risks at home, and exercise to increase strength and balance.

Town A Public Library

September 10-Oct 4

Tuesdays & Fridays:  
10am-12pm

**Town A Organization 2****Silver Sneakers**

A fun, energizing program that helps older adults take greater control of their health by encouraging physical activity and offering social events. Physical fitness classes are lead at the YMCA by certified instructors. The program focuses on better overall health through increasing; flexibility, circulation, strength and stamina.

Town A Organization 2  
XXX 7th Ave, Town A, IA  
XXXXX  
319-XXX-XXXX

Free for members;  
\$12 for nonmembers

Town D Organization 1  
XXXX 10th Ave, Town D, IA  
XXXXX  
319-XXX-XXXX

Free for members;  
\$12 for nonmembers

**Silver Yoga**

Practice basic yoga movements and breathe work while developing your mind-body connection.

Town A Organization 2  
XXX 7th Ave, Town A, IA  
XXXXX  
319-XXX-XXXX

Free for members;  
\$12 for nonmembers

Town D Organization 1  
XXXX 10th Ave, Town D, IA  
XXXXX  
319-XXX-XXXX

Free for members;  
\$12 for nonmembers

**Strong Bones**

This strength training class designed for those at risk of osteopenia or osteoporosis, includes full body exercises that encourage bone health while focusing on proper form.

Town D Organization 1  
XXXX 10th Ave, Town D, IA  
XXXXX  
319-XXX-XXXX

Free for members;  
\$12 for nonmembers

## STEP 5: TOWN A FALLS PREVENTION RESOURCES (CONTINUED)

### YMCA Programs of the Cedar Rapids Metro Area

Fit N Fun			
This low-impact cardio class works every muscle in the body and produces a safe, fun, uplifting workout.		Town A Organization 3 XXX Point Rd, Town A, IA XXXXX 319-XXX-XXXX	Free for members; \$12 for nonmembers
Zumba Gold			
Designed for active older adults, this lively dance-fitness class is both invigorating and easy-to-follow. Bring your friends and enjoy an afternoon of fun and fitness.		Town D Organization 1 XXXX 10th Ave, Town D, IA XXXXX 319-XXX-XXXX	Free for members; \$12 for nonmembers
Tai Chi			
Tai chi is a great way to improve balance, prevent falls, and relieve pain associated with arthritis. This gentile exercise, often referred to as “meditation in motion,” focuses on a series of slow, guided movements. Participants see a range of benefits including increased balance, flexibility and mobility.		Town A Organization 2 XXX 7th Ave, Town A, IA XXXXX 319-XXX-XXXX	Free for members; \$12 for nonmembers
Aqua Exercise			
This is a great option for you if you love the water, are trying to get back in shape, have trouble with arthritis or simply want to switch up your workout routine.			Free for members; \$12 for nonmembers
Posture Perfect			
This class is designed to produce good posture, including stretching, strengthening and balance. It focuses on simple exercises that strengthen bones, improve posture and provide relief from pain associated with osteoporosis, osteopenia, and arthritis.			Free for members; \$12 for nonmembers
Town A Organization 2 Active Older Adult Memberships*			
Monthly: \$56.50	Annual: \$630.00	Class Punch Card: \$60 for 10 classes or \$110 for 20 classes	Walk-in Day Pass fee: \$12

Town A Organization 2 offers income-based memberships to individuals with annual gross adjusted income under \$50,000, or to households with annual gross adjusted income under \$60,000. Income Based Memberships must be signed up for in-person at any branch. Please bring in your most recent W-2 or your last two most recent pay stubs for proof of income.

## STEP 5: TOWN B FALLS PREVENTION RESOURCES

**Matter of Balance**

Matter of Balance is an 8 session program is held 2 times a week for 4 weeks for those who experience concerns about falling, which cause them to restrict their activities. Individuals who attend this class will learn how to view falls as controllable, set goals for increasing activity, make changes to reduce fall risks at home, and exercise to increase strength and balance.

Area Agency on Aging  
319-XXX-XXXX  
XXX 4th Ave., Town B, IA  
XXXXX

County Public Health  
Department  
319-XXX-XXXX  
XXXX 5th Ave., Town B,  
IA XXXXX

Medical Center  
319-XXX-XXXX  
XXX 22nd Ave., Town B, IA  
XXXXX

Free for members;  
\$5 per class for nonmembers

**OTAGO**

OTAGO is a series of 17 strength and balance exercises delivered by a Physical Therapist in the home to reduce falls for frail older adults. The program consists of leg muscle strengthening, balance retraining exercises, and a walking plan. Exercises are individually prescribed and increase in difficulty during a series of 5 home visits by the trained instructor.

Delivered in home by the  
following 3 organizations:

Home Health Care  
319-XXX-XXXX

County Home Health Care  
319-XXX-XXXX

Medical Center  
319-XXX-XXXX

Check with your home health  
care specialist for insurance  
coverage.

**Arthritis Aquatics**

Arthritis Aquatics involves doing gentle exercises in a 92-degree therapy pool to help reduce pain and muscle tension, restore flexibility, and maintain normal joint movement.

Medical Center – Health  
Fitness Center  
319-XXX-XXXX  
XXX 22nd Ave., Town B, IA  
XXXXX

Monday-Saturday:  
8am-8:40am

Saturday: 10-10:40am

Monday/Wednesday/Friday:  
11-11:40am

Tuesday/Thursday:  
3:30-4:10pm

Free for members;  
\$5 for nonmembers

## STEP 5: TOWN B FALLS PREVENTION RESOURCES (CONTINUED)

FAME – Fitness And Mobility Exercise		
FAME helps improve strength, balance and cognition losses that result from having a stroke. Participating in supervised exercise also helps to improve lung function and cardiac health to reduce the risk of another stroke or heart disease. <b>Physician approval required.</b>	Medical Center – Health Fitness Center 319-XXX-XXXX XXX 22nd Ave., Town B, IA XXXXX	Monday/Wednesday: 11am-12pm  Free for members; \$5 for non-members
ABLE – A Better Life Every day		
ABLE is for people who have difficulty reaching or maintaining a healthy weight. Participants will meet with fitness specialists to create personalized exercise plans, get exercise booklets with cardiovascular and resistance exercises every week and have medical fitness checkups every three months to track progress. <b>Physician approval required.</b>	Medical Center – Health Fitness Center 319-XXX-XXXX XXX 22nd Ave., Town B, IA XXXXX	Monday/Wednesday: 11am-12pm  Tuesday/Thursday: 5-6pm  Free for members; \$5 for non-members
Delay the Disease		
Delay the Disease is a supervised exercise program for people with Parkinson's disease. Specific exercises, weight training and activity may delay physical symptoms of the disease. The program consists of a fitness specialist leading stretching and exercising for one hour. Staff will make changes in your workouts based on your improvement and limitations.	Medical Center – Health Fitness Center 319-XXX-XXXX XXX 22nd Ave., Town B, IA XXXXX	Tuesday/Thursday: 12:30-1:30pm  Free for members; \$5 for non-members
	Town B Organization 2 319-XXX-XXXX XXX Main Blvd., Town B, IA XXXXX	Monday/Wednesday 10:30-11:30am  Free for Members; Community: \$8.25 day pass
SilverSneakers® I – Muscular Strength & Range of Movement Classes		
Have fun and move to music through a variety of exercises designed to increase muscular strength, range of movement, and activity for daily living. Hand-held weights, elastic tubing with handles, and a ball are offered for resistance. A chair is used for seated or standing support. Medicare Advantage Plus may be covered.	Town B Organization 2 319-XXX-XXXX XXX Main Blvd., Town B, IA XXXXX	Tuesdays/Thursdays 10:30-11:15am  Friday Coffee Socials at 10:30am.  Members free; Community: \$8.25 day pass

## STEP 5: TOWN B FALLS PREVENTION RESOURCES (CONTINUED)

### A.O.A. Fitness Program

A great opportunity for those who are interested in making exercise a part of their lives. This program is available to adults 55 and older. It consists of various exercises to make your life a healthy one. Classes offer several activities from strength training, stretching and more! You choose the activities and days to participate. First time guests may bring a friend and try the class free.

Town B Organization 2  
319-XXX-XXXX  
XXX Main Blvd., Town B, IA  
XXXXX

#### **Monday, Wednesday, and Friday:**

Low Impact Aerobics & Stretching: 8:30-9:10am

Independent Cardio/ Strength Training: 9:15-10am

Swimming: 10-11am

Coffee & Fellowship: 9:30-10:30am

Members free;  
Community: \$8.25 day pass

### Town B Organization 2 Membership Prices:

Senior Membership (62 years & older):  
Automatic Bank Draft: \$29.00  
Annual Full Pay: \$327.75

Senior Household Membership (Primary adult on membership must be 62 year or older)  
Automatic Bank Draft: \$48.75  
Annual Full Pay: \$554.50

### Medical Center Health Fitness Center Membership Prices: (\$2 increase starting Sept 1, 2019)

All senior memberships (65+) are 20% off. SilverSneakers and Renew Active memberships supported.

Individual Membership: 1-time Enrollment fee=\$50 +  
3-month: \$48/month  
6-month: \$46/month  
12-month: \$44/month

Individual + 1 additional Person Membership: 1-time Enrollment fee=\$75 +  
3-month: \$64/month  
6-month: \$62/month  
12-month: \$60/month

Pool Membership: (No enrollment fee)  
\$32/month

### Need assistance with transportation to attend these classes?

- Retired & Senior Volunteer Program (RSVP): Contact Mary XXXXXX at 319-XXX-XXXX to complete service application then contact 3 days prior to service to schedule ride. Rides are donation based and priority is given to medical appointments.
- Southeast Iowa Bus (SEIBUS) for rural residents: call 1-866-XXX-XXXX 25 hours in advance to schedule a ride for \$5 round trip. Schedule is subject to change so advanced planning is recommended.
- Town B Urban Service: Fixed routes and demand responses 6 days a week by calling 319-XXX-XXXX for a \$1.25 one-way fare.

## STEP 5: FIRE DEPARTMENT SCRIPT FOR PROGRAMS

ROI signed prior to RW ☐ Yes ☐ No

Date ROI signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Fire Department Script for Programs

Client Name \_\_\_\_\_

Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### At the time Remembering When is completed:

"The Remembering When program has given us a chance to talk through fire and fall prevention strategies and make modifications to your home. The Area Agency on Aging provides more opportunities in our community to reduce your risks of falling."

(Provide list of Milestones programs to Older Adult.)

"Here is a list of the programs that the Area Agency on Aging (AAA) and other community organizations offer that you could attend. A staff member from AAA will call you to describe the programs, check your interest in participating, and determine the type of support you may need to participate in a falls prevention program. For example, you may have class preferences that better fit your schedule, you may need help with finding transportation, or you may have preferences on program cost. If you have any questions before then, you can call the number provided on the flyer."

Interest in AAA contact ☐ Yes ☐ No

Date Remembering When™ was completed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Completed by \_\_\_\_\_

# Remembering When™ PLUS

PARTNERS LINKING YOU TO SERVICES



University of Iowa Injury Prevention Research Center

(319) 467-4504 • [iprc@uiowa.edu](mailto:iprc@uiowa.edu)

[www.uiiprc.org](http://www.uiiprc.org)

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**IOWA**

College of  
Public Health