STrategies to Reduce Injuries and Develop confidence in Elders

STRIDE

Manual of Procedures

(MOP)

Appendices

TITLE: RANDOMIZED TRIAL OF A MULTIFACTORIAL FALL INJURY PREVENTION STRATEGY

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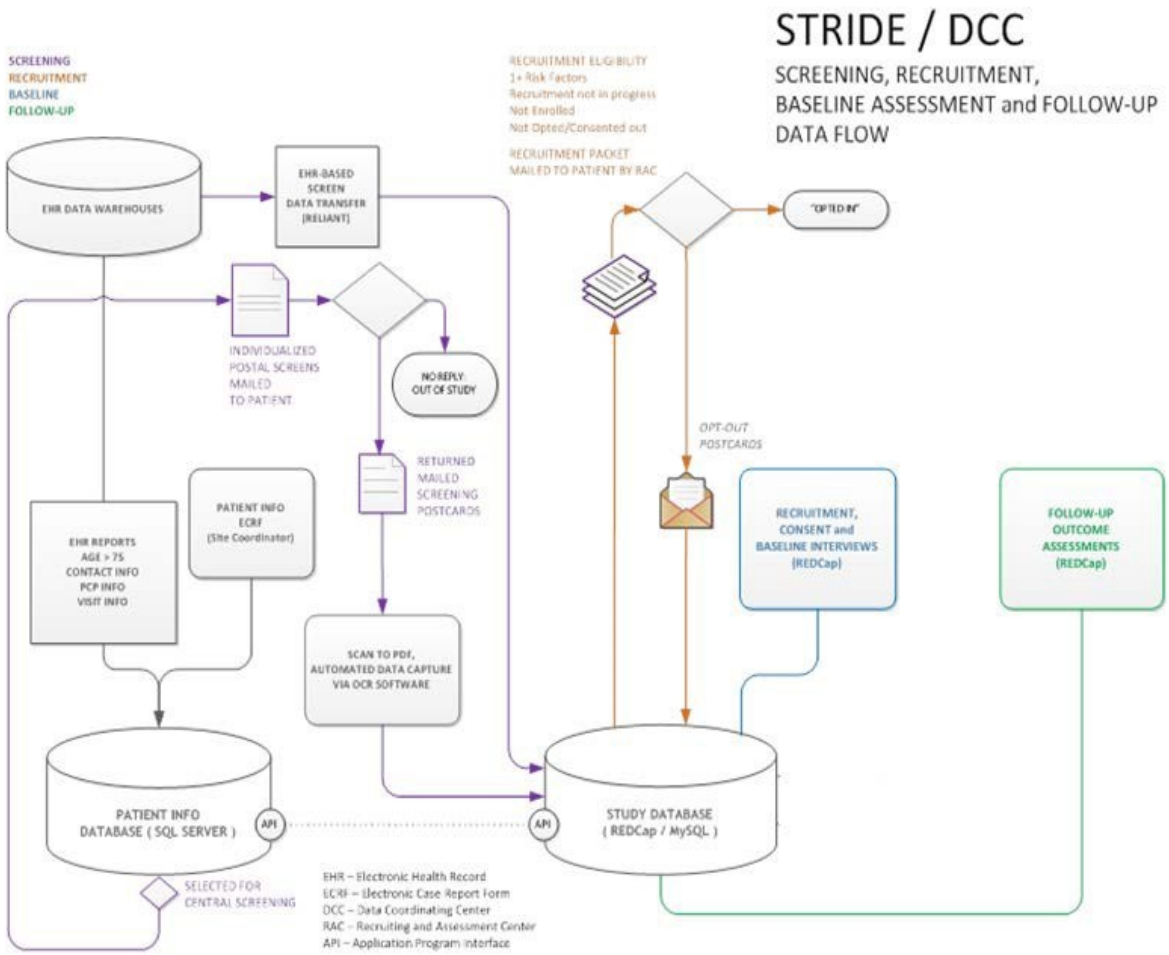
APPENDICES CHAPTER 3 – SCREENING AND RECRUITMENT

APPENDIX 3.1 STRIDE DCC WORK FLOW



APPENDIX 3.2 CENTRAL SCREENING – FIRST CLINIC LETTER

[LETTER TO BE ON "LETTERHEAD FROM LOCAL HEALTH CARE SYSTEM/CLINIC"]

«Address»

«City», «State» «Zip»

«Date»

Dear «Salutation» «LastName»,

[NAME OF LOCAL HEALTHCARE SYSTEM/CLINIC] is a health care organization committed to excellent patient care. As part of our commitment to improving patient care, we are working with researchers at [NAME OF LOCAL HEALTHCARE SYSTEM/CLINIC] and at Yale University.

The first step is to find out how many of our patients at [Name of local clinic] are at risk of falling. Enclosed is a postcard that asks 3 questions about your fall risk. Please consider helping us by answering these 3 questions. Return the postcard by dropping it in the mail. No postage is required.

To thank you for taking the time to complete this postcard, we have enclosed a bookmark as a small token of our appreciation.

Thank you for reading this letter and for helping us to understand how to improve the health of people at (Name of healthcare system) and other older Americans.

Sincerely,

_____, MD

[TITLE]

[PRACTICE]

APPENDIX 3.3 SCREENING—FALL SCREENING POSTCARD

STrategies to
Reduce
Injuries and
Develop confidence in
Elders

Please select your answer to each question below with an "X".

1. Have you fallen 2 or more times in the past year?	☐YES	☐NO
2. Have you fallen and hurt yourself in the past year?	☐YES	☐NO
3. Are you afraid that you might fall because of balance or walking problems?	☐YES	☐NO

Thank you for your help.

APPENDIX 3.3.1 STORY CARD

"When I fell and broke my hip last year, I thought I would no longer be able to be independent. My doctor told me that I could get my strength and health back.

With my daughter's help, I've recovered and we have both learned how to prevent falls!"

Josefa, 90 & Leticia, 60

1 in 3 adults over 65 will fall.

Together, we can prevent falls.

"We strongly believe that fall prevention is vitally important for the health and well-being of every senior."

- Dr. Yan Chen
Primary Care Physician at Healthcare Partners, Temple City
STRIDE Site Clinical Director

Healthcare system logo/name

STRIDE
STrategies to
Reduce
Injuries and
Develop confidence in
Elders

Mount Sinai is participating in the STRIDE Study.

This is a nationwide study to keep older adults active and independent by decreasing their risk of injuries due to falls.

Facts about Falls

- **1 in 3 adults over the age of 65 will fall each year.**
- **Falling once doubles your chance of falling again**
- **1 out of 5 falls causes a serious injury such as broken bones or head trauma**

Together, we can learn how to reduce the risk of falls for our older patients.

You may be invited to participate!

Please watch the mail for STRIDE materials.

www.stride-study.org

Funded by the National Institute on Aging and Patient-Centered Outcomes Research Institute

APPENDIX 3.3.2 BOOKMARK

APPENDIX 3.4 RECRUITMENT - OPT OUT POSTCARD

APPENDIX 3.4.1 MARTHA STEWART CARD

My mom lived to the age of 93 and was active and independent up to the end. Through her final decades, we worked together to fall-proof her home. But there is more that you can do.

A team of leading falls experts has developed the new STRIDE Fall Prevention Program, which is being tested in 10 sites across the nation. You're receiving this card because your doctor is involved in STRIDE.

I encourage you to be a part of STRIDE so we can learn how best to reduce falls and injuries.

Best Regards,

Martha Stewart

APPENDIX 3.5 RECRUITMENT - CENTRAL SCREENING – SECOND CLINIC LETTER

[LETTER TO BE ON "LETTERHEAD FROM LOCAL HEALTH CARE SYSTEM/CLINIC"]

«StreetAddress»

«City», «State» «zipcode»

«Date»

Dear «Salutation» «LastName»,

As part of [NAME OF LOCAL HEALTHCARE SYSTEM/CLINIC]'s commitment to improving patient care, we are working with providers here and around the country on a major new research study. The purpose of this study is to learn better ways for healthcare systems to prevent falls and injuries from falls. This study is called **STRIDE (ST**rategies to **R**educe **I**njuries and **D**evelop confidence in **E**lders).

Enclosed is a letter from the STRIDE Assessment Center, asking you to consider taking part in this important research study. You are being invited to participate in this study based on your answers to questions on the recent fall risk postcard that you returned.

Participation in the study is voluntary. If you choose to participate, you are free to stop taking part in the study at any time. Your decision to take part or not will have no effect on the care that you receive from any provider at [name of health system].

Please read the enclosed STRIDE study letter from the research team. Feel free to contact the STRIDE study staff at Yale University with any questions at toll- free number 1-844-978-7433 (STRIDE) or by email at STRIDE@yale.edu.

Sincerely,
_____, MD

[TITLE]

[PRACTICE NAME]

APPENDIX 3.6 RECRUITMENT - CLINIC LETTER FOR CLINIC SCREENING

[LETTER TO BE ON "LETTERHEAD FROM LOCAL HEALTH CARE SYSTEM/CLINIC"]

«StreetAddress»

«City», «State» «zipcode»

«Date»

Dear «Salutation» «LastName»,

As you know, [NAME OF LOCAL HEALTHCARE SYSTEM/CLINIC] is committed to excellent patient care. As part of our commitment to improving patient care, we are working with physicians and other clinicians here at [NAME OF LOCAL HEALTHCARE SYSTEM/CLINIC] and around the country on a major new research study.

The purpose of this study is to learn better ways for healthcare systems to prevent falls and injuries from falls. This study is called **STRIDE (ST**rategies to **R**educe **I**njuries and **D**evelop confidence in **E**lders).

Enclosed is a letter from the STRIDE Assessment Center, asking you to consider taking part in this important research study. You are being invited to participate because you may be at increased risk of falling based on a questionnaire that you were asked during a prior office visit.

Participation in the study is voluntary. If you choose to participate, you are free to stop taking part in the study at any time. Your decision to take part or not will have no effect on the care that you receive from any provider at [NAME OF LOCAL HEALTHCARE SYSTEM/CLINIC].

Please read the enclosed STRIDE study letter from the research team. Feel free to contact the STRIDE study staff at Yale University with any questions at toll- free number 1-844-978-7433 (STRIDE) or by email at STRIDE@yale.edu. Thank you for considering participation in this important study.

Sincerely,

_____, MD

[TITLE]

[PRACTICE NAME]

APPENDIX 3.7 RECRUITMENT - STRIDE LETTER

STrategies to Reduce Injuries and Develop confidence in Elders

STRIDE

SITE LOGO

«StreetAddress»
«City», «State» «zipcode»

«Date»

Dear «Salutation» «LastName»,

You are invited to take part in a research study called STRIDE.

STRIDE stands for (**ST**rategies to **R**educe **I**njuries and **D**evelop confidence in **E**lders). The purpose of this study is to learn better ways for healthcare systems to prevent falls and injuries from falls.

We are inviting you to join because you are a patient in [NAME OF HEALTH SYSTEM OR CLINIC] age 70 or older and returned the fall risk postcard.

- Patients at some practices will receive a brochure with information about falls and how to avoid them.
- Patients at other practices will be called to schedule a visit with a specially trained nurse (Falls Care Manager) at no cost to you. During the visit a fall risk evaluation will be done and a treatment plan to reduce fall risk will be created.

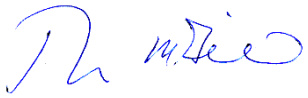
You will receive a telephone call in about two weeks from the STRIDE Assessment Center. The study staff will tell you more about the STRIDE study and answer any questions you might have. The caller will discuss your interest in participating.

If you decide to join the STRIDE study, you will be asked some information about yourself and your health history. You will also be asked about any falls and falls-related injuries that you have had.

- Please keep the enclosed calendar. We will explain how to fill it out during telephone call.
- If you do not wish to participate in this study, please return the enclosed yellow postcard by dropping it in the mail – no postage required.

If you have a question about the study or would like to contact study staff, please call us at 1-844-978-7433 (STRIDE) or by email at STRIDE@yale.edu.

Sincerely,



Thomas Gill, M.D.

STRIDE Assessment Center on behalf of the STRIDE research team

APPENDIX 3.7.1 WELCOME LETTER – RANDOMIZATION GROUP

STrategies to Reduce Injuries and Develop confidence in Elders

Congratulations! Your doctor's practice is part of Group A.

□ Your doctor will be told about your risk of falling and getting hurt from a fall.

□ Enclosed is a brochure with information on falls and how to avoid them.

STrategies to
Reduce
Injuries and
Develop confidence in
Elders

Congratulations! Your doctor's practice is part of Group B.

□ Your doctor will be told about your risk of falling and getting hurt from a fall.
□ You will be called to schedule a visit with a specially trained nurse (Falls Care Manager) at no cost to you. During the visit a fall risk evaluation will be done.
□ The nurse Falls Care Manager will work with you and your doctor to make a treatment plan to reduce your risk of falling and getting hurt.
□ You will receive a call to schedule a visit with the Falls Care Manager within the next month.

APPENDIX 3.8 PATIENT BROCHURE (FULL BROCHURE ON WEBSITE)

STRIDE

STrategies to Reduce Injuries and Develop confidence in Elders

Open the Door to

1-844-9STRIDE (1-844-978-7433)
Email: stride@yale.edu Website:
www.stride-study.org

Stay Active & Independent

We can help show you how...

APPENDIX 3.9 PRIVACY AND CONSENT SUMMARY

STrategies to Reduce Injuries and Develop confidence in Elders

STRIDE

STRIDE RESEARCH STUDY INFORMATION SHEET

Why you are being contacted?

We are inviting you to join the STRIDE study based on your answers on the fall risk postcard you returned or that you were provided during a clinic visit.

Why is STRIDE important?

The purpose of the study is to learn better ways for healthcare systems to prevent falls and injuries from falls. This study will include 6,000 people from 10 different healthcare systems around the country. The study is expected to last up to 3 years.

What does the study involve?

1) Your doctor's practice has been randomly assigned to one of two groups (Group A or Group B), much like the flip of a coin.

- In half of the practices, (Group A) your doctor will be told about your answers on a fall risk postcard and you will receive a brochure with information on falls and how to avoid them.
- In the other practices (Group B) your doctor will be told about your answers on a fall risk postcard. You will be called to schedule a visit with a specially trained nurse (Falls Care Manager) at no cost to you. During this visit, a fall risk evaluation will be done. The Falls Care Manager will work with you and your doctor to make a treatment plan to reduce your risk of falling and getting hurt.

2) The STRIDE research component involves:

- Phone Interview: If you agree to participate, you'll be asked to complete a phone interview. You will be asked some questions about your health and ability to care for yourself and accomplish daily tasks. You will also be asked about any recent falls, and concerns that you may have about falling.
- Calendar: After the interview, we will ask you to keep track of any falls and injuries on a monthly calendar that we will send to you. The calendars will be reviewed during follow- up telephone calls.
- Follow-up Telephone calls: You will also receive a call every 4 months to ask about any falls or other changes to your health.
- Permission to view your health records: If you agree to participate, we will need your permission to look at your medical records.

- Voluntary participation: Whether or not you choose to participate in this study, you will continue to receive care from your regular doctor or nurse and his/her team. This means you can decide to say *yes* or *no* to participation in the study. Either way, your decision will not affect your present or future medical care. You may also change your mind and stop your participation in the study at any time.

What about Privacy?

The information you share with us is private. We are required by law to protect the privacy of health information obtained for research. During this study, information about you and your health will be collected and shared with researchers conducting the study. We share your health information only when we must, for example for quality control and public health purposes. We require anyone who receives it from us to protect your privacy.

If you would like more information about our privacy policy:

*Partners HealthCare Notice for Use and Sharing of Protected Health Information http://www.partners.org/Assets/Documents/Notices/Partners_Privacy_Policy_Englis h.pdf.]

The STRIDE Research Study is approved by The Institutional Review Board (IRB). IRB is a group of people who review research to protect your rights. They have approved this study and the procedures for collecting information. If you would like to speak with someone not involved in this research about your rights as a research subject, or complaints you may have about the research, contact the Partners Human Research committee (or IRB) at (617) 424-4100.

APPENDIX 3.9.1 MAGNETIC CLIP

APPENDIX 3.9.2 NIA FLYER – WHAT TO DO IN CASE OF A FALL

Falls and Older Adults

If You Fall

Whether you're at home or somewhere else, a sudden fall can be startling and upsetting. If you do fall, stay as calm as possible. Take several deep breaths to try to relax.

How to Get Up From a Fall

1. Remain still on the floor or ground for a few moments. This will help you get over the shock of falling.
2. Decide if you're hurt before getting up. Getting up too quickly or in the wrong way could make an injury worse.
3. If you think you can get up safely without help, roll over onto your side.
4. Rest again while your body and blood pressure adjust. Slowly get up on your hands and knees, and crawl to a sturdy chair.
5. Put your hands on the chair seat and slide one foot forward so that it is flat on the floor. Keep the other leg bent so the knee is on the floor.
6. From this kneeling position, slowly rise and turn your body to sit in the chair.

If you're hurt or can't get up on your own, ask someone for help or call 911. If people who are nearby do not feel confident in helping you get up, call 911. If you're alone, try to get into a comfortable position and wait for help to arrive.

Consider Emergency Response Devices

If you are often alone, and at increased risk of falling, consider getting a personal emergency response system. This service, which works through your telephone line, provides a button or bracelet to wear at all times in your home.

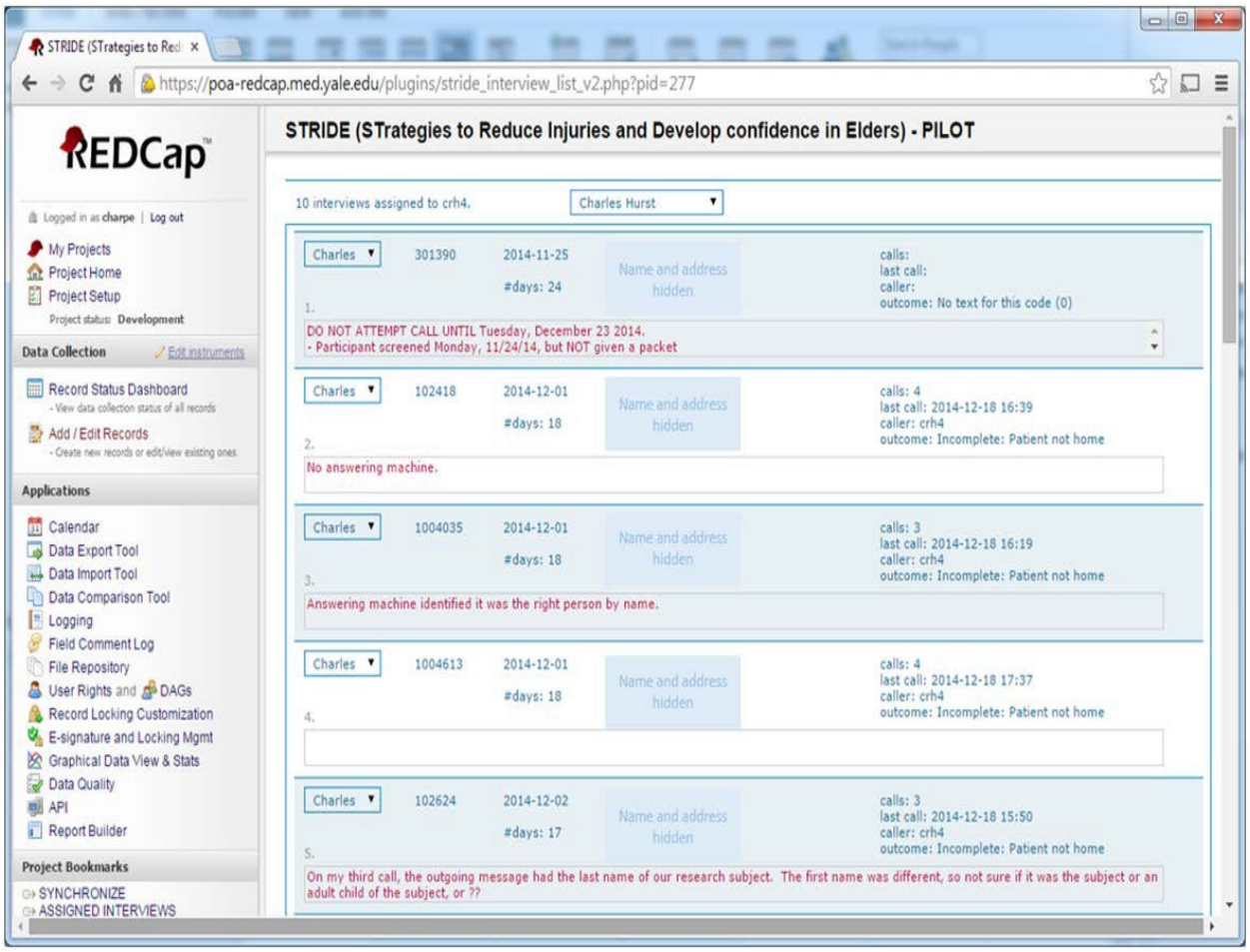
Tell Your Doctor

Be sure to discuss any fall with your doctor. The doctor can assess whether a medical issue or other cause of the fall needs to be addressed. Knowing the cause can help you plan to prevent future falls. After a fall, your doctor might refer you to other health care providers who can help prevent future falls.

Note: The content of this document was slightly adapted from information produced by the National Institute on Aging (NIA) at the National Institutes of Health (NIH), available online through the NIHSeniorHealth, a web resource for older adults developed by the National Library of Medicine (NLM) in partnership with NIA: http://nihseniorhealth.gov/falls/ifyoufall/01.html/National

NIH flyer - what to do in case of a fall NIA approved version 08 27 2015

APPENDIX 3.10 REDCAP PLUG IN TO SUPPORT INTERVIEWS WORKFLOW



APPENDIX 3.11 STRIDE INFORMED CONSENT TELEPHONE SCRIPT

STRIDE VERBAL INFORMED CONSENT –10-18-2016

Project Title: Randomized Trial of a Multifactorial Fall Injury Prevention Strategy

Communicating Primary Investigator: Shalender Bhasin, MD

Joint Primary Investigators: Thomas Gill, MD; David B. Reuben, MD

Site: Yale Recruitment and Assessment Center

Script for Obtaining Verbal Consent to Participate in STRIDE Study via Phone:

Hello Ms./Mr. [PATIENT'S NAME],

My name is NAME. I am calling from the STRIDE study that is taking place at [PRACTICE NAME]

CENTRAL SCREEN: you recently returned the falls risk post card sent out by [PRACTICE NAME]. Then we sent you some information about the STRIDE study. Did you get this information?

OR

CLINIC SCREEN: after your recent clinic visit at [PRACTICE NAME] we mailed you a packet of information about the STRIDE study. Did you get this information?

IF THEY DO NOT RECALL GETTING INFORMATION, OFFER TO RE-SEND AND MAKE CERTAIN TO CALL THEM WITHIN A FEW DAYS OF RECEIVING

If you have a few minutes, I'd like to go over what's involved in the STRIDE study and see if you have any questions and are interested in participating.

If "YES", continue.

If NO: "Is there a better time for me to call?"

[IF PARTICIPANT CONCERNED ABOUT CALL AND ASKS THAT YOU SPEAK WITH SURROGATE, PROCEED TO PERMISSION TO CONTACT SURROGATE SECTION].

I would like to ask you two other questions.

Do you currently live in a nursing home? Yes No

Are you currently enrolled in hospice? Yes No

[IF YES TO EITHER QUESTION ABOVE]: You are not eligible to participate in the study. Thank you for your interest.

[IF NO, CONTINUE WITH INTERVIEW.]

The name STRIDE stands for **ST**rategies to **R**educe **I**njuries and **D**evelop confidence in **E**lders. We are inviting

you to join based on your answers [on the post card you returned / during your recent clinic visit at [PRACTICE])]. You said that {FILL IN BASED ON "YES" RESPONSE(S) – E.G., YOU INDICATED THAT YOU HAVE FALLEN AT LEAST TWICE IN THE PAST YEAR}.

The STRIDE study will include 6,000 people from 10 different healthcare systems around the country. The study is expected to last up to 3 years.

Why are we doing this research study?

We are doing this study to learn better ways for individuals to prevent falls – before they happen.

What does the study involve?

- The study is voluntary.
- Whether or not you decide to take part in this study, you will continue to receive care from your regular doctor and his/her team.
- If you don't want to join or if you later drop out of the study, it will not harm your relationship with your own doctors.
- If you want to join the study, you will receive information about things you can do to prevent falls and related injuries.

I have several more questions to ask you, but before continuing, I would like to ask you a few questions to test your memory. This is necessary to make sure you are able to fully participate in this study. May I ask you the questions now? [IF YES, CONTINUE; IF NO, THANK THE PARTICIPANT AND END THE CONVERSATION]

{INSERT CALLAHAN 6-ITEM COGNITIVE ASSESSMENT QUESTIONS} –

I would like to ask you some questions that use your memory. I am going to name 3 objects. Please wait until I say all 3 words, then you repeat them. Remember what the 3 objects are because I am going to ask you to name them again later.

1. APPLE Recall: Yes No
2. TABLE Recall: Yes No
3. PENNY Recall: Yes No

Now I'm going to ask you a few basic questions.
What is the year? Correct: Yes No
What is the month? Correct: Yes No
What is the day of the week? Correct: Yes No

* Use an additional set of questions, such as verifying name, address and phone number a distractor.

What were the 3 objects I asked you to remember?
4. APPLE Recall: Yes No
5. TABLE Recall: Yes No
6. PENNY Recall: Yes No

6 Item Recall Summary: Number of objects missed (only choose one).
0.1. 2. 3. 4. 5. 6.

Scoring: A score of 4-6 missed indicates a need for surrogate.

{IF ABLE, CONTINUE WITH CONSENT, IF QUESTIONABLE OR UNABLE, ASK IF THERE IS ANOTHER PERSON IN THE HOME WHOM YOU COULD TALK TO; SEE SCRIPT FOR SURROGATE CONSENT}

[DOES NOT PASS COGNITIVE SCREEN]

PERMISSION TO CONTACT A SURROGATE

Based on your answers, with your permission, I would like to talk about the study with someone you trust. Is there someone I can contact? This can be your spouse, a child or someone else who knows you best.

[IF NO: I am sorry, but you are not eligible to participate in the study. Thank you for your interest.]

[IF YES:]

What is his/her name? _____

May I contact [SURROGATE NAME] to answer questions on your behalf?

Yes No

What is SURROGATE'S relationship to you?
□ Spouse
□ Son or Daughter
□ Niece or Nephew
□ Grandchild
□ Brother or Sister
□ Friend/Neighbor
□ OTHER RELATIVE (please specify): _____

Can you please give me a phone number so that I can contact [SURROGATE NAME]:
_____

[IF YES: Thank you, I will speak with SURROGATE"S NAME and, if s/he agrees, get back to you. SEE SCRIPT FOR SURROGATE CONSENT; END INTERVIEW]

[PASSES COGNITIVE SCREEN]

Based on your answers, I would like to tell you more about the study. During this call, if I use words that are not clear, please stop me and ask me to explain. Your doctor's practice has been assigned, at random, much like the flip of a coin to offer one of two different fall prevention programs.

In half of the practices (Group A):

- Your doctor will be told about your risk of falling.
- We will send you a brochure with information about falls and how to avoid them.
- You are encouraged to talk with your doctor about ways to reduce your risk of falling and getting hurt.

In the other practices (Group B):

- Your doctor will be told about your risk of falling.
- You will be contacted to schedule a visit at your doctor's office with a nurse Falls Care Manager.
- Before the office visit, you will receive a questionnaire to fill out.
- The Falls Care Manager will give you a call to discuss your upcoming visit.
- During the visit, the Falls Care Manager will check your risk of getting hurt because of falling. The Falls Care Manager will work with you and your doctor to make a treatment plan. The plan will include a list of suggestions to reduce your risk of falling. This visit will last about 1 hour.

I do not know which of the two programs your doctor's practice is offering, but we will provide you with this information in the next few weeks.

Before I tell you more about the study, I would like to know whether you would be willing to participate in either of the two fall prevention programs?

Yes No

[If "YES", CONTINUE.]
[IF "NO"]: Thank you for your time. Have a good day.
[IF NO]: NOTES REGARDING REASON: _____

If you agree to participate, I will describe for you the next steps:

- We'll ask you to complete a phone interview today. The interview will take about 30 minutes. We will ask you some questions about your health, how you take care of ~~for~~ yourself and how you do daily tasks. We will ask you about any recent falls, and about worries you may have about falling. We will also ask you to provide contact information.
- After today, we will ask you to keep track of any falls and injuries on a monthly calendar. We will send you a special calendar for this. The calendar will help you answer questions when we call you every 4 months.
- We will look at your medical records and be able to link your records to information from Medicare. This is to confirm when you have had an injury from a fall or another event that results in your need for healthcare.

Privacy:

- The information you share with us is private. The law requires us to protect the privacy of health information obtained for research. During this study, we will collect information about you and your health. We will share this information with researchers conducting the study. We share your health information only when we must, for example for quality control and public health purposes. We require anyone who receives your health information from us to protect your privacy.

- If you would like more information about our privacy policy, I can provide you with more in writing or online.
- [IF PARTICIPANT WANTS MORE INFORMATION**:** *Partners HealthCare Notice for Use and Sharing of Protected Health Information http://www.partners.org/Assets/Documents/Notices/Partners_Privacy_Policy_English.pdf.]

Contact Information:

- Please feel free to contact us with any questions or concerns.
- If you do not wish to participate and do not want us to contact you in the future, please let us know.

- You can contact us
    - toll-free by phone (1-844-9-STRIDE) (1-844-978-7433),
    - email (STRIDE@yale.edu) or
    - postal mail (Attn: Dr. Thomas Gill, STRIDE Study, 300 George St, Suite 775, New Haven, CT 06511).
- The Partners Institutional Review Board (IRB) is a group of people who review research to protect your rights. They have approved the STRIDE Research study and the way we will collect information.
- If you would like to speak with someone not involved in this research about your rights as a research subject, or have complaints about the research, contact the Partners Human Research committee (or IRB) at (617) 424-4100.

We will mail you a copy of the information I have just discussed with you. Please keep it for your files.

Regardless of what you decide to do, you should feel free to talk with your doctor if you have any concerns about falls or if you have a fall or an injury from a fall.

Questions
Do you have any questions about the study or what you'll need to do?

Have all your questions been answered? Would you like to take part in the study?

Do I have your consent to enroll you in the STRIDE Study?

Yes No

INTERVIEWER: CONFIRM THAT THE SUBJECT HAS CONSENTED TO PARTICIPATE IN STRIDE:

Yes No

Name of Participant:

Name and signature of person obtaining consent:

Date

By signing this form, the person obtaining consent verifies that the form was read aloud in its entirety, the subject passed the cognitive screen, and all questions were answered.

APPENDIX 3.12 SURROGATE CONSENT – PATIENT ANSWERS PHONE

STRIDE SURROGATE CONSENT

7/05/2016

Project Title: Randomized Trial of a Multifactorial Fall Injury Prevention Strategy

Communicating Primary Investigator: Shalender Bhasin, MD

Joint Primary Investigators: Thomas Gill, MD; David B. Reuben, MD

Site: Yale Recruitment and Assessment Center

Script for Obtaining Surrogate Consent to Participate in STRIDE Study via Phone (after subject has failed cognitive screen and given permission for surrogate to answer on his/her behalf):

(WHEN THE SURROGATE RESPONDENT IS CONTACTED PROCEED WITH THE FOLLOWING INTERVIEW SCRIPT):

Hello Ms./Mr. [INSERT NAME OF SURROGATE],

My name is [NAME]. I am calling from the STRIDE research study. [PATIENT'S NAME's] name was given to us by [PRACTICE]. We are inviting (PATIENT'S NAME) to participate based on information (he/she) provided. The STRIDE study is testing better ways to care for people at risk for fall-related injuries.

CENTRAL SCREEN: A few weeks ago [PATIENT'S NAME], or someone on his/her behalf, returned a post card questionnaire about falls. Then we sent [PATIENT'S NAME] some information about the STRIDE study. Do you recall [PATIENT'S NAME] getting that information?
OR
CLINIC SCREEN: A few weeks ago, after [PATIENT'S NAME's recent clinic visit at [PRACTICE], we mailed [PATIENT'S NAME] a packet of information about the STRIDE study. Do you recall [PATIENT'S NAME] getting that information?

While speaking with [PATIENT'S NAME] about the STRIDE study we sensed (he/she) may not fully understand what we were saying. (He/she) has given us your name as someone who can answer questions on his/her behalf. That is why we are calling you. In order for a (TYPE OF RELATIVE/RELATIONSHIP/PATIENT NAME) to participate in the study, we would like to ask you to provide some information about him/her.

Is now a good time to tell you more about this study?

IF YES: PROCEED

IF NO: TRY TO ARRANGE FOR A TIME TO FOLLOW UP

Can I confirm what your relationship is to [PATIENT'S NAME]?

□ Spouse
□ Son or Daughter
□ Niece or Nephew
□ Grandchild
□ Brother or Sister
□ Friend/Neighbor
□ OTHER RELATIVE (please specify): _____

PITTSBURGH SURROGATE REQUIREMENT: BLOOD RELATIVE OR PERSON THAT HAS MADE HEALTHCARE DECISIONS FOR THE PATIENT.IF REQUIREMENT NOT MET, THANK PERSON FOR THEIR TIME AND INTEREST, END INTERVIEW.

INTERVIEWER: IF NON-BLOOD RELATIVE (FRIEND/NEIGHBOR/OTHER), CONFIRM THAT FRIEND/NEIGHBOR/OTHER HAS MADE HEALTHCARE DECISIONS: Yes No

I would like to begin with two questions about [PATIENT's NAME],

Does he/she currently live in a nursing home? Yes No

Is he/she currently enrolled in hospice? Yes No

[IF YES TO EITHER QUESTION ABOVE]:
[PATIENT's NAME] is not eligible to participate in the study. Thank you for your interest.

[IF NO TO BOTH QUESTIONS, CONTINUE INTERVIEW]

Thank you. The name STRIDE stands for **ST**rategies to **R**educe **I**njuries and **D**evelop confidence in **E**lders.

Why are we doing this research study?
We are doing this study ~~is~~ to learn better ways for individuals to prevent falls – before they happen.

The STRIDE study will include 6,000 people from 10 different healthcare systems around the country. The study is expected to last up to 3 years.

What does the study involve?

- The study is voluntary.
- Whether or not PATIENT'S NAME decides to take part in this study, S/HE will continue to receive care from HIS/HER regular doctor and his/her team.
- If PATIENT'S NAME doesn't want to join or later drops out of the study, it will not harm his/her relationship with his/her own doctors.
- If PATIENT'S NAME wants to join the study, s/he will receive information about things s/he can do to prevent falls and related injuries.

During this call, if I use words that are not clear, please stop me and ask me to explain.

PATIENT'S NAME's doctor's practice has been assigned, at random to one of two fall prevention programs much like the flip of a coin.

In half of the practices (Group A):

- PATIENT'S NAME doctor will be told about PATIENT'S NAME'S risk of falling.
- We will send PATIENT'S NAME a booklet with information about falls and how to avoid them.
- You are encouraged to talk with PATIENT'S NAME'S doctor about ways to reduce PATIENT'S NAME's risk of falling and getting hurt.

In the other practices (Group B):

- PATIENT'S NAME'S doctor will be told about PATIENT'S NAME'S risk of falling.
- You will be contacted to schedule a visit for PATIENT'S NAME at his/her doctor's office with a nurse Falls Care Manager.
- Before the office visit, you will receive a questionnaire to fill out for PATIENT'S NAME.
- The Falls Care Manager will give you a call to discuss PATIENT'S NAME'S upcoming visit.
- During the visit, the Falls Care Manager will check PATIENT'S NAME'S risk of getting hurt because of falling. The Falls Care Manager will work with you and PATIENT'S NAME'S doctor to make a treatment plan. The plan will include a list of suggestions to reduce PATIENT'S NAME'S risk of. This visit will last about 1 hour.

I do not know which of the two programs PATIENT'S NAME'S doctor's practice is offering but we will provide you with this information in the next few weeks.

Regardless of what you decide to do, you should feel free to talk with your doctor if you have any concerns about PATIENT'S NAME's falls or if PATIENT'S NAME has a fall or an injury from a fall.

Are you willing to provide consent for PATIENT'S NAME to participate in of the two fall prevention programs?

Yes No

[If "YES", CONTINUE.]
[IF "NO"]: Thank you for your time. Have a good day.
[IF NO]: NOTES REGARDING REASON: _____

If you agree that PATIENT'S NAME can take part in this study:

- We'll ask you to complete a phone interview for PATIENT'S NAME today. The interview will take about 30 minutes. We will ask you some questions about his/her health, how he/she takes care for him/herself and how PATIENT'S NAME does daily tasks. We will ask you about any recent falls PATIENT'S NAME may have had, and about worries PATIENT'S NAME may have about falling. We will also ask you to provide contact information.
- After today, we will ask you to help PATIENT'S NAME keep track of any falls and injuries on a monthly calendar. We will send a special calendar for this. This calendar will help you to answer questions when we call you every 4 months.
- We will look at PATIENT'S NAME's medical records and be able to link his/her records to information from Medicare. This is to confirm when PATIENT'S NAME has had an injury from a fall or another event that results in his/her need for healthcare.

Privacy:

- The information you share with us is private. The law requires us to protect the privacy of health information obtained for research. During this study, we will collect information about PATIENT'S NAME and his/her health. We will share this information with researchers conducting the study. We share private health information only when we must, for example for quality control and public health purposes. We require anyone who receives your health information from us to protect your privacy.

- If you would like more information about our privacy policy, I can provide you with more in writing or online.
- [IF PARTICIPANT WANTS MORE INFORMATION**:** *Partners HealthCare Notice for Use and Sharing of Protected Health Information http://www.partners.org/Assets/Documents/Notices/Partners_Privacy_Policy_English.pdf.]

Contact Information:

- Please feel free to contact us with any questions or concerns.
- If you or PATIENT'S NAME does not wish to participate and does not want us to contact you in the future, please let us know.
- You can contact us
    - toll-free by phone (1-844-9-STRIDE) (1-844-978-7433),
    - email (STRIDE@yale.edu) or
    - postal mail (Attn: Dr. Thomas Gill, STRIDE Study, 300 George St, Suite 775, New Haven, CT 06511).
- The Partners Institutional Review Board (IRB) is a group of people who review research to protect the rights of human subjects. They have approved the STRIDE Research study and the way we will collect information.
- If you would like to speak with someone not involved in this research about PATIENT'S NAME's rights as a research subject, or have complaints about the research, contact the Partners Human Research committee (or IRB) at (617) 424-4100.

We will mail you a copy of the information I have just discussed with you. Please keep it for your files.

Surrogate information

I want to be sure I have your name correctly. What is your name? _____ (If necessary)

How long have you known (NAME OF PATIENT)? _____months/years

How many days per week (0-7) do you see and/or talk with the (NAME OF PATIENT)?
a) Face-to-Face contacts _____ b) Telephone contacts _____

Questions

Do you have any questions about the study or what the study will involve or (NAME OF PATIENT)'s involvement?

Have all your questions been answered?
Yes……No

Do you agree to answer questions for (NAME OF PATIENT) for the STRIDE study?
Yes……No

Do I have your consent to enroll (NAME OF PATIENT) in the STRIDE Study?

Yes No

INTERVIEWER CONFIRM THAT SURROGATE HAS GIVEN CONSENT

Yes No

Name of Participant:

Name of Surrogate: _____

Name and signature of person obtaining consent:

Date

By signing this form, the person obtaining consent verifies that:

- the form was read aloud in its entirety,
- the surrogate provided consent for the patient,
- all questions were answered.

ASSENT

I will also need to confirm with PATIENT'S NAME, his/her willingness to participate in the study. Can I speak with/recontact PATIENT'S Name? Yes No

ASK THE PARTICANT: Is this [PATIENT'S NAME]? Yes No

I am calling about a research study about falls and your health.

We want to learn better ways to prevent falls.

The study will last for up to 3 years.

Would you be willing to take part in this study?

YES NO

Can (SURROGATE NAME) answer questions on your behalf for this study?

YES NO

Would you allow us to look at your medical records?

YES NO

Patient provided assent? Yes to all 3 questions No Unable to answer

INTERVIEWER: CONFIRM THAT THE SUBJECT HAS PROVIDED ASSENT

Yes No Unable to answer

Name and Signature of person obtaining assent

Date of assent _____

[IF THE SUBJECT ASSENTS, CONDUCT BASELINE INTERVIEW WITH SURROGATE.]

[IF THE SUBJECTS REFUSES ASSENT OR IS UNABLE TO PROVIDE ASSENT]:
I am sorry, but PATIENT'S NAME is not eligible to participate in the study. Thank you for your interest.]

APPENDIX 3.13 SURROGATE CONSENT – SURROGATE ANSWERS PHONE

STRIDE SURROGATE CONSENT

7/05/2016

Project Title: Randomized Trial of a Multifactorial Fall Injury Prevention Strategy

Communicating Primary Investigator: Shalender Bhasin, MD

Joint Primary Investigators: Thomas Gill, MD; David B. Reuben, MD

Site: Yale Recruitment and Assessment Center

Script for Obtaining Surrogate Consent to Participate in STRIDE Study via Phone:

(WHEN THE SURROGATE RESPONDENT IS CONTACTED PROCEED WITH THE FOLLOWING INTERVIEW SCRIPT):

Hello Ms./Mr. [INSERT NAME OF SURROGATE],

My name is [NAME]. I am calling from the STRIDE research study. [PATIENT'S NAME's] name was given to us by [PRACTICE]. We are inviting (PATIENT'S NAME) to participate based on information (he/she) provided. The STRIDE study is testing better ways to care for people at risk for fall-related injuries.

CENTRAL SCREEN: A few weeks ago [PATIENT'S NAME], or someone on his/her behalf, returned a post card questionnaire about falls. Then we sent [PATIENT'S NAME] some information about the STRIDE study. Do you recall [PATIENT'S NAME] getting that information?
OR
CLINIC SCREEN: A few weeks ago, after [PATIENT'S NAME's] recent clinic visit at [PRACTICE], we mailed [PATIENT'S NAME] a packet of information about the STRIDE study. Do you recall [PATIENT'S NAME] getting that information?

Is now a good time to tell you more about this study?

IF YES: PROCEED

IF NO: TRY TO ARRANGE FOR A TIME TO FOLLOW UP

Can I confirm what your relationship is to [PATIENT'S NAME]?
□ Spouse
□ Son or Daughter
□ Niece or Nephew
□ Grandchild
□ Brother or Sister
□ Friend/Neighbor
□ OTHER RELATIVE (please specify): _____

PITTSBURGH SURROGATE REQUIREMENT: BLOOD RELATIVE OR PERSON THAT HAS MADE HEALTHCARE DECISIONS FOR THE PATIENT.IF REQUIREMENT NOT MET, THANK PERSON FOR THEIR TIME AND INTEREST, END INTERVIEW.

INTERVIEWER: IF NON-BLOOD RELATIVE (FRIEND/NEIGHBOR/OTHER), CONFIRM THAT FRIEND/NEIGHBOR/OTHER HAS MADE HEALTHCARE DECISIONS: Yes No

I would like to begin with two questions about [PATIENT's NAME],

Does he/she currently live in a nursing home? Yes No

Is he/she currently enrolled in hospice? Yes No

[IF YES TO EITHER QUESTION ABOVE]:
[PATIENT's NAME] is not eligible to participate in the study. Thank you for your interest.

[IF NO TO BOTH QUESTIONS, CONTINUE INTERVIEW]

Thank you. The name STRIDE stands for **ST**rategies to **R**educe **I**njuries and **D**evelop confidence in **E**lders.

Why are we doing this research study?
We are doing this study ~~is~~ to learn better ways for individuals to prevent falls – before they happen~~.~~

The STRIDE study will include 6,000 people from 10 different healthcare systems around the country. The study is expected to last up to 3 years.

What does the study involve?

- The study is voluntary.
- Whether or not PATIENT'S NAME decides to take part in this study, S/HE will continue to receive care from HIS/HER regular doctor and his/her team.
- If PATIENT'S NAME doesn't want to join or later drops out of the study, it will not harm his/her relationship with his/her own doctors.
- If PATIENT'S NAME wants to join the study, s/he will receive information about things s/he can do to prevent falls and related injuries.

After I tell you more about the study, would PATIENT'S NAME be able to come to the phone?

[IF NO, May I ask why not?

- IF THE REASON IS A PERMANENT DISABILITY – COGNITVE FUNCTION, SEVERE HEARING IMPAIRMENT, OTHER REASON THE PATIENT IS NEVER ABLE TO USE THE PHONE: I am sorry, but PATIENT'S NAME is not eligible to participate in the study. Thank you for your interest.]

[INTERVIEWER: CODE REASON FOR PERMANENT DISABILITY]

Cognitive Function ☐

Severe hearing impairment ☐

Other reason the patient is never able to use the telephone ☐

NOTES REGARDING REASON:

_____

_____

_____

- IF THE REASON IS A TEMPORARY DISABILITY OR OTHER SITUATION THAT MIGHT CHANGE– CURRENTY IN THE HOSPITAL, AWAY AT REHAB, OTHER REASON THE PATIENT MAY BE ABLE TO USE THE PHONE AT ANOTHER TIME: Is there a good time for me to call back and speak with PATIENT'S NAME?

[INTERVIEWER: CODE REASON FOR TEMPORARY DISABILITY OR OTHER]

Currently in a hospital or rehab facility ☐

Illnesses/Not a good time (cancer treatments, scheduled for surgery, not feeling well today, etc.) ☐

Death in family ☐

Other ☐

NOTES REGARDING REASON:

_____

_____

_____

Call back date: __ __ / __ __ / __ __ __ __

During this call, if I use words that are not clear, please stop me and ask me to explain.

PATIENT'S NAME's doctor's practice has been assigned, at random, to one of two fall prevention groups, much like the flip of a coin.

In half of the practices (Group A):

- PATIENT'S NAME doctor will be told about PATIENT'S NAME'S risk of falling.
- We will send PATIENT'S NAME a booklet with information about falls and how to avoid them.
- You are encouraged to talk with PATIENT'S NAME'S doctor about ways to reduce PATIENT'S NAME's risk of falling and getting hurt.

In the other practices (Group B):

- PATIENT'S NAME'S doctor will be told about PATIENT'S NAME'S risk of falling.
- You will be contacted to schedule a visit for PATIENT'S NAME at his/her doctor's office with a nurse Falls Care Manager.
- Before the office visit, you will receive a questionnaire to fill out for PATIENT'S NAME.

- The Falls Care Manager will give you a call to discuss PATIENT'S NAME'S upcoming visit.
- During the visit, the Falls Care Manager will check PATIENT'S NAME'S risk of getting hurt because of falling. The Falls Care Manager will work with you and PATIENT'S NAME'S doctor to make a treatment plan. The plan will include a list of suggestions to reduce PATIENT'S NAME'S risk of falling. This visit will last about 1 hour.

I do not know which of the two programs PATIENT'S NAME'S doctor's practice is offering but we will provide you with this information. in the next few weeks.

Regardless of what you decide to do, you should feel free to talk with your doctor if you have any concerns about PATIENT'S NAME's falls or if PATIENT'S NAME has a fall or an injury from a fall.

Are you willing to provide consent for PATIENT'S NAME to participate in either of the two fall prevention programs?

Yes No

[If "YES", CONTINUE.]
[IF "NO"]: Thank you for your time. Have a good day.
[IF NO]: NOTES REGARDING REASON: _____

If you agree that PATIENT'S NAME can take part in this study:

- We'll ask you to complete a phone interview for PATIENT'S NAME today. The interview will take about 30 minutes. We will ask you some questions about his/her health, how he/she takes care for him/herself and how PATIENT'S NAME does daily tasks. We will ask you about any recent falls PATIENT'S NAME may have had, and about worries PATIENT'S NAME may have about falling. We will also ask you to provide contact information.
- After today, we will ask you to help PATIENT'S NAME keep track of any falls and injuries on a monthly calendar. We will send a special calendar for this. This calendar will help you to answer questions when we call you every 4 months.
- We will look at PATIENT'S NAME's medical records and be able to link his/her records to information from Medicare. This is to confirm when PATIENT'S NAME has had an injury from a fall or another event that results in his/her need for healthcare.

Privacy:

- The information you share with us is private. The law requires us to protect the privacy of health information obtained for research. During this study, we will collect information about PATIENT'S NAME and his/her health. We will share this information with researchers conducting the study. We share private health information only when we must, for example for quality control and public health purposes. We require anyone who receives your health information from us to protect your privacy.
- If you would like more information about our privacy policy, I can provide you with more in writing or online.
- [IF PARTICIPANT WANTS MORE INFORMATION**:** *Partners HealthCare Notice for Use and Sharing of Protected Health Information http://www.partners.org/Assets/Documents/Notices/Partners_Privacy_Policy_English.pdf.]

Contact Information:

- Please feel free to contact us with any questions or concerns.
- If you or PATIENT'S NAME does not wish to participate and does not want us to contact you in the future, please let us know.
- You can contact us
    - toll-free by phone (1-844-9-STRIDE) (1-844-978-7433),

  - email (STRIDE@yale.edu) or
  - postal mail (Attn: Dr. Thomas Gill, STRIDE Study, 300 George St, Suite 775, New Haven, CT 06511).
- The Partners Institutional Review Board (IRB) is a group of people who review research to protect the rights of human subjects. They have approved the STRIDE Research study and the way we will collect information.
- If you would like to speak with someone not involved in this research about PATIENT'S NAME's rights as a research subject, or have complaints about the research, contact the Partners Human Research committee (or IRB) at (617) 424-4100.

We will mail you a copy of the information I have just discussed with you. Please keep it for your files.

Surrogate information
I want to be sure I have your name correctly. What is your name? _____ (If necessary)

How long have you known (NAME OF PATIENT)? _____months/years

How many days per week (0-7) do you see and/or talk with the (NAME OF PATIENT)?
a) Face-to-Face contacts _____ b) Telephone contacts _____

Questions
Do you have any questions about the study or what the study will involve or (NAME OF PATIENT)'s involvement?

Have all your questions been answered?
Yes……No

Do you agree to answer questions for (NAME OF PATIENT) for the STRIDE study?
Yes……No

Do I have your consent to enroll (NAME OF PATIENT) in the STRIDE Study?

Yes No

INTERVIEWER CONFIRM THAT SURROGATE HAS GIVEN CONSENT

Yes No

Name of Participant:

Name of Surrogate:

Name and signature of person obtaining consent:

Date

By signing this form, the person obtaining consent verifies that:
- the form was read aloud in its entirety,
- the surrogate provided consent for the patient,
- all questions were answered.

ASSENT

I will also need to confirm with PATIENT'S NAME, his/her willingness to participate in the study. Can I speak with/contact PATIENT'S Name? Yes No

ASK THE PARTICANT: Is this [PATIENT'S NAME]? Yes No

I am calling about a research study about falls and your health.

We want to learn better ways to prevent falls.

The study will last for up to 3 years.

Would you be willing to take part in this study?

YES NO

Can (SURROGATE NAME) answer questions on your behalf for this study?

YES NO

Would you allow us to look at your medical records?

YES NO

Patient provided assent? Yes to all 3 questions No Unable to answer

INTERVIEWER: CONFIRM THAT THE SUBJECT HAS PROVIDED ASSENT

Yes No Unable to answer

Name and Signature of person obtaining assent

Date of assent _____

[IF THE SUBJECT ASSENTS, CONDUCT BASELINE INTERVIEW WITH SURROGATE.]

[IF THE SUBJECTS REFUSES ASSENT OR IS UNABLE TO PROVIDE ASSENT]:
I am sorry, but PATIENT'S NAME is not eligible to participate in the study. Thank you for your interest.]

APPENDIX 3.14 COGNITIVE SCREENING – CALLAHAN 6-ITEM SCREENER

Script:

I would like to ask you some questions that use your memory. I am going to name 3 objects. Please wait until I say all 3 words, then you repeat them. Remember what the 3 objects are because I am going to ask you to name them again later.

Interviewer may repeat names 3 times if necessary but repletion is not scored.

*	APPLE	Recall:	Yes	No	DO NOT
*	TABLE	Recall:	Yes	No	INCLUDE IN
*	PENNY	Recall:	Yes	No	SCORE

Now I'm going to ask you a few basic questions

1. What is the year?	Correct:	Yes	No
2. What is the month?	Correct:	Yes	No
3. What is the day of the week?	Correct:	Yes	No

* Use an additional set of questions, such as verifying name, address and phone number as a distractor.

What were the 3 objects I asked you to remember?

4.	APPLE	Recall:	Yes	No
5.	TABLE	Recall:	Yes	No
6.	PENNY	Recall:	Yes	No

APPENDIX 3.15 STRIDE INTERVIEWER TRAINING AND CERTIFICATION CURRICULUM

Overview

1. Introduction to Stride Study – History, methodology, goals, timeline
2. Interviewer expectations
3. Human Subjects training
4. Informed consent/ Ethical overview
5. HIPAA : Protecting subjects confidentiality and privacy

Technology for STRIDE Interviewers

1. Yale ITS, netIDS, e-mail, voice mail, cell phones
2. REDCAP introduction, training/practice
3. LLFDI software

Interview Skills

1. Customer Service
2. Verbal Consent Process
3. Probing
4. Importance of maintaining blinding
5. How to handle and document
    A. Surrogate interviews –
    B. Partial Interviews
    C. Refusals,
    D. Complaints
6. Other Documentation

Tools and Practice:

1. Recruitment materials – what's already been sent to potential participants (brochure, letters, etc)
2. Cognitive Screening
3. Calendar training
4. Interview
    A. short
    B. extended

Testing

1. MOP quiz
2. Practice with observation.
3. Sample interviews and reviews
4. Role play

Challenging situations

1. “I never fall”
2. “How did you get my name?”
3. Concerned family member
4. Moves to SNF after enrollment
5. Death

Certifications

1. Interview
2. LLFDI
3. REDCap
4. MOP

APPENDIX 3.16 STRIDE CERTIFICATION/ RECERTIFICATION

Telephone Screening

_____ _ _ _ _ _ _ _

Name **Staff id**

1. Attendance at STRIDE training Session_____/____/_____
2. REDCap training/review_____/_____/_____

Description of REDCAP training

_____

_____

_____

_____

_____

3. Required Reading
   MOP: Chapters xxxxxx
4. Conduct 3 interviews with older adults via the telephone in the presence of a supervisor.
5. Date of Certification _____
   _____

Signature of Program Coordinator and Date signature of supervisor and Date

_____ _ _ _ _ _ _ _ __

Interviewers Name Staff ID

APPENDIX 3.16.1 STRIDE CERTIFICATION

Observes the Following Procedural Steps:

1. □ Properly greets participant
2. □ Reads slowly in a natural conversational rhythm and in a normal tone of voice
3. □ Always reads the entire question before getting the participant's response
4. □ Asks every question
5. □ Repeats questions if it is answered inappropriately, but repeats it exactly as written.
6. □ Offers to reread a question if participant does not understand the question
7. □Asks questionnaire items in order and exactly as worded.
8. □ Correctly codes participant's responses on the data collection forms

Comments:_____
_____

_____
_____

_____
_____
_____

_____

_____

Observer:_____ Date Observed_____

APPENDICES CHAPTER 5 - INTERVENTION

5.22 MEDICATION RISK REDUCTION PROCEDURE

5.23 MEDICATION SYMPTOMS-ADHERENCE TRIGGERS FOR REFERRAL TO PHARMD OR SCD

5.24 AVOIDING THE BAD EFFECTS OF MEDICATION

5.25 SLEEP HYGIENE

5.26 MEDICATION RISK REFERRALS TO PHARMACIST AND SCD

5.27 TRAVEL SAFETY CHECKLIST

5.28 ALL ABOUT CALCIUM

5.29 DAIRY FORMS OF CALCIUM

5.30 NON DAIRY FORMS OF CALCIUM

5.31 NOCTURIA HANDOUT

5.32 ELDERCARE LOCATOR

5.33 COMMUNITY SAFETY ADVICE

5.34 MY EXERCISE PLAN FOR STRENGTH AND BALANCE

5.35 IMPLEMENTATION OF BEST PRACTICES FOR CBE

5.36 PHARMACIST OR SCD RECS TO PCP

5.37 YOU MAY BE AT RISK—ANTIHISTAMINES

5.38 YOU MAY BE AT RISK—ANTIPSYCHOTICS

5.39 YOU MAY BE AT RISK—SEDATIVE HYPNOTICS

5.40 YOU MAY BE AT RISK—SULFONYLUREAS

5.41 POSTURAL HYPOTENSION PROCEDURE

5.42 PATIENTS WHO LEAVE HEALTH SYSTEM

5.43 MANAGING POSTURAL HYPOTENSION

5.44 FEET AND FOOTWEAR PROCEDURE

5.45 FRIDS SYMPTOMS LIST

5.46 TEMPLATE FOR REFERRAL TO ORTHOTISTS

5.47 TEMPLATE FOR REFERRAL TO PODIATRISTS

5.48 PROPER SHOES—STRIDE

APPENDIX 5.1 PRE-VISIT QUESTIONNAIRE (PVQ)

Falls Care Program Pre-Visit Questionnaire

To help us get to know you better, please complete this form before your visit and bring it with you to the visit. It will help us to work with you to reduce your risk of falling.
We look forward to working with you.

I. PERSONAL INFORMATION (*Please print all responses throughout the form*)

Name of Patient: _____
Last First Middle

Email address: _____

WHO COMPLETED THIS FORM:

☐ Self (***skip to section II***) ☐ Other (*provide information below*)

Relationship to the patient: _____

Name: _____
Last First Middle

Phone: (____)_____ (___)_____
Home Mobile

Email address: _____

What are the best times to contact the person completing the form (M-F, 8am-5pm)? _____

II. PHYSICIAN INFORMATION

Name of patient's PRIMARY CARE DOCTOR or PROVIDER:

_____
Last Name First Name

Phone: (____) _____ (___) _____
Office Fax

Do you have any other doctors/providers (e.g., cardiologist, neurologist, rheumatologist, or orthopedist, ophthalmologist, podiatrist)? ☐ Yes ☐ No

Other Provider's Name	Specialty	Phone

PVQ Updated 8_1_16 1

III. INFORMATION ABOUT FALLING

Are you afraid of falling? ☐ Yes ☐ No

Have you had a fall in the past year? ☐ Yes ☐ No

If no, skip to **Do you use a walking aid.**

If yes, how many times have you fallen during the past year _____

When was your most recent fall? _____

Below, please indicate the circumstances and consequences of your most recent fall.

Where were you when you fell?

_____

What were you doing when you fell?

_____

Did you trip over something? ☐ Yes ☐ No

Did you report your fall to your healthcare provider? ☐ Yes ☐ No

Did you have lightheadedness or heart fluttering prior to the fall? ☐ Yes ☐ No

Did you consume alcohol within two hours of your fall? ☐ Yes ☐ No

Did you lose consciousness when you fell? ☐ Yes ☐ No

Did you lose control of your urine when you fell? ☐ Yes ☐ No

Were you able to get up by yourself? ☐ Yes ☐ No

Were you injured when you fell? ☐ Yes ☐ No

If yes, what was the injury?

_____

Do you use a walking aid? ☐ Yes ☐ No

If yes, which one(s)? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Motorized scooter

When do you use the walking aid? ☐ All the time ☐ Only _____

Have you received physical (PT) or occupational therapy (OT) in the past year?

☐ Yes ☐ No

If yes, which ones, where, when?

	Month/year Completed	Month/year Completed
☐ PT in office	___/____	☐ PT at home ___/____
☐ OT in office	___/____	☐ OT at home ___/____

Have you been examined by an eye doctor in the past year?

☐ Yes – Date: _____ ☐ No

IV. YOUR HEALTH

Your medications:
Please list all medications and supplements, including those prescribed to you and those you purchase without a prescription (e.g., Tylenol, allergy relief medications, sleep aids), and supplements or natural products (e.g., vitamins) that you are currently taking regularly or as needed.

Prescribed medication name	Dose	Number of pills and times per day	What is this medication for?	How long have you been taking this medication?
Example: Lasix	*20mg*	*1 pill twice a day*	*Heart failure*	*2 years*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Do you think that any of the medications you are taking make you unsteady, dizzy or lightheaded?

☐ Yes ☐ No If yes, which one(s)? _____

Do you think that any of the medications you are taking make you drowsy, foggy, or too sleepy?

☐ Yes ☐ No If yes, which one(s)? _____

Do you think that any of the medications you are taking make you need to go to the toilet frequently?

☐ Yes ☐ No If yes, which one(s)? _____

Do you sometimes take medications differently than they are prescribed (such as skipping or reducing doses?)

☐ Yes ☐ No If yes, which one(s)? _____

Do you ever forget to take any of your medications?

☐ Yes ☐ No If yes, which one(s)? _____

When you feel better, do you sometimes stop taking any of your medications?

☐ Yes ☐ No If yes, which one(s)? _____

If you feel worse when you take one of your medications, do you sometimes stop taking it?

☐ Yes ☐ No If yes, which one(s)? _____

Do you ever stop taking your medications because they are too expensive?

☐ Yes ☐ No If yes, which one(s)? _____

Which medical conditions and symptoms do you have now or have had in the past? (Please check all that apply):

EYE & EAR

☐ Distant vision loss ☐ Macular degeneration ☐ Multifocal glasses

☐ Near vision loss ☐ Glaucoma

☐ Cataracts ☐ Diabetic vision loss

HEART

☐ Orthostatic Hypotension
☐ Heart valve problem
☐ Irregular heartbeats (Arrhythmia)
☐High blood pressure
☐Atrial fibrillation
☐ Aortic stenosis
☐ Shortness of breath with walking

BONES, JOINTS, AND MUSCLES

☐ Osteoporosis
☐ Leg pain with walking
☐ Foot problems
☐ Rheumatoid arthritis
☐ Foot pain
☐ Leg pain at rest
☐ Fracture occurring from fall at standing height or less

☐ Fractured Bone: ☐ hip ☐ spine ☐ wrist ☐ other (specify): _____

☐ Arthritis *(check affected area on body):* ☐ hip ☐ knee ☐ neck ☐ shoulder ☐ back ☐ hands

☐ Joint replacement (check affected area on body): ☐ hip ☐ knee

Have either of your parents fractured a hip? ☐ Yes ☐ No ☐ Don't Know

NERVOUS SYSTEM

☐ Balance problems
☐ Parkinson's disease
☐ Dizziness or unsteadiness
☐ Neuropathy/nerve damage
☐ Lightheadedness
☐ Numbness or loss of feeling
☐ Vertigo or spinning sensation

KIDNEY & URINARY TRACT

☐ Loss of urine or getting wet (incontinence)
If yes,
☐ Sudden urge to void
☐ Getting to the toilet on time

☐ Urination at night
If yes, how many times a night:_____

☐ Kidney disease

MENTAL HEALTH

☐ Alzheimer's disease or other Dementia
☐ Problems with memory
☐ Anxiety
☐ Depression
☐ Insomnia or problems with sleep
☐ Daytime sleepiness
☐ Other _____

PAIN

Do you have pain?

Where is your pain located?

Does your pain limit your ability to participate in daily activities or do things that are important to you?

ENDOCRINE (Glands and hormones)

☐ Diabetes ☐ Early Menopause (before age 45)

Have you ever taken any steroid medications (such as Prednisone)?

☐ Yes ☐ No If yes, which one(s)? _____

V. YOUR LIFE

Who do you live with? (Please check all that apply):

☐ Alone ☐ Spouse or Partner ☐ Child

☐ Other family member(s): _____

☐ Other, not family member(s): _____

Who would you call if you were sick and needed help? (check all that apply)

☐ Spouse/Partner ☐ Neighbor ☐ Daughter

☐ Friend ☐ Son ☐ Other (specify): _____

Please list name(s) and phone number(s) of person(s) checked off above:

Name:_____ **Phone:** (_____)_____

Name: _____ **Phone:** (_____)_____

Do we have your permission to speak to the person(s) listed above on your behalf?

☐ Yes ☐ No

List your principal occupation and other significant past occupations (indicate current status)

1. _____ ☐ Working full-time ☐ Working part-time ☐ Retired
2. _____ ☐ Working full-time ☐ Working part-time ☐ Retired

Do you employ someone to provide health-related care or help you in your home?

☐ Yes ☐ No

If yes, how many hours per day and days per week, is the paid helper available to you?

_____ Hours _____ Days per week *(e.g. 3 hours, 5 days per week)*

_____ Hours _____ Days per week *(complete if hours vary on different days)*

Does this adequately meet your needs? ☐ Yes ☐ No

Do you get help from family members or friends in your home? ☐ Yes ☐ No

If yes, how many hours per day and days per week, is the helper available to you?

_____ Hours,_____ Days per week *(e.g. 3 hours, 5 days per week)*

Does this adequately meet your needs? ☐ Yes ☐ No

Please name family/friend who provides help: _____

If this family/friend were to get sick or hospitalized, who would provide help?

_____

Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

☐ Daily ☐ A few days a week (specify number of days: _____)

☐ Less than once a week ☐ Never

How much do you drink at a time? (One drink = 12 oz of beer or 8-9 oz of malt liquor or 5 oz of table wine or 1.5 oz of hard alcohol)

☐ 1 drink ☐ 2 drinks ☐ 3 drinks ☐ 4 drinks ☐ 5+ (how many_____)

Has anyone ever been concerned about your drinking? ☐ Yes ☐ No

Have you ever smoked cigarettes? ☐ Yes ☐ No

If yes, do you currently smoke cigarettes? ☐ Yes ☐ No

☐ No... If no, when did you quit? Year _____

VI. YOUR HOME

Which of the following best describes your residence?

☐ Single-family house ☐ Condo or retirement community

☐ Board & Care/Assisted Living ☐ Apartment

☐ Mobile Home ☐ Other (specify): _____

How long have you lived at your current residence? _____

Number of levels? _____ Number of stairs? _____

VII. YOUR ACTIVITIES

Do you currently participate in any regular activity to improve or maintain your physical fitness? *(either on your own or in a formal class)* ☐ Yes ☐ No

***If yes*, what do you do?**

_____

How many days per week do you exercise (check box):

Amount of time per day _____ (minutes/hours)

Would you like to exercise more than you do right now? ☐ Yes ☐ No

HELP WITH DAILY ACTIVITIES (Please check the most appropriate box for each task)

	No Help Needed	Help Needed	Who Helps?
Eating	☐	☐	_____
Getting from bed to chair	☐	☐	_____
Getting to the toilet	☐	☐	_____
Getting dressed	☐	☐	_____
Bathing or showering	☐	☐	_____
Walking across the room *(includes using a cane or walker)*	☐	☐	_____
Using the telephone	☐	☐	_____
Taking your medicines	☐	☐	_____
Preparing meals	☐	☐	_____
Managing money *(e.g., keeping track of expenses or paying bills)*	☐	☐	_____
Moderately strenuous housework *(e.g., doing laundry)*	☐	☐	_____
Shopping for personal items *(e.g., toiletries or medicine)*	☐	☐	_____
Shopping for groceries	☐	☐	_____
Driving	☐	☐	_____
Climbing a flight of stairs	☐	☐	_____
Walking ¼ mile (3-4 blocks)	☐	☐	_____
Getting to places beyond walking Distance *(e.g. by bus, taxi or car)*	☐	☐	_____

VIII. COMMUNITY SERVICES

Please check the box for each community-based service you are currently receiving and any services you would be interested in receiving in the future.

	Currently receiving	Interested in receiving
Walking program	☐	☐
Falls prevention program	☐	☐
Home Health Care	☐	☐
Home safety modification *(e.g., grab bars, commodes)*	☐	☐
Medication management program	☐	☐
Veteran's services	☐	☐
Exercise program	☐	☐

If receiving or interested in an exercise program, what type?

_____

Do you have transportation available to attend treatment programs or activity programs that are offered outside of your home at least 1 day per week? ☐ Yes ☐ No

IX. OTHER HEALTH CONCERNS

In order to best serve you, please list any specific health concerns that you would like the **Falls Care Manager** to know about before your visit.

Include any information NOT already reported in this form:

Please review the Home Safety Checklist enclosed in your packet and bring it to your appointment with you.

Thank you for taking the time to complete this form.

APPENDIX 5.2 HOW TO GET UP FROM A FALL (PHILIPS)

How to get up from a fall

1. Prepare

Getting up quickly or the wrong way could make an injury worse. If you are hurt, call for help using a medical alert service or a telephone.

Look around for a sturdy piece of furniture, or the bottom of a staircase. Don't try and stand up on your own.

Roll over onto your side by turning your head in the direction you are trying to roll, then move your shoulders, arm, hips, and finally your leg over.

2. Rise

Push your upper body up. Lift your head and pause for a few moments to steady yourself.

Slowly get up on your hands and knees and crawl to a sturdy chair.

Place your hands on the seat of the chair and slide one foot forward so it is flat on the floor.

3. Sit

Keep the other leg bent with the knee on the floor.

From this kneeling position, slowly rise and turn your body to sit in the chair.

Sit for a few minutes before you try to do anything else.

Talk to your primary care provider about having a fall-risk evaluation. The fact that you have fallen once means you have a high risk of falling again.

PHILIPS Lifeline

Philips Lifeline. Sharing your concern for falls safety.

Source: Baker, Dorothy, Ph.D., RNCS, Research Scientist, Yale University School of Medicine New Haven, Connecticut; Connecticut Collaboration for Fall Prevention.

PHILIPS

APPENDIX 5.3 PVQ COVER LETTER

[STRIDE logo] [Practice letterhead]

[Date]
[Participant name]
[Participant address]

Dear [Mr/Ms lastname]:

I am delighted that you have decided to participate in the STRIDE study. I look forward to working with you and our specially trained registered nurse over the coming months to preserve your independence and mobility by preventing falls. We will all be partners in this effort.

To get started, please review the enclosed form. Please fill in the blanks and correct any information that is incorrect or out of date. A family member or friend who knows you well may help.

Soon one of my staff will call you to schedule times for you to get to know our nurse, [FCM name]. First, we will find a convenient time for you to have a short phone call with the nurse. We will also find a convenient time for you to come to my office to meet the nurse in person. She will spend about 90 minutes with you at my office. A family member or friend who knows you well is welcome to attend too. **Please be sure to bring your completed form (enclosed) to this visit**, so that, together, you can make a plan for preserving your independence and mobility by preventing falls. Please also bring the shoes that you usually wear. Soon after your visit, I will review your plan and make suggestions from a medical point of view. Nurse [last name] and I will continue to partner with you in carrying out your plan over the next several months.

I believe that your participation in this program will be beneficial. It could prevent a serious injury from a fall. It is a good investment of our time and effort to preserve your independence, your mobility and your quality of life.

Sincerely,

[e-signature]

[primary care provider's name, degree]

APPENDIX 5.4 CDC HOME FALL PREVENTION CHECKLIST (FULL BROCHURE ON WEBSITE)

This checklist is based on the original version printed by the Centers for Disease Control and Prevention. Support for this version was provided by MetLife Foundation.

2005

Check for Safety

CDC FOUNDATION

MetLife Foundation

A Home Fall Prevention Checklist for Older Adults

Department of Health and Human Services
Centers for Disease Control and Prevention

For more information, contact:
Centers for Disease Control and Prevention
770-488-1506
www.cdc.gov/injury

CDC FOUNDATION

MetLife Foundation

APPENDIX 5.5 FALLS AND FRACTURES AGE PAGE

National Institute on Aging

AgePage

Falls and Fractures

A simple thing can change your life—like tripping on a rug or slipping on a wet floor. If you fall, you could break a bone, like thousands of older men and women do each year. A broken bone might not sound awful. But, for older people, a break can be the start of more serious problems.

Many things can cause a fall. Your eyesight, hearing, and reflexes might not be as sharp as they were when you were younger. Diabetes, heart disease, or problems with your thyroid, nerves, feet, or blood vessels can affect your balance. Some medicines can cause you to feel dizzy or sleepy, making you more likely to fall.

But don't let a fear of falling keep you from being active. Doing things like getting together with friends, gardening, walking, or going to the local senior center helps you stay healthy. The good news is that there are simple ways you can prevent most falls.

Take The Right Steps

If you take care of your overall health, you may be able to lower your chances of falling. Most of the time, falls and accidents don't "just happen." Here are a few hints that will help you avoid falls and broken bones:

- Stay physically active. Plan an exercise program that is right for you. Regular exercise improves muscles and makes you stronger. It also helps keep your joints, tendons, and ligaments flexible. Mild weight-bearing activities, such as walking or climbing stairs, may slow bone loss from osteoporosis.
- Have your eyes and hearing tested. Even small changes in sight and hearing may cause you to fall. When you get new eyeglasses, take time to get used to them. Always wear your glasses when you need them. If you have a hearing aid, be sure it fits well, and wear it.
- Find out about the side effects of any medicine you take. If a drug makes you sleepy or dizzy, tell your doctor or pharmacist.
- Get enough sleep. If you are sleepy, you are more likely to fall.
- Limit the amount of alcohol you drink. Even a small amount of alcohol can affect your balance and reflexes.
- Stand up slowly. Getting up too quickly can cause your blood pressure to drop. That can make you feel wobbly.

- Use a walking stick if you need help feeling steady when you walk. If your doctor tells you to use a cane or walker, make sure it is the right size for you and the wheels roll smoothly. This is very important when you're walking in areas you don't know well or in places where the walkways are uneven.
- Be very careful when walking on wet or icy surfaces. They can be very slippery! Try to have sand or salt spread on icy areas by your front or back door.
- Wear non-skid, rubber-soled, low-heeled shoes, or lace-up shoes with non-skid soles that fully support your feet. It is important that the soles are not too thin or too thick. Don't walk around on stairs or floors in socks or in shoes and slippers with smooth soles.

Always tell your doctor if you have fallen since your last checkup—even if you aren't hurt when you fall.

Weak Bones

Osteoporosis is a disease that makes bones weak and more likely to break. Many people think osteoporosis is only a problem for women, but it can also affect older men. For people with osteoporosis, even a minor fall may be dangerous. Talk to your doctor about whether you have osteoporosis.

Your Own Medical Alarm

Think about getting a home-monitoring system. Usually, you wear a button on a chain around your neck. If you fall or need emergency help, you push the button to alert the service. You can find local "medical alarm" services in your yellow pages. Most medical insurance companies and Medicare do not cover home-monitoring systems. Be sure to ask about costs.

Make Your Home Safe

There are many changes you can make to your home that will help you avoid falls and ensure your safety.

In Stairways, Hallways, and Pathways

- Have handrails on both sides of the stairs, and make sure they are tightly fastened. Hold the handrails when you use the stairs, going up or down. If you must carry something while you're on the stairs, hold it in one hand and use the handrail with the other. Don't let what you're carrying block your view of the steps.
- Make sure there is good lighting with light switches at the top and bottom of stairs and on each end of a long hall. Remember to use the lights!

- Keep areas where you walk tidy. Don't leave books, papers, clothes, and shoes on the floor or stairs.
- Check that all carpets are fixed firmly to the floor so they won't slip. Put no-slip strips on tile and wooden floors. You can buy these strips at the hardware store.
- Don't use throw rugs or small area rugs.

In Bathrooms and Powder Rooms

- Mount grab bars near toilets and on both the inside and outside of your tub and shower.
- Place non-skid mats, strips, or carpet on all surfaces that may get wet.
- Remember to turn on night lights.

In Your Bedroom

- Put night lights and light switches close to your bed.
- Keep your telephone near your bed.

In Other Living Areas

- Keep electric cords and telephone wires near walls and away from walking paths.
- Tack down all carpets and large area rugs firmly to the floor.
- Arrange your furniture (especially low coffee tables) and other objects so they are not in your way when you walk.
- Make sure your sofas and chairs are the right height for you to get in and out of them easily.
- Don't walk on newly washed floors—they are slippery.

- Keep items you use often within easy reach.
- Don't stand on a chair or table to reach something that's too high—use a "reach stick" instead or ask for help. Reach sticks are special grabbing tools that you can buy at many hardware or medical-supply stores. If you use a step stool, make sure it is steady and has a handrail on top. Have someone stand next to you.
- Don't let your cat or dog trip you. Know where your pet is whenever you're standing or walking.
- Keep emergency numbers in large print near each telephone.

Home Improvements Prevent Falls

Many State and local governments have education and/or home modification programs to help older people prevent falls. Check with your local health department, senior affairs office, or area agency on aging to see if there is a program near you.

For More Information

Here are some helpful resources:

Eldercare Locator
1-800-677-1116 (toll-free)
www.eldercare.gov

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333
1-800-232-4636 (toll-free)
1-888-232-6348 (TTY/toll-free)
www.cdc.gov/ncipc

National Resource Center on Supportive Housing and Home Modification
University of Southern California
Fall Prevention Center of Excellence
3715 McClintock Avenue, Room 228
Los Angeles, CA 90089-0191
1-213-740-1364
www.homemods.org

Rebuilding Together
1899 L Street, NW, Suite 1000
Washington, DC 20036
1-800-473-4229 (toll-free)
www.rebuildingtogether.org

Looking for more information about exercise? Check out ***Go4Life***® at *www.nia.nih.gov/Go4Life*. This exercise and physical activity campaign from the National Institute on Aging has exercises, success stories, and free video and print materials.

For more information on osteoporosis, home safety for people with Alzheimer's disease, or other resources on health and aging, contact:

National Institute on Aging Information Center
P.O. Box 8057
Gaithersburg, MD 20898-8057
1-800-222-2225 (toll-free)
1-800-222-4225 (TTY/toll-free)
www.nia.nih.gov
www.nia.nih.gov/espanol

To sign up for regular email alerts about new publications and other information from the NIA, go to *www.nia.nih.gov/health*.

Visit *www.nihseniorhealth.gov*, a senior-friendly website from the National Institute on Aging and the National Library of Medicine. This website has health and wellness information for older adults. Special features make it simple to use. For example, you can click on a button to make the type larger.

National Institute on Aging
National Institutes of Health
NIH...Turning Discovery Into Health®

U.S. Department of Health and Human Services

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APPENDIX 5.6 CARE PLAN: MY FALL RISK ASSESSMENT

My Fall Risk Assessment

Participant Name **Study ID** **Date**

Risk Factor	Why Does It Matter?	Is this a risk for me?	Is this a priority for me?	Comments
Changes in leg strength, balance and/or walking 	People with decreased leg strength and changes in balance and/or gait are more likely to trip, slip and fall.	Yes No	Yes No	"undecided" "active plan in place"
Medications 	Medications that cause lightheadedness or tiredness (e.g., sleeping pills) can increase the likelihood of falling.			
Postural Hypotension 	Postural hypotension, or a drop in blood pressure when a person changes positions, increases the chances of falling.			
Feet Footwear 	Problems with feet, footwear can make it more difficult to walk.			
Home Environmental hazards 	Objects on the floor, loose throw rugs, low lighting, and not having hand rails can increase the likelihood of tripping, slipping, and falling.			
Risk of Osteoporosis 	Osteoporosis, or fragile bones, increases the chances of injury during or after a fall.			
Vitamin D supplements	People who do not take Vitamin D supplements are more likely to fall and have an injury.			
Vision problems 	Problems with vision can lead to missteps.			

My Falls Care Plan Updated 3_7_16

APPENDIX 5.6.1 CARE PLAN: MY PRIORITIES LONG VERSION

Priority: Changes in leg strength, balance and/or walking

My Goal for the next month is:

Why it matters to me (e.g., increased balance will…..)

How will I do this?

When will I do this?

The things that could make it difficult to do this are:

My plan for overcoming these difficulties includes:

Support/Resources my Falls Care Manager will assist me with in order to achieve these goals include:

How will I monitor progress?

Priority: Medications

My Goal for the next month is:

Why it matters to me (e.g., increased balance will…..)

How will I do this?

When will I do this?

The things that could make it difficult to do this are:

My plan for overcoming these difficulties includes:

Support/Resources my Falls Care Manager will assist me with in order to achieve these goals include:

How will I monitor progress?

Priority: Postural Hypotension

My Goal for the next month is:

Why it matters to me (e.g., increased balance will…..)

How will I do this?

When will I do this?

The things that could make it difficult to do this are:

My plan for overcoming these difficulties includes:

Support/Resources my Falls Care Manager will assist me with in order to achieve these goals include:

How will I monitor progress?

Priority: Feet, Footwear or Walking Aid

My Goal for the next month is:

Why it matters to me (e.g., increased balance will.....)

How will I do this?

When will I do this?

The things that could make it difficult to do this are:

My plan for overcoming these difficulties includes:

Support/Resources my Falls Care Manager will assist me with in order to achieve these goals include:

How will I monitor progress?

Priority: Home/ Environmental hazards

My Goal for the next month is:

Why it matters to me (e.g., increased balance will.....)

How will I do this?

When will I do this?

The things that could make it difficult to do this are:

My plan for overcoming these difficulties includes:

Support/Resources my Falls Care Manager will assist me with in order to achieve these goals include:

How will I monitor progress?

Priority: Not Enough Vitamin D

My Goal for the next month is:

Why it matters to me (e.g., increased balance will…..)

How will I do this?

When will I do this?

The things that could make it difficult to do this are:

My plan for overcoming these difficulties includes:

Support/Resources my Falls Care Manager will assist me with in order to achieve these goals include:

How will I monitor progress?

Priority: Risk of Osteoporosis and related Fracture

My Goal for the next month is:

Why it matters to me (e.g., increased balance will…..)

How will I do this?

When will I do this?

The things that could make it difficult to do this are:

My plan for overcoming these difficulties includes:

Support/Resources my Falls Care Manager will assist me with in order to achieve these goals include:

How will I monitor progress?

Priority: Vision Problem

My Goal for the next month is:

Why it matters to me (e.g., increased balance will…..)

How will I do this?

When will I do this?

The things that could make it difficult to do this are:

My plan for overcoming these difficulties includes:

Support/Resources my Falls Care Manager will assist me with in order to achieve these goals include:

How will I monitor progress?

APPENDIX 5.6.2 CARE PLAN: MY PRIORITIES SHORT VERSION

Fall Risk Factors that Matter Most to Me

[Name of Health System] Name:
Study ID: Date:

My priority fall risk factor(s)	My plans
1.	[Please refer to preliminary independence plan . . . . . or Specific preliminary plan(s)]
2.	
3.	[Please refer to preliminary independence plan . . . . . or Specific preliminary plan(s)]
4.	
5.	[Please refer to preliminary independence plan . . . . . or Specific preliminary plan(s)]

Initial Visit: Educational Materials Provided

- ✓ Falls and Fractures Age Page
- ✓ How to Get Up from a Fall
- ✓ Eldercare Locator
- ✓ Community Safety

My Additional Educational Materials:

- ☐ Home Exercise Handout
- ☐ Avoid Bad Effects of Medications
- ☐ Sleep Hygiene
- ☐ Postural Hypotension
- ☐ Proper Shoes
- ☐ Home Safety
- ☐ Travel Safety
- ☐ Age Page Bone Thief
- ☐ Vitamin D Fact Sheet
- ☐ Cataracts
- ☐ Cracked sidewalk
- ☐ All About Calcium
- ☐ Non-Dairy Sources of Calcium
- ☐ Nocturia

Call your Falls Care Nurse, _____ at ### ### #### if you:

- Are unable to keep scheduled appointments
- Have changed your mind regarding the plans you have made
- Have received medical care for a fall or following a fall

Follow-up:

My Nurse will Call Me: Care Plan follow-up call, 3-4 month call, 9 month call
My Visits: 6 month visit mm/dd/yy, 12 month visit mm/dd/yy

My Care Plan Second Page – Short 3_11_16
Modified from "My Priorities_Initial visit" from K. Burek

APPENDIX 5.7 COMPREHENSIVE VISIT NOTE

Falls Care Program
Initial Assessment & Care Plan

Date: @TODAY@

Name: @NAME@ **MRN:** @MRN@
DOB: @DOB@ **Sex:** @SEX@

Phone Number: @PH@
Mailing address: @ADD@

Caregiver/Decision maker:
Name/Relationship: @EC1NM@
Involvement in care: {Is/is not:9024} involved in personal care;
{Is/is not:9024} involved in decision making
Mailing Address: @EMCNTADDR@
Phone Number:@EC1HPH@
Email: @EMAIL@

Primary Care Physician: @PCP@.
@PCPPH@
@PCPADD@

Rheumatologist:
Orthopedist:
Neurologist:
Other:

Chief Complaint:
@NAME@ is referred to the Falls Care Program for co-management of falls and coordination of falls prevention care.

History of Present Illness: @NAME@ is an @AGE@ year old @SEX@ with FALLS RISK FACTOR BASED ON SCREEN. There have been *** falls in the last year. The most recent fall was WHEN and was WHERE. HE/SHE DID/DID NOT trip over something. It was ASSOCIATED/UNASSOCIATED with lightheadedness, palpitations, loss of consciousness, incontinence. HE/SHE was ABLE/UNABLE to get up unassisted. HE/SHE was evaluated by a doctor for the fall and there was INJURY/NO INJURY. HE/SHE has not fallen but has excessive fear of falling.

@NAME@ is INDEPENDENT/DEPENDENT with ADLs, and is INDEPENDENT/DEPENDENT with IADLs. HE/SHE uses a cane, walker, wheelchair,. Motorized scooter, S/HE uses the walking aid all the time / only

During the past year @NAME@ has received PT in the office, PT in the home, OT in the office, OT in the home. HIS/HER last eye examination was WHEN.

Past Medical History:

@PMH@
Prior use of community services for falls prevention:

Fall-related symptoms and known conditions include Postural HYPOTENSION,
, DISTANT VISION LOSS, NEAR VISION LOSS, CATARACTS, MACULAR DEGENERATION, GLAUCOMA, DIABETIC VISION LOSS, MULTIFOCAL GLASSES XXX,
, OSTEOPOROSIS, PRIOR FRACTURE, RHEUMATOID ARTHRITIS, PARENT FRACTURED HIP, VERTIGO OR SPINNING SENSATION or VERTIGO OR SPINNING SENSATION, LIGHTHEADEDNESS, SYNCOPE, PERIPHERAL NEUROPATHY, PARKINSONS DISEASE, LEG WEAKNESS, URINARY INCONTINENCE, NOCTURIA AT LEAST 3 TIMES PER NIGHT, ALZHEIMER'S DISEASE OR DEMENTIA, SEVERE HEARING LOSS EVEN WHEN USING AIDS *** from PVQ

Pain : Location, severity, limits function

Medication List:
@CMED@
Calcium Supplement: @Calcium@
Vitamin D

Medication-related symptoms: UNSTEADY or LIGHTHEADED; DROWSY, FOGGY, or TOO SLEEPY; URINARY OR BOWEL FREQUENCY. Which medication

Medication-related adherence problems: FORGETS TO TAKE MEDICATIONS, STOPS TAKING MEDICATIONS WHENT FEELS BETTER, STOPS TAKING MEDICATIONS BECAUSE THEY ARE TOO EXPENSIVE

Social History:
Primary Language: @LANGUAGE@
@SOC@
Activity/Exercise: ***
Currently smoking
Alcohol use: (3 or more units/d)

Living Situation:
Housing (stairs/levels):
Length at Residence:
Lives with:
Caregivers (non-paid and paid):
Safety Concerns:
Wandering:
Transportation available for fall prevention programs:

DAILY ACTIVITIES:

Activity	No Help Needed	Help Needed	Who Helps?	Comments
Feeding	☐	☐		
Getting from bed to chair	☐	☐		
Getting to the toilet	☐	☐		
Getting dressed	☐	☐		

Bathing or showering	☐	☐
Walking across the room (includes using cane or walker)	☐	☐
Using the telephone	☐	☐
Taking your medicines	☐	☐
Preparing meals	☐	☐
Managing money (like keeping track of expenses or paying bills)	☐	☐
Moderately strenuous housework such as doing the laundry	☐	☐
Shopping for personal items like toiletries or medicines	☐	☐
Shopping for groceries	☐	☐
Driving	☐	☐
Climbing a flight of stairs	☐	☐
Walking ¼ mile (3-4 blocks)	☐	☐
Getting to places beyond walking distance (e.g. by bus, taxi, or car)	☐	☐

PHYSICAL EXAMINATION:

Vital Signs: @LASTENCSP@
Supine BP ***/*** Pulse ***
Standing (1 minute) BP *** /*** Pulse ***
Standing (3 minute) BP ***/*** Pulse ***
Symptoms: unsteady. lightheaded. vertigo. None

Height:

Weight:

General Appearance: No acute distress.

Visual acuity: OS: 20/*** OD: 20/*** OU: 20/*** (date of exam***) **[recorded from eye exam conducted within last year]**

Foot: ulcers, bunions, hammertoes, calluses, corns, nail abnormalities
Right, Left, Both
Causing pain, gait abnormality

SPPB: Walking speed:
Chair stand:
Standing balance:
Gait abnormality asymmetry or unilateral weakness, tripping:
SPPB Total Score:

Mini-Cog: 3-item recall:
Clock drawing test:
Mini-Cog Total Score:
MOCA Score:

Falls-injury-related tests

BMD Method: T score:

FRAX risk of hip fracture cumulatively in the next 10 years is ***% and of any major osteoporotic fracture is ***%.

ASSESSMENT:

@NAME@ is an @AGE@ year old @SEX@ with the following risk modifiable factors for falls-related injuries:

 # Medication risk factors

The patient's medication list has been referred the PHARMACIST; SITE CLINICAL DIRECTOR for medications review and suggestions for modification.

 # Postural hypotension

A. The patient does not meet the criteria for postural hypotension and has no symptoms.
B. The patient does not meet the criteria for postural hypotension but has symptoms. We will continue to monitor for the development of postural hypotension and have provided CDC recommendations to the patient.
C. The patient meets criteria for postural hypotension but is asymptomatic.
D. The patient meets the BP criteria for postural hypotension, is symptomatic, and is at high risk for falling.

 # Visual impairment

A. The patient has fallen or is at risk of falling and has not seen an eye doctor in at least one year.

*The patient has fallen or is at risk of falling and is active outdoors and has multifocal lenses, which increase the risk of falling when used outdoors. The patient does not have single-lens distance glasses, which are preferred for use outdoors.

B. Although the patient has age-related macular degeneration, diabetic retinopathy, glaucoma, cataracts, or near or far vision loss, which increase the risk of falling, the patient has vision better than 20/40 and does not need further evaluation at this time.
C. The patient has cataracts which increase the risk of falling.
D. The patient has vision ≤ 20/70 and a home evaluation by an occupational therapist has been demonstrated to be beneficial. The patient has age-related macular degeneration, diabetic retinopathy, glaucoma, cataracts, or near or far vision loss which increase the risk of falling.
E. Patient has seen an eye doctor within a year and has no other vision risk factors. The patient does not need further evaluation at this time.

 # Feet and footwear

A. The patient has distal leg (ankle or foot) problem that requires further evaluation and therapy.
B. The patient has symptoms peripheral neuropathy and may require further evaluation.
C. The patient has foot ulcers, bunions, hammertoes, calluses, corns, nail abnormalities, exam, skin and/or nail problems, and, particularly if he/she is diabetic, needs to be evaluated and treated by a podiatrist.
D. The patient is wearing shoes that are inappropriate and likely to be unsafe.
E. The patient has no feet or footwear problems.

 # Vitamin D deficiency

A. The patient is not taking Vitamin D at this time and has been reluctant to take vitamin D.
B. The patient is not taking Vitamin D at this time and is agreeable to taking Vitamin D.
C. The patient is taking Vitamin D at an appropriate dosage or is taking a vitamin D analog.

 # Osteoporosis

A. The patient has received at least five years of treatment with a bisphosphonate. Because of the association of atypical femoral fractures with prolonged treatment, we recommend considering stopping treatment temporarily (drug holiday). How long to wait before restarting drug therapy is unclear.
B. The patient is currently receiving osteoporosis treatment for less than five years.
C. National Osteoporosis Foundation guidelines recommend treatment if bone mineral density < 2.5 SD or 10-year hip fracture risk **>3**% or major osteoporotic fracture risk **> 20**%. The patient meets one of these criteria.
D. National Osteoporosis Foundation guidelines recommend treatment if bone mineral density < 2.5 SD or 10-year hip fracture risk **>3**% or major osteoporotic fracture risk **> 20**%. The patient does not meet either of these criteria.

 # Strength, gait, or balance problems/ changes

A. Patient has severe mobility disorder and would benefit from home physical therapy.
   * Patient has severe mobility disorder and would benefit from home physical therapy. Patient's cognitive status may influence therapy program and subsequent need for supervision.
B. The patient has moderate to severe mobility disorder and is appropriate for physical therapy but does not meet criteria for being homebound.
   * The patient has moderate mobility and balance disorder and is appropriate for physical therapy but does not meet criteria for being homebound. Patient's cognitive status may influence therapy program and subsequent need for supervision.
C. Based upon the observed limitations, we would recommend community based exercise for this patient.
D. Patient has minimal mobility limitation but the following condition[s] justifies the need for PT: asymmetry, leg weakness, or abnormal gait found on Short Physical Performance Battery; vestibular symptoms; excessive fear of falling; need for device or brace modification; Parkinsonian symptoms.
   * Patient has minimal mobility limitation and outpatient PT is recommended because of clinically significant pain.

   **Patient has minimal mobility limitation and outpatient PT recommended because of cognitive impairment. Patient's cognitive status may influence therapy program and subsequent need for supervision.

   *** Patient has minimal mobility limitation and outpatient PT recommended because of clinically significant pain and cognitive impairment. Patient's cognitive status may influence therapy program and subsequent need for supervision.

 # Home safety

A. Hazards in the home and a history of recent falls there suggest that the patient is at risk for future falls in the home. This risk could be reduced by a home assessment, followed by home safety equipment and/or modification. Patient is eligible for Medicare coverage of a home safety assessment by an outpatient OT because the patient is "functionally impaired" on the basis of ***
B. Hazards in the home and a history of recent falls there suggest that the patient is at risk for future falls in the home. This risk could be reduced by a home assessment, followed by home safety equipment and/or modification. Patient is NOT eligible for Medicare coverage of a home safety assessment by a home care agency or an outpatient OT because the Medicare criteria for

coverage are not met. However, the patient is willing to pay for a home safety evaluation and recommendations.

C. There were no home safety concerns identified on the checklist.

In addition, the falls assessment identified the following concerns that may be relevant to falls prevention.

A. Vertigo
B. Nocturia at least 3 times per night
C. Severe hearing loss even when using aids

Patient Engagement:

CARE PLAN: The patient has selected the following risk factors to work on initially.

Medications

The PHARMACIST; SITE CLINICAL DIRECTOR will communicate specific recommendations to the primary care physician.

Postural hypotension

A. No recommendations
B. I have provided education about causes of postural hypotension and CDC recommendations about patient behaviors to reduce postural hypotension. We will recheck the patient's blood pressure in two weeks.
C. Please see the patient to decide whether to provide medical management for postural hypotension, as shown in the attached Postural Hypotension algorithm. I have provided education about causes of postural hypotension and CDC recommendations about patient behaviors to reduce postural hypotension.
D. As we discussed by phone, the patient needs to be evaluated ASAP to providing medical management for postural hypotension, as shown in the attached Postural Hypotension algorithm. I have provided education about causes of postural hypotension and CDC recommendations about patient behaviors to reduce postural hypotension.
E. The patient has not chosen to work on modifying this risk factor at this time.

Visual impairment

A. Refer to an eye doctor for further evaluation.
B. Refer to an eye doctor for further evaluation for the need for an additional pair of single-lens distance glasses for use outdoors.
C. Refer to ophthalmology for consideration of cataract surgery. We have provided information about cataract surgery.
D. Home health OT referral for home safety inspection and recommendations.
E. [No recommendation]
F. The patient has not chosen to work on modifying this risk factor at this time.

o Education provided about:

- o Walking using reading or wearing bifocal/multifocal glasses
- o Minimizing changes in lighting intensity
- o Nightlights

Feet and footwear

A. Consider evaluation for distal leg (ankle or foot) weakness or asymmetry, if not previously diagnosed, and consider physical therapy referral for treatment.
B. Consider evaluation for symptoms and signs of peripheral neuropathy that has not been previously

diagnosed.

C. Consider referral to a podiatrist for more comprehensive foot and nail care.
D. Consider referral to orthotic or shoe expert for customized foot wear or fabrication of an orthosis for better foot support.
E. The patient has not chosen to work on modifying this risk factor at this time.

o Education provided about:

o Safer footwear
o Circulation and nerve function for balance
o Visual cues regarding appropriate foot placement

Vitamin D deficiency

A. It would be helpful to encourage the patient to take at least 800-1000 IU/day.
B. I have told the patient to take Vitamin D_3 800-1000 IU per day
C. The patient has not chosen to work on modifying this risk factor at this time.

Osteoporosis

A. Consider stopping treatment temporarily (drug holiday). The patient should continue to receive vitamin D 800 IU and calcium carbonate 1200 mg per day (Calcium citrate if receiving proton pump inhibitor or achlorhydria) unless otherwise contraindicated.
B. Continue bisphosphonate treatment for five years and then consider stopping treatment temporarily (drug holiday). The patient should continue to receive vitamin D 800 IU and calcium carbonate 1200 mg per day (Calcium citrate if receiving proton pump inhibitor or achlorhydria) unless otherwise contraindicated.
C. Consider treatment for osteoporosis. Usually the initial treatment is with a bisphosphonate (alendronate, ibandronate, risedronate, or zoledronic acid). In addition, the patient should receive vitamin D 800 IU and calcium carbonate 1200 mg per day (Calcium citrate if receiving proton pump inhibitor or achlorhydria) unless otherwise contraindicated.
D. The patient should receive vitamin D 800 IU and calcium carbonate 1200 mg per day (Calcium citrate if receiving proton pump inhibitor or achlorhydria) unless otherwise contraindicated. Based on the patient's risk, no additional treatment is recommended at this time.
E. The patient has not chosen to work on modifying this risk factor at this time.

Strength, gait, or balance

A. Refer to HH (use STRIDE order sheet)
or
Refer to outpatient PT per patient preference. Patient is capable of attending appointments (use STRIDE order sheet)
B. Refer to Outpatient PT (use STRIDE order sheet)
or
Patient has been referred to community-based exercise program, per patient preference
C. Patient has been referred to community-based exercise program
D. Refer to outpatient PT (use STRIDE order sheet).
E. The patient has not chosen to work on modifying this risk factor at this time.

Home safety

A. Consider signing the attached referral to *** Home Care Agency for a home safety evaluation and recommendations for risk reduction. Falls Care Manager will arrange the referral and coordinate and communicate with the home care agency to facilitate any home modifications and/or equipment purchases.

B. Consider signing the attached referral to ***, OT, for a home safety evaluation and recommendations for risk reduction. Falls Care Manager will arrange the referral and coordinate and communicate with the OT to facilitate any home modifications and/or equipment purchases.
C. Consider recommending a patient-paid referral to a home care agency or an outpatient occupational therapist for a home safety evaluation and recommendations for risk reduction. Falls Care Manager will arrange the evaluation and communicate and coordinate with the home care agency or outpatient OT to facilitate any home modifications and/or equipment purchases.
D. The patient has not chosen to work on modifying this risk factor at this time.

Other recommendations:

A. Consider referral to vestibular specialist* for vestibular evaluation and intervention. The patient reports vertigo but does not have lightheadedness or postural hypotension.
B. Consider evaluation and/or treatment of nocturia. The patient reports urinating at least 3 times per night.
C. Consider further evaluation and treatment of hearing loss (e.g., removal of cerumen, telephone amplification, or reevaluation of hearing aids
D.

Education about **what to do in the case of fall, including** how to get up after falling was provided**. The patient was instructed to notify both their PCP and their FCM after a fall.**

FOLLOW-UP: Phone call in *** to discuss care plan and response from Dr. ***

@MECRED@
Falls Care Manager
@TD@

APPENDIX 5.8 FOLLOW-UP CALL STRUCTURE

Follow-up Phone Call

Preparation:

- Review patient's Independence Plan
- Have EHR and Independence Plan in view throughout phone call

Introduction:

Hello, this is nurse_____, calling from Dr._____'s office (or_____clinic). I'm your Falls Care Manager. We last spoke on_____when [you came to the office/ we talked on the phone]. Today, I'm calling to see how you are doing – and how your Independence Plan is going. Do you have a few minutes to talk now?

1. **Changes in health and medications:**
   - *Great! First, I'm interested in how you are doing - Have you had any **changes in your health** since we last spoke on [date]?*
   - *Have you had any changes in your medications since we last spoke?*
     If yes, note drug, dose, administration details_____

2. **Specific symptoms that can contribute to falls:** *Have any **new or worsening problems** come up that might cause you to fall? For example:*

   Weakness or balance problems?

   Vision problems?

   Dizziness or faintness?

   Anything else that might cause a fall?

3. **Falls since last visit:**
   - *Have you had a fall since we talked last spoke on [date]?*

   ____If no, skip to item 5

   ___If yes, and this is the first conversation with the FCM about the fall start with an open ended question

   Can you take a few minutes to tell me about the fall(s)?
   What do you think caused the fall? _____
   Has this happened before? _____
   Where did the fall occur?_____
   Did you report your fall to your healthcare provider? _____

4. Review My Independence Plan:

- *Ok, next, I would like to spend a few minutes discussing your Independence Plan with you, is that okay? Do you have it nearby?*
- If yes, *Would you like to get it now – or have me call you back in a few minutes?*
- If no, *That's OK, I have a copy which we can use to talk through your plans.*
- *I am looking at your plan and seeing the front page (the page with the pictures). During our most recent visit in the clinic, we identified factors that increase your risk of falling. Those were xxx, xxx, xxx. Do you have any questions about those risk factors or why they matter for your independence?*
- *Also, at that time, you identified priorities and some actions that you wanted to take to prevent falls and preserve your independence. The risk factors you wanted to work on at that time were xxx, xxx, xxx. Does that sound right? Are these still your priorities?*
    - If yes, *May I ask you about how your plan has been going?*

For each risk which the patient planned to address, use your motivational interviewing skills to assess and promote the patient's progress in completing his/her planned actions:

Priority (if physical component is identified by patient as a priority) on My Independence Plan:

Have you been able to participate regularly in the physical activities, such as leg-strengthening and balance exercises, that you planned?

If "yes," affirmation, praise and ask " *I am interested in learning about when and how you are practicing these?*

If "no," empathize and explore barriers

What difficulty did you run into?

You know what works best for you. Can you think of a way to overcome this?

How can I help you overcome this difficulty?

May I make a suggestion that might help you overcome this difficulty?

Shall we modify the action to make it more manageable?

Priority 2 on My Independence Plan_____:

Have you been able to complete [the actions] which you planned to complete?

If "yes," affirmation, praise

If "no," empathize and explore barriers

What difficulty did you run into?

Can you think of a way to overcome this?

How can I help you overcome this difficulty?
May I make a suggestion that might help you overcome this difficulty?

Shall we modify the action to make it more manageable?

Priority 3 on My Independence Plan_____:

Have you been able to complete [the actions] which you planned to complete?

If "yes," affirmation, praise

If "no," empathize and explore barriers

What difficulty did you run into?

Can you think of a way to overcome this?

How can I help you overcome this difficulty?

May I make a suggestion that might help you overcome this difficulty?

Shall we modify the action to make it more manageable?

5. **Modification of Independence Plan:** If patient has one or more fall risks for which remedial actions have not been planned yet, elicit current interest:
   - *Have you had a chance to think more about xxx (risk factor identified but not prioritized)?*
   - [Listen for "change talk".]
   - *Overall, are you ready to make changes to reduce this risk of falling?*
   - *Are you interested in reducing this risk of falling?* [Explore barriers.]
   - If patient desires to take action on a new risk, move the risk into a priority status, add it to the "reducing risks" part of the Independence plan, and establish who will do what / when / how progress will be evaluated. (You do not have to make a complete plan at this time; the initial action may be limited to consulting with the PCP or investigating a CBE. You can simply note the first steps and when you will follow up on the newly prioritized risk.
   - If patient still does not wish to take action on the risk, invite him/her to ask any questions at any time. If appropriate, you could also ask "OK. Could I ask you, imagine you made this change, how do you think your life would be different?" The goal is to get the patient to imagine a hypothetical situation in which

they do make the change, which may help them reflect on the situation and perhaps increase their readiness next time.

6. **Potential FCM Actions:** Content in Section 7 is to **guide FCM** in preparation for section 8. FCM can mark actions here that are relevant to information assessed during this call, and then refer to this content when summarizing the call with patient.
   - ___FCM will continue to evaluate the patient's independence plan with the patient, conduct regular reassessment of fall risk factors and provide ongoing support on education related to fall prevention.
   - ___Based on the evaluation of the patient's independence plan the FCM will implement changes according to the intervention protocols
   - ___There are no specific referrals or re-assessments FCM should/ can recommend
   - ___FCM should discuss/ recommend referring patient to primary care provider --if there is an acute condition predisposing to falls, or precipitating falls, that should be referred back to a medical provider?
   - ___FCM should discuss / recommend re-assessing specific fall risk factors based on phone interview. Mark relevant risks to be re-assessed below

Triggers and precipitating factors identified in phone interview	Protocol to follow
Changes in balance, gait or strength, or pain, or Safety, including assistive device issues (proper fitting and use)	1. Strength, Gait and Balance
Risky medications or total drug burden	2. Medications
Dizziness, lightheadedness	3. Postural hypotension, medications (if vertigo: referral to vestibular specialist)
New visual complaints	4. Visual impairment
New fracture	5. Osteoporosis, Strength, Gait and Balance
Lack of footwear, or improper footwear	6. Feet and footwear
Environmental factors in the home	7. Home safety
	8.

7. **Summarizing the conversation, plan and follow up:**
   - *Thank you for spending time on the phone today, before we end our call, I'd like to spend a few minutes summarizing our discussion.*
     - *Is it okay if I summarize my understanding of the conversation?*
       - If so, summarize
         a. Patient's overall health/ fall risk, as described by them
         b. The circumstances around a fall (if they had one)
         c. The status of their Independence Plan
         d. Changes to the Independence Plan --- that you made together

- *I also have a few ideas that might help to strengthen your Independence Plan based on our conversation today, can I share those now?*
    - **a.** Your recommendations based on interview **(refer to section 7)**
        - i. Do you recommend referral to PCP or other provider and why.
        - ii. Do you recommend a re-assessment of a fall risk factor, which one(s) and why, how might that happen? (by phone or in-person visit),
    - **b.** If patient is agreeable to recommendations you make, include those in documentation (see below).

8. <u>Closing the call:</u>

- *Thank you. Can we set up a time to touch base again?* (Base timing of follow-up on patient's health, recent falls, and progress (and need for support) in implementing the Independence Plan).

<u>Documentation:</u>

- FCM software scheduling, data / risk factor / Care plan update as needed

- Complete Independence Plan tracking form (on paper or in software)
- List the specific actions that the patient/caregiver and the FCM agreed to take (such as schedule appointment w/PCP, buy single-lens glasses, call podiatrist)
- EHR telephone note
- Communicate to other professionals on patient's team as needed

APPENDIX 5.9 FOLLOW-UP PVQ

Falls Care Program Pre-Visit Questionnaire

To prepare for your visit, please update the following information to help us identify any current risks for falls-related injuries.

Name:_____ **Date:**_____/_____/_____
Month Day Year

Are you afraid of falling? ☐ Yes ☐ No

Have you had a fall since your last Fall Care visit? ☐ Yes ☐ No

If yes, how many times have you fallen since your last visit? _____

Please explain:_____

Have you had any new vision problems since your last Fall Care visit? ☐ Yes ☐ No

Have you been examined by an eye doctor in the past year? ☐ Yes ☐ No

Do you wear multifocal glasses? ☐ Yes ☐ No

Do you have any foot problems? ☐ Yes ☐ No

Have there been any changes in the medicines you take since your last visit? ☐ Yes ☐ No *If yes,* which one(s)? _____

Do you think any of the medicines you are taking are causing the following symptoms? ☐ Yes ☐ No *If yes,* please indicate:

Symptom	Name of Medicine(s)
☐ Unsteadiness or dizziness	_____
☐ Frequent trips to the bathroom	_____
☐ Drowsy, Foggy, or sleepy	_____

Do you sometimes take medications differently than prescribed (e.g, skip or reduce doses?) ☐ Yes ☐ No *If yes,* which one(s)? _____

Do you ever forget to take any of your medications? ☐ Yes ☐ No
If yes, which one(s)? _____

When you feel better, do you sometimes stop taking any of your medications? ☐ Yes ☐ No *If yes,* which one(s)? _____

Sometimes if you feel worse when you take one of your medications, do you stop taking it? ☐ Yes ☐ No *If yes,* which one(s)? _____

Do you ever stop taking your medications because they are too expensive? ☐ Yes ☐ No *If yes,* which one(s)? _____

Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

☐ Daily ☐ A few days a week (specify number of days:_____)
☐ Less than once a week ☐ Never

How much do you drink at a time? (One drink = 12 oz of beer or 8-9 oz of malt liquor or 5 oz of table wine or 1.5 oz of hard alcohol)

☐ 1 drink ☐ 2 drinks ☐ 3 drinks ☐ 4 drinks ☐ 5+ (how many_____)

Has anyone ever been concerned about your drinking? ☐ Yes ☐ No

Do you have pain? ☐ Yes ☐ No *If yes,* where is your pain located? _____

Does your pain limit your ability to participate in daily activities or do the things that are important to you? ☐ Yes ☐ No

Are you currently participating in any regular activity to improve or maintain your physical activity? ☐ Yes ☐ No

If yes, please specify: _____

In order to best serve you, please list any specific health concerns that you would like the **falls care manager** to know about before your visit.

Include any information NOT already reported in this form:

Thank you for taking the time to complete this form.

APPENDIX 5.10 MODIFIED SPPPB SCRIPT AND SCORE SHEET

Study ID _____ Date _____Tester Initials _____

Modified SHORT PHYSICAL PERFORMANCE BATTERY PROTOCOL AND SCORE SHEET

All of the tests should be performed in the same order as they are presented in this protocol. Instructions to the participants are shown in ***bold italic*** and should be given exactly as they are written in this script.

1. CHAIR STAND TEST
Repeated Chair Stands

1. ***Do you think it would be safe for you to try to stand up from a chair five times without using your arms?***
2. [Demonstrate and explain the procedure according to the following script]
   Please stand up straight as QUICKLY as you can five times, without stopping in between. After standing up each time, sit down and then stand up again. Keep your arms folded across your chest. I'll be timing you with a stopwatch.

3. [When the participant is properly seated, say]: ***"Ready? Stand"*** and begin timing as you say Stand..

4. [Count out loud as the participant arises each time, up to five times.]

5. [Stop if participant becomes tired or short of breath during repeated chair stands.]

6. [Stop the stopwatch when he/she has straightened up completely for the fifth time.]

7. [Also stop:
   - If participant uses his/her arms
   - After 30 seconds, if participant has not completed the 5 stands
   - At your discretion, if concerned for participant's safety]

8. If the participant stops and appears to be fatigued before completing the five stands, confirm this by asking ***"Can you continue?"***

9. If participant says "Yes," continue timing. If participant says "No," stop and reset the stopwatch.

SCORING
Repeated Chair Stand Test

	YES	NO
A. Safe to stand five times	☐	☐

B. If five stands done successfully, record time in seconds.

Time to complete five stands (sec): ____ ____ . ____ ____ sec

C. If participant did not attempt test or failed, circle why:

Tried but unable	1
Participant could not hold position unassisted	2
Not attempted, you (tester) felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (specify) _____	6
Participant refused	7

Study ID _____ Date _____Tester Initials _____

Scoring: Repeated Chair Test

Participant unable to complete 5 chair stands or completes stands in >30 sec:	☐ 0 points
If chair stand time is 16.70 sec or more:	☐ 1 point
If chair stand time is 13.70 to 16.69 sec:	☐ 2 points
If chair stand time is 11.20 to 13.69 sec:	☐ 3 points
If chair stand time is 11.19 sec or less:	☐ 4 points

After completing the repeated chair stand test ask the participant to remain standing for the balance tests. If the participant declined to try the test, was unable to complete the test, or became fatigued an wished to stop the test, assist the participant to a standing position.

2. BALANCE TESTS

The participant must be able to stand unassisted without the use of a cane or walker. You may help the participant to get up.

Now let's begin the evaluation.
I would now like you to try to move your body in different movements.
I will first describe and show each movement to you. Then I'd like you to try to do it.
If you cannot do a particular movement, or if you feel it would be unsafe to try to do it, tell me and we'll move on to the next one.
Let me emphasize that I do not want you to try to do any exercise that you feel might be unsafe.

Do you have any questions before we begin?

A. Side-by-Side Stand

1. ***Now I will show you the first movement.*** [DEMONSTRATE HERE]

2. ***I want you to try to stand with your feet together, side-by-side, for about 10 seconds.***

3. ***You may use your arms, bend your knees, or move your body to maintain your balance, but try not to move your feet.***

4. ***Try to hold this position until I tell you to stop.***

[Stand next to the participant to help him/her into the side-by-side position.]

[Supply just enough support to the participant's arm to prevent loss of balance.]

[When the participant has his/her feet together, ask]

5. ***"Are you ready?"*** [Then let go and begin timing as you say]

6. ***"Ready, begin."***

[Stop the stopwatch and say ***"Stop"*** after 10 seconds or when the participant steps out of position or grabs your arm. If participant is unable to hold the position for 10 seconds, record result and go to the gait speed test.]

Study ID _____ Date _____Tester Initials _____

SCORING – SIDE-BY-SIDE STAND
Held for 10 sec ☐ 1 point
Not held for 10 sec ☐ 0 points
Not attempted ☐ 0 points (circle reason)
If 0 points, end Balance Tests

Number of seconds held if
less than 10 sec: ___ . ___ sec

If participant did not attempt test or failed, circle why:	
Tried but unable	1
Participant could not hold position unassisted	2
Not attempted, you (tester) felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (specify) _____	6
Participant refused	7

B. Semi-Tandem Stand

1. ***Now I will show you the second movement.*** [DEMONSTRATE HERE and read the following script]

2. ***Now I want you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 10 seconds. You may put either foot in front, whichever is more comfortable for you.***

3. ***You may use your arms, bend your knees, or move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop.***

[Stand next to the participant to help him/her into the side-by-side position.]

[Supply just enough support to the participant's arm to prevent loss of balance.]

[When the participant has his/her feet together, ask] ***"Are you ready?"***

[Then let go and begin timing as you say] ***"Ready, begin."***

[Stop the stopwatch and say ***"Stop"*** after 10 seconds or when the participant steps out of position or grabs your arm. If participant is unable to hold the position for 10 seconds, record result and go to the gait speed test.]

SCORING – Semi-Tandem STAND
Held for 10 sec ☐1 point
Not held for 10 sec ☐0 points
Not attempted ☐0 points (circle reason)
If 0 points, end Balance Tests

Number of seconds held if
less than 10 sec: ___ . ___ sec

If participant did not attempt test or failed, circle why:	
Tried but unable	1
Participant could not hold position unassisted	2
Not attempted, you (tester) felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (specify) _____	6
Participant refused	7

C. Tandem Stand

1. ***Now I will show you the third movement.*** [DEMONSTRATE HERE]

2. ***Now I want you to try to stand with the heel of one foot in front of and touching the toes of the other foot for about 10 seconds. You may put either foot in front, whichever is more comfortable for you.***

Study ID _____ Date _____Tester Initials _____

3. ***You may use your arms, bend your knees, or move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop.***

[Stand next to the participant to help him/her into the side-by-side position.]

[Supply just enough support to the participant's arm to prevent loss of balance.]

[When the participant has his/her feet together, ask] ***"Are you ready?"***

[Then let go and begin timing as you say] ***"Ready, begin."***

[Stop the stopwatch and say "Stop" after 10 seconds or when the participant steps out of position or grabs your arm.

SCORING –Tandem Stand

Held for 10 sec	☐2 points
Not held for 3 to 9.99 sec	☐1 point
Held for less than 3 sec	☐0 points
Not attempted	☐0 points (circle reason)

Number of seconds held if less than 10 sec: ___ . ___ sec

If participant did not attempt test or failed, circle why:	
Tried but unable	1
Participant could not hold position unassisted	2
Not attempted, you (tester) felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (specify) _____	6
Participant refused	7

TOTAL BALANCE SCORE:

Side-by-side: _____ points Semi-Tandem: _____points Tandem: _____

TOTAL (SUM OF ALL THREE BALANCE TESTS: _____ POINTS

3. GAIT SPEED TEST

Note: the walking course should be 3 meters (9 feet 10 inches) in length, unobstructed, with enough room at the end for the participant to maintain the walking pace beyond the finish line without running into something. At least 3 feet is recommended. The course should be clearly marked with colored tape, duct tape, or the equivalent.

Now I am going to observe how you normally walk. If you use a cane or other walking aid and you feel you need it to walk a short distance, then you may use it.
[Remember that this test requires participants to walk at their "NORMAL" WALKING SPEED]

A. Single Gait Speed Test

1. ***This is our walking course. I want you to walk to the other end of the course at your usual speed, just as if you were walking down the street to go to the store.***

   [Demonstrate the walk for the participant: Tip – be sure to look at the participant when speaking and remind subject to walk PAST the tape line at the other end of the course.]

2. ***Walk all the way past the other end of the tape before you stop. I will walk with you. Do you feel this would be safe?***

APPENDIX 5.11 SUMMARY SPPB ADMINISTRATION AND SCORING

STRIDE Short Physical Performance Battery

1. Repeated Chair Stand Test

5 repeats
Measures the time required to perform five rises from a chair to a fully upright position as fast as possible without use of the arms

≤11.19 sec	4 pt
11.20-13.69 sec	3 pt
13.70-16.69 sec	2 pt
≥16.7 sec	1 pt
>30 sec or unable	0 pt

Note: After final stand, keep subject standing and begin balance tests
If subject stopped before 5 stands, assist to standing position

2. Balance Tests

Side-by-Side Stand
Feet together side-by-side for 10 sec

< 10 sec (0 pt) → Go to 3-meter Gait Speed test

10 sec (1 pt)

< 10 sec (+0 pt)

Semi-Tandem Stand
Heel of one foot against side of big toe of the other for 10 sec

→ Go to 3-meter Gait Speed test

10 sec (+1 pt)

Tandem Stand
Feet aligned heel to toe for 10 sec

10 sec	(+2 pt)
3.0 -9.99 sec	(+1 pt)
<3.0 sec	(+0 pt)

3. Gait Speed Test

Measures the time required to walk 3 meters at a normal pace (use one test only)

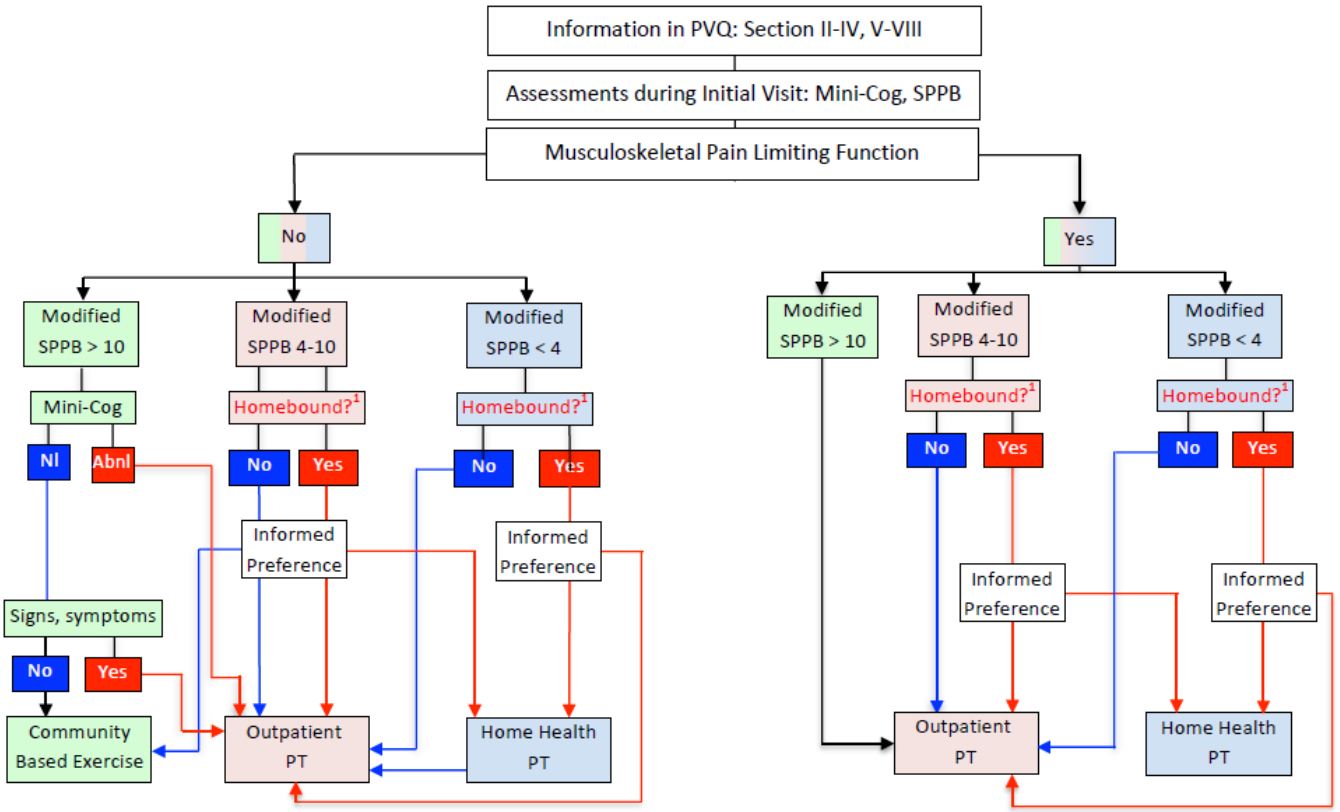
<3.62 sec	4 pt
3.62-4.65	3 pt
4.66-6.52	2 pt
>6.52	1 pt
Unable	0 pt

4. Composite Score

1. Chair Stand score: _____ 2. Balance Score: _____ 3. Gait Speed score: _____

Total Score: _____

APPENDIX 5.12 STRENGTH, GAIT AND BALANCE PROTOCOL



Signs, symptoms:

- Asymmetry/weakness of leg, abnormal gait (observed during SPPB)
- Vestibular symptoms
- Excessive fear of falling
- Need for mobility device (reported on PVQ)
- Parkinson's disease in EHR (or "signs" observed during SPPB)

[1]See CMS definition for homebound next on page

Instructions for Use:

1. Does patient have pain affecting physical function? If no, use left side of flow chart; if yes, use right side.
2. Use appropriate SPPB score
3. Determine homebound status
4. Identify whether there is cognitive impairment or signs/ symptoms
5. Follow color-coded flow to exercise intervention.
6. Consult with patient for mutually agreeable intervention

[1]**CMS Definition Homebound**: (see: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R192BP.pdf)

1. A physician must certify that the patient is confined to his/her home. In determining whether homebound criteria are met, the patient's condition over a period of time rather than for short periods within the home health stay should be examined.

2. CMS makes clear that the aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet the specific criteria outlined below.

3. CMS Criteria for Homebound Status

    1. **Criteria One**: The patient must either:
        - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence or
        - Have a condition such that leaving his or her home is medically contraindicated.
        - If the patient meets one of the Criteria-One conditions, then the patient must also meet two additional requirements defined in Criteria-Two

    2. **Criteria Two:**
        - There must exist a normal inability to leave home AND
        - Leaving home must require a considerable and taxing effort.

APPENDIX 5.13 MINI COG

MINI-COG™

Instructions

ADMINISTRATION	SPECIAL INSTRUCTIONS
1. Get patient's attention and ask him or her to remember three unrelated words. Ask patient to repeat the words to ensure the learning was correct.	• Allow patient three tries, then go to next item. • The following word lists have been validated in a clinical study:[1-3] **Version 1**: • Banana • Sunrise • Chair **Version 2**: • Daughter • Heaven • Mountain **Version 3**: • Village • Kitchen • Baby **Version 4**: • River • Nation • Finger **Version 5**: • Captain • Garden • Picture **Version 6**: • Leader • Season • Table
2. Ask patient to draw the face of a clock. After numbers are on the face, ask patient to draw hands to read 10 minutes after 11:00 (or 20 minutes after 8:00).	• Either a blank piece of paper or a preprinted circle (other side) may be used. • A correct response is all numbers placed in approximately the correct positions AND the hands pointing to the 11 and 2 (or the 4 and 8). • These two specific times are more sensitive than others. • A clock should not be visible to the patient during this task. • Refusal to draw a clock is scored abnormal. • Move to next step if clock not complete within three minutes.
3. Ask the patient to recall the three words from Step 1.	Ask the patient to recall the three words you stated in Step 1.

Scoring

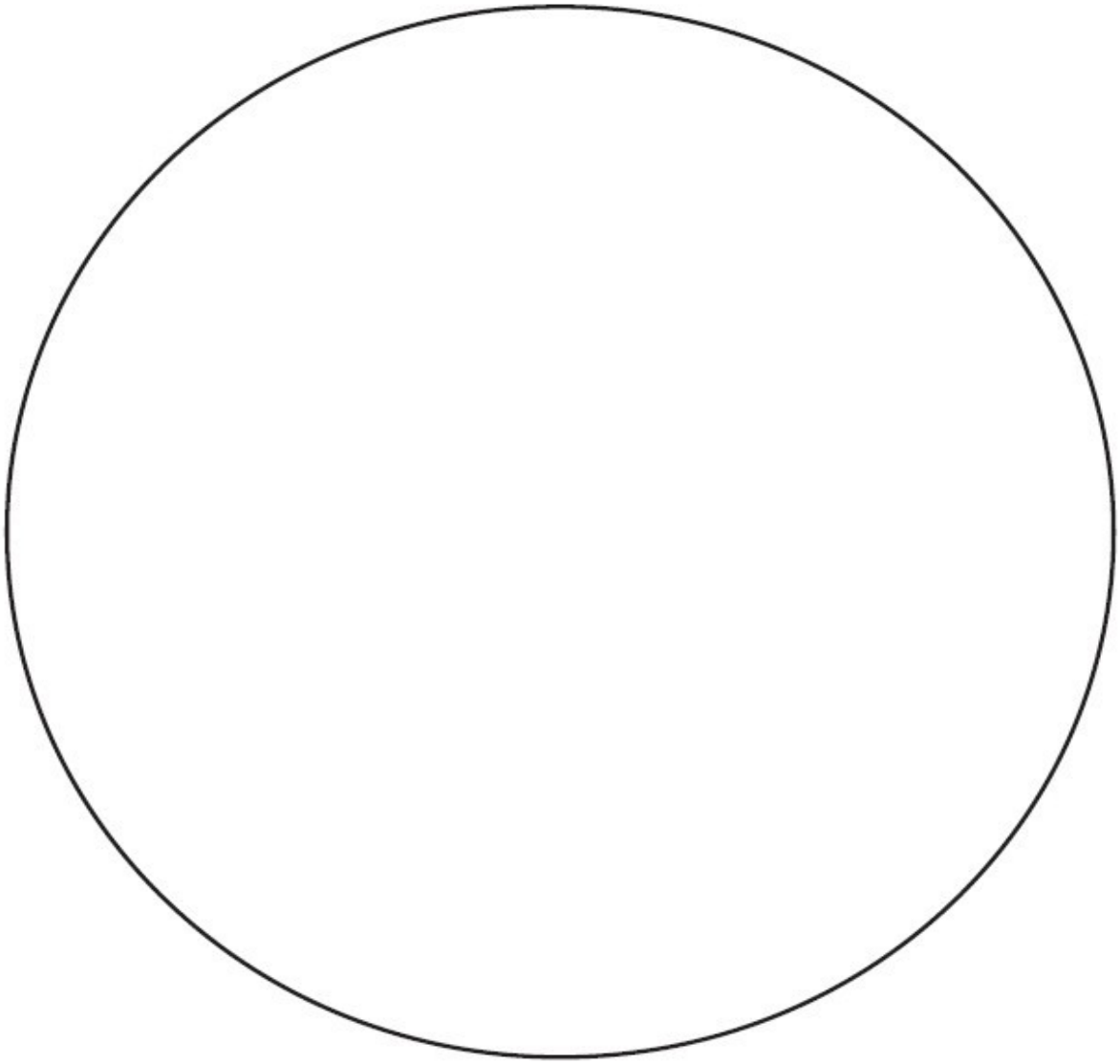
3 recalled words	Negative for cognitive impairment
1-2 recalled words + normal CDT	Negative for cognitive impairment
1-2 recalled words + abnormal CDT	Positive for cognitive impairment
0 recalled words	Positive for cognitive impairment

References

1. Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The mini-cog: a cognitive "vital signs" measure for dementia screening in multi-lingual elderly. Int J Geriatr Psychiatry. 2000;15(11):1021-1027.
2. Borson S, Scanlan JM, Chen P, Ganguli M. The Mini-Cog as a screen for dementia: validation in a population-based sample. J Am Geriatr Soc. 2003;51(10):1451-1454.
3. McCarten JR, Anderson P Kuskowski MA et al. Finding dementia in primary care: the results of a clinical demonstration project. J Am Geriatr Soc. 2012;60(2):210-217.

CLOCK DRAWING TEST

Patient Name: _____ Date: _____



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APPENDIX 5.14 TEMPLATE FOR HOME HEALTH REFERRAL

[insert practice logo]

Home Health Care Referral

Patient: **Date:**

Falls Care Manager: **Phone:**
Email:

Primary Care Physician: **Phone:**
Email:

Dear [Home Health Provider],

[Patient] is a [age] year old [sex] who is at high risk for falls. [He/She] has been seen by our Falls Care Manager, [FCM name] on [date] for a comprehensive fall risk assessment. We have attached a summary of the assessment, a current medication list and the fall prevention plan of care developed collaboratively with the patient.

[Patient] has the following medical conditions:

Condition 1 Condition 4

Condition 2 Condition 5

Condition 3 Condition 6

[Patient] has fallen [#] times in the last year and these falls were [injurious/not injurious].

We have identified the following risk factors for falls and fall-related injuries:

Risk 1 Risk 4

Risk 2 Risk 5

Risk 3 Risk 6

[Patient] currently lives at home [with? type of home?]. Given [Patient's] limited function and homebound status we have recommended a home health assessment and management of [his/her] fall risks.
Please provide the following services:

Skilled Nursing Physical Therapy Occupational Therapy

Please provide the following interventions:

- Progressive and structured strength and balance exercises provided by physical therapy, preferably based on the Otago or Life Exercise Programs
- Evaluation of the patient's home environment for safety concerns and provide modifications and/or adaptive equipment to mitigate these risks.
- Evaluation by occupational therapy due to visual deficits for implementation of necessary modifications to decrease fall risk.
- A full medication reconciliation with an evaluation of the patient's ability to manage in-home medications independently and/or the ability of a caregiver to support medication management
- Implement any necessary modifications to improve the patient's medication adherence
- Monitor the patient's response to the following medication changes: [order instructions] and report to [provider] [frequency] or more often for adverse effects
- An assessment of postural vital signs (lying, standing after 1 minute then standing after 3 minutes) [# times per week] and report results to [provider] [frequency] or more often for [parameters]. Teach measures to manage postural hypotension
- Other:

Upon discharge, please provide a summary report that includes:

- Number of home health visits provided by each discipline
- Interventions provided and specific education related to the identified fall risks
- Assessment of the patient's current physical function, ADL/IADL status
- Any home modification recommendations that were suggested and/or implemented
- Medical equipment/adaptive devices patient received
- Any changes in medication, the current status of the patient's adherence to [his/her] regimen and any interventions recommended and/or implemented to improve adherence
- Referrals to outpatient, community-based exercise programs and/or other outside resources to promote continued self-management

For further questions regarding the above ordered interventions please contact our Falls Care Manager, [FCM name] at the phone number or email above.
Thank You,

[Physician Signature]

[Physician Name]

APPENDIX 5.15 TEMPLATE FOR REFERRALS TO OUTPATIENT PT

Outpatient Physical Therapy Referral

Patient: Date:
Primary Care Physician: Phone: Email:

Dear Physical Therapy Provider:

Mr. Participant LastName is a age year old person who is at high risk for falls. He has been seen by our primary care practice and we have conducted a comprehensive medical and functional evaluation. We have attached a summary including the plan of care developed collaboratively with the patient.

Ms. has the following medical conditions:

She has fallen 3 times in the last year and these falls were injurious

We have identified the following issues that might be addressed in outpatient physical therapy:

☐ Moderate to severe mobility limitations (Short Physical Performance Battery score 4-10) and may also have the conditions indicated below (checked ☐) that may influence the therapy program and subsequent need for supervision.

☐ Minimal mobility limitation (Short Physical Performance Battery >10) but also has one or more of the following conditions (checked ☐):

- ☐ Cognitive impairment (abnormal Mini-Cog)
- ☐ Significant pain

- ☐ Cognitive impairment (abnormal Mini-Cog) that may influence the therapy program and subsequent need for supervision
- ☐ Significant pain (Brief Pain Inventory score > 3)
- ☐ Gait asymmetry, leg weakness, or other abnormal gait found on Short Physical Performance Battery testing
- ☐ Vestibular symptoms
- ☐ Excessive fear of falling
- ☐ Need for device or brace modification
- ☐ Parkinsonian symptoms

Outpatient Physical Therapy Referral

After reviewing our assessments, please send us a physical therapy plan of care using the attached template.

Also, on discharge please provide a summary report (as per your standard protocol) that includes:

- Number of visits provided
- Assessment of physical function (including the Short Physical Performance Battery)
- Services provided (e.g. therapy interventions)
- Medical equipment patient received or recommended (e.g. assistive devices)
- Recommendations for continued self-management (e.g. home exercise program)
- Any other recommended referrals for further medical, therapy, or community-based interventions

Our falls care manager is FCM_Name R.N. and can be reached at FCM_Phone or FCM_email if you need any assistance at any time or need to speak to the physician.

Thank You,

Physician Signature

Physician's Name
Physician's Address
Physician's Contact Number

APPENDIX 5.16 CBE COMMUNICATIONS

Record of Exercise

Community-Based Exercise Program Communication Template

Patient Patient Name Date Date

Provider Organization: Provider name, e.g., South Shores YMCA

Mr./Ms. Patient's name is at risk for falls. Based on the assessments and medical history Dr. XXX and I have conducted, we believe this participant would be a good candidate for your [program name] fall prevention program. We have encouraged Mr./Ms. Patient's name to contact you to set up an orientation and start exercising with you.

For falls preventions programs to be effective, it is imperative that the elements below are applied with high fidelity.

- Resistance exercise training for at least the major muscle groups of the lower extremities
- Balance training
- Offered at least twice a week
- Adaptable to participant capabilities
- Potential for progression in frequency, intensity, and or duration
- Exercises that can provide high challenge to the participants
- Instruction in exercise techniques
- Supervision

If Mr./Ms. Patient's name is willing, please consider assisting him or her to keep a record of their participation with you. Attached is a blank calendar that could be used for this purpose. A check mark indicating attendance would be adequate. If the participant is willing, please ask him or her to take the calendars to the FCM on the next visit. This may assist both the patient and the FCM by promoting ongoing exercise.

Additionally, in your interactions with the patient, please emphasize the importance of self-management (i.e., taking responsibility for exercising to prevent falls and preserve independence). Please use the training materials you received during the Provider Training to access information on these topics.

We appreciate your help with this patient.

Please feel free to contact us if you have any questions or concerns:

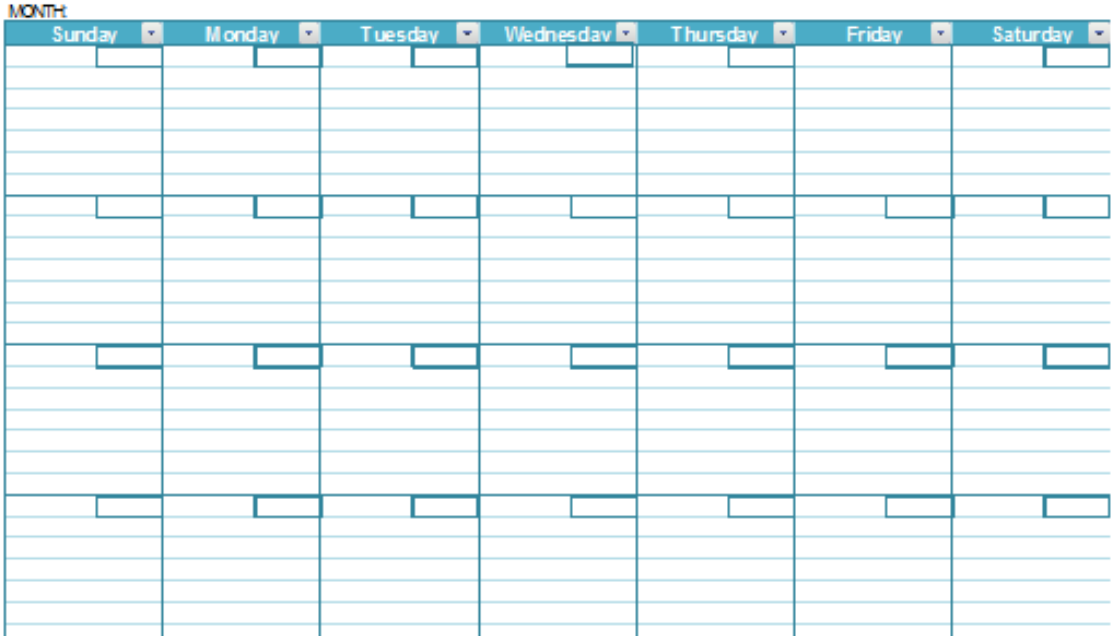
FCM Name R.N., Falls Care Manager

Tel: Telephone number

email: FCM email address

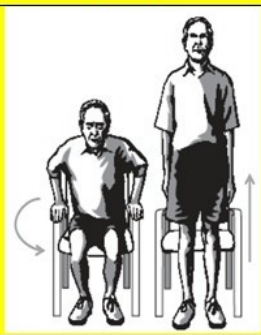
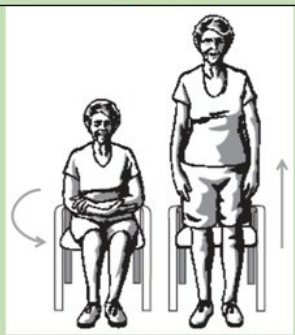
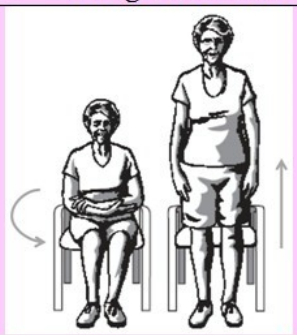
Record of Exercise

MONTH:



APPENDIX 5.17 HOME EXERCISE HANDOUTS

EXERCISE 1: Sit-to-Stand

Level 1	Level 2	Level 3	Level 4
Sit to Stand Using Two Hands	Sit to Stand Using One Hand	Sit to Stand Using No Hands	Sit to Stand Quickly Using No Hands
			
INSTRUCTIONS FOR ALL CHAIR STAND EXERCISES Sit on a firm, well supported chair that is not too low. See illustration. Position chair back against a wall Point feet forward, lean forward over your knees and stand up			
Push off with both hands when you stand up.	Push off with one hand when you stand up.	Stand up without using your hands to push.	Stand up quickly without using your hands.
Repeat ____ times	Repeat ____ times	Repeat ____ times	Repeat ____ times
DO THIS EXERCISE ☐	DO THIS EXERCISE ☐	DO THIS EXERCISE ☐	DO THIS EXERCISE ☐

Notes: _____

_____

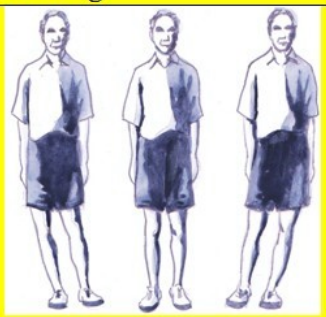
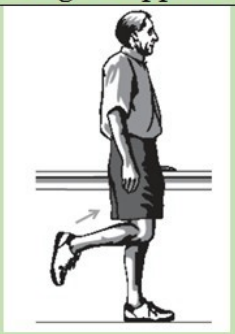
EXERCISE 2: Heel Raises

Level 1	Level 2	Level 3	Level 4
Heel Raise Hold Using Two Hands	Heel Raise Hold Using Two Fingers	Heel Raise Without Holding	Toe Walking, one hand or 2 finger support
			
INSTRUCTIONS FOR HEEL RAISE EXERCISES Use a table or chair for support. Look straight ahead, feet hip width apart and pointing forward. Come up as high as you can on your toes, lower heels to floor, repeat.			**INSTRUCTIONS** Use an open wall, table, or counter for support. . Hold as needed. Point feet forward.
Hold with one or two hands.	Hold with one hand or two fingers.	Try not to hold on but be close to support if needed.	Come up on toes then walk ____ steps. Lower heels and repeat in opposite direction.
Repeat ____ times	Repeat ____ times	Repeat ____ times	Repeat ____ times
DO THIS EXERCISE ☐	DO THIS EXERCISE ☐	DO THIS EXERCISE ☐	DO THIS EXERCISE ☐

Notes: _____

_____

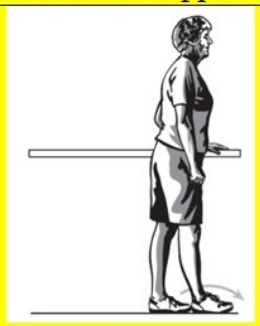
EXERCISE 3: Weight Shifting and 1-Leg Balance

Level 1	Level 2	Level 3	Level 4
Side-to-Side Weight Shifting	Single Leg Stance Using One Hand for Support	Single Leg Stance Using Two Finger Support	Single Leg Stance Without Holding
			
INSTRUCTIONS FOR WEIGHT SHIFTING While standing, place feet slightly wider than hip width apart.	**INSTRUCTIONS FOR ONE-LEG STAND EXERCISES** Stand up tall beside a table, counter top, or chair. Point feet forward, raise one foot backward. Stand on one leg. Try to hold this position for 10 seconds on each leg.		
Lean the body gently to the right while keeping both feet in contact with the floor. Repeat in opposite direction.	Hold on with one hand.	Hold on with two fingers.	Try to do this exercise without holding but stand close to support if you need it.
Repeat ____ times	Repeat ____ times	Repeat ____ times	Repeat ____ times
DO THIS EXERCISE ☐	DO THIS EXERCISE ☐	DO THIS EXERCISE ☐	DO THIS EXERCISE ☐

Notes: _____

_____

EXERCISE 4: Heel to Toe Standing and Walking

Level 1	Level 2	Level 3	Level 4
Heel-Toes Standing One Hand Support	Heel-Toes Standing No Support	Heel-toe Walking One Hand Support	Heel-toe Walking No Support
			
INSTRUCTIONS HEEL TOE STANDING Stand up tall beside a table or chair for support. Place one foot directly in front of the other foot so your feet form a straight line with feet pointing forward. Hold this position for 10 seconds. Change position of feet, opposite foot forward.		**INSTRUCTIONS HEEL-TOE WALKING** Stand up tall beside an open wall or table. Place one foot directly in front of the other foot so your feet form a straight line pointing forward. Alternate foot position front to back as you walk ahead Repeat for 10 or more steps. Turn around and repeat.	
Hold onto the table with one hand. Try to maintain the foot position for 10 seconds.	Try not to hold onto the table while doing this exercise except as needed to regain balance.	Hold on with one hand and progress to two fingers when ready.	Try to do this exercise without holding but be close to support if you need it.
Repeat ____ times	Repeat ____ times	Repeat ____ times	Repeat ____ times
DO THIS EXERCISE ☐	DO THIS EXERCISE ☐	DO THIS EXERCISE ☐	DO THIS EXERCISE ☐

Notes: _____

_____

EXERCISE 5: Knee Bends

Level 1	Level 2	Level 3	Level 4
¼ Knee Bends Using 1 or 2 Hands for Support	¼ Knee Bends No support	½ Knee Bends Hold support	½ Knee Bends No support
			
INSTRUCTIONS FOR KNEE BENDS Stand up tall facing a table or chair for hold for support as needed. Place your feet hip-width apart and pointing forward. Slowly bend knees squatting down either a fourth or half the way down – see instructions below. Stop if knees go in front of your toes When you feel your heels start to lift, straighten up.			
Hold on with one or both hands. Squat down about one fourth of the way.	Have a table or sturdy object nearby to touch if needed. Squat down ¼ way without holding on.	Hold on with one or both hands. Squat down about half way.	Have a table or sturdy object nearby to touch if needed. Squat down half way without holding on.
Repeat ____ times	Repeat ____ times	Repeat ____ times	Repeat ____ times
DO THIS EXERCISE ☐	DO THIS EXERCISE ☐	DO THIS EXERCISE ☐	DO THIS EXERCISE ☐

Notes: _____

_____

APPENDIX 5.17.1 LINK TO STRIDE HOME EXERCISE VIDEO

STrategies to
Reduce
Injuries and
Develop confidence in
Elders

STRIDE

Link to STRIDE Exercise Video:

http://healthcare.partners.org/streaming/STRIDE/index.html

APPENDIX 5.17.2 NAVIGATION GUIDE TO STRIDE HOME EXERCISE GUIDE

Navigating the Video for your Home Exercise for Fall Prevention and Independence Program

This short guide will help you navigate easily through the three sections of the STRIDE Home Exercise Video

- INTRODUCTION to exercise for fall prevention and independence
- HOME EXERCISE descriptions and video clips of how to do the exercises correctly
- TIPS for SUCCESS- things you can do to get the most out of your exercise routine

The ⎈ symbols indicate important information that will help you control the video and moving between the three sections of the video.

THE **HOME SCREEN** will appear when you first start the video as shown here

HOME SCREEN:

(▶) indicates the three main parts of the video, **Introduction**, **Home Exercise Menu**, and **Tips for Success** portions of the video.

⎈ Use your mouse (left button) to click on ▶ to launch any of the three segments.

NOTE: You do not have to watch the entire video although viewing all three parts will be helpful and is recommended.

V1.0 12-7-17 1

Navigating the Video for your Home Exercise for Fall Prevention and Independence Program

Introduction: Contents include:

- Objectives
- Review of the exercise handouts
- General information about the exercises
- Safety recommendations
- Benefits you can expect
- Expert commentary on the value of exercise for fall prevention
- General guidelines for performing and progress in your home exercise
- Menu for the five groups of the home exercises.

Controlling the Video

A Control Bar appears at the bottom of each screen in the video only when you pass the mouse cursor over any part of the screen. Hovering the cursor over the control bar will enable you to use the controls by sliding the mouse cursor to the desired spot.

The control bar is visible on all screens except the HOME SCREEN and the MAIN HOME EXERCISE SCREEN.

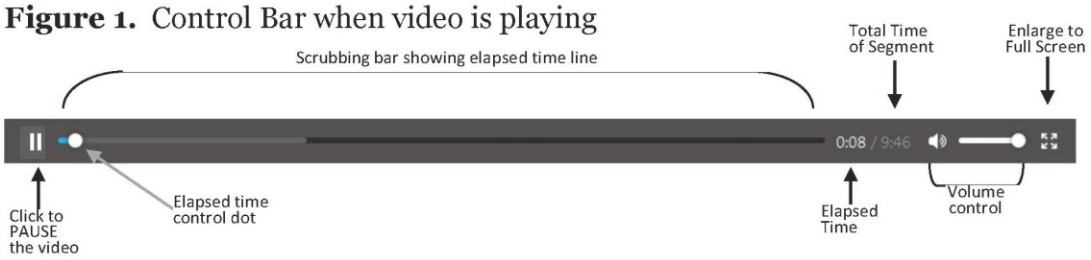
Parts of the Control Bar

- **Figure 1** shows the Control Bar when the video is playing;
- **Figure 2.** shows the Control Bar when the video is paused. The only difference between Figure 1 and Figure 2 is the symbol at the far left of the bar.

When the video is playing, use your left mouse button to click on the ⏸ symbol to pause

- When the video is paused, click on the ▶ to restart.
- The white (or blue) dot on the scrubbing bar can be pulled right or left with your mouse cursor to quickly move to a place of your choice in the segment. Place your mouse cursor on the dot, click and hold the left mouse button and pull the dot anywhere along the elapsed time line.

Figure 1. Control Bar when video is playing



Navigating the Video for your Home Exercise for Fall Prevention and Independence Program

Figure 2. Control Bar when video is paused.

The end of the **Introduction** shows a black screen. To begin viewing any of the home exercises, use your left mouse button to click on below Home Exercise Menu as shown here.

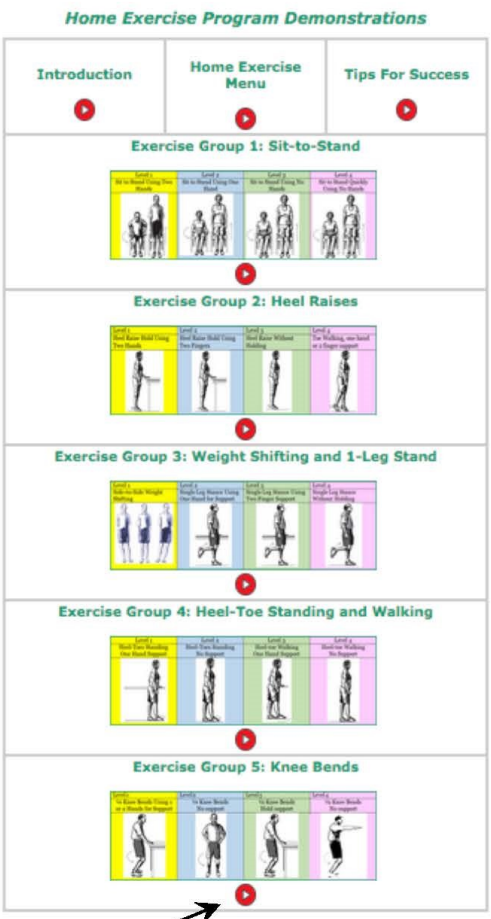
This section of the video contains all 20 home exercises with an introduction, written instructions, and demonstrations of how to do each exercise correctly and safely.

- You have complete freedom to choose and view any exercise you wish without having to watch them all.
- The Home Exercise Menu Main Screen with all five exercise groups is shown below
    - Depending on the Internet browser you use, you will see one of the two screens shown on the next page.

○ Choosing an exercise group to review is done by clicking the red button to the right of each exercise group or below each exercise group.

Navigating the Video for your Home Exercise for Fall Prevention and Independence Program

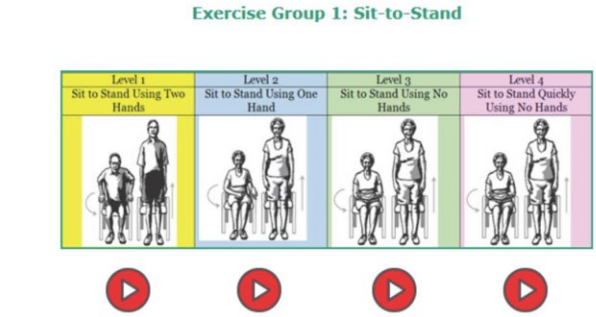
Home Exercise Menu Main Screen



When you are on one of these two screens, you may choose any exercise group by using the left mouse button to click on ▶ that appears with each group.

- Let's choose Group 1 as an example.
- Use your left mouse button to click on ▶ next to Exercise Group 1.
- After clicking on this button, a new screen will show illustrations of all four levels of the Group 1 exercises as shown in the figure on the next page.

Navigating the Video for your Home Exercise for Fall Prevention and Independence Program

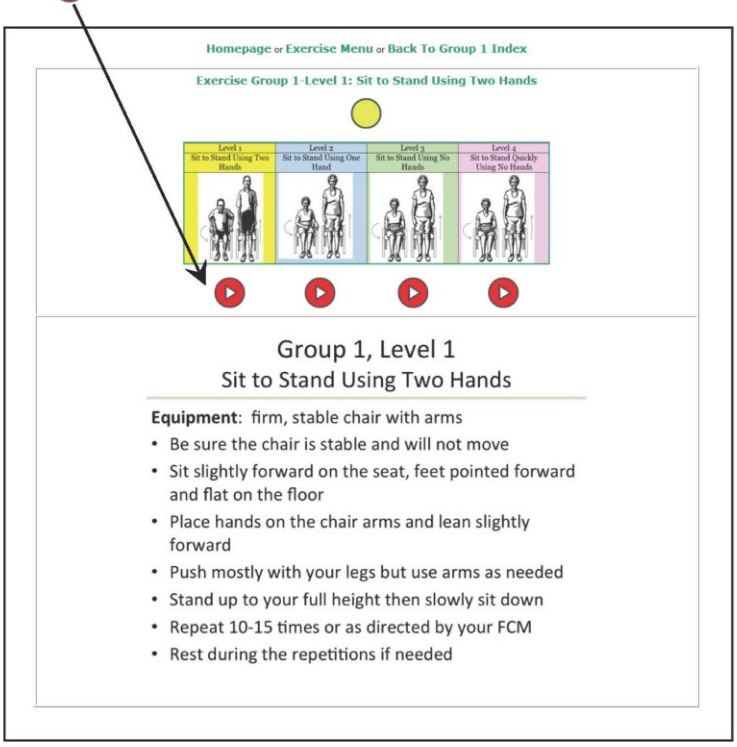


EXERCISE 1
SIT-TO-STAND EXERCISES

Each of the five exercise groups start with a short narration on the importance of the exercise

Click on the red button below the specific level of the exercise you chose with your Falls Care Manager. For example, let's choose level 1.

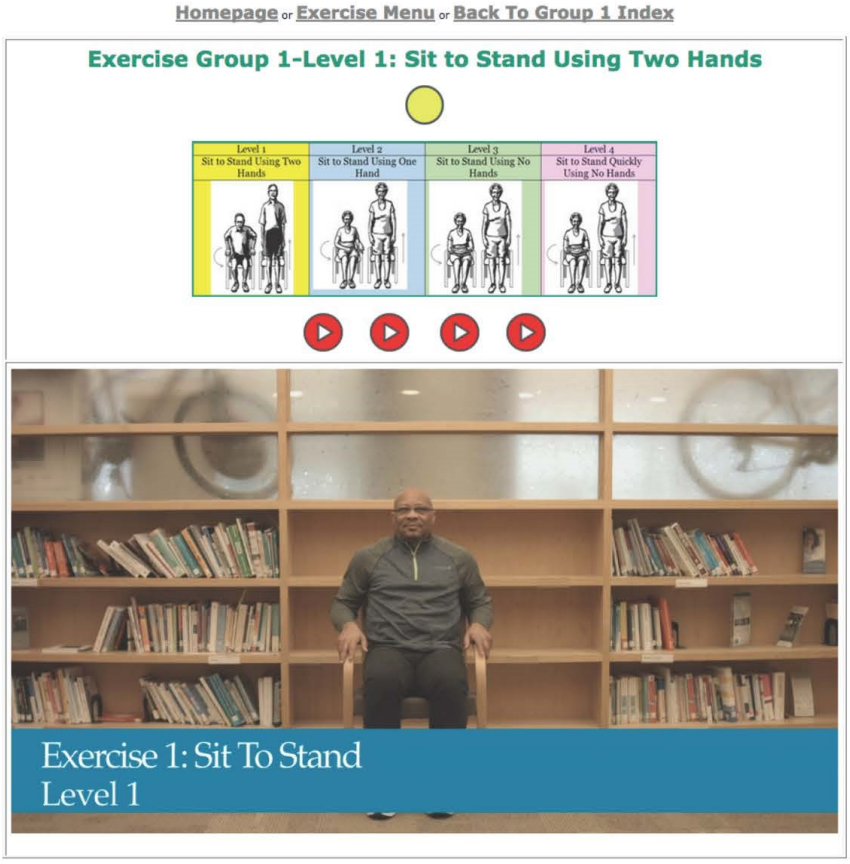
- Click on below level 1.



Navigating the Video for your Home Exercise for Fall Prevention and Independence Program

Review the instructions on the screen (see example above) on how to perform the exercise correctly.

- You may pause the video to allow more time to review instructions.
- The video will then play a demonstration of the exercise with narration describing how to do the exercise correctly and safely.



-

You may use the control bar at the bottom of the screen to pause or drag the elapsed time control button to play the video as often as you like.

When the demonstration ends, look at the top of the page and note the words **Homepage Exercise Menu** or **Back To Group _ Index**

- Clicking on **Homepage** will take you to the first screen of the video that shows all three segment options.

Navigating the Video for your Home Exercise for Fall Prevention and Independence Program

- Clicking on **Exercise Menu** will take you to the menu of all five exercise groups from which you may chose the next exercise in your recommended program.
- Clicking on **Group Index** will return you to the screen showing the four levels of exercise group you are currently reviewing.

- You may wish to click on **Exercise Menu** so that you can choose the next exercise group and the specific level recommended for you.
- You would then repeat the process described above for all the exercises you and your Falls Care Manager agreed upon.

 After you have viewed and practiced your exercises, click on **Homepage** to go back to the main menu showing the three parts of this video.

- You might now wish to click on **Tips for Success**, a 2-minute segment that will offer several suggestions for getting the most benefit from your home exercise routine.

Finally, please be sure to maintain contact with your Falls Care Manager as you progress through your exercise routine. She will be able to help you progress and continue to improve and reduce your risk of falls.

Stay on your feet. It's the best place to be!

E.B. White, 1984.

APPENDIX 5.17.3 STRIDE HOME EXERCISE MANUAL (FULL MANUAL ON WEBSITE)

Home Exercise Manual

A Guide to Improved Strength, Balance, and Independence

Version 1.1
September 20, 2017

APPENDIX 5.18 ESSENTIALS OF EXERCISE

Essential Elements Required in all Exercise Interventions

EXERCISE

- Tai Chi
- Otago
- Stepping-On

OR

- Balance plus at least one of the following
  - Strength training (preferred)
  - Flexibility exercises
  - Endurance exercise
- Dance such as line dancing, ballroom dancing, Jazzercise, Zumba
- Brisk walking as the only type of exercise should be excluded

ADAPTABILITY

POTENTIAL FOR PROGRESSIVE OVERLOAD (FREQUENCY, DURATION, AND/OR INTENSITY)

EXERCISES THAT OFFER HIGH CHALLENGE TO THE PARTICIPANTS

INSTRUCTION IN EXERCISE TECHNIQUES

SUPERVISION

APPENDIX 5.19 EXAMPLES OF APPROVED CBE PROGRAMS

Appendix X.XX - Examples of Approved Community Based Exercise Programs

CDC Endorsed Fall Prevention Exercise Programs	Examples of Acceptable Alternative Exercise Programs	Unacceptable Community-based Exercise Programs
Most Tai Chi Exercise, e.g.,	Most dance	Balance Training
- Tai Ji Quan Moving for Better Balance	- Line dancing, Jazzercise	Gentle Joints Fitness
- YMCA Moving for Better Balance	- Ballroom dancing,	Keep on Moving
- Tai Chi for Arthritis	- Jazzercise	Pilates
- Tai Chi for Older Adults	- Zumba	Qi Gong
- Kinetic Tai Chi	Matter of Balance	Senior Lap Swim
OTAGO Exercise Program	Silver Sneakers Strength and Balance,	Senior walking
Stepping-On	Silver Sneakers Classic	Sit and Get Fit
	Silver Sneakers Tai chi and Qigong	Stepping Out
	SilverSneakers Step (1 on 1 with trainer)	Tabata
	Active Older Adults	Walk the Block Mall Walkers
	Taking Control with exercise	Water Aerobics
	Enhance Fitness	Yoga
	Gentle Sculpt	
	Fit-4-Life	
	Better Balance	
	Posture/Balance/Strength	
	YMCA Senior Fitness	
	Otago Group Exercise	
	Active Older Adults Cardio	
	Aerobic exercise to enhance balance, and muscle strength	
	Be Well Exercise Class	
	Beijing Exercise ASSN Whole Body Exercise (Tai Chi like exercise)	
	Bone Builders	
	Exercise by Michigan Rehab	
	Functional Fitness	
	Lifetime Wellness or Lifetime Fitness	
	Posture Balance Strength	
	Silver and Fit	
	Silver Hearts Fitness Classes	
	Stretch and Strength	

APPENDIX 5.20 TOPICAL OUTLINE OF IN-PERSON TRAINING

AGENDA

1

Training for STRIDE Exercise Intervention Providers

I.	Introductions	**10 min**
II.	Description of the STRIDE Study a. Why STRIDE? b. STRIDE Study design	**10 min**
III.	Description of patient processing a. Algorithm for flow of patients to exercise interventions b. Provision to Home Health, Outpatient Physical Therapy, or Community Based Exercise c. Patient-FCM Decision Making through Motivational Interviewing	**5 min**
IV.	Exercise for fall prevention	**10 min**
V.	STRIDE exercise interventions a. Home Health Care i. Patient characteristics ii. Exercise interventions b. Outpatient Physical Therapy i. Patient characteristics ii. Exercise Interventions c. Community-Based Exercise Programs 1. Participant characteristics 2. Approved exercise programs for fall prevention may include 1. Centers of Disease Control and Prevention (CDC)-endorsed 2. Acceptable alternative exercise programs verified to include the STRIDE Essential Elements.	 15 min 15 min 15 min
VI.	Roles of Exercise Intervention Providers a. High fidelity program delivery i. Basic principles ii. Local Fidelity Working Groups b. Monitoring c. Self Management	**10 min**
VII.	Frequently Asked Questions	**5 min**
VIII.	Provider Resources	**5 min**
IX.	Summary and Discussion	20 min

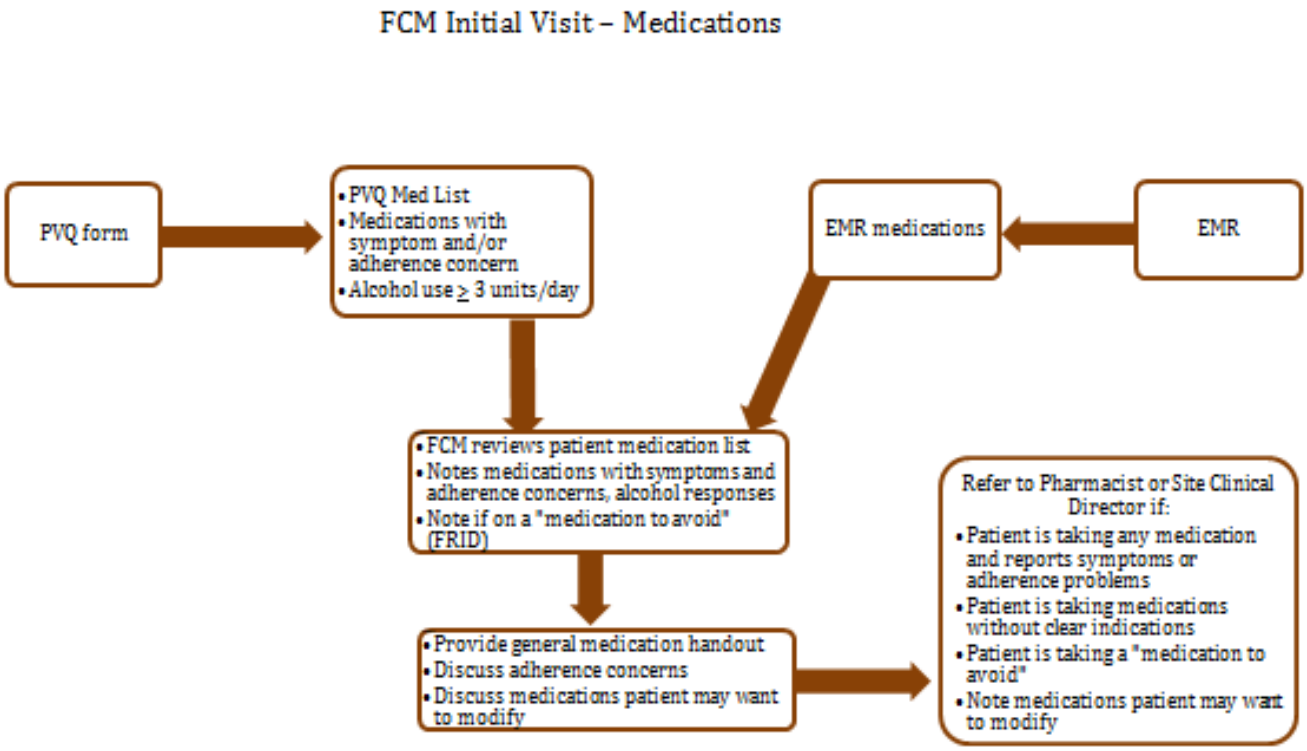
APPENDIX 5.21 MEDICATIONS TO AVOID

Medications to Avoid

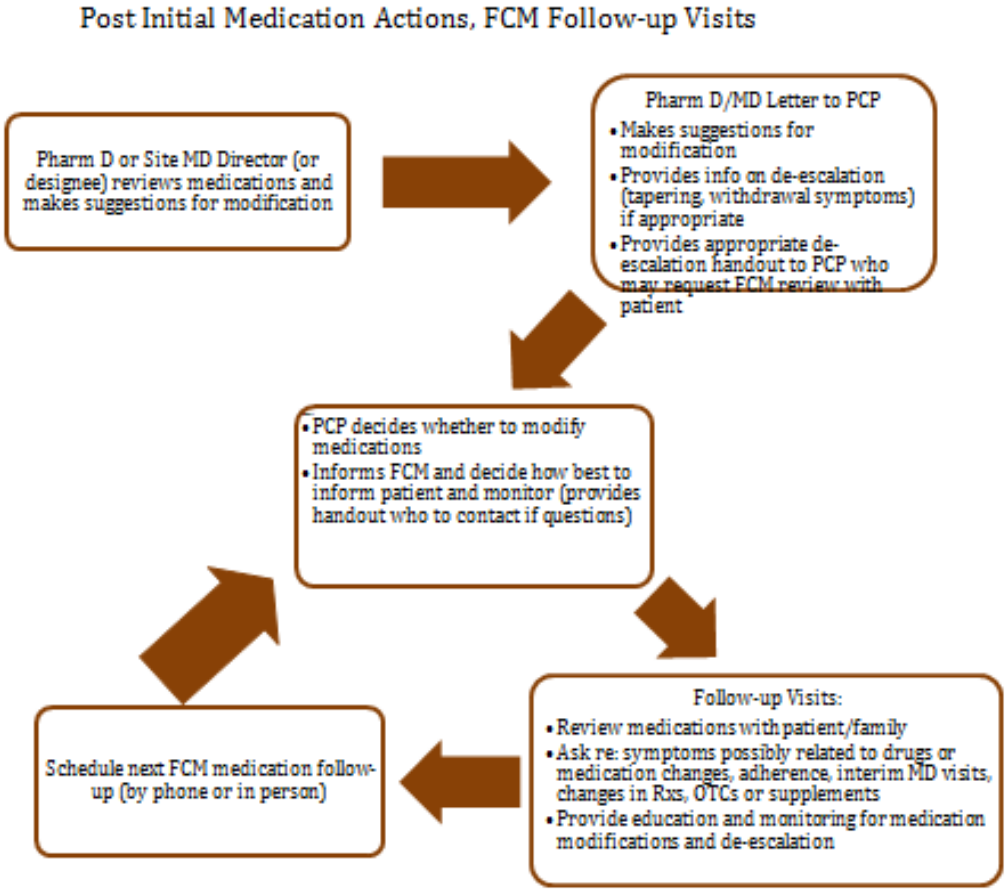
Benzodiazepines	Doxylamine (Unisom)
Alprazolam (Xanax)	Hydroxyzine (Atarax)
Chlordiazepoxide (Librium)	Triprolidine (Tripohist)
Clonazepam (Klonopin)	Meclizine (Antivert)
Diazepam (Valium)	Dimenhydrinate (Dramamine)
Flurazepam (Dalmane)	Long Acting Hypoglycemics
Lorazepam (Ativan)	Glyburide (Micronase)
Oxazepam (Serax)	Chlorpropramide (Diabinase)
Quazepam (Doral)	Skeletal Muscle Relaxants
Temazepam (Restoril)	Carisoprodol (Soma)
Triazolam (Halcion)	Cyclobenzaprine (Flexeril)
Zolpidem (Ambien)	Methocarbamol (Robaxin)
Eszopliclone (Lunesta)	Metaxalone (Skelaxin)
Zaleplon (Sonata)	Tizanidine (Zanaflex)
Estazolam (ProSom)	Tertiary Tricyclic Antidepressants
Chlordiazepoxide/ amitriptyline (Limbitrol)	Amitriptyline (Elavil)
Chlordiazepoxide/ clidinium (Librax)	Clomipramine (Anafranil)
First Generation Antihistamines	Doxepin (Silenor)
Diphenhydramine (Benedryl)	Imipramine (Tofranil)
Brompheniramine (J-TANPD)	Protriptyline (Vivactil)
Chlorpheniramine (Aller-Chlor)	Trimipramine (Surmontil)
Carbinoxamine (Arbinoxa)	
Clemastine (Tavist)	
Cyproheptadine (PMS-cyproheptadine)	
Promethazine (Phenergen)	

APPENDIX 5.22 MEDICATION RISK REDUCTION PROCEDURE

Medication Risk Reduction Algorithm – Panel 1



Medication Risk Reduction Algorithm – Panel 2



APPENDIX 5.23 MEDICATION SYMPTOM ADHERENCE TRIGGERS FOR REFERRAL TO PHARMD OR SCD

Medication-related symptoms and adherence issues that trigger referral to Pharmacist or Site Clinical Director

Do you think that any of the medicines you are taking make you unsteady or dizzy?

☐ Yes ☐ No If yes, which one(s)? _____

Do you think that any of the medicines you are taking make you drowsy, foggy, or too sleepy?

☐ Yes ☐ No If yes, which one(s)? _____

Do you think that any of the medicines you are taking make you need to go to the toilet frequently?

☐ Yes ☐ No If yes, which one(s)? _____

Do you sometimes take medications differently than they are prescribed (e.g, skip or reduce doses?)

☐ Yes ☐ No If yes, which one(s)? _____

Do you ever forget to take any of your medications?

☐ Yes ☐ No If yes, which one(s)? _____

When you feel better, do you sometimes stop taking any of your medications?

☐ Yes ☐ No If yes, which one(s)? _____

Sometimes if you feel worse when you take one of your medications, do you stop taking it?"

☐ Yes ☐ No If yes, which one(s)? _____

Do you ever stop taking your medications because they are too expensive?

☐ Yes ☐ No If yes, which one(s)? _____

APPENDIX 5.24 AVOIDING BAD EFFECTS OF MEDICATION

What You Can Do to Help Avoid Bad Effects of Medications

Medications help you prevent and treat symptoms and diseases. Sometimes they can cause health problems as well. The more medications you take, the more likely you are to have a bad effect, such as a fall. There are steps you can take to avoid such problems:

- Keep an updated medication list with correct names, doses, and time of day that you take them. Include over-the-counter and herbal medications.
- Bring your medication list to every visit with all your doctors and other health care providers, review it with them, and note changes on the list. It is especially important to do this after you have been seen in the Emergency Department or have been hospitalized.
- When you review your medication list with your doctor or health care provider, ask if there are any medications that can be reduced or stopped. Don't reduce or stop a medication on your own - ask your doctor first.
- When a new medication is added, find out what it is for, how it will help you, and what the risks of taking it are. Ask if there are any common side effects that you should be aware of, and ask if there are any interactions with medications you are already taking.
- If you have symptoms such as fatigue, dizziness, unsteadiness, poor appetite, or confusion, or have had a fall, ask your doctor:
    - if these symptoms are due to any of the medications you are taking;
    - to check your blood pressure lying AND standing, because a drop in pressure when you stand can be a sign of too much medication;
    - which medications can be decreased or stopped.
- Ask your health care provider before starting non-prescription or herbal medications, especially ones for sleep, colds, or allergies. There may be interactions with medications that you are already taking, or side effects that you are unaware of.
- Ask your health care provider if there is any treatment, instead of medication, that will help your health problem(s). Examples of non-pharmacological treatment include exercise, massage therapy, and changes in diet and fluid intake.
- Your pharmacist can help identify potential problem interactions or side effects of medications. Use one pharmacy so that they have a complete record of the medications that you are taking.

APPENDIX 5.25 SLEEP HYGIENE

Sleep Hygiene: Patient Handout compiled from Geriatrics at Your Fingertips 2014

Measures recommended to improve sleep hygiene:

- During the daytime:
  - Get out of bed at the same time each morning regardless of how much you sleep the night before.
  - Exercise daily but not within 2 hours of bedtime.
  - Get adequate exposure to bright light during the day.
  - Decrease or eliminate naps, unless necessary part of sleeping schedule.
  - Limit or eliminate alcohol, caffeine, and nicotine, especially before bedtime.

- At bedtime:
  - If hungry, have a light snack before bed (unless there are symptoms of GERD or it is otherwise medically contraindicated), but avoid heavy meals at bedtime.
  - Don't use bedtime as worry time. Write down worries for next day and then don't think about them.
  - Sleep only in your bedroom.
  - Control nighttime environment, i.e., comfortable temperature, quiet, dark.
  - Wear comfortable bedclothes.
  - If it helps, use soothing noise (e.g, a fan or other appliance or a "white noise" machine).
  - Remove or cover the clock.
  - No television watching in the bedroom.

- Maintain a regular sleeping time, but don't go to bed unless sleepy.
- Develop a sleep ritual (e.g, hot bath 90 minutes before bedtime followed by preparing for bed for 20-30 minutes, followed by 30-40 minutes of relaxation, meditation, or reading).
- If unable to fall asleep within 15-20 minutes, get out of bed and perform soothing activity, such as listening to soft music or reading (but avoid exposure to bright light or computer screens).

APPENDIX 5.26 MEDICATION RISK REFERRALS TO PHARMD OR SCD

Template

FCM Initial Communication to Pharmacist or Site Clinical Director

Patient: _____ Date: ___/_____/_____
FCM:_____ Phone: _____ Email: _____
PCP: _____ Phone: _____ Email: _____

Dear [Pharmacist/Site clinical Director]:

Based on the attached "reconciled medication list," Mr/s. _____ appears to have medications, or symptoms related to medications, that often affect the risk of falling and/or fractures. **Please review the attached list and suggest alternative medications or regimens, if appropriate, to the PCP within three working days.** Also attached, for your information, is a set of STRIDE guidelines for tapering/discontinuing certain medications that can increase older patients' risks of falling. Please feel free to send these to the PCP too, if appropriate.

After receiving your recommendations, the PCP will revise the patient's medication orders, as deemed appropriate, and communicate those revisions to me. I will then work with the PCP and the patient/caregiver to implement a safe, effective medication regimen throughout the months ahead.

Thank you for your prompt participation in this important care process.

Sincerely,

_____
Falls Care Manager
STRIDE Study

Attachments: Reconciled Medication List
STRIDE Guidelines for Tapering/Discontinuing Medications

APPENDIX 5.27 TRAVEL SAFETY CHECKLIST

"Check for Safety"
A Travel Safety Checklist for Older Adults Who Travel

Independence is a quality that everyone values in their lives. And maintaining independence as you age is important. The ability to travel to new places, or to visit those you love, should be a joyful experience.

More than one in three people age 65 years or older falls each year. While falls frequently happen at home, they occur during travel as well. Encountering unfamiliar surroundings can contribute to falls and result in serious injuries. But, falls while traveling can be avoided. ***We want to help you travel safely!***

Hazards you may find in your own home may be found in places to which you travel. These include: objects on floors; slippery floors, tubs, and showers; throw rugs; wires and cords; loose carpet on stairs; lack of proper handrails on both sides of stairs; and poor lighting. Changes due to weather conditions – rain, snow, and ice – are important factors as well. You can avoid these hazards when traveling in many of the same ways you avoid them at home.

There are additional situations to be aware of when you travel. The following checklist will help you to notice potential dangers that sometimes cause people to fall when they travel.

1

This checklist highlights four issues to think about and it suggests ***positive actions you can take to avoid falls***. By following these suggestions, you can enjoy traveling as safely as possible.

1. REST and RELAXATION: Look carefully at your travel plans.

Q: Will your plans allow plenty of time for sleeping at night and rest during the day?

- Plan your travel times so you'll *be as well rested as possible* while you are away. If your destination requires traveling with connections by air, train, or bus, create an itinerary that allows ample time between gates and departures.

Q: Will your plans allow plenty of time for you to do all that you want to do each day?

- Plan your activities so you can be *relaxed without hurrying* throughout each day, even when unexpected travel delays occur. Giving yourself extra time has the added benefit of letting you enjoy something you discovered that you hadn't planned!

2. WEATHER: Check the weather forecast for your travel destination.

Q: Will there be rain, ice, snow or strong wind in the place(s) you'll be going?

- Pack equipment and clothes – such as a cane or walker with rubber feet, or a pair of rubber-soled shoes or boots – that will help prevent falling on slippery surfaces. *Supportive, well-fitting footwear with firm, slip-resistant soles are recommended to avoid falls – both indoors and outdoors.*

Q: Will the weather be cold or hot?

- Bring *warm clothing* for cold weather — and drink plenty of water to prevent dehydration and dizziness in hot weather.

Q: Will you travel to high altitudes?

- Walk slowly and rest frequently. If you use oxygen, be sure to bring it with you.

3. PHYSICAL HAZARDS for FALLING: Look out for physical hazards everywhere you go during your travels.

Q: Is your luggage difficult to handle?

- Check your heavy luggage, and request help retrieving it. Consider luggage with four wheels which is easier to move, and eliminate dragging heavy bags.

Q: Are the shower floor, bathtub bottom, or bathroom floor in your room slippery when they're wet?

Place *non-skid mats,* when available, over slippery surfaces, and *move very carefully* on these surfaces. Reserve "accessible" hotel rooms with non-skid mats, grab bars and raised seat height toilets.

Q: Do you have to step over a barrier between the tub or shower?

Use *extreme caution* – hold on to solid grab bars and/or ask for assistance.

Q: Do bathrooms have solid grab bars near the toilet?

If not, get on and off the toilet *very carefully* or *ask for help*.

Q: Are streets, sidewalks, stairs, or other outdoor walking surfaces uneven or slippery?

Ask for help, use extreme caution, or don't walk on them. Wear sturdy, well-fitting flat shoes that provide extra support and traction. Also, there are a number of ice-traction device products available that attach easily over your footwear.

4

Q: Might you lose your balance as you step onto or off of moving transportation, such as escalators, elevators, cars, buses, trains, subways, light rail or airplanes?

Take your time, use caution, avoid escalators, and ask for assistance if you think it might help. There are always people who are glad to help – and you may meet someone interesting along the way!

Q: Are there *pets* nearby?

Stand still and ask the owner to prevent pets from running underfoot and jumping toward you.

4. ALCOHOL: Before drinking, consider the possible effects of alcohol on your balance, judgment and alertness. It is also important to remember and *follow any advice from your doctor related to alcohol use and the medications you are taking.*

Q: Will you be walking, encountering physical hazards, or needing to be alert in your travels?

Avoid alcohol or consume smaller amounts than usual, close to your room. If you must travel after consuming alcohol, take a taxi.

5

APPENDIX 5.28 ALL ABOUT CALCIUM

All About Calcium

What is Calcium and What Does it Do?

Calcium is a mineral that is necessary for life. Calcium builds bones and keeps them strong. It is also necessary for nerves and muscles to function normally, and we need it for our skin, nails, and hair. Calcium is stored in our bones and teeth, but we can't produce new calcium. So if we don't eat enough, the body takes it from the bones, leaving them more fragile. That's why it's important to replace calcium from the food we eat.

How Much Calcium Do You Need?

Men and women over age 51 need 1,200 mg of calcium daily.

How Do I Know How Much Calcium I'm Getting?

To find out how much calcium is in packaged food, check the nutrition facts label. It will list a percentage based on a daily value of 1000 mg. Calcium listed as 30% means the food has 300 mg of calcium per serving.

Calcium-Rich Food Sources

Food is the best source of calcium. Dairy products, such milk, yogurt and cheese are high in calcium. Green vegetables such as broccoli and kale also contain calcium. Juice, soymilk, and cereals often have added calcium.

Calcium Supplements

Calcium pills can be used to supplement the diet. If you eat enough calcium in your diet you don't need calcium pills. If needed, calcium pills can be bought without a prescription. **Ask your doctor or pharmacist about any possible interactions between calcium pills and your other medications.**

Calcium carbonate and calcium citrate are the best forms to buy. Look for labels that say, "purified" or have the USP symbol. The label will also tell you how many doses or pills to take. Many types are available:

Calcium carbonate supplements

- Viactiv Soft Calcium Chews with Vitamins D & K
- Tums 500
- Caltrate 600
- GNC Calcium Complete (400 mg)
- Os-Cal 500

Calcium citrate supplements

- Citracal
- TwinLab Calcium Citrate Caps (300 mg)
- GNC Calcimate Plus 800 (Calcium Citrate Malate)
- Solgar Calcium Citrate (250 mg)
- Citrical Ultradense Calcium Citrate (200 mg)

When to Have Calcium

Take calcium-rich foods or pills spaced throughout the day.

If you find that the Calcium causes gas or constipation, try increasing fluids or try another type of calcium.

APPENDIX 5.29 DAIRY FORMS OF CALCIUM

Dairy Forms of Calcium

Fortified and enrich foods are foods in which calcium has been added

Milk, fortified with vitamin A and D,
1 cup (8oz.):
Whole = 276 mg of calcium
Reduced fat, 2% = 293 mg of calcium
Low-fat, 1% = 305 mg of calcium
Non-fat = 316 mg of calcium

Eggnog, 1 cup (8oz.) = 330 mg of calcium

Milk, dry, nonfat, instant,
fortified with vitamin A and D,
1/3 cup dry powder = 283 mg of calcium
(Makes 1 cup (8oz.) reconstituted milk)

Created by Vivian Chavez, RN, BSN January 2016

Dairy Forms of Calcium

Plain yogurt:

Regular, 6 oz. = 209 mg of calcium

Low-fat, 6 oz. = 311 mg of calcium

Frozen yogurt, 1 cup = 174 mg of calcium

Cream cheese, 3 oz. = 82 mg of calcium

Ice cream, per 1 cup serving:

Vanilla = 168 mg of calcium

Chocolate = 144 mg of calcium

Strawberry =158 mg of calcium

Created by Vivian Chavez, RN, BSN January 2016

Dairy Forms of Calcium

Heavy whipping cream, fluid,

1 cup = 157 mg of calcium

*This will yield 2 cups of whipped

Sour cream, 1/2 cup = 116 mg of calcium

Ricotta cheese, part skim milk,

1/2 cup = 337 mg of calcium

Cottage cheese, large curd, 1 cup = 174 mg of calcium

Cottage cheese, small curd, 1 cup = 187 mg of calcium

Created by Vivian Chavez, RN, BSN January 2016

Dairy Forms of Calcium

American cheese slices, fortified with vitamin D, 1 oz. slice = 293 mg of calcium

American white cheese slices, fortified with vitamin D, 1 oz. slice = 293 mg of calcium

Mozzarella cheese, part skim milk, 1 oz. = 222 mg of calcium

Cheddar Cheese, 1 oz. = 201 mg of calcium

Created by Vivian Chavez, RN, BSN January 2016

Dairy Forms of Calcium

Monterey cheese, 1 oz. = 211 mg of calcium

Colby cheddar and jack cheese, 1 oz. = 211 mg of calcium

Provolone cheese, 1 oz. = 214 mg of calcium

Swiss cheese, 1 oz. = 252mg of calcium

Muenster cheese, 1 oz. = 203 mg of calcium

Created by Vivian Chavez, RN, BSN January 2016

Dairy Forms of Calcium

References

US Department of Agriculture, Agricultural Research Service, Nutrient Data Laboratory. USDA National Nutrient Database for Standard Reference, Release 28. Version Current: September 2015. Internet: http://www.ars.usda.gov/nea/bhnrc/ndl

Bing images. (n.d.). Retrieved January 11, 2016 from http://www.bing.com/images/search

APPENDIX 5.30 NON DAIRY FORMS OF CALCIUM

Non-Dairy Forms of Calcium

Men and women over age 51 need 1,200 mg of calcium daily.

Bok choy, cooked,
1 cup = 158 mg of calcium

Broccoli, cooked, 2 cups = 124 mg of calcium

Turnip greens, cooked, 1 cup = 197 mg of calcium

Okra, raw, chopped,
1 1/2 cups = 123 mg of calcium

Okra, cooked, 1 cup = 124 mg of calcium

Created by Vivian Chavez, RN, BSN December 2015

Non-Dairy Forms of Calcium

Refried beans, 1 cup = 69 mg of calcium

Refried beans, 1 can = 128 mg of calcium

Kidney beans, all types, cooked, boiled, without salt, 2 cups = 124 mg of calcium

Soybeans, cooked, boiled, without salt, 1 cup = 261 mg of calcium

Soybeans, raw, 1 cup = 504 mg of calcium

Navy beans, cooked, boiled, without salt, 1 cup = 126 mg of calcium

Black beans, cooked, boiled, without salt, 2 cups = 92 mg of calcium

Created by Vivian Chavez, RN, BSN December 2015

Non-Dairy Forms of Calcium

Blackberries, 2 cups = 84 mg of calcium

Apricots, dried, chopped, 1 1/2 cups = 108 mg of calcium

Kiwi, 2 cups, sliced = 122 mg of calcium

Prickly pear, raw, chopped, 1 cup = 83 mg of calcium

Fig, dried, chopped, 1 cup = 241 mg of calcium
Fig, raw, 5 fruits = 110 mg of calcium

Created by Vivian Chavez, RN, BSN December 2015

Non-Dairy Forms of Calcium

Oranges, 1 fruit = 52 mg of calcium

Tangerine, 3 fruits = 99 mg of calcium

Brazil nuts, 2 oz. (12 nuts) = 90 mg of calcium

Almonds, 2 oz. (46 almonds) = 152 mg of calcium

Sesame seeds, whole, roasted and toasted = 90 mg of calcium

Created by Vivian Chavez, RN, BSN December 2015

Non-Dairy Forms of Calcium

Butternut squash, cooked, chopped, 1 1/2 cups = 124 mg of calcium

Spinach, raw, 4 cups (half a 10 oz. package) = 120 mg of calcium

Spinach, cooked, 1 cup = 245 mg of calcium

Mustard greens, cooked, 1 cup = 104 mg of calcium

Mustard greens, raw, 4 cups = 116 mg of calcium

Kale, raw, 1 cup, chopped = 90 mg of calcium

Kale, cooked, boiled, without salt, 1 cup = 100 mg of calcium

Created by Vivian Chavez, RN, BSN December 2015

Non-Dairy Forms of Calcium

Fortified and enrich foods are foods in which calcium has been added

Dry ready-to-eat cereals, fortified = approximately 100 to 1000 mg of calcium per serving

Hot Cereal:

Cream of Wheat, enriched, 3/4 cup = 200 mg of calcium

Instant oatmeal, enriched, 1 pack = 187 mg of calcium

Bread, whole wheat, 2 slices = 104 mg of calcium

Chia seeds, dried, 1 oz. = 179 mg of calcium

Created by Vivian Chavez, RN, BSN December 2015

Non-Dairy Forms of Calcium

Coconut milk, sweetened, fortified with calcium and vitamins, 1 cup (8oz) = 451 mg of calcium

Almond milk, unsweetened, 1 cup (8oz) = 516 mg of calcium

Rice milk with 50% more calcium, 1 cup (8oz) = 300 mg of calcium

Lactose free milk, calcium enriched, 1 cup (8oz) = 300 mg of calcium

Created by Vivian Chavez, RN, BSN December 2015

Non-Dairy Forms of Calcium

Soymilk, calcium added, 1 cup (8oz):
Regular = 301 mg of calcium
Low fat = 199 mg of calcium
Nonfat = 282 mg of calcium

Orange juice, enriched, 1 cup (8oz) = 300 mg of calcium

Lactose free yogurt:
Almond yogurt = approximately 200 to 450 mg of calcium per serving
Soy yogurt = approximately 250 to 500 mg of calcium per serving
Coconut yogurt = approximately 200 to 450 mg per serving of calcium
Lactose free yogurts = approximately 200 mg of calcium per serving

Created by Vivian Chavez, RN, BSN December 2015

Non-Dairy Forms of Calcium

Molasses, 2 tablespoon = 82 mg of calcium

Tofu firm, 1/2 cup = 253

Sardine, canned, in oil, drained solid with bones = 351 mg of calcium

Pink salmon, canned, drained solid with bone 3oz = 241 mg of calcium

Pink salmon, 1 can, skin and bones removed = 145 mg of calcium

Created by Vivian Chavez, RN, BSN December 2015

Non-Dairy Forms of Calcium

References

US Department of Agriculture, Agricultural Research Service, Nutrient Data Laboratory. USDA National Nutrient Database for Standard Reference, Release 28. Version Current: September 2015. Internet: http://www.ars.usda.gov/nea/bhnrc/ndl

Bing images. (n.d.). Retrieved December 16, 2015 from http://www.bing.com/images/search

APPENDIX 5.31 NOCTURIA HANDOUT

Nocturia

GETTING UP AT NIGHT TO EMPTY YOUR BLADDER

WHAT IS NOCTURIA?

Nocturia is frequently waking up at night to pass urine. It often increases with age.

If you need to make several trips to the toilet at night (more than two) you may find this distressing or your sleep may be disturbed. This may also indicate that you have a bladder health problem. Nighttime trips to the bathroom can also increase the chances of slipping, tripping or falling.

WHAT CAUSES NOCTURIA?

☐ **Hormonal Changes.** As you age, you produce less anti-diuretic hormone. Anti-diuretic hormone is a chemical your body makes to help hold onto fluid at night, so you make less urine. Lower levels of this hormone mean that more urine is produced at night.

- **Prostate Problems.** Men's prostate glands often grow with age. An enlarged prostate can prevent your bladder from emptying properly, so you need to pass urine more often.

☐ **Urge Incontinence** (also known as overactive bladder)**.** If you have a sudden need to pass urine, you may leak urine before you are able to reach a toilet.

☐ **Bladder Infections.** Bacteria entering your bladder can cause symptoms such as dark, cloudy and smelly urine; a burning feeling or pain when passing urine; confusion; and not being able to empty your bladder completely.

- **Diabetes**. High blood sugar may cause frequent urination.

- **Heart problems.** Your heart and circulation may become less efficient with age. You may find fluid collects in your body's tissues, especially around your ankles. Your body can absorb this extra fluid more easily when you are lying down, for example while you are asleep. It is absorbed into your blood stream and removed by your kidneys as extra urine.

- **Sleep Related Problems.** You are more likely to feel the urge to go to the toilet while you are awake. Therefore, if you keep waking up in the night or have problems sleeping, you are more likely to need to pass urine.

- **Drinking too much fluid.** The number of times you need to urinate can increase if you drink too much fluid especially close to bed time.

IS THERE ANYTHING I CAN DO?

If you have nocturia, consider the following:

1. **Reduce the amount you drink before you go to bed.** For example, have your last drink at 8pm instead of 10pm. However, make sure you are still drinking the recommended daily amount. This is six to eight cups of fluid a day – about three to four pints or two litres. Reducing the amount you drink does not help.

2. **Have fewer drinks that contain caffeine**, such as tea, coffee, chocolate and cola. These can irritate your bladder and change your sleep patterns, as can alcohol.

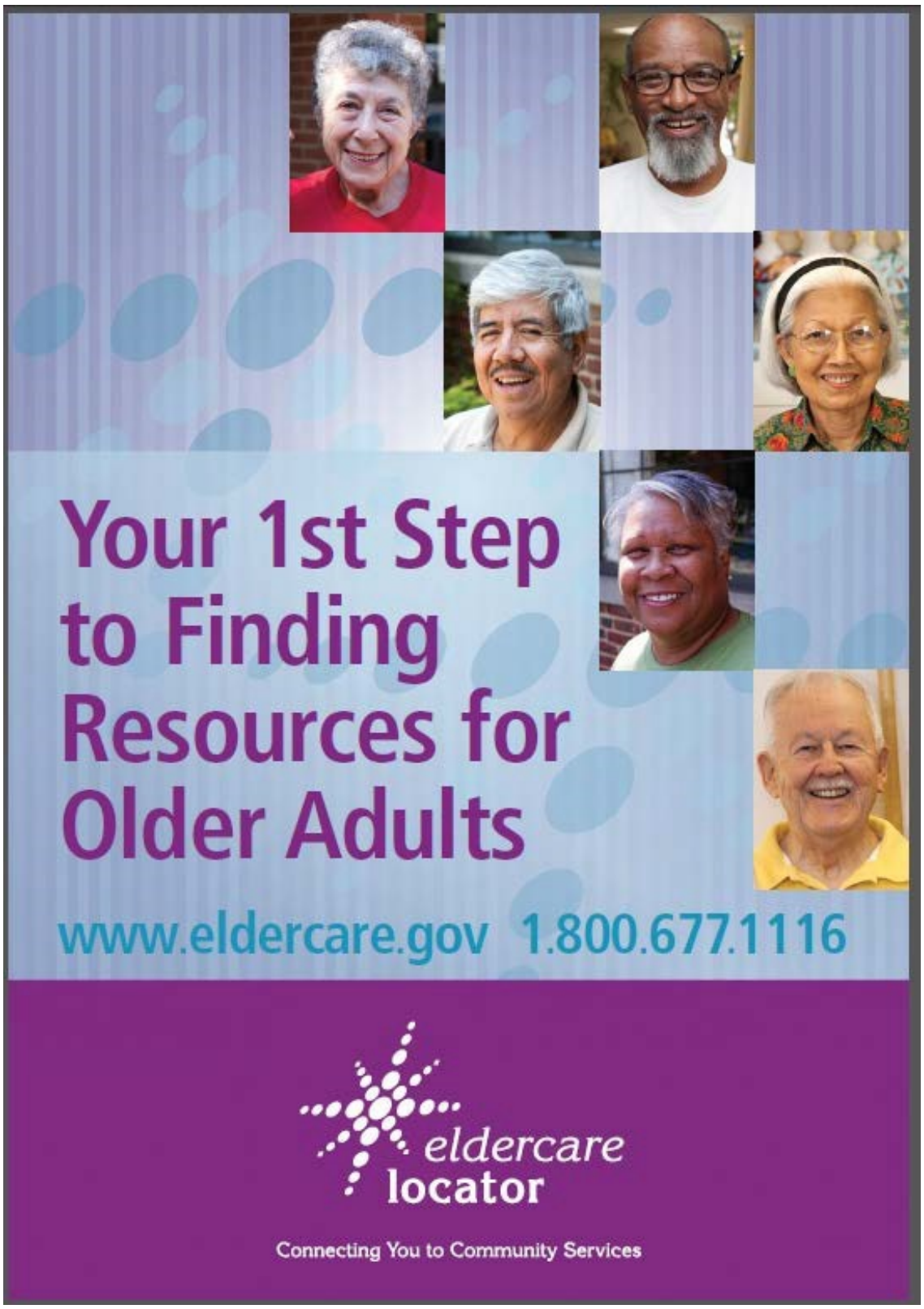
3. **If you regularly have swollen ankles, sit or lie down for about an hour during the day** (even 10 minutes can help). Raise your legs and feet so they are at or above the level of your heart. It may also help to wear support stockings.

4. **Some medicines make your body produce more urine**, or promote its flow. In many cases this is how the medicine works to treat the condition (for example, water tablets for high blood pressure). If you are unsure if your medicines could be causing nocturia, ask your doctor. Do not stop taking your medicines without the advice of your doctor.
5. **Think about whether anything is disturbing your sleep**, such as light or temperature. If you have painful conditions that disturbed your sleep, consult with your doctor. Avoid naps during the day to see if this helps you sleep better at night. Also, avoid stimulants like drinks containing caffeine before bed.

ADDITIONAL TREATMENT FOR NOCTURIA

If nocturia continues, you may have a bladder problem that requires medical treatment. Speak to you doctor about other treatments that may be helpful.

APPENDIX 5.32 ELDERCARE LOCATOR



Are you interested in home-delivered meals?

Do you need
a ride to a doctor's appointment?

Are you taking care of yourself while
taking care of an aging friend or relative?

Do you need assistance
with light chores around the house?

Want to find out about opportunities to
stay involved in your community?

The Eldercare Locator can help!

www.eldercare.gov

1.800.677.1116

When you call the Eldercare Locator you will be connected with local aging resources, such as, your Area Agency on Aging (AAA), Aging and Disability Resource Center (ADRC), Title VI Native American aging program, State Health Insurance Assistance Program (SHIP), Long-term Care Ombudsman or Elder Abuse Prevention. These agencies are familiar with programs and services for older adults and caregivers. The following are some examples of services and supports commonly available to you through these resources:

Staying at Home

- **Nutrition Programs** – Home-delivered meals or group meal programs
- **Transportation** – Rides to the doctor, store and for other errands
- **In-home Services** – Light housework, personal care, medication management, meal preparation

Meeting Your Housing Needs

- **Home Repair** – Programs to help keep your home in good repair
- **Home Modification** – Grab bars, wheelchair ramps or other modifications to your home
- **Housing Choices** – Housing alternatives in your community

Assisting Caregivers

- **Adult Day Care** – A protective setting for older adults in need of assistance during the day
- **Caregiver Support** – Programs to support those taking care of older adults
- **Respite Care** – Opportunities to relieve caregivers of daily duties

Getting Involved

- **Employment Services** – Opportunities to explore training and employment options
- **Senior Center Programs** – Meals, recreation and socialization
- **Volunteer Services** – Opportunities to stay involved and give back

Finding Additional Resources

- **Legal Assistance** – Advice and representation for legal matters, such as government program benefits, tenant rights, consumer issues
- **Financial Assistance** – Counseling and assistance on financial management and benefits
- **Case Management** – Help identifying needs and coordinating services
- **Elder Abuse** – What to do if yourself or a loved one is being exploited, neglected or abused
- **Health Insurance Counseling** – Assistance with health insurance related questions, including Medicare Part D prescription drug options

www.eldercare.gov

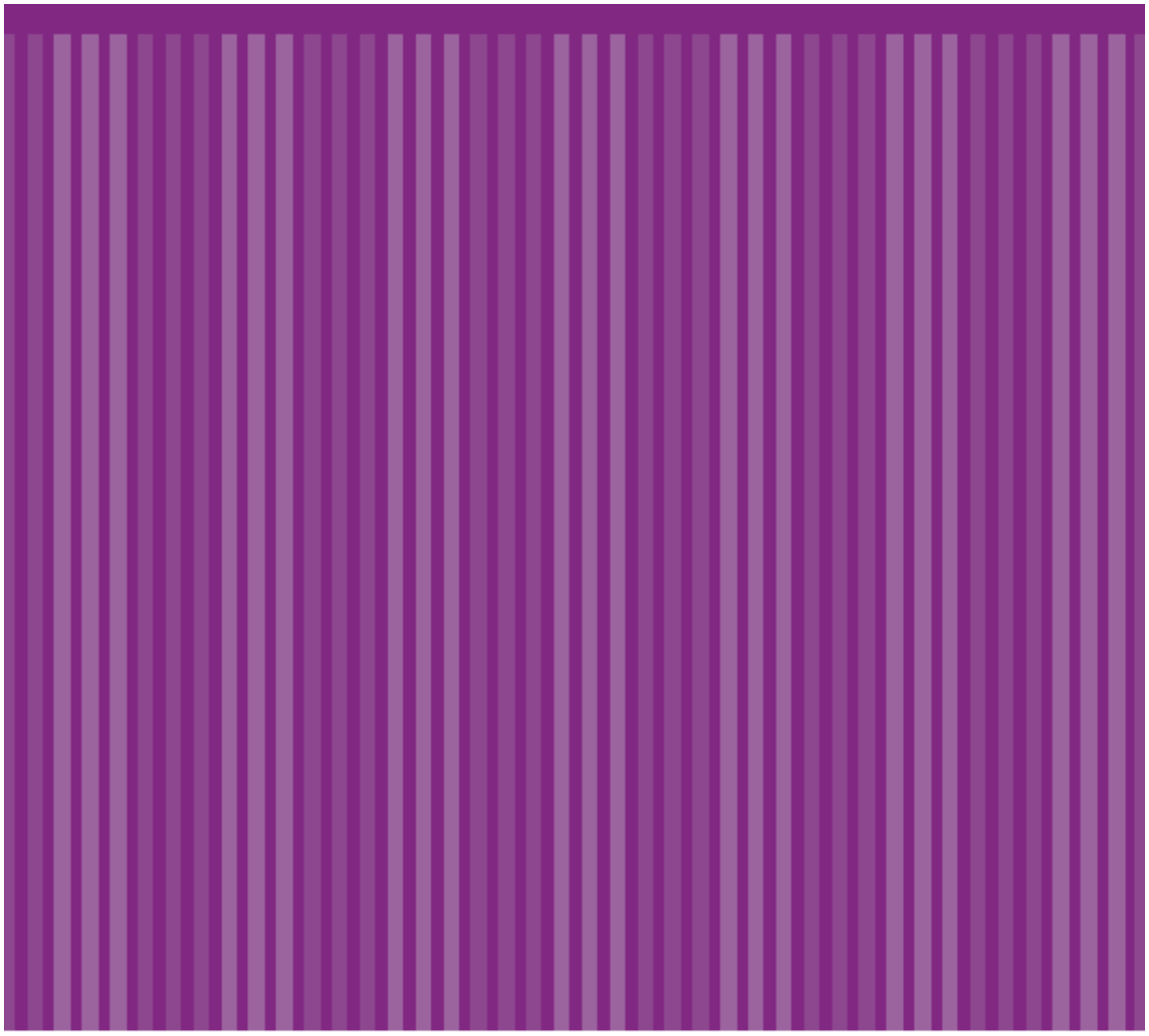
1.800.677.1116

When you call 1.800.677.1116

- Speak with an Information Specialist from 9 a.m. to 8 p.m. Eastern Time, who can help connect you to a trusted resource about programs and services for older adults and caregivers in your community.
- Learn about long-term care services and supports, transportation options, caregiver issues and government benefits eligibility.
- Speak with a Spanish-speaking Information Specialist (other languages also available).

When you visit www.eldercare.gov

- Locate information about resources in your area for older adults and caregivers.
- Access an extensive listing of publications, information, links and resources for older adults and caregivers.
- Chat online with an Information Specialist.



eldercare locator

Connecting You to Community Services

1.800.677.1116 www.eldercare.gov

The Eldercare Locator is the first step to finding resources for older adults in any U.S. community and a free national service funded by a grant from the U.S. Administration on Aging (AoA). The Eldercare Locator is administered by the National Association of Area Agencies on Aging (n4a).

AoA Administration on Aging

n4a Advocacy. Action. Answers on Aging.

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APPENDIX 5.33 COMMUNITY SAFETY ADVICE

Safety in the Community

Voices of Experience: Tips from people who "learned the hard way"

Managing

- Learn about (and use) community services that can provide help, such as removal of snow or leaves, 24-hour pharmacies and grocery stores that take orders by phone or internet and deliver, especially in bad weather.
- Ask for help from others.
- If possible, find out in advance whether getting to your destination is safe and easy.

Walking

- Wear a cell phone or personal emergency notification device.
- Avoid wearing reading glasses when walking outdoors.
- Wear gloves, rather than walking with hands in pockets.
- Use a cane or walker to increase stability.
- Carry items with one hand, leaving one hand free for doorknobs, handrails and balancing.
- If you use a backpack or shoulder bag, use one with a strap long enough to go across your chest. This will allow your hands to be free and prevent you being pulled off-center by weight on one shoulder.

- Make more trips carrying smaller loads.
- Take extra care when transferring awkward items like walkers and groceries into and out of vehicles.
- Look carefully at floor surfaces in unfamiliar buildings. Floors made of highly polished marble or tile can be very slippery and dangerous especially if the floor is wet.

- When floors have runners in place, stay on them whenever possible, and wipe shoes thoroughly before stepping off.
- Stop at curbs to check the height before stepping up or down. Be careful where curbs have been cut away for bike or wheelchair access. Don't rush to cross a street before the signal light changes.

Lighting

- Turn on the lights for outdoor stairways and walkways at night.
- Turn on the light outside the front door before leaving home in the evening.
- Stand still until your eyes adjust to the light, whether going from bright to dark or dark to bright.

Stairs

- Keep one hand on the rail when going up or down stairs.
- Count your steps when going up or down stairs.
- Avoid carrying things that require both hands and block your ability to see the stairs.
- Use escalators with care: step on carefully, keep one hand on the handrail, and move clear of the escalator when stepping off.
- If you have a walker, use elevators rather than escalators.

APPENDIX 5.34 MY EXERCISE PLAN FOR STRENGTH AND BALANCE

My Exercise Plan for Strength and Balance

We are excited about your interest in improving your balance and strength with exercise!

Exercise is good for you. When your muscles are strong your balance will be better. When your balance is good, you can do more things you want to do and do them more easily.

We have put together an exercise program that is just for you. There are several levels of challenge for each exercise but you will start at the level you are able to do now. As your strength and balance improve, you can challenge yourself with the next highest level.

Exercise works best when you do it regularly, ideally every day. If every day is too much, then try 3-4 times a week.

Here are a few important things to remember when you exercise.

Goals for each exercise level

1. Be safe, and ask yourself every day if you can progress to greater challenges.
2. Try to do the recommended exercises once a day every day. If you can't do the exercise every day, then try for 3-4 times a week.
3. Repeat each exercise 10 times. Repeating an exercise 10 times is called a "set."
4. Take breaks between the exercises as needed.
5. Exercises may be spaced throughout your day if you wish.

Ways to challenge and progress

1. Add one more set of 10 repetitions to some or all exercises.
2. Progress to next highest level. Try to do this when you feel confident in your ability to do the exercise. When you can complete a set (repeating the exercise 10 times) five days in a row, you may be ready to move up a level.

    a. Think about how you might be more active during your day: When sitting down or standing up, do so 2-5 times.

b. Try to walk at least 10 minutes daily at an easy to moderate pace. Avoid brisk walking

Safety

Never exercise holding on to an object that may move, such as a chair that is not against a sturdy object. Always use the side of a stable object like a counter or solid table, unless otherwise instructed.

Exercise should not cause more pain.

If you experience any of the following while exercising, stop and contact your health care provider.

- **Dizziness,**
- **Chest pain, or**
- **Shortness of breath (you are unable to speak because you are short of breath).**

If you have any questions about the exercise program, do not hesitate to call

_[FCM]_____, RN. Telephone: _____

Exercise Journal

We made an exercise journal for you. You can use your journal to write down what you think and how you feel about exercising. Write down how your body feels before and after your exercise. You can share this information when you talk with your Falls Care Manager. An example journal entry is shown below.

Exercise Calendar

We made an exercise calendar for you. You can write down the days when you do your balance and strengthening exercises or when you walk. Just check off the days or time you spent exercising each day. You can share how things are going with your Falls Care Manager. An example of a completed exercise calendar is also included.

Here are some ways that keeping an exercise calendar can be helpful:

☐ Helps you keep track of your progress

- ☐ Helps to remind you to exercise
- ☐ Helps you keep your goals in sight
- ☐ Provides information to review with your FCM

Best wishes to you for a very successful exercise program.

Date: *May 2, 2016*

Notes: (EXAMPLE)

The exercises are getting easier. Still hard to do the sit-to-stands because of my sore hip but I've noticed some improvement. I will try to add some walking next week.

Date: _____

My Notes:

_____
_____
_____
_____
_____

Date: _____

My Notes:

_____
_____
_____
_____
_____

SAMPLE Exercise Calendar						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Date: *4/3/16*	Date: *4/4/16*	Date: *4/5/16*	Date:	Date: *4/7/16*	Date: *4/8/16*	Date: *4/9/16*
Walk 15 minutes	*Exercises 1,2,3,5*	*Exercises 1,2,3,5*		*Exercises 1,2,3,5*	*Exercises 1,2,3,5*	*Walk 15 minutes*
Date:____	Date:_____	Date:_____	Date:_____	Date:_____	Date:_____	Date:_____
Date:____	Date:_____	Date:_____	Date:_____	Date:_____	Date:_____	Date:_____

My Exercise Calendar						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Date:____	Date:_____	Date:_____	Date:_____	Date:_____	Date:____	Date:_____
Date:____	Date:_____	Date:_____	Date:_____	Date:_____	Date:____	Date:_____
Date:____	Date:_____	Date:_____	Date:_____	Date:_____	Date:____	Date:_____

APPENDIX 5.35 IMPLEMENTATION OF BEST PRACTICES FOR CBE

Implementation of Best Practices for Exercise to Prevent Falls

OBJECTIVE: To help ensure the fidelity of Community Based Exercise (CBE) program delivery in a pragmatic, sustainable manner.

1. Patient is provisioned to CBE
2. FCM provides patient with an "exercise prescription." See page 2.
3. FCM requests the patient use a checklist when attending CBE to ensure that the important components of exercise for fall prevention are included:
    a. Exercises that improve balance
    b. Exercises that strengthen legs
    c. Exercises that can be done easily at the start
    d. Exercises that become more challenging as the patient progresses
    e. Exercise sessions are enjoyable
    f. Exercise sessions are beneficial

See patient handout on page 2

SAMPLE EXERCISE PRESCRIPTION

Patient Name: Sam Smith Date: 5/2/2016

Exercise Program: Brookline Tai Chi (20% Senior Discount)

Location: 131 Cypress St, Brookline, MA 02445 Phone:(617) 277-2975

Times and Days: 10:00 AM. May attend any or all classes offered on Tuesday, Wednesday, Thursday, Saturday

Length of exercise session: 60 minutes each

Days per week: 1 to 4

Follow Up with Nurse Falls Care Manager:

Things to Look For in Your Exercise Program	YES	NO
1. Does your exercise program include exercises to improve your balance?	☐	☐
2. Does your exercise program include exercises to strengthen your legs?	☐	☐
3. Does your exercise program include exercise that starts at a level that you can do?	☐	☐
4. Does your exercise program challenge you to try harder with exercises that become more difficult over time?		

APPENDIX 5.36 PHARMACIST OR SCD RECS TO PCP

Template Medications
Pharm D/Site Director to PCP

Patient_____
Date _____

Your patient xxxxxx has been evaluated for fall risk by the STRIDE program.

Your patient 's reconciled medication list including perceived indications is on page 2.
Please note that S/he often uses alcohol.

The following medications may be contributing to her risk of falls:

Drugs that may be causing patient's symptoms	Adherence Concern	Symptom Concern
Codeine	Feels better without	nauseated
Lorazepam	Feels better without	foggy
Benadryl		foggy
Paroxetine		nauseated
alcohol		toilet frequently
Other fall risk increasing drugs	**Adherence concern**	
Timoptic		

As the STRIDE physician/Pharm D, I would suggest the following medication changes to reduce this patient's risk of falls:

1. Stop Benadryl-- FCM will provide education on antihistamines, instructions on sleep hygiene and handout on other medications that can interfere with sleep.

2. Stop codeine—currently taking twice a day. FCM will provide instructions to decrease to once a day for 3-4 days, then stop.

Please circle which specific changes, if any, you would you like to make. The FCM will work with you and the patient to instruct and monitor the patient's response, using the attached de-escalation suggestions [attach antihistamine and opiate de-escalation pages]

APPENDIX 5.37 YOU MAY BE AT RISK FIRST GENERATION ANTIHISTAMINES (FULL BROCHURE ON WEBSITE)

You May Be at Risk

You are taking a first-generation antihistamine

- ☐ Brompheniramine (Bromfed®, Dimetapp®, Bromfenex®, Dimetane®, BPN®, Lodrane®, Ala-Hist® IR, Dimetane®, Disomer®, J-Tan®, Veltane®)
- ☐ Carbinoxamine (Clistin®, Palgic®, Rondec®, Rhinopront®)
- ☐ Chlorpheniramine (Antagonate®, Chlor-Trimeton®, Efidac 24®, Kloromin®, Phenetron®, Pyridamal 100®,Teldrin®)
- ☐ Cyproheptadine (Periactin®, Peritol®)
- ☐ Diphenhydramide (Aler-Dryl®, Allergia-C®, Allermax®, Benadryl®, Compoz Nighttime Sleep Aid®, Diphedryl®, Diphen®, Diphenadryl®, Diphenhist®,Dytan®, Hydramine®, Nytol®, Sominex®, Unisom®
- ☐ Dexbrompherinamine (Drixorale®)
- ☐ Dimenhydrinate (Dramamine®)
- ☐ Clemastine (Dayhist® AllergyTavist®, Tavist® Allergy, Meclastin®)
- ☐ Doxylamine (Aldex AN®, Nighttime Sleep Aid, Unisom® SleepTabs)
- ☐ Hydroxyzine (Atarax®, Hypam®, Orgatrax®, Vistaril®)
- ☐ Promethazine (Phenergan®, Promethegan® Suppository, Remsed®, Phenergan®, Phenadoz®
- ☐ Triprolidine (Actidil ®, Myidil®, Actifed®, Zymine®)

IRSC CIHR McGill iugm Institut universitaire de gériatrie de Montréal Université de Montréal

You May Be at Risk 1

APPENDIX 5.38 YOU MAY BE AT RISK ANTIPSYCHOTICS (FULL BROCHURE ON WEBSITE)

You May Be at Risk

You are currently taking an antipsychotic drug

- ☐ Quetiapine (Seroquel®)
- ☐ Clozapine (Clozaril®, FazaClo®)
- ☐ Pimozide (Orap®)
- ☐ Ziprasidone (Zeldox®, Geodon®, Zipwell®)
- ☐ Perphenazine (Trilafon®)
- ☐ Haloperidol (Haldol®)
- ☐ Aripiprazole (Abilify®)
- ☐ Loxapine (Xylac®, Loxatine®)
- ☐ Chlorpromazine (Promapar®, Thorazine®)
- ☐ Prochlorperazine (Compazine®, Compro®, Procomp®)
- ☐ Risperidone (Risperdal®)
- ☐ Olanzapine (Zyprexa®)
- ☐ Fluphenazine (Modecate®, Permitil®, Prolixin®)

IRSC CIHR McGill iugm Université de Montréal

You May Be at Risk 1

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APPENDIX 5.39 YOU MAY BE AT RISK SEDATIVE HYPNOTICS (FULL BROCHURE ON WEBSITE)

You may be at risk IF

You are taking one of the following sedative-hypnotic medications:

- ☐ Alprazolam (Xanax®)
- ☐ Chlorazepate
- ☐ Chlordiazepoxide
- ☐ Chlordiazepoxide-amitriptyline
- ☐ Clidinium-Chlordiazepoxide
- ☐ Clobazam
- ☐ Clonazepam (Rivotril®, Klonopin®)
- ☐ Diazepam (Valium®)
- ☐ Estazolam
- ☐ Flurazepam
- ☐ Loprazolam
- ☐ Lorazepam (Ativan®)
- ☐ Lormetazepam
- ☐ Nitrazepam
- ☐ Oxazepam (Serax®)
- ☐ Quazepam
- ☐ Temazepam (Restoril®)
- ☐ Triazolam (Halcion®)
- ☐ Eszopiclone (Lunesta®)
- ☐ Zaleplon (Sonata®)
- ☐ Zolpidem (Ambien®, Intermezzo®, Edluar®, Sublinox®, Zolpimist®)
- ☐ Zopiclone (Imovane®, Rhovane®)

IRSC CIHR McGill iugm Institut universitaire de gériatrie de Montréal Université de Montréal

APPENDIX 5.40 YOU MAY BE AT RISK SULFONYLUREAS (FULL BROCHURE ON WEBSITE)

You May Be at Risk

You are currently taking a sulfonylurea diabetic medication:

- ☐ Chlorpropamide (Diabinese®, Glucamide®)
- ☐ Glyburide (DiaBeta®, Glynase® PresTab®, Micronase®)

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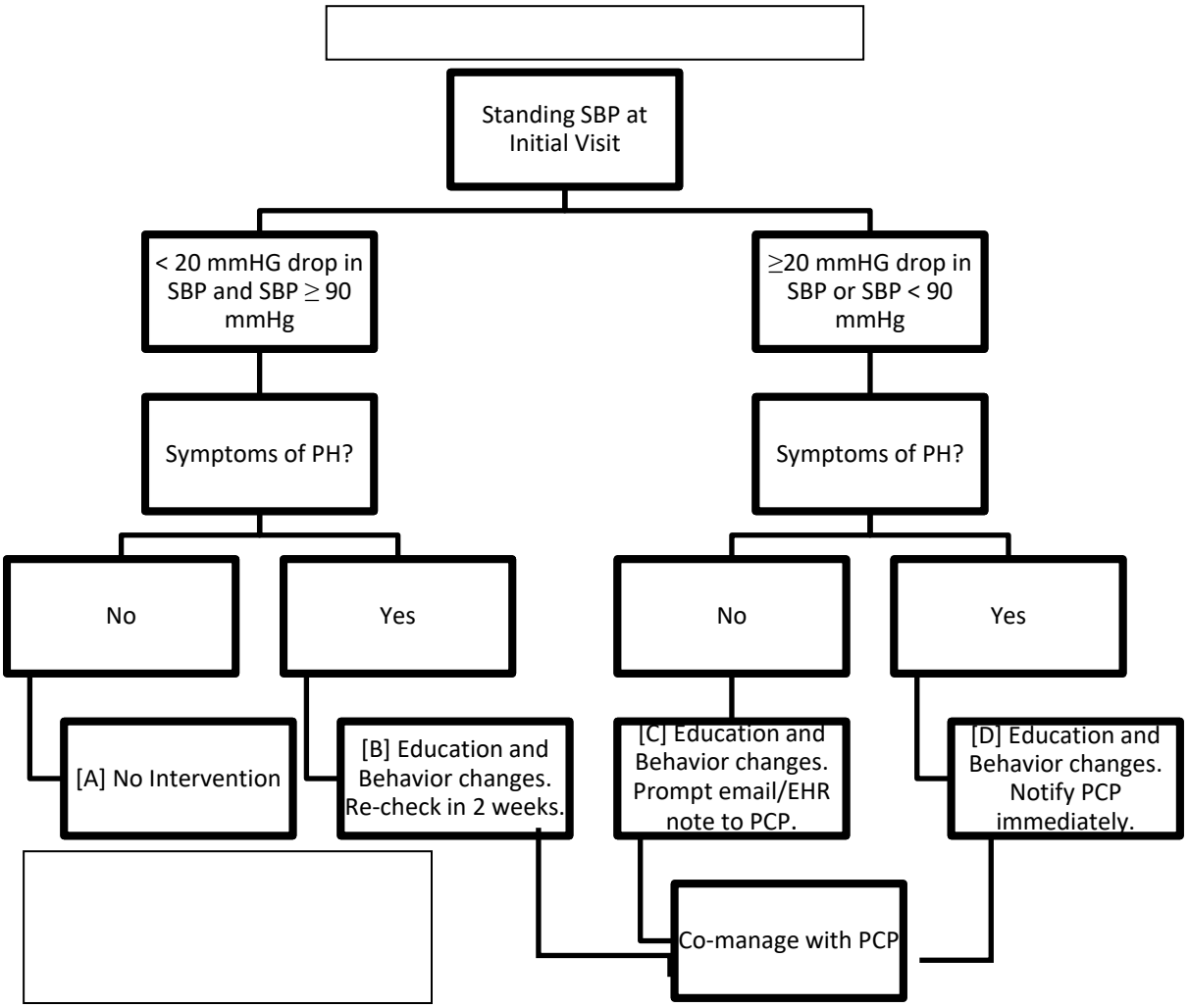
APPENDIX 5.41 POSTURAL HYPOTENSION PROCEDURE



Triggers for Communications with PCP

A. The patient's SBP does not drop more than 20 mmHg, and the SBP remains > 90 mmHG and is asymptomatic. No templated communication but will be recorded in Falls Care Manager's note.
B. The patient's SBP does not drop more than 20mmHg, and the SBP > 90 mmHg but is symptomatic triggers communication template B.
C. The patient has a drop of ≥ 20 mmHg or SBP < 90 when standing but is asymptomatic triggers communication template C.
D. The patient has a drop of ≥ 20 mmHg or SBP < 90 when standing and is symptomatic triggers communication template D.

Education

FCM discusses with patient:

What causes postural hypotension?

- Dehydration
- Medications for depression, sleep, heart problems and blood pressure (e.g. "water pills")
- Taking a larger number of medications

- How does postural hypotension cause falls?
- What symptoms have *you* experienced?

Communication of Initial Recommendations for Postural Hypotension

FCM's Communication of Initial Recommendations for Postural

Recommendation:

A. No recommendations.

B. I have provided the patient with education materials and CDC recommendations for patient behaviors to reduce symptoms. I will recheck the patient's orthostatic blood pressures in two weeks.

Background: At the initial FCM visit, the patient had a drop of < 20 mmHg (and a systolic BP > 90 mmHg when standing), but reports [dizziness, lightheadedness, faintness, wooziness] upon arising.

Assessment: The patient does not meet the BP criteria for **postural** hypotension, but has **postural** symptoms.

C. **Please see the patient to decide whether to provide medical management for postural hypotension, as shown in the attached Postural Hypotension algorithm.** I would be glad to arrange the visit. I have provided the patient with educational materials and CDC recommendations for patient behaviors to reduce symptoms.

Background: At the initial FCM visit, the patient had a drop of ≥ 20 mmHg and/or a SBP < 90 mmHg when standing, but is asymptomatic upon rising.

Assessment: The patient meets the BP criteria for **postural** hypotension, but is asymptomatic. I defer to your clinical judgment about initiating medical treatment.

D. **As we discussed by telephone, the patient needs to be evaluated ASAP to providing medical management for postural hypotension, as shown in the attached Postural Hypotension algorithm.** I would be glad to arrange the visit. I have provided the patient with educational materials and CDC recommendations for patient behaviors to reduce symptoms.

Background: The patient has a drop of ≥ 20 mmHg and/or a SBP < 90 mmHg when standing and reports [dizziness, lightheadedness, faintness, wooziness] upon arising.

Assessment: The patient meets the BP criteria for postural hypotension, is symptomatic, and is at high risk for falling.

APPENDIX 5.42 PATIENTS WHO LEAVE THE HEALTHSYSTEM

All Participants currently receive:

- ☐ From RAC: What to do in case of a fall
- ☐ With PVQ letter: CDC home fall prevention checklist
- ☐ At Initial Visit: Falls and fractures
- ☐ At Initial Visit: How to get up from a fall
- ☐ At Initial Visit: Elder care locator
- ☐ At Initial Visit: Community safety advice

Recommendations for patients who move out of the health system:

- ☐ Letter from FCM encouraging participant to discuss fall risk factors with PCP
- ☐ Checklist of risk factors to bring to PCP.
- ☐ Copies of the handouts listed above

STRIDE Logo Site Logo

«StreetAddress»

«City», «State» «zipcode»

«Date»

Dear «Salutation» «LastName»,

I understand that you are no longer receiving health care from (INSERT PCP NAME and HEALTH SYSTEM). This means I will not be able to continue as your Falls Care Manager. I am still committed to helping you prevent falls.

I am sending you some information about preventing falls. I am also sending you a fall checklist. This list includes risks that the STRIDE study thinks may prevent falls. I encourage you to review this list with your new Doctor. I also encourage you to make sure you share your medical record with your new Doctor. I have made a note in your medical record about your falls risk. There are several ways that you can prevent falls and stay independent. Continuing the work you have already begun by talking with your Doctor about falls is a great next step.

I wish you all the best as you take steps to maintain your independence.

Sincerely,

STRIDE Nurse Falls Care Manager

Many people don't realize how common falls are. In fact, 1 in 3 adults over 65 will fall. Not all falls are caused by accidents and falls can be prevented. Talk to your doctor about how you can prevent falls. Bring this checklist to your next visit to your doctor and find out what you can do to reduce your risk of falling.

Are there medicines that I am taking that might increase my risk of falling?

Medicines help prevent and treat illness. Sometimes they can cause health problems as well. Review your medicines with your doctor. Ask if any can be reduced or stopped. Let your doctor know if you think a medicine is causing symptoms such as dizziness or fatigue. Don't reduce or stop a medicine on your own, ask your doctor first.

Should I see a physical therapist to find out about how exercise can prevent falls?

Staying active is a very good way to prevent falls. There are many programs that can help you stay active. A physical therapist can design an exercise program that is right for you.

Should I be taking calcium supplements?

Calcium builds bones and keeps them healthy. When we don't get enough calcium for our body's needs, it is taken from our bones. Getting enough calcium will help keep your bones strong so that if you do fall, you might prevent a fracture.

Should I be taking vitamin D supplements?

Vitamin D helps your body absorb calcium. Taking Vitamin D supplements will help keep your bones strong so that if you do fall, you might prevent a fracture.

Do I have any foot problems that I should see a podiatrist about?

A podiatrist (foot doctor) can help:

- If you have painful or swollen feet
- If you feel tingling or "pins and needles" in your feet
- If you have changes in the shape of your feet, such as bunions
- If you aren't sure where to buy shoes that can prevent falls.

Does my blood pressure drop when I stand up?

If your blood pressure drops when you go from a lying down to sitting, or sitting to standing up this could increase your risk for falling. Ask your doctor to check.

Have I been to an eye doctor in the last year?

Your eye doctor can make sure you are wearing the best type of eye glasses for your lifestyle and check for cataracts. Improving your vision can reduce your risk of falls.

After reviewing the CDC home fall prevention checklist, I would like to find out about how to get a home safety evaluation.

Getting rid of risks in your home can help you prevent falls. Many local agencies have education and/or home modification programs to help older people prevent falls. Check with your local health department, senior affairs office, or area agency on aging to see if there is a program near you

APPENDIX 5.43 MANAGING POSTURAL HYPOTENSION

Postural hypotension (or orthostatic hypotension) is when your blood pressure drops when you go from lying down to sitting up or from sitting to standing. When your blood pressure drops, less blood can go to your organs and muscles. This can make you likely to fall.

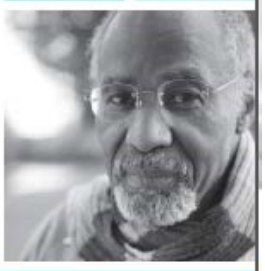
For information about fall prevention, go to: www.cdc.gov/injury

For more information about hypotension, go to:

www.mayoclinic.com

www.webmd.com

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



Postural Hypotension

What It Is and How to Manage It

What are the symptoms?

Although many people with postural hypotension have no symptoms, others do. These symptoms can differ from person to person and may include:

- Dizziness or lightheadedness
- Feeling about to faint, passing out or falling
- Headaches, blurry or tunnel vision
- Feeling vague or muddled
- Feeling pressure across the back of your shoulders or neck
- Feeling nauseous or hot and clammy
- Weakness or fatigue

When do symptoms tend to happen?

- When standing or sitting up suddenly
- In the morning when blood pressure is naturally lower
- After a large meal or alcohol
- During exercise
- When straining on the toilet
- When you are ill
- If you become anxious or panicky

What causes postural hypotension?

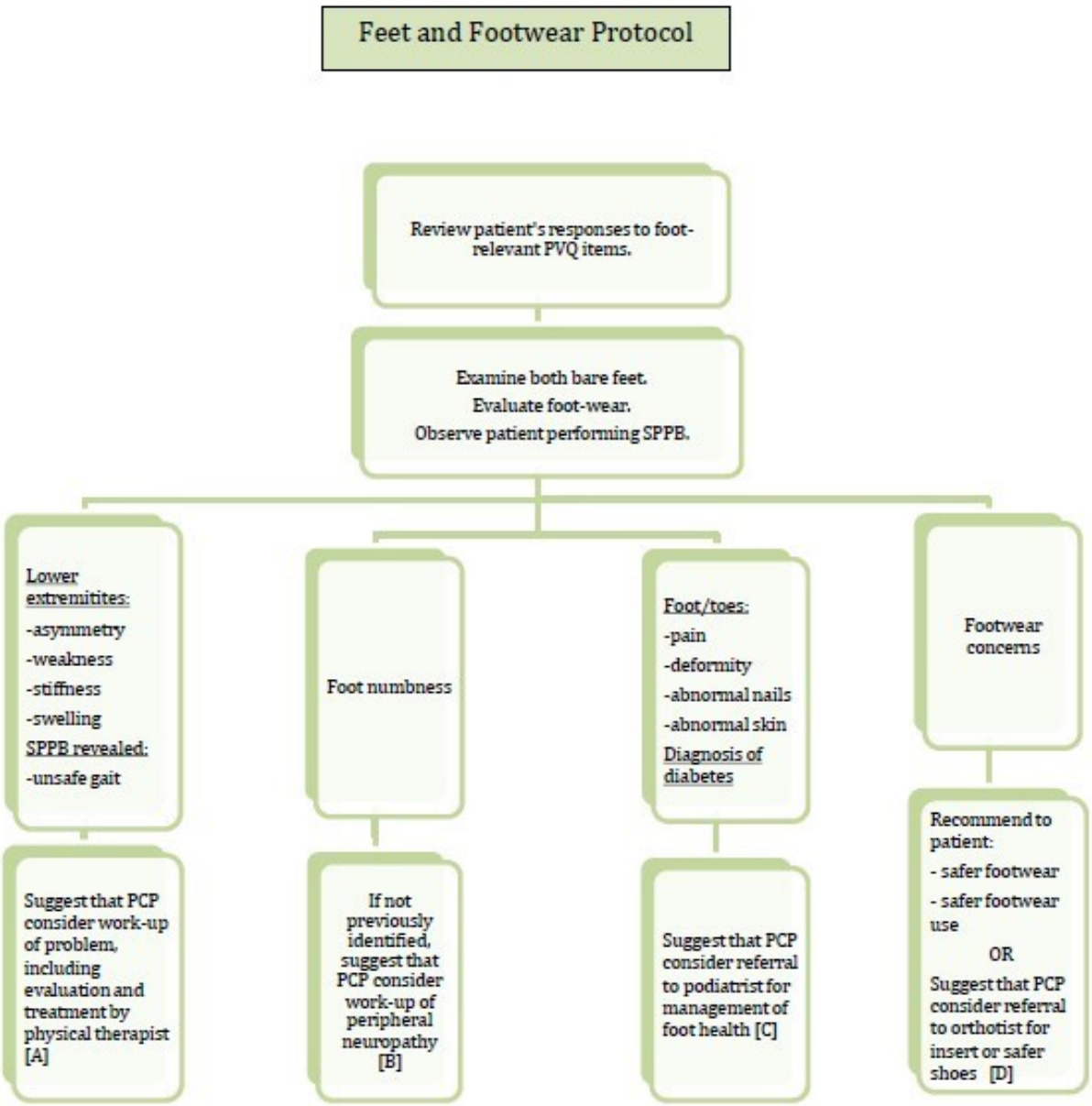
Postural hypotension may be caused by or linked to:

- High blood pressure
- Diabetes, heart failure, atherosclerosis or hardening of the arteries
- Taking some diuretics, antidepressants or medicines to lower blood pressure
- Neurological conditions like Parkinson's disease and some types of dementia
- Dehydration
- Vitamin B12 deficiency or anemia
- Alcoholism
- Prolonged bed rest

What can I do to manage my postural hypotension?

- Tell your healthcare provider about any symptoms.
- Ask if any of your medicines should be reduced or stopped.
- Get out of bed slowly. First sit up, then sit on the side of the bed, then stand up.
- Take your time when changing position, such as when getting up from a chair.
- Try to sit down when washing, showering, dressing or working in the kitchen.
- Exercise gently before getting up (move your feet up and down and clench and unclench your hands) or after standing (march in place).
- Make sure you have something to hold onto when you stand up.
- Do not walk if you feel dizzy.
- Drink 6-8 glasses of water or low-calorie drinks each day, unless you have been told to limit your fluid intake.
- Avoid taking very hot baths or showers.
- Try sleeping with extra pillows to raise your head.

APPENDIX 5.44 FEET AND FOOTWEAR PROTOCOL



Foot and Footwear Problems
Communication of FCM

Recommendations:

A. Suggest that the PCP consider evaluation of the problem, if not previously diagnosed, and consider a referral for physical therapy.

Background:

- PVQ – Tripped over something during a fall, leg weakness
- FCM SPPB gait evaluation – Asymmetry of leg use, foot drag

Assessment: The patient has ankle or foot problem that requires further evaluation and therapy.

B. Suggest that the PCP consider evaluation of peripheral neuropathy, if not previously diagnosed.

Background:

- PVQ – Foot numbness

Assessment: The patient has decreased sensation in feet, which could contribute to risk of falling.

C. Suggest that the PCP consider referral to a podiatrist for management of foot health.

Background:

- PVQ – Foot pain or deformity, Diabetes
- FCM exam – Foot pain to palpation, feet deformed, nail hygiene poor, foot skin breakdown

Assessment: The patient has foot ulcers, bunions, hammertoes, calluses, corns, nail abnormalities, skin and nail problems, diabetes may increase patient's risk for continuing foot problems and consequent falling.

D. Suggest that the PCP consider referral to orthotist for shoe inserts, customized foot wear, or an orthosis for better foot support.

Background:

- PVQ – Patient is wearing shoes with poor support for his/her feet

Assessment: The patient's shoes are likely to increase his/her risk of falling.

APPENDIX 5.45 FRIDS SYMPTOM LIST

Medication Class	Generic Name	Brand Name	Drowsy, Foggy, Too Sleepy	Unsteady	Dizziness (clarify if postural)	Cognitive Impairment	Confusion	Slowed Reaction Time	Parkinsonism	Postural Lightheadedness or Hypotension (ref 3)	Weight gain/DM	Insomnia	Urinary incontinence; go to the toilet frequently	Syncope	Weakness/ fatigue
Anxiolytics/hypnotics															
Benzodiazepines or BRA															
	Alprazolam	Xanax	Y	Y	Y	Y	Y	Y							
	Chlordiazepoxide	Librium	Y	Y	Y	Y	Y	Y							
	Clonazepam	Klonopin	Y	Y	Y	Y	Y	Y							
	Diazepam	Valium	Y	Y	Y	Y	Y	Y							
	Flurazepam	Dalmane	Y	Y	Y	Y	Y	Y							
	Lorazepam	Ativan	Y	Y	Y	Y	Y	Y							
	Oxazepam	Serax	Y	Y	Y	Y	Y	Y							
	Quazepam	Doral	Y	Y	Y	Y	Y	Y							
	Temazepam	Restoril	Y	Y	Y	Y	Y	Y							
	Triazolam	Halcion	Y	Y	Y	Y	Y	Y							
	Zolpidem	Ambien	Y	Y	Y	Y	Y	Y							
	eszopiclone	lunesta	Y	Y	Y	Y	Y	Y							
	Zaleplon	Sonata	Y	Y	Y	Y	Y	Y							
	Estazolam	ProSom	Y	Y	Y	Y	Y	Y							
	Chlordiazepoxide/ amitriptyline	Limbitrol	y	y	Y	Y	Y	Y							
	Chlordiazepoxide/ clidinium	Librax	y	y	Y	Y	Y	Y							
Antipsychotics*															
Typicals	Chlorpromazine	Thorazine	H	Y			H	Y	L	H	H				
	Prochlorperazine maleate	Compazine	H	Y			H	Y	L	H	H				
**Listed from low to high potency	Mesoridazine	Serentil		Y				Y							
	Thioridazine	Mellaril	H	Y			H	Y	L	H	L				
	Fluphenazine	Prolixin	L	Y			N	Y	H	N	L				
	Haloperidol	Haldol	M	Y			N	Y	H	N	L				
	Loxapine	Loxitane	M	Y			L	Y	M	L	M				
	Molindone	Moban		Y				Y							
	Perphenazine	Trilafon	M	Y			N	Y	M	N	L				
	Thiothixene	Navane	L	Y			N	Y	H	L	M				
	Trifluoperazine	Stelazine	L	Y			N	Y	H	L	M				
	Pimozide	Orap	L	Y			L	Y	H	L	L				
Atypicals	Aripiprazole	Abilify	L	Y			N	Y	L	N	N				
	Risperidone	Risperdal	L	Y			N	Y	H	M	M				
	Ziprasidone	Geodon	L	Y			N	Y	L	L	N				
	Olanzapine	Zyprexa	M	Y			M	Y	L	L	H				
	Quetiapine	Seroquel	M	Y			L	Y	N	M	M				
	Clozapine	Clozaril	H	Y			H	Y	N	H	H				

Medication Class	Generic Name	Brand Name	Drowsy, Foggy, Too Sleepy	Unsteady	Dizziness (clarify if postural)	Cognitive Impairment	Confusion	Slowed Reaction Time	Parkinsonism	Postural Lightheadedness or Hypotension (ref 3)	Weight gain/DM	Insomnia	Urinary incontinence; go to the toilet frequently	Syncope	Weakness/ fatigue
Antidepressants															
TCAs	Amitriptyline	Elavil	Y	Y	Y		Y	Y		Y					
	Amoxapine	Asendin	Y	Y	Y		Y	Y		Y					
	Clomipramine	Anafranil	Y	Y	Y		Y	Y		Y					
	Desipramine	Norpramin	Y	Y	Y		Y	Y		Y					
	Doxepin	Silenor	Y	Y	Y		Y	Y		Y					
	Imipramine	Tofranil	Y	Y	Y		Y	Y		Y					
	Maprotiline	Ludiomil	Y	Y	Y		Y	Y		Y					
	Nortriptyline	Pamelor	Y	Y	Y		Y	Y		Y					
	Protriptyline	Vivactil	Y	Y	Y		Y	Y		Y					
	Trimipramine	Surmontil	Y	Y	Y		Y	Y		Y					
SSRI/SNRI															
	Citalopram	Celexa			Y					Y	Y	Y			Y
	Escitalopram	Lexapro			Y					Y	Y	Y			Y
	Fluoxetine	Prozac			Y					Y	Y	Y			Y
	Fluvoxamine	Luvox CR			Y					Y	Y	Y			Y
	Paroxetine	Paxil			Y					Y	Y	Y			Y
	Sertraline	Zoloft			Y					Y	Y	Y			Y
Others	Duloxetine	Cymbalta			Y					Y	Y	Y			Y
	Venlafaxine	Effexor XR			Y					Y	Y	Y			Y
	Bupropion	Zyban			Y							Y			
	Nefazodone	Serzone			Y										
	Trazodone	Oleptro	Y	Y	Y		Y	Y		Y					
	Mirtazapine	Remeron	Y	Y	Y		Y	Y		Y		Y			
	Isocarboxazid	Marplan	Y	Y	Y		Y	Y		Y	Y				

Medication Class	Generic Name	Brand Name	Drowsy, Foggy, Too Sleepy	Unsteady	Dizziness (clarify if postural)	Cognitive Impairment	Confusion	Slowed Reaction Time	Parkinsonism	Postural Lightheadedness or Hypotension (ref 3)	Weight gain/DM	Insomnia	Urinary incontinence; go to the toilet frequently	Syncope	Weakness/ fatigue
Antihypertensives															
diuretics,			Y	Y			Y			Y			Y		Y
alpha blockers,										Y			Y	Y	
beta blockers,										Y				Y	Y
centrally acting antihypertensives	hardly used!!									Y					
calcium channel blockers,										Y					
ACE inhibitors										Y					
ARBs										Y					
Opioids															
	Codeine		Y	Y	Y	Y	Y	Y		Y					Y
	Codeine/APAP	Tylenol #3	Y	Y	Y	Y	Y	Y		Y					Y
	Fentanyl	Duragesic	Y	Y	Y	Y	Y	Y		Y					Y
	Hydrocodone/ Ibuprofen	Vicoprofen	Y	Y	Y	Y	Y	Y		Y					Y
	Hydrocodone/APA	Vicodin	Y	Y	Y	Y	Y	Y		Y					Y
	Hydromorphone	Dilaudid	Y	Y	Y	Y	Y	Y		Y					Y
	Levophanol	Levo-Drimoran	Y	Y	Y	Y	Y	Y		Y					Y
	Meperidine (DO NOT USE)	Demerol	Y	Y	Y	Y	Y	Y		Y					Y
	Methadone	Dolophine	Y	Y	Y	Y	Y	Y		Y					Y
	Morphine	MS Contin	Y	Y	Y	Y	Y	Y		Y					Y
	Oxycodone/APAP	Percocet	Y	Y	Y	Y	Y	Y		Y					Y
	Oxycodone/Aspirin	Percodan	Y	Y	Y	Y	Y	Y		Y					Y
	Oxycodone	OxyCONTIN	Y	Y	Y	Y	Y	Y		Y					Y
	Oxymorphone	Opana	Y	Y	Y	Y	Y	Y		Y					Y
First Generation Antihistamines															
	diphenhydramine	Benedryl	Y		Y		Y								Y
	Brompheniramine	J-TANPD	Y		Y		Y								Y
	Chlorpheniramine	Aller-Chlor	Y		Y		Y								Y
	Carbinoxamine	Arbinoxa	Y		Y		Y								Y
	Clemastine	Tavist	Y		Y		Y								Y
	Cyproheptadine	PMS-cyproheptadi	Y		Y		Y								Y
	Promethazine	Phenergen	Y		Y		Y								Y
	doxylamine	Unisom	y		y		Y								Y
	hydroxyzine	Atarax	y		y		Y								Y
	triprolidine	Tripohist	y		y		Y								Y
	Meclizine	Antivert	y		y		Y								Y
	Dimenhydrinate	Dramamine	y		y		Y								Y
Hypoglycemic agents															
	Glyburide	Micronase									Y			Y	Y
	chlorpropramide	Diabinase									Y			Y	Y
Skeletal Muscle Relaxants and Antispasmodics															
	Baclofen	Lioresal	Y	Y	Y		Y			Y					Y
	Carisoprodol	Soma	Y	Y	Y		Y			Y					Y
	Cyclobenzaprine	Flexeril	Y	Y	Y		Y			Y					Y
	Methocarbamol	Robaxin	Y	Y	Y		Y			Y					Y
	Metaxalone	Skelaxin	Y	Y	Y		Y			Y					Y
	Tizanidine	Zanaflex	Y	Y	Y		Y			Y					Y

Medication Class	Generic Name	Brand Name	Drowsy, Foggy, Too Sleepy	Unsteady	Dizziness (clarify if postural)	Cognitive Impairment	Confusion	Slowed Reaction Time	Parkinsonism	Postural Lightheadedness or Hypotension (ref 3)	Weight gain/DM	Insomnia	Urinary incontinence; go to the toilet frequently	Syncope	Weakness/ fatigue
Cholinesterase inhibitors (syncope)															
	Donepezil	Aricept													
	Galantimine	Razadyne												Y	
	Rivastigmine	Exelon												Y	
														Y	
Alcohol															
ref (3) Perlmuter LC et al Am J Ther 2013; 20:279 (from uptodate)															

APPENDIX 5.46 TEMPLATE FOR REFERRALS TO ORTHOTISTS

[Template for Referrals to Orthotists]

Patient: _____ Date of referral: ___/____/20__
Falls Care Manager:_____ Phone: _____ Email: _____
Primary Care Provider: _____ Phone: _____ Email: _____

Dear [Dr/Mr/Ms. last name]

[Mr/s. full name] is [a/n xxx] year-old patient of ours who is at **high risk for falling**. [S/he has fallen xx times in the last year and injured his/her xxxx].

Based on our recent comprehensive evaluation, [Mr/s. last name's] risk of falling is increased by [his/her] [specify footwear problem(s)]. [S/he] has expressed an interest in reducing this risk. **Please assess and manage his/her falls risks related to [his/her footwear problems].**

[His/her] risk of falling is also increased by [foot problems, vision problems, strength/balance problems, osteoporosis, inadequate vitamin D intake, postural hypotension, medication risk, home safety risks].
[S/he] has the following medical conditions: [XXXXX].
[S/he] takes the following medications: [XXXXX].
[S/he] also:

- Lives [alone, with her spouse/other, in assisted living facility]
- Uses [private car, taxi, public transit, ambulance] for transportation
- [Gets frequent help from xxx]
- [Uses a cane/walker/wheelchair for ambulation].

When you complete your assessment and initial treatment of [Mr/s. last name], please send me promptly a summary report that includes:

- Your assessment of [his/her] footwear problems
- The care you provided for these problems
- Recommendations you gave to [him/her] for self-care and follow-up visits
- Your recommendations to me for [his/her] follow-up care.

If you would like addition information, assistance, or an opportunity to speak with me about [Mr/s. last name's] condition or care, please contact by phone or email (above) the falls care manager who works with me.

Thank you for your assistance,

_____
[PCP name]

APPENDIX 5.47 TEMPLATE FOR REFERRALS TO PODIATRISTS

[Template for Referrals to Podiatrists]

Patient: _____ Date of referral: ___/____/20__
Falls Care Manager:_____ Phone: _____ Email: _____
Primary Care Provider: _____ Phone: _____ Email: _____

Dear Dr. [last name]

[Mr/s. full name] is [a/n xxx] year-old patient of ours who is at **high risk for falling**. [S/he has fallen xx times in the last year and injured his/her xxxx].

Based on our recent comprehensive evaluation, [Mr/s. last name's] risk of falling is increased by [his/her] [specify foot problem(s)]. [S/he] has expressed an interest in reducing this risk. **Please assess and manage his/her falls risks related to [his/her foot problems].**

[His/her] risk of falling is also increased by [footwear problems, vision problems, strength/balance problems, osteoporosis, inadequate vitamin D intake, postural hypotension, medication risk, home safety risks].
[S/he] has the following medical conditions: [XXXXX].
[S/he] takes the following medications: [XXXXX].
[S/he] also:

- Lives [alone, with her spouse/other, in assisted living facility]
- Uses [private car, taxi, public transit, ambulance] for transportation
- [Gets frequent help from xxx]
- [Uses a cane/walker/wheelchair for ambulation].

When you complete your assessment and initial treatment of [Mr/s. last name], please send me promptly a summary report that includes:

- Your assessment of [his/her] foot problems
- The care you provided for these problems
- Recommendations you gave to [him/her] for self-care and follow-up visits
- Your recommendations to me for [his/her] follow-up care.

If you would like addition information, assistance, or an opportunity to speak with me about [Mr/s. last name's] condition or care, please contact by phone or email (above) the falls care manager who works with me.

Thank you for your assistance,

_____
[PCP name]

APPENDIX 5.48 PROPER SHOES STRIDE

Proper Shoes can Prevent Falls and Preserve Independence

Inside and outdoors, the footwear that is least likely to cause falls is:

- Comfortable
- Firm-fitting
- Low and broad in the heel
- Not smooth on the bottom.

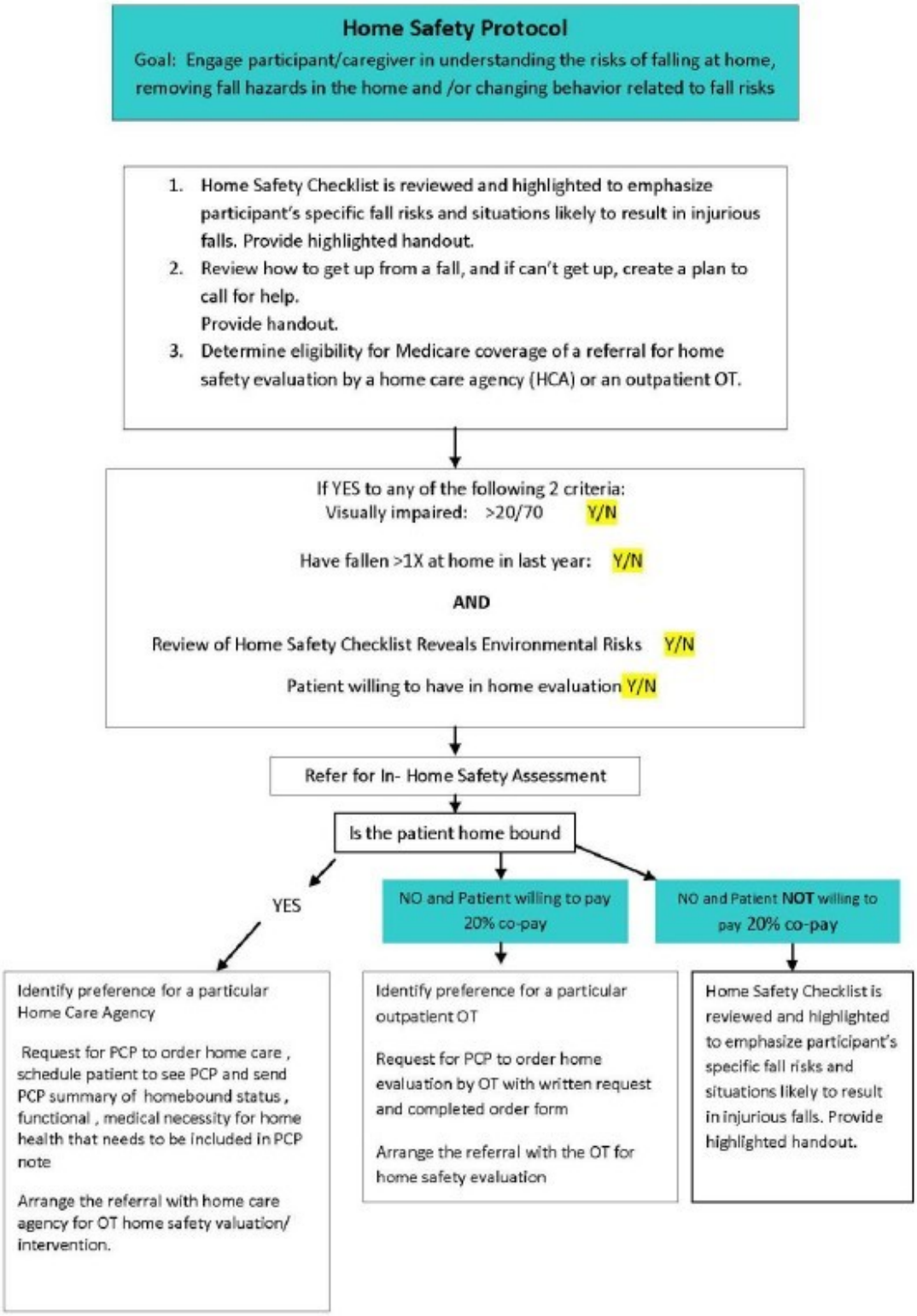
The footwear that is most likely to cause falls includes:

- Slippers
- Open or loose heels, as in flip-flops and "crocks"
- Walking barefoot or wearing only socks.

Your doctor or your podiatrist (foot doctor) can help:

- If you have painful or swollen feet
- If you feel tingling or "pins and needles" in your feet
- If you have changes in the shape of your feet, for example, bunions
- If you aren't sure where to buy shoes that can prevent falls and preserve your independence.

APPENDIX 5.49 HOME SAFETY PROCEDURE



APPENDIX 5.50 FALLS TRIGGERS AND PREDISPOSING FACTORS

Box 1: Fall triggers

Was the fall triggered by any of the following?	Probes
Tripping?	What did the patient trip on?
Slipping?	What did the patient slip on?
Dizziness when standing up?	Ask the patient to describe the dizzy sensation.
Blacking out or losing consciousness?	
Legs giving out?	Why?
Losing balance?	What was the patient doing? …Reaching? …Turning? …Leaning over? …Walking fast?

Box 2: Predisposing factors

What else was going on right before the fall?	Probes
Was the patient distracted? …in a hurry? …tired? …sleepy?	
Was the patient trying to do two things at once?	What were the two things?
Was the patient using her/his (cane, walker, wheelchair) when the fall happened?	Was the fall related to the (cane, walker, wheelchair)? How so?
Was the patient using glasses when the fall happened?	If glasses were in use: what type of glasses (Distance? Reading glasses? Bifocals?) Was fall related to the glasses? How so?

	If glasses were not in use: Was fall related to not wearing glasses? How so?
Did the patient just eat a full meal?	
Was the patient trying to do something physically demanding? …potentially unsafe?	What was the patient trying to do?
Where there any physical symptoms before the fall? …urge to urinate? …vision changes? …weakness in a specific part of the body? …heart racing?	Which part of the body?
What was the lighting like when the fall happened?	
Were there any obstacles where the patient fell? ….uneven surfaces?	
Was the patient barefoot, wearing socks, or wearing shoes when the fall happened?	What type of shoes was the patient wearing?

APPENDIX 5.51 HOME SAFETY RECOMMENDATIONS

Home Safety

Environmental hazards in the home can lead to falls and injuries. The following suggestions may increase your safety at home.

AREA	RECOMMENDATIONS
KITCHEN	
Slip/Trip Hazards	• Remove throw rugs, runners, cords, and small objects. • Use slip resistant mat at sink. • Do not wax floors or use only nonskid wax. • Tack down or tape carpet edges. • Identify high threshold with florescent tape or remove. • Repair torn flooring.
Lighting (dim, shadows, glare)	• Adjust curtains/blinds. • Change light bulbs. • Use night light.
Reaching/Bending	• Store commonly used items on lower shelf or on countertops. • Store pots/pans on back burner or on hooks.
Step Stool (hazardous design, unsteady)	• Avoid using step stool. • Purchase new step stool with handrail, wide step.
Chair (hazardous design, height, not sturdy)	• Remove wheels. • Repair.
Table (moveable, not sturdy)	• Anchor against wall. • Avoid table as support. • Repair.

AREA	RECOMMENDATIONS
HALLWAYS/PASSAGEWAYS	
Slip/Trip	• Remove throw rugs, runners, cords, and small objects. • Use nonskid mesh carpet backing. • Tack down or tape carpet edges. • Do not wax floors or use only nonskid wax. • Clear pathways of furniture. • Identify high threshold with florescent tape or remove.
Lighting (dim, shadows, glare)	• Add lamps. • Use night lights. • Change bulbs. • Adjust curtains, blinds.
LIVING ROOM	
Slip/Trip	• Clear pathways of furniture. • Remove throw rugs, runners, cords, and small objects. • Tack down or tape carpet edges. • Use nonskid mesh carpet backing. • Do not wax floors or use only nonskid wax. • Mark high threshold with florescent tape or remove.
Lighting (dim, shadows, glare)	• Add lamps. • Adjust curtains, blinds. • Change bulbs. • Use night lights.
Chair/Sofa (too low, soft, armless, sit-stand-sit difficult)	• Use alternative firm chair/sofa with arms. • Add firm cushions or folded blankets to raise seat.

AREA	RECOMMENDATIONS
BEDROOM	
Slip/Trip	• Remove throw rugs, runners, cords, and small objects. • Tack down or tape carpet edges. • Use nonskid mesh carpet backing. • Do not wax floors or use only nonskid wax. • Mark high threshold with florescent tape or remove. • Clear pathways of furniture.
Lighting (dim, shadows, glare)	• Add lamps. • Adjust curtains, blinds. • Change bulbs. • Use night lights.
Bed (high, low, soft, not positioned to best advantage)	• Adjust bed frame to best height for transfers. • Add bed board to increase firmness • Reposition bed for easy access.
Bending/Reaching	• Place commonly used clothing on shelves or in bureau drawers at waist or shoulder height.

AREA	RECOMMENDATIONS
BATHROOM	
Slip/Trip	• Remove throw rugs. • Use bath mat with nonskid backing after bath. • Keep bath mat off floor when not in use. • Clear pathways. • Mark high threshold with florescent tape or remove. • Remove molding or reverse swing of door to increase width for easy access.
Bathtub/Shower	• Use nonskid rubber mat in shower or tub. • Install grab bars. • Replace worn rubber tips of tub chair/benches. • Install grab bars, commode frame. • Install raised seat on toilet. • Repair wobbly toilet seat.
Lighting (dim, shadows, glare)	• Change bulbs. • Use night lights. • Adjust curtains, blinds.
Door Locks (present)	• Remove locks. • NEVER lock door.
STAIRS	
Slip/Trip	• Mark top and bottom steps with florescent tape. • Mark steps that are higher or lower than others. • Repair loose treads or carpeting. • Use rough texture pain or abrasive strips on outdoor steps. • Clear all objects from stairs.
Lighting (dim, shadow, glare)	• Install switches at top and bottom of stairs. • Keep flashlight at top and bottom of stairs. • Change bulbs. • Use night lights. • Adjust curtains, blinds.
Railings) presence, length, sturdiness)	• Install railings on both sides, extending full length of stairs. • Repair existing railings.

AREA	RECOMMENDATIONS
UTILITIES	
Smoke Detectors	• Install. • Replace batteries.
Telephones (accessibility)	• Install phone in at least kitchen and bedroom. • Replace wall phones with table design. • Put list of important phone numbers near phone in large print. • Keep phone cords out of walking areas. • Use a portable phone.
Climate Control (in living areas)	• Keep winter temperature around 72 degrees F. • Keep fan or air conditioner available for summer. • Open windows for ventilation.

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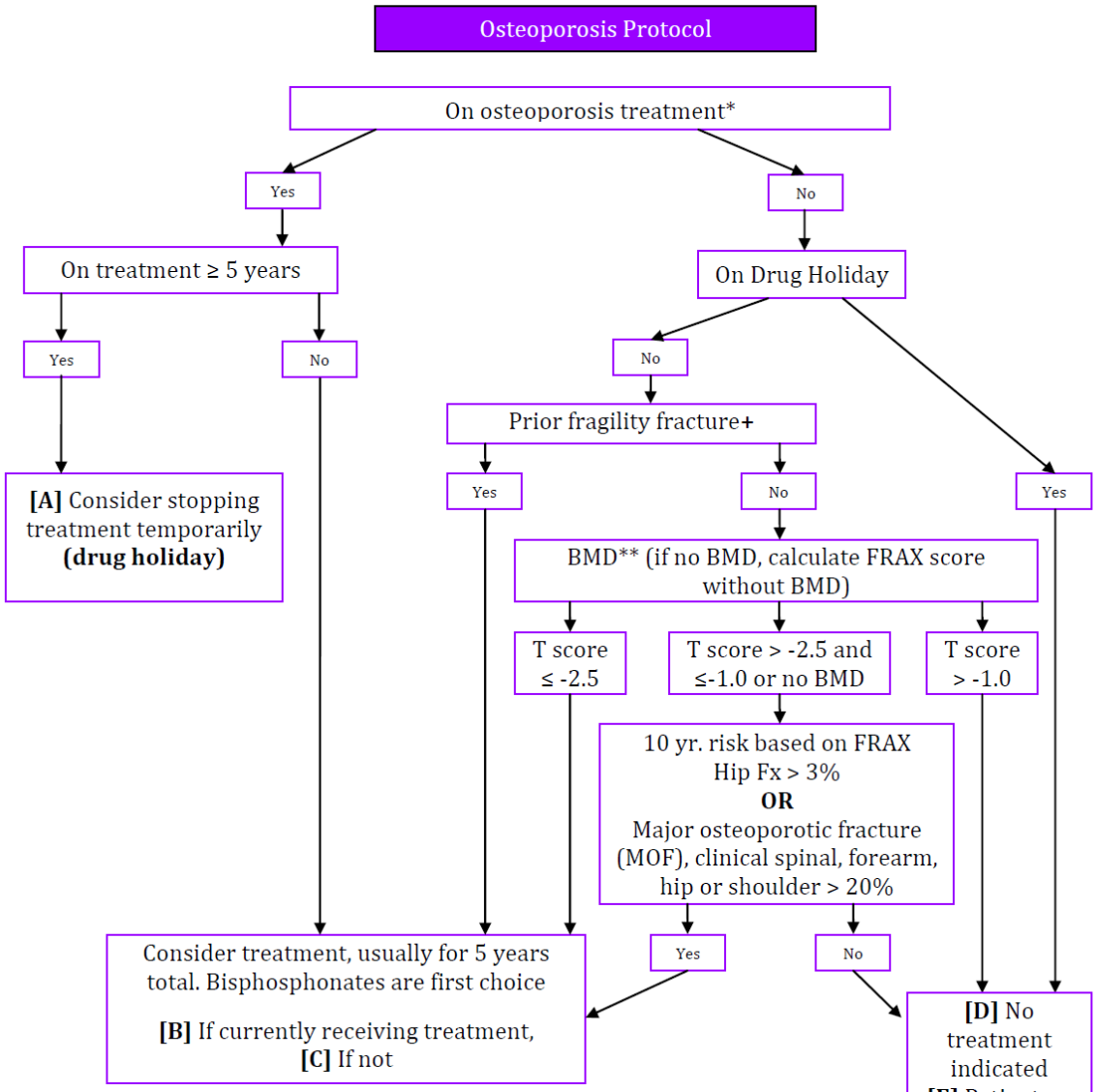
Climate Control (in living areas)	• Keep winter temperature around 72 degrees F. • Keep fan or air conditioner available for summer. • Open windows for ventilation.

APPENDIX 5.52 OSTEOPOROSIS PROCEDURE



*All get vitamin D 800-1000 IU and calcium carbonate 1,200 mg/day. Calcium citrate if receiving PPI or achlorhydria.

+Fragility fractures are those occurring from a fall from a standing height or less, without major trauma such as a motor vehicle accident. Common locations of fragility fractures include: particularly at the spine, hip, wrist, humerus, rib, and pelvis. Certain skeletal locations, including the skull, cervical spine, hands, feet, and ankles are not associated with fragility fractures.

**Score at hip or spine.

Osteoporosis Protocol Updated 3/30/17

FCM's Communication of Initial Recommendations to the Patient's PCP

Osteoporosis:

A. Consider stopping treatment temporarily (drug holiday). The patient should continue to receive vitamin D 800 -1000 IU and calcium carbonate 1,200 mg per day (calcium citrate if receiving PPI or achlorhydria) unless otherwise contraindicated.
Background: The patient has received at least five years of treatment with a bisphosphonate. Prolonged treatment has been associated with atypical femoral fractures.

Assessment: We recommend considering stopping treatment temporarily (drug holiday). How long to wait before restarting drug therapy is unclear.

B. Continue bisphosphonate treatment for five years and then reconsidering. The patient should continue to receive vitamin D 800 - 1000 IU and calcium carbonate 1,200 mg per day (calcium citrate if receiving PPI or achlorhydria) unless otherwise contraindicated.
Background: Currently guidelines recommend treating for five years and then considering stopping treatment temporarily (drug holiday).

Assessment: The patient is currently receiving osteoporosis treatment for less than five years.

C. Consider further evaluation and treatment for osteoporosis. Bisphosphonates (all have generic versions) and denosumab reduce the risk of hip, non-vertebral, and vertebral fractures; bisphosphonates are commonly used as first line treatment for those who do not have contraindications. You may also wish to consult with an osteoporosis expert.
Background: National Osteoporosis Foundation guidelines recommend treatment if bone mineral density < -2.5 SD or if osteopenia (T score between -1.0 and -2.5) and a 10-year fracture risk hip fracture >3% or major osteoporotic fracture > 20%.

Assessment: The patient's lowest T score is ___, 10 year fracture risk is __%, and risk of major osteoporotic fracture is__%.

D. I have provided the patient with education about the role of calcium in falls prevention and health.
Background: The patient is already receiving calcium and vitamin D OR prefers not to take the recommended vitamin D 800-1000 IU and calcium carbonate 1,200 mg per day (calcium citrate if receiving PPI or achlorhydria) daily because: [reason].

Assessment: Suboptimal calcium and vitamin D status increases the patient's risk of fall-related injuries.

E. Patient is on Drug Holiday – No further actions at this time

Osteoporosis Protocol Updated 3/30/17

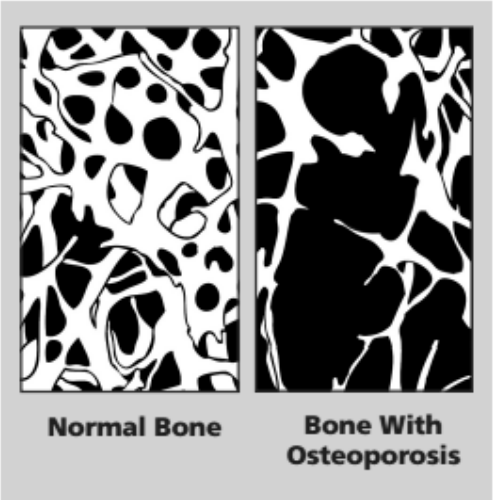
APPENDIX 5.53 OSTEOPOROSIS AGE PAGE

Osteoporosis

Adapted from NIA's "Osteoporosis: The Bone Thief"

Osteoporosis is a disease that weakens bones to the point where they break easily—most often bones in the hip, backbone (spine), and wrist.
Osteoporosis is called the "silent disease"—because you may not notice any changes until a bone breaks. All the while, though, your bones have been losing strength for many years.

Bone is living tissue. To keep bones strong, your body breaks down old bone and replaces it with new bone tissue. As people enter their 40s and 50s, more bone may be broken down than is replaced. A close look at the inside of bone shows something like a honeycomb. When you have osteoporosis, the spaces in this honeycomb grow larger. And the bone that forms the honeycomb gets smaller. The outer shell of your bones also gets thinner. All of this makes your bones weaker.



Who Has Osteoporosis?

Ten million Americans have osteoporosis. They are mostly women, but men also have this disease. In general, the risk of osteoporosis grows as you get older. You may be at greater risk for osteoporosis if you:

- Have a family history of broken bones or osteoporosis
- Have broken a bone as an adult
- Do not get enough calcium or vitamin D
- Get too little exercise

- Had extended bed rest
- Used certain medicines for a long time
- Have a small body frame

Osteoporosis in Women

At the time of menopause, women may lose bone quickly for several years. After that, the loss slows down but continues. Other women at great risk include those who are of European or Asian ancestry, had surgery to remove their ovaries before their periods stopped, or had early menopause.

Osteoporosis in Men

In men, the loss of bone mass is slower. But, by age 65 or 70, men and women are losing bone at the same rate. Experts don't know as much about this disease in men as they do in women. However, many of the things that put men at risk are the same as those for women. Men with low testosterone levels are also at higher risk.

Older men who break a bone easily or are at risk for osteoporosis should talk with their doctors about testing and treatment.

What is Osteopenia?

Around 34 million Americans have osteopenia. Whether your doctor calls it osteopenia or just says you have low bone mass, consider it a warning. Bone loss has started, but you can still take action to keep your bones strong and maybe prevent osteoporosis later in life. That way you will be less likely to break a wrist, hip, or vertebrae (bone in your spine) when you are older.

Can My Bones Be Tested?

For some people the first sign of osteoporosis is to realize they are getting shorter or to break a bone easily. If you are a woman age 65 or older and are not already known to have osteoporosis, a bone density test called a DXA test (dual-energy x-ray absorptiometry) is recommended to assess your risk of fractures. If you are a man, your doctor may recommend a DXA based on your specific health conditions. The DXA test gives you important information to help you understand your risk for a fracture or broken bone. It could show that you have normal bone density. Or, it could show that you have low bone mass or even osteoporosis.

How Can I Keep My Bones Strong?

There are things you should do at any age to prevent weakened bones. Eating foods that are rich in calcium and vitamin D is important. So is including regular weight-bearing exercise in your lifestyle. Those are the best ways to keep your bones strong and healthy.

Calcium. Getting enough calcium all through your life helps to build and keep strong bones. Women over age 50 need 1,200 milligrams (mg) of calcium every day. Men over age 70 need 1,200 mg. Foods that are high in calcium are the best source. For example, eat low-fat dairy foods, canned fish with soft bones such as salmon, and some dark-green leafy vegetables. Check the labels on foods like orange juice, breads, and cereals to find those with calcium added. If you think you aren't getting enough calcium in your diet, check with your doctor first. He or she may tell you to try a calcium supplement. Calcium carbonate and calcium citrate are two common forms. Too much calcium can cause problems for some people so be careful. On most days, you should not get more than 2,000 mg of total calcium. That includes calcium from all sources—foods, drinks, and supplements.

Vitamin D. Your body uses vitamin D to absorb calcium. Most people's bodies are able to make enough vitamin D if they are out in the sun without sunscreen for 10 to 15 minutes at least twice a week. You can also get vitamin D from eggs, fatty fish, and cereal and milk fortified with vitamin
D. If you think you are not getting enough vitamin D, check with your doctor. Each day you should have 800 International Units (IU) if you are over age 70. As with calcium, be careful. More than 4,000 IU of vitamin D each day may cause side effects.

Exercise. Your bones and muscles will be stronger if you are physically active. Weight-bearing exercises, done three to four times a week, are best for preventing osteoporosis. Walking, jogging, playing tennis, and dancing are examples of weight-bearing exercises. Try some strengthening and balance exercises too. They may help you avoid falls, which could cause a broken bone.

Medicines. Some common medicines can make bones weaker. These include a type of steroid drug called glucocorticoids used for arthritis and asthma, some antiseizure drugs, certain sleeping pills, and some cancer drugs. An overactive thyroid gland or using too much thyroid hormone for an underactive thyroid can also be a problem. If you are taking these

medicines, talk to your doctor about what you can do to help protect your bones.

Lifestyle. People who smoke have an increased chance of breaking a bone. For this

and many other health reasons, stop smoking. Limit how much alcohol you drink. Too much alcohol can put you at risk for falling and breaking a bone.

What Can I Do For My Osteoporosis?

Treating osteoporosis means stopping the bone loss and rebuilding bone to prevent breaks. Diet and exercise can help make your bones stronger. But, they may not be enough if you have lost a lot of bone density. There are also several medicines to think about. Some will slow your bone loss, and others can help rebuild bone. Talk with your doctor to see if one of these might work for you:

Bisphosphonates. These medicines stop the breakdown of bone and increase bone density. They can make it less likely that you will break a bone, most of all in your spine, hip, or wrist. Side effects may include nausea, heartburn, and stomach pain. A few people have muscle, bone, or joint pain while using these medicines. These pills must be taken in a certain way—when you first get up, before you have eaten, and with a full glass of water. You should not lie down, eat, or drink for at least one-half hour after taking the drug. Even if you follow the directions closely, these drugs can cause serious digestive problems, so be aware of any side effects. These pills are available in once-daily, once-a week, and once-a-month versions. Some bisphosphonates are given by injection once every 3 months or once a year.

Parathyroid Hormone (PTH). Also called teriparatide, this shot is given daily for up to 2 years to postmenopausal women and to men who are at high risk for broken bones. It improves bone density in the spine and hip. Common side effects include nausea, dizziness, and leg cramps.

Denosumab. A shot given twice a year, this treatment is for postmenopausal women and men who are at high risk for broken bones. It lessens the risk of fractures in the spine, wrist, and hip. Common side effects include pain in the back, arms, legs, and muscles; high cholesterol; and bladder infections.

Raloxifene. This drug is used to prevent and treat osteoporosis in women. It is a SERM (selective estrogen receptor modulator). It prevents bone loss and spine fractures but may cause hot flashes or increase the risk of blood clots in some women.

Estrogen. Doctors sometimes prescribe this female hormone to women around the time of menopause to treat symptoms like hot flashes or vaginal dryness. Because estrogen also slows bone loss and increases bone mass in your spine and hip, it can be used to prevent osteoporosis. But, estrogen use is thought to be risky for some women. Talk to your doctor. Ask about the benefits, risks, and side effects, as well as other possible

treatments for you.

Can I Avoid Falling?

When your bones are weak, a simple fall can cause a broken bone. This can mean a trip to the hospital and maybe surgery. It might also mean being laid up for a long time, especially in the case of a hip fracture. So, it is important to prevent falls. Some things you can do:

- Make sure you can see and hear well. Use your glasses or a hearing aid if needed.
- Ask your doctor if any of the drugs you are taking can make you dizzy or unsteady on your feet.
- Use a cane or walker if your walking is unsteady.
- Wear rubber-soled and low-heeled shoes.
- Make sure all the rugs and carpeting in your house are firmly attached to the floor, or don't use them.
- Keep your rooms well lit and the floor free of clutter.
- Use nightlights.

You can find more suggestions in the National Institute on Aging's Falls and Fractures Age Page, available from the National Institute on Aging Information Center listed in For More Information.

Here are some helpful resources:

Food and Drug Administration 1-888-463-6332 (toll-free) www.fda.gov

National Osteoporosis Foundation 1-800-231-4222 (toll-free) www.nof.org

National Institutes of Health Osteoporosis and Related Bone Diseases— National Resource Center
1-800-624-2663 (toll-free) 1-202-466-4315 (TTY) www.bones.nih.gov

National Library of Medicine MedlinePlus
www.medlineplus.gov
For more information on health and aging, contact:

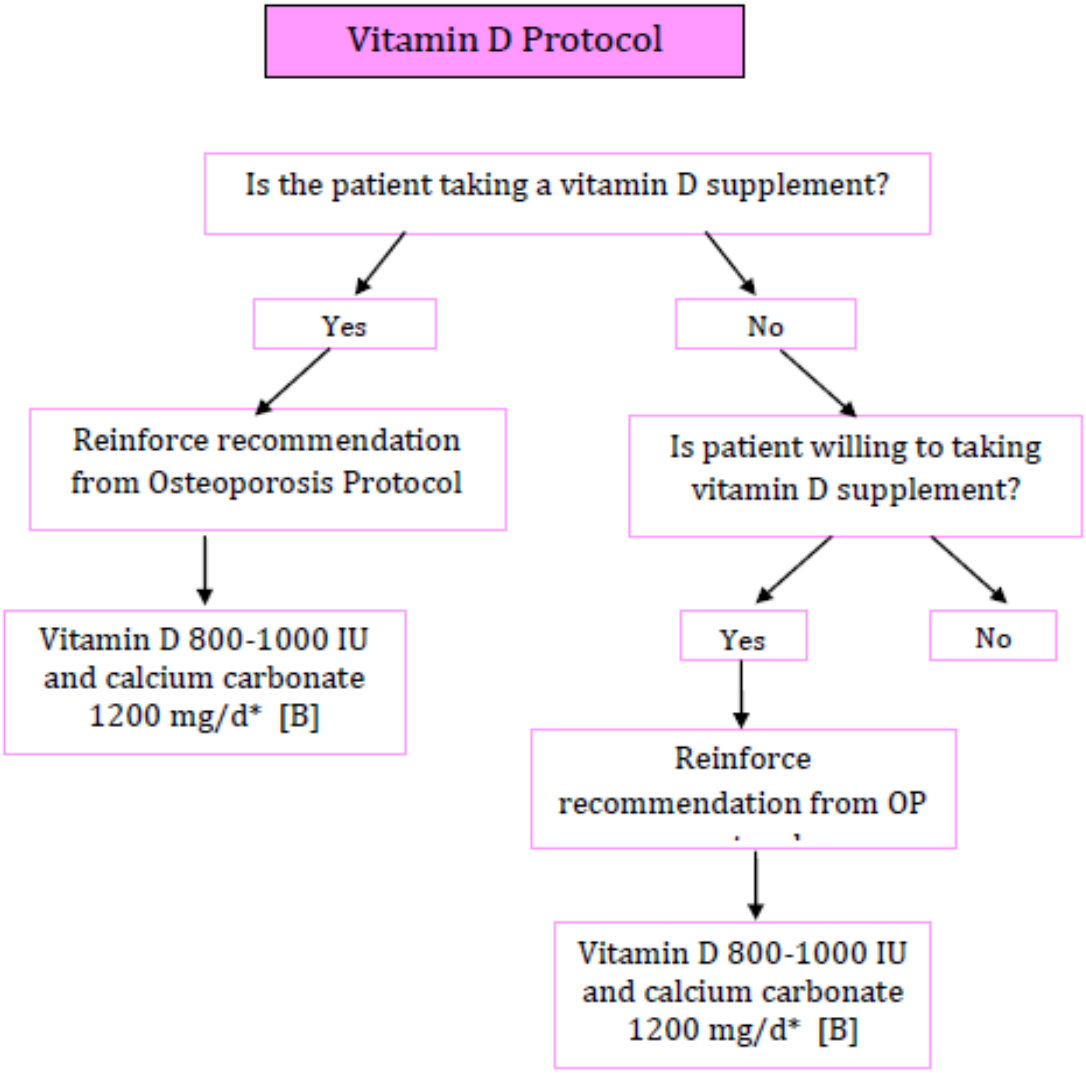
National Institute on Aging Information Center 1-800-222-2225 (toll-free)
1-800-222-4225 (TTY/toll-free)
www.nia.nih.gov www.nia.nih.gov/espanol

To sign up for regular email alerts about new publications and other information from the NIA, go to www.nia.nih.gov/health.

Visit www.nihseniorhealth.gov, a senior friendly website from the National Institute on Aging and the National Library of Medicine. This website has health and wellness information for older adults. Special features make it simple to use. For example, you can click on a button to make the type larger.

For tips on exercise and physical activity, visit Go4Life® at www.nia.nih.gov/Go4Life.

APPENDIX 5.54 VITAMIN D PROCEDURE



*Calcium citrate if receiving PPI or achlorhydria.

Vitamin D Algorithm and Communication Template

FCM's Communication to PCP Regarding Initial Recommendations for Vitamin

Recommendations:

A. No recommendation
I have provided the patient with education about the role of vitamin D in falls prevention and health.
Background: The patient prefers not to take the recommended D_3 800 – 1,000 IU Q Day because: [reason].

Assessment: Suboptimal vitamin D status would increase the patient's risk of falls and injuries.

B. Please prescribe vitamin D_3 800 – 1,000 IU Q Day.
I have provided the patient with education about the role of vitamin D in falls prevention and health. The patient is interested and willing to add this supplement to their regimen. I will assess patient's tolerance and adherence to this prescription.

APPENDIX 5.55 VITAMIN D FACT SHEET

National Institutes of Health
Office of Dietary Supplements

Vitamin D Fact Sheet for Consumers

Very few foods naturally have vitamin D. Fatty fish such as salmon, tuna, and mackerel are among the best sources. Fortified foods like milk provide most of the vitamin D in American diets.

What is vitamin D and what does it do?

Vitamin D is a nutrient found in some foods that is needed for health and to maintain strong bones. It does so by helping the body absorb calcium (one of bone's main building blocks) from food and supplements. People who get too little vitamin D may develop soft, thin, and brittle bones, a condition known as rickets in children and osteomalacia in adults.

Vitamin D is important to the body in many other ways as well. Muscles need it to move, for example, nerves need it to carry messages between the brain and every body part, and the immune system needs vitamin D to fight off invading bacteria and viruses. Together with calcium, vitamin D also helps protect older adults from osteoporosis. Vitamin D is found in cells throughout the body.

How much vitamin D do I need?

The amount of vitamin D you need each day depends on your age. Average daily recommended amounts from the Food and Nutrition Board (a national group of experts) for different ages are listed below in International Units (IU):

Life Stage	Recommended Amount
Birth to 12 months	400 IU
Children 1–13 years	600 IU
Teens 14–18 years	600 IU
Adults 19–70 years	600 IU
Adults 71 years and older	800 IU
Pregnant and breastfeeding women and teens	600 IU

What foods provide vitamin D?

Very few foods naturally have vitamin D. Fortified foods provide most of the vitamin D in American diets.

- Fatty fish such as salmon, tuna, and mackerel are among the best sources.
- Beef liver, cheese, and egg yolks provide small amounts.
- Mushrooms provide some vitamin D. In some mushrooms that are newly available in stores, the vitamin D content is being boosted by exposing these mushrooms to ultraviolet light.
- Almost all of the U.S. milk supply is fortified with 400 IU of vitamin D per quart. But foods made from milk, like cheese and ice cream, are usually not fortified.
- Vitamin D is added to many breakfast cereals and to some brands of orange juice, yogurt, margarine, and soy beverages; check the labels.

Can I get vitamin D from the sun?

The body makes vitamin D when skin is directly exposed to the sun, and most people meet at least some of their vitamin D needs this way. Skin exposed to sunshine indoors through a window will not produce vitamin D. Cloudy days, shade, and having dark-colored skin also cut down on the amount of vitamin D the skin makes.

However, despite the importance of the sun to vitamin D synthesis, it is prudent to limit exposure of skin to sunlight in order to lower the risk for skin cancer. When out in the sun for more than a few minutes, wear protective clothing and apply sunscreen with an SPF (sun protection factor) of 8 or more. Tanning beds also cause the skin to make vitamin D, but pose similar risks for skin cancer.

People who avoid the sun or who cover their bodies with sunscreen or clothing should include good sources of vitamin D in their diets or take a supplement. Recommended intakes of vitamin D are set on the assumption of little sun exposure.

What kinds of vitamin D dietary supplements are available?

Vitamin D is found in supplements (and fortified foods) in two different forms: D_2 (ergocalciferol) and D_3 (cholecalciferol). Both increase vitamin D in the blood.

Am I getting enough vitamin D?

Because vitamin D can come from sun, food, and supplements, the best measure of one's vitamin D status is blood levels of a form known as 25-hydroxyvitamin D. Levels are described in either nanomoles per liter (nmol/L) or nanograms per milliliter (ng/mL), where 1 nmol/L = 0.4 ng/mL.

In general, levels below 30 nmol/L (12 ng/mL) are too low for bone or overall health, and levels above 125 nmol/L (50 ng/mL) are probably too high. Levels of 50 nmol/L or above (20 ng/mL or above) are sufficient for most people.

By these measures, some Americans are vitamin D deficient and almost no one has levels that are too high. In general, young people have higher blood levels of 25-hydroxyvitamin D than older people and males have higher levels than females. By race, non-Hispanic blacks tend to have the lowest levels and non-Hispanic whites the highest. The majority of Americans have blood levels lower than 75 nmol/L (30 ng/mL).

Certain other groups may not get enough vitamin D:

- Breastfed infants, since human milk is a poor source of the nutrient. Breastfed infants should be given a supplement of 400 IU of vitamin D each day.
- Older adults, since their skin doesn't make vitamin D when exposed to sunlight as efficiently as when they were young, and their kidneys are less able to convert vitamin D to its active form.
- People with dark skin, because their skin has less ability to produce vitamin D from the sun.
- People with disorders such as Crohn's disease or celiac disease who don't handle fat properly, because vitamin D needs fat to be absorbed.
- Obese people, because their body fat binds to some vitamin D and prevents it from getting into the blood.

What happens if I don't get enough vitamin D?

People can become deficient in vitamin D because they don't consume enough or absorb enough from food, their exposure to sunlight is limited, or their kidneys cannot convert vitamin D to its active form in the body. In children, vitamin D deficiency causes rickets, where the bones become soft and bend. It's a rare disease but still occurs, especially among African American infants and children. In adults, vitamin D deficiency leads to osteomalacia, causing bone pain and muscle weakness.

What are some effects of vitamin D on health?

Vitamin D is being studied for its possible connections to several diseases and medical problems, including diabetes, hypertension, and autoimmune conditions such as multiple sclerosis. Two of them discussed below are bone disorders and some types of cancer.

Bone disorders

As they get older, millions of people (mostly women, but men too) develop, or are at risk of, osteoporosis, where bones become fragile and may fracture if one falls. It is one consequence of not getting enough calcium and vitamin D over the long term. Supplements of both vitamin D_3 (at 700-800 IU/day) and calcium (500-1,200 mg/day) have been shown to reduce the risk of bone loss and fractures in elderly people aged 62-85 years. Men and women should talk with their health care providers about their needs for vitamin D (and calcium) as part of an overall plan to prevent or treat osteoporosis.

Cancer

Some studies suggest that vitamin D may protect against colon cancer and perhaps even cancers of the prostate and breast. But higher levels of vitamin D in the blood have also been linked to higher rates of pancreatic cancer. At this time, it's too early to say whether low vitamin D status increases cancer risk and whether higher levels protect or even increase risk in some people.

Can vitamin D be harmful?

Yes, when amounts in the blood become too high. Signs of toxicity include nausea, vomiting, poor appetite, constipation, weakness, and weight loss. And by raising blood levels of calcium,

too much vitamin D can cause confusion, disorientation, and problems with heart rhythm. Excess vitamin D can also damage the kidneys.

The upper limit for vitamin D is 1,000 to 1,500 IU/day for infants, 2,500 to 3,000 IU/day for children 1-8 years, and 4,000 IU/day for children 9 years and older, adults, and pregnant and breastfeeding teens and women. Vitamin D toxicity almost always occurs from overuse of supplements. Excessive sun exposure doesn't cause vitamin D poisoning because the body limits the amount of this vitamin it produces.

Are there any interactions with vitamin D that I should know about?

Like most dietary supplements, vitamin D may interact or interfere with other medicines or supplements you might be taking. Here are several examples:

- Prednisone and other corticosteroid medicines to reduce inflammation impair how the body handles vitamin D, which leads to lower calcium absorption and loss of bone over time.
- Both the weight-loss drug orlistat (brand names Xenical® and Alli®) and the cholesterol-lowering drug cholestyramine (brand names Questran®, LoCholest®, and Prevalite®) can reduce the absorption of vitamin D and other fat-soluble vitamins (A, E, and K).
- Both phenobarbital and phenytoin (brand name Dilantin®), used to prevent and control epileptic seizures, increase the breakdown of vitamin D and reduce calcium absorption.

Tell your doctor, pharmacist, and other health care providers about any dietary supplements and medicines you take. They can tell you if those dietary supplements might interact or interfere with your prescription or over-the-counter medicines, or if the medicines might interfere with how your body absorbs, uses, or breaks down nutrients.

Vitamin D and healthful eating

People should get most of their nutrients from food, advises the federal government's *Dietary Guidelines for Americans.* Foods contain vitamins, minerals, dietary fiber and other substances that benefit health. Dietary supplements might help in some situations to increase the intake of a specific vitamin or mineral. For more information on building a healthy diet, refer to the *Dietary Guidelines for Americans* and the U.S. Department of Agriculture's food guidance system, ChooseMyPlate.

Where can I find out more about vitamin D?

For general information on vitamin D:

- Office of Dietary Supplements Health Professional Fact Sheet on Vitamin D
- Vitamin D, MedlinePlus®

For more information on food sources of vitamin D:

- U.S. Department of Agriculture's (USDA's) National Nutrient Database
- Nutrient list for vitamin D (listed by food or vitamin D content), USDA

For more advice on buying dietary supplements:

- Office of Dietary Supplements Frequently Asked Questions: Which brand(s) of dietary supplements should I purchase?

For information on the government's food guidance system:

- ChooseMyPlate
- Dietary Guidelines for Americans

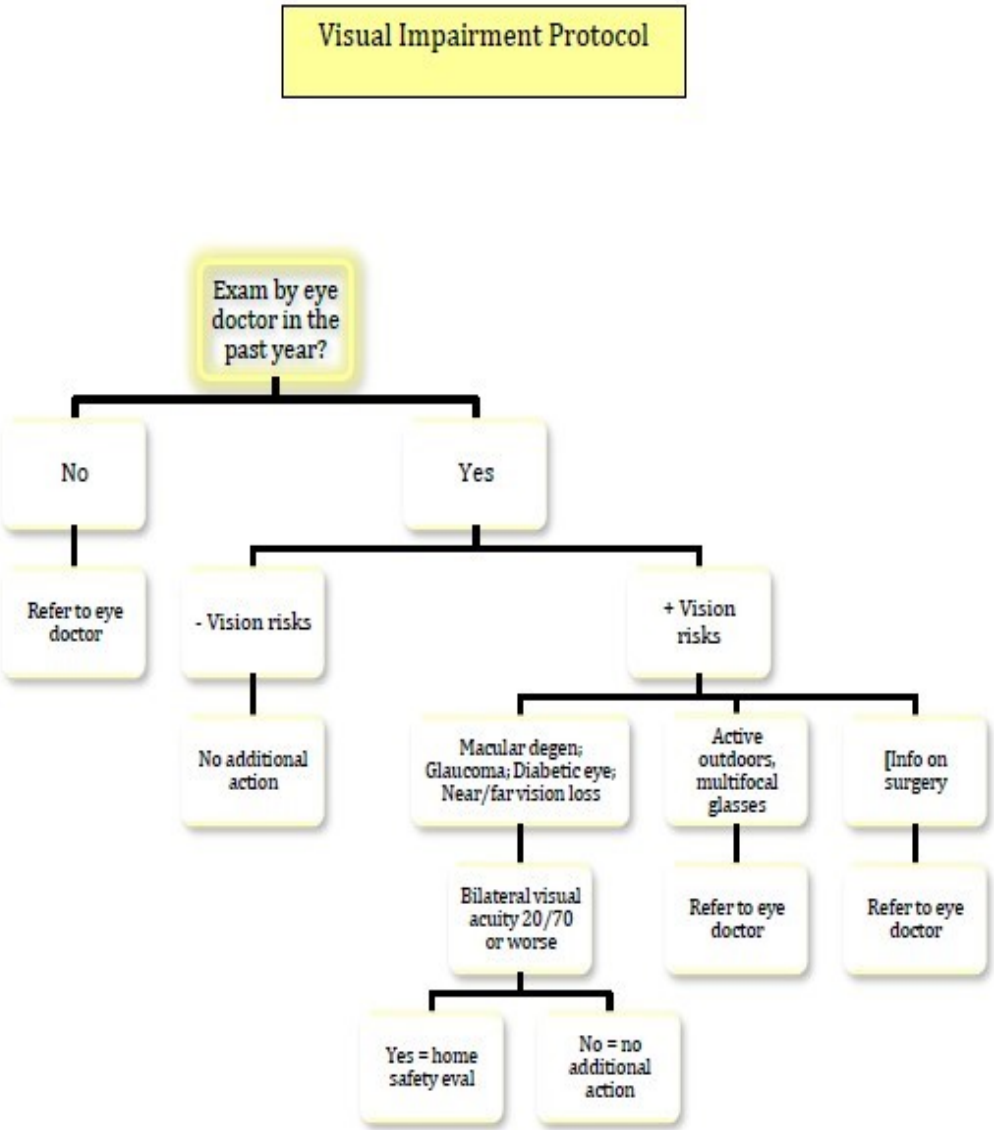
Disclaimer

This fact sheet by the Office of Dietary Supplements provides information that should not take the place of medical advice. We encourage you to talk to your health care providers (doctor, registered dietitian, pharmacist, etc.) about your interest in, questions about, or use of dietary supplements and what may be best for your overall health. Any mention in this publication of a specific brand name is not an endorsement of the product.

For more information on this and other supplements, please visit our Web site at: http://ods.od.nih.gov or e-mail us at: ods@nih.gov

Reviewed: June 24, 2011

APPENDIX 5.56 VISUAL IMPAIRMENT PROCEDURE



*If available, use visual acuity results recorded within the past year (rather than doing a Snellen) to determine need for a safety evaluation by HHC.

**Acuity thresholds must be met in both eyes for Medicare to cover evaluation by HHC.

Visual Impairment
Communication of Initial Recommendations to the Patient's PCP

Recommendations:

A. Please consider referral to annual eye doctor for evaluation.

Background: The patient has fallen or is at risk of falling and has not seen an eye doctor in at least one year.

B. Please consider referral to an eye doctor for evaluation.
***Refer to an eye doctor for further evaluation for the need for an additional pair of single-lens distance glasses for use outdoors.**

Background: The patient has fallen or is at risk of falling and is active outdoors and has multifocal lenses, which increase the risk of falling when used outdoors. The patient does not have single-lens distance glasses, which are preferred for use outdoors.

Assessments: Uncorrected visual impairment places patients at increased risk of falling.

C. Please consider referral to ophthalmology for consideration of cataract surgery. We provided information about cataract surgery.

Background: The patient has cataracts which increase the risk of falling.

Assessment: The patient is at increased risk of falling because of prior falls, fear of falling, difficulty maintaining balance when bathing, dressing or getting in and out of a chair, or using a cane, walker or other device when walking inside or outside the home.

D. Please consider referral to a home care agency for home safety evaluation and recommendations.

Background: The patient has visual acuity in both eyes of ≤ 20/70, and a home evaluation by an occupational therapist has been demonstrated to be beneficial.

Assessment: The patient has age-related macular degeneration, diabetic retinopathy, glaucoma, cataracts, or near/far vision loss, which increase the risk of falling.

E. [No recommendations]

Background: The patient has vision 20/60 or better.

Assessment: The patient has age-related macular degeneration, diabetic retinopathy, glaucoma, cataracts, or near/far vision loss which increase the risk of falling but no additional treatments are recommended at this point..

F. [No recommendations]

Background: Patient has seen an eye doctor within a year and has no other risk factors.

Assessment: Patients who have had recent vision examinations and no risk vision factors do not need additional vision assessments or treatments.

APPENDIX 5.57 TEMPLATE FOR REFERRALS TO OPHTHALMOLOGIST

[Referrals to ophthalmologists for cataract surgery]

Patient: _____ Date of referral: ___/____/20__
Falls Care Manager:_____ Phone: _____ Email: _____
Primary Care Provider: _____ Phone: _____ Email: _____

Dear Dr. [last name]

[Mr/s. full name] is [a/n xxx] year-old patient of ours who is at **high risk for falling**. [S/he has fallen xx times in the last year and injured his/her xxxx].

Based on our recent comprehensive evaluation, [Mr/s. last name's] risk of falling may be increased by [his/her] cataract(s). [S/he] has expressed an interest in reducing this risk. **Please assess and manage his/her falls risks related to [his/her cataract(s)].**

[His/her] risk of falling is also increased by [use of multifocal lenses during frequent outdoor activities, feet/footwear problems, strength/balance problems, osteoporosis, inadequate vitamin D intake, postural hypotension, medication risk, home safety risks].
[S/he] has the following medical conditions: [XXXXX].
[S/he] takes the following medications: [XXXXX].
[S/he] also:

- Lives [alone, with her spouse/other, in assisted living facility]
- Uses [private car, taxi, public transit, ambulance] for transportation
- [Gets frequent help from xxx]
- [Uses a cane/walker/wheelchair for ambulation].

When you complete your assessment and initial treatment of [Mr/s. last name], please send me promptly a summary report that includes:

- Your assessment of [his/her] cataract status
- The care you provided
- Recommendations you gave to [him/her] for self-care and follow-up visits
- Your recommendations to me for [his/her] follow-up care.

If you would like addition information, assistance, or an opportunity to speak with me about [Mr/s. last name's] condition or care, please contact by phone or email (above) the falls care manager who works with me.

Thank you for your assistance,

_____
[PCP name]

APPENDIX 5.58 TEMPLATE FOR REFERRALS TO OPTOMETRISTS

[For referrals to optometrists/ophthalmologists for non-surgical vision care]

Patient: _____ Date of referral: ___/____/20__
Falls Care Manager:_____ Phone: _____ Email: _____
Primary Care Provider: _____ Phone: _____ Email: _____

Dear Dr. [last name]

[Mr/s. full name] is [a/n xxx] year-old patient of ours who is at **high risk for falling.** [S/he has fallen xx times in the last year and injured his/her xxxx].

Based on our recent comprehensive evaluation, [Mr/s. last name's] risk of falling may be increased by [his/her having not had a vision examination during the past year, using multifocal lenses during frequent outdoor activities]. [S/he] has expressed an interest in reducing this risk. **Please assess and manage his/her falls risks related to [his/her vision].**

[His/her] risk of falling is also increased by [feet/footwear problems, strength/balance problems, osteoporosis, inadequate vitamin D intake, postural hypotension, medication risk, home safety risks].
[S/he] has the following medical conditions: [XXXXX].
[S/he] takes the following medications: [XXXXX].
[S/he] also:

- Lives [alone, with her spouse/other, in assisted living facility]
- Uses [private car, taxi, public transit, ambulance] for transportation
- [Gets frequent help from xxx]
- [Uses a cane/walker/wheelchair for ambulation].

When you complete your assessment and initial treatment of [Mr/s. last name], please send me promptly a summary report that includes:

- Your assessment of [his/her] vision status
- The care you provided
- Recommendations you gave to [him/her] for self-care and follow-up visits
- Your recommendations to me for [his/her] follow-up care.

If you would like addition information, assistance, or an opportunity to speak with me about [Mr/s. last name's] condition or care, please contact by phone or email (above) the falls care manager who works with me.

Thank you for your assistance,

_____
[PCP name]

APPENDIX 5.59 TEMPLATE FOR REFERRALS TO OTS FOR VISION PROBLEMS

[Referrals to OTs for home safety/visual acuity]

Patient: _____ Date of referral: ___/____/20__
Falls Care Manager:_____ Phone: _____ Email: _____
Primary Care Provider: _____ Phone: _____ Email: _____

Dear Dr. [last name]

[Mr/s. full name] is [a/n xxx] year-old patient of ours who is at **high risk for falling**. [S/he has fallen xx times in the last year and injured his/her xxxx].

Based on our recent comprehensive evaluation, [Mr/s. last name's] risk of falling at home may be increased by poor visual acuity (20/XX OD, 20/XX OS, 20/XX OU). [S/he] has expressed an interest in reducing this risk. **Please assess and manage his/her risk of falling at home.**

[His/her] risk of falling is also increased by [feet/footwear problems, strength/balance problems, osteoporosis, inadequate vitamin D intake, postural hypotension, medication risk].
[S/he] has the following medical conditions: [XXXXX].
[S/he] takes the following medications: [XXXXX].
[S/he] also:

- Lives [alone, with her spouse/other, in assisted living facility]
- Uses [private car, taxi, public transit, ambulance] for transportation
- [Gets frequent help from xxx]
- [Uses a cane/walker/wheelchair for ambulation].

When you complete your assessment and initial management of [Mr/s. last name's] home safety risks, please send me promptly a summary report that includes:

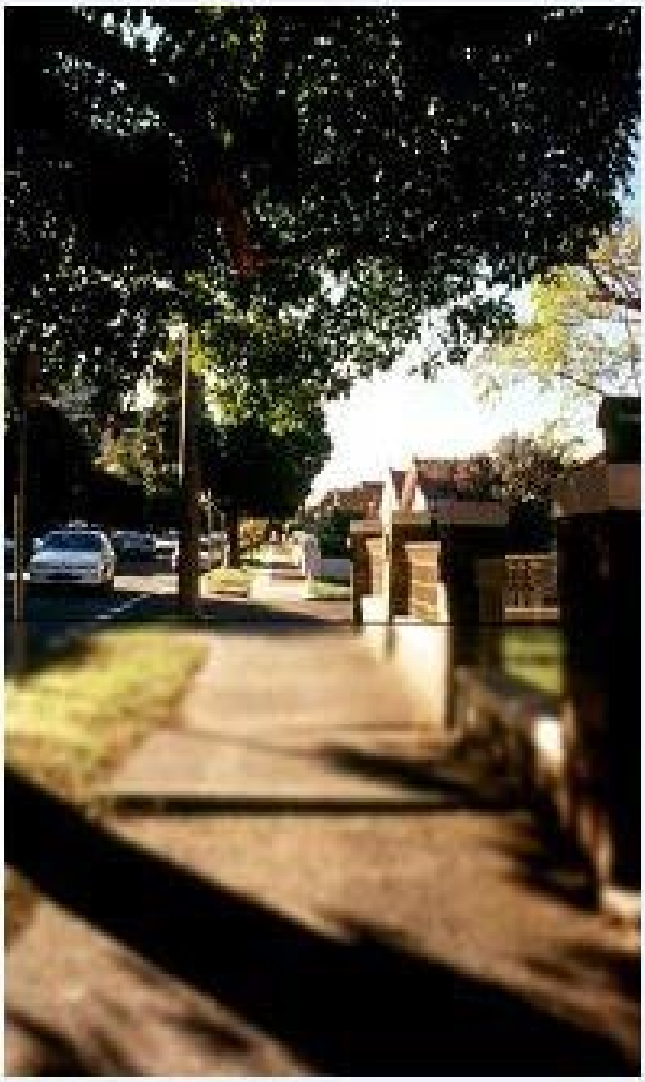
- Your assessment of [his/her] home safety risks
- The interventions you provided
- Recommendations you gave to [him/her] for self-management
- Your recommendations to me for [his/her] follow-up care.

If you would like addition information, assistance, or an opportunity to speak with me about [Mr/s. last name's] home safety, please contact by phone or email (above) the falls care manager who works with me.

Thank you for your assistance,

_____
[PCP name]

APPENDIX 5.60 CRACKED SIDEWALK PICTURES



APPENDIX 5.61 CATARACT SURGERY INFORMATION

The Doctor Says I have Cataracts: What Should I Do about Them?

What is a cataract?

A cataract is a clouding of the front of the eye that occurs gradually as most people get older. Cataracts cause your vision to become cloudy and hazy. Sometimes they also cause double vision, halos around objects, or glare from lights.

Removing cataracts

Nobody relishes the thought of undergoing surgery for cataracts, but it would probably improve your vision. Just as important, recent studies have shown that having a cataract removed reduces an older person's risk of falling, and it improves the quality of their lives.

Preventing falls and fractures; improving quality of life

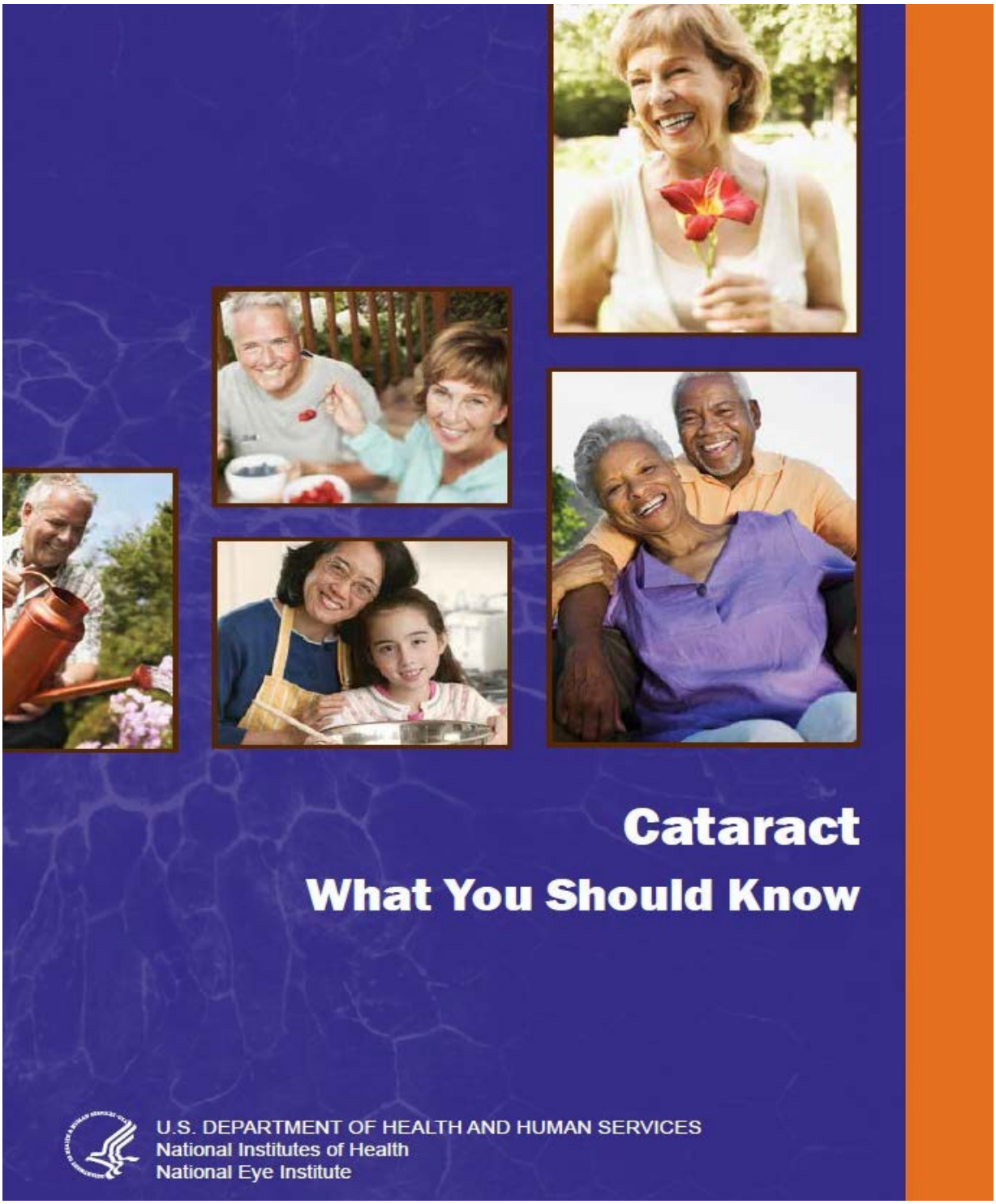
In a study of more that 300 older persons with cataracts, those who had their cataracts removed had 34% fewer falls during the following year. They also had fewer fractures, increased daily activity levels, better mood, increased and confidence.

If your eye doctor says you have a cataract, ask him or her to explain the benefits and risks of having it removed.

More information

For additional information, please read the attached information about cataracts sheet produced by the U.S. National Eye Institute.

APPENDIX 5.62 CATARACTS NEI (FULL BROCHURE ON WEBSITE)



APPENDIX 5.63 TABLE OF CONTENTS: FCM WEBSITE MOP DOCUMENTS

You may find the below documents referred to in this chapter on the internal stride- study.org portal website under the Falls Care Manager tab. The letter and number indicate their location, and the corresponding appendix number is in parentheses.

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FOLDER B.1: Handouts for All Patients

B.1.1 FALLS AND FRACTURES AGE PAGE (Appendix 5.5)

B.1.2 HOW TO GET UP FROM A FALL - PHILIPS (Appendix 5.2)

B.1.3 ELDERCARE LOCATOR (Appendix 5.32)

B.1.4 COMMUNITY SAFETY ADVICE (Appendix 5.33)

FOLDER B.2: Handouts Based on Risk Factors

B.2.1 CATARACT SURGERY INFORMATION (Appendix 5.61)

B.2.2 CATARACTS—NEI (Appendix 5.62)

B.2.3 CRACKED SIDEWALK PICTURES (Appendix 5.60)

B.2.4 PROPER SHOES—STRIDE (Appendix 5.48)

B.2.5 OSTEOPOROSIS AGE PAGE (Appendix 5.53)

B.2.6 VITAMIN D FACT SHEET (Appendix 5.55)

B.2.7 MANAGING POSTURAL HYPOTENSION (Appendix 5.43)

B.2.8 AVOIDING THE BAD EFFECTS OF MEDICATION (Appendix 5.24)

B.2.9 SLEEP HYGIENE (Appendix 5.25)

B.2.10 HOME SAFETY RECOMMENDATIONS (Appendix 5.51)

B.2.11 TRAVEL SAFETY CHECKLIST (Appendix 5.27)

B.2.13 ALL ABOUT CALCIUM (Appendix 5.28)

B.2.14 NON DAIRY FORMS OF CALCIUM (Appendix 5.30)

B.2.15 NOCTURIA HANDOUT (Appendix 5.31)

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B.2.17 MY EXERCISE PLAN FOR STRENGTH AND BALANCE (Appendix 5.34)

B.2.18 EXERCISE HANDOUTS (Appendix 5.17)

B.2.19 LINK TO STRIDE HOME EXERCISE VIDE (Appendix 5.17.1)

B.2.20 NAVIGATION GUIDE TO STRIDE HOME EXERCISE VIDEO (Appendix 5.17.2)

B.2.21 STRIDE HOME EXERCISE MANUAL (Appendix 5.17.3)

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B.3.3 YOU MAY BE AT RISK—SEDATIVE HYPNOTICS (Appendix 5.39)

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FOLDER C: Post Visit Forms

FOLDER C.1: Communication Templates

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C.1.05 MEDICATION RISK REFERRALS TO PHARMACIST AND SCD (Appendix 5.26)

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FRIDS SYMPTOMS LIST (Appendix 5.50)

FOLDER: MEDICATION DE-ESCALATION

ANTIDPRESSANTS DE-ESCALATION (Appendix 5.65)

ANTIHYPERTENSIVES DE-ESCALATION(Appendix 5.66)

ANTIPSYCHOTICS DE-ESCALATION (Appendix 5.67)

BENZODIAZEPINES OR BENZODIAZEPINE RECEPTOR AGONISTS DE-ESCALATION (Appendix 5.68)

CHOLINESTERASE INHIBITORS DE-ESCALATION (Appendix 5.69)

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C.2.5 TEMPLATE FOR REFERRALS TO ORTHOTISTS (Appendix 5.46)

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APPENDIX 5.64 NIA: WHAT TO DO IN CASE OF A FALL

Falls and Older Adults

If You Fall

Whether you're at home or somewhere else, a sudden fall can be startling and upsetting. If you do fall, stay as calm as possible. Take several deep breaths to try to relax.

How to Get Up From a Fall

1. Remain still on the floor or ground for a few moments. This will help you get over the shock of falling.
2. Decide if you're hurt before getting up. Getting up too quickly or in the wrong way could make an injury worse.
3. If you think you can get up safely without help, roll over onto your side.
4. Rest again while your body and blood pressure adjust. Slowly get up on your hands and knees, and crawl to a sturdy chair.
5. Put your hands on the chair seat and slide one foot forward so that it is flat on the floor. Keep the other leg bent so the knee is on the floor.
6. From this kneeling position, slowly rise and turn your body to sit in the chair.

If you're hurt or can't get up on your own, ask someone for help or call 911. If people who are nearby do not feel confident in helping you get up, call 911. If you're alone, try to get into a comfortable position and wait for help to arrive.

Consider Emergency Response Devices

If you are often alone, and at increased risk of falling, consider getting a personal emergency response system. This service, which works through your telephone line, provides a button or bracelet to wear at all times in your home.

Tell Your Doctor

Be sure to discuss any fall with your doctor. The doctor can assess whether a medical issue or other cause of the fall needs to be addressed. Knowing the cause can help you plan to prevent future falls. After a fall, your doctor might refer you to other health care providers who can help prevent future falls.

Note: The content of this document was slightly adapted from information produced by the National Institute on Aging (NIA) at the National Institutes of Health (NIH), available online through the NIHSeniorHealth, a web resource for older adults developed by the National Library of Medicine (NLM) in partnership with NIA: http://nihseniorhealth.gov/falls/ifyoufall/01.html/National

NIH flyer - what to do in case of a fall NIA approved version 08 27 2015

APPENDIX 5.65 ANTIDEPRESSANTS DE-ESCALATION

Antidepressants

All antidepressants are likely associated with increased falls (not enough data on some)

Tertiary TCAs should be avoided in older adults if possible, very anticholinergic. (imipramine, amitriptyline, clomipramine, doxepin)

1. Alternative Treatments

Nonpharmacological:

Depression: therapy (interpersonal, Cognitive Behavioral), bright light therapy **Anxiety:**

therapy (CBT), relaxation techniques, support groups Pharmacological:

- ☐ Anxiety: buspirone
- ☐ Neuropathy:
  - topicals (lidocaine,[Lidoderm], capsaicin)
  - substitute nortriptyline, desipramine for tertiary amines;
  - low dose gabapentin or pregabilin
- ☐ Preferred drugs if patient has specific adverse events but requires antidepressants
  - Drowsiness, unsteadiness, confusion: SSRIs, SNRIs, bupropion
  - Insomnia: trazodone, nefazodone, mirtazapine
  - Weakness/Fatigue: Bupropion, Nefazodone, trazodone, mirtazapine

2. Drug Tapering

• All antidepressants should be tapered except perhaps fluoxetine (Prozac), which has a long half- life. Taper over at least four weeks if taken for at least eight weeks.

• Consider more prudent approach (e.g., for paroxetine, venlafaxine) of reducing dose by 25% every four to six weeks.

• Tapering may not completely eliminate symptoms. Educate patients symptoms are usually transient and mild. If symptoms are problematic, return to previous dose or switch to fluoxetine. 3. Withdrawal symptoms and risk factors

Withdrawal symptoms (FINISH syndrome):
• Flu-like symptoms, Insomnia, Imbalance, Sensory disturbances, Hyperarousal.
• Symptoms usually begin & peak within one week, last one day to three weeks, & are usually mild.
• Most common with paroxetine (Paxil) & venlafaxine (Effexor)

APPENDIX 5.66 ANTIHYPERTENSIVE DE-ESCALATION

Antihypertensives

(diuretics, alpha blockers, beta blockers, centrally acting antihypertensives, calcium channel blockers, ACE inhibitors, ARBs)

Treatment Goal for older adults:

JNC 8: treat hypertensive persons aged 60 years or older to a BP goal of less than 150/90 mm Hg. The same thresholds and goals are recommended for hypertensive adults with diabetes or nondiabetic chronic kidney disease (CKD).

Drug Tapering and Withdrawal

Diuretics: often can be tapered down after HF exacerbation. Beta blockers:

- Taper over one to two weeks.
- **Withdrawal symptoms**: Tachycardia, ventricular arrhythmia, anxiety, myocardial ischemia, angina, heart attack, rebound hypertension.
- **Risk factors for withdrawal:** hypertension, coronary artery disease (diagnosed or undiagnosed)

Clonidine:

- Taper oral over two to four days. Beta-blockers increase risk of rebound hypertension during withdrawal (noncardioselective most problematic [e.g., propranolol]). If patient is taking a beta-blocker, consider taper of beta-blocker first. Monitor BP closely after clonidine taper.
- Transdermal clonidine: Risk of withdrawal lower than with oral, but consider tapering patches over two to four days or switching to oral clonidine taper.
- **Withdrawal symptoms**: Rebound hypertension, headache, restlessness, anxiety, insomnia, sweating, tachycardia, tremor, muscle cramps, hiccups, nausea, salivation; rarely encephalopathy, stroke, death.
- **Risk factors for withdrawal**: use for over one month, concomitant beta-blocker use, daily dose >1.2mg daily, hypertension, cardiovascular disease.

APPENDIX 5.67 ANTIPSYCHOTICS DE-ESCALATION

Antipsychotics

1. Alternative Treatments

Agitated Delirium; Behavioral Complications of Dementia

Nonpharmacological: see handout

Pharm: short term use of low dose haloperidol, quetiapine, resperidone. Begin taper once behavior stabilizes.

☐ Preferred drugs if patient has specific adverse events but requires antipsychotic
- Parkinsonism: low dose quetiapine
- Seizures: resperidone or haloperidol
- Confusion: haloperidol, risperidone
- Drowsiness: Risperidone
- Postural Hypotension: haloperidol, aripiprazole
- Weight Gain: haloperidol, aripiprazole, ziprasidone

2. Drug Tapering See McGill

handout

3. Withdrawal symptoms and risk factors

Withdrawal symptoms:

• Sweating, salivation, runny nose, flu-like symptoms, paresthesia, bronchoconstriction, urination, gastrointestinal symptoms, anorexia, vertigo, insomnia, agitation, anxiety, restlessness, movement disorders, psychosis.

4. Handouts

--Canadian antipsychotic deprescribing

APPENDIX 5.68 BENZODIAZEPINES OR BENZODIZSEPINE RECEPTOR AGONISTS DE-ESCALATION

Benzodiazepines or Benzodiazepine Receptor Agonists

1. Alternative Treatments

Insomnia:

Nonpharmacological: Sleep hygiene, Sleep restriction, Cognitive Behavioral Therapy for Insomnia, Bright light therapy

Pharm: ramelteon has not been associated with falls. Low dose trazadone and mirtazapine are also used, however there are no data about falls with these doses

Anxiety:

Nonpharm: therapy (CBT), relaxation techniques, support groups

Pharm: buspirone, SSRI or SNRI. SSRI and SNRI can also cause falls, but are less likely to cause sedation and cognitive impairment.

2. Drug Tapering: See McGill

handout

3. Withdrawal symptoms and risk factors

Withdrawal symptoms:

• Sweating, tachycardia, tremor, insomnia, anxiety, agitation, nausea, vomiting, hallucinations, seizures.

Risk factors: use over one year, high dose, short or intermediate half-life (e.g., triazolam [Halcion], alprazolam [Xanax] (especially if daily dose >4 mg for >12 weeks), lorazepam [Ativan]).

4. Handouts

--McGill sedative-hypnotic packet (with withdrawal plan, sleep hygiene and anxiety alternatives)

--For FCM: Insomnia GAYF handout- sleep hygiene, meds that interfere with sleep; bright light

--For patients: sleep hygiene handouts

APPENDIX 5.69 CHOLINESTERASE INHIBITORS DE-ESCALATION

Cholinesterase inhibitors All can cause

syncope Alternative Treatments

Vitamin E 2000 IU/d (JAMA. 2014 Jan 1;311(1):33-44)

For moderate to severe AD, consider memantine

- ☐ Discontinue memantine if loss of speech or locomotion.

APPENDIX 5.70 FIRST GENERATION ANITHISTAMINES DE-ESCALATION

First Generation Antihistamines

Prescribing caveat: antihistamines should not be prescribed for insomnia in older adults Alternative

Treatments

Insomnia:

Nonpharmacological: Sleep hygiene, Sleep restriction, Cognitive Behavioral Therapy for Insomnia, Bright light therapy

Pharm: ramelteon has not been associated with falls. Low dose trazadone and mirtazapine are also used, however there are no data about falls with these doses.

Pruritis:

NonPharmacological:

- ☐ Skin moisturization,
- ☐ Cool environment (Light-weight clothing, air-conditioned environments, and the use of lukewarm (rather than hot) water during showers or baths, lotions that provide a cooling sensation on the skin, such as calamine lotion or lotions with up to a 4% concentration of menthol (eg, Sarna or Men-Phor).
- ☐ Avoidance of skin irritants
- ☐ Stress reduction
- Physical interventions – Scratching may increase symptoms of pruritus, resulting in a perpetual itch-scratch cycle. Occlusion of localized areas of pruritus with Unna boots or other occlusive dressings (eg, DuoDerm) may help to break this cycle [8]. Keeping fingernails trimmed to a short length may also help to minimize skin damage induced from scratching.

Pharmacological: 2nd generation antihistamines (fexofenadine [Allegra], certirizine[Zyrtec],Claritin [loratadine])

Allergies:

Pharmacological:

- 2nd generation antihistamines (fexofenadine [Allegra], certirizine[Zyrtec],Claritin [loratadine])
- Nasal steroids or antihistamines
- Ophthalmological antihistamines

Handouts

--McGill first generation antihistamine de-escalation packet

--McGill sedative-hypnotic packet (with withdrawal plan, sleep hygiene and anxiety alternatives)

--For FCM: Insomnia GAYF handout- sleep hygiene, meds that interfere with sleep; bright light

--For patients: sleep hygiene handouts

APPENDIX 5.71 HYPOGLYCEMIC AGENTS DE-ESCALATION

Hypoglycemic Agents

Treatment HbA1c for Older Adults

7-7.5% Healthy older adults

7.5-8.0% Complex/Intermediate (3+ coexisting chronic illnesses, or 2+ IADL impairments, or mild-to - mod cognitive impairment)

8.5-9.0% Very complex/poor health LTC or end-stage chronic illness or mod-to-severe cog imp or 2+ADL dependencies

Ref: Kirkman MS et al Diabetes Care. 2012 Dec;35(12):2650-64.

Prescribing caveat: glyburide and chlorpropramide should be avoided in older adults because of possibility of prolonged hypoglycemia

Handout

McGill Sulfonyurea handout (also warning signs of hypoglycemia and alternative treatments for DM- diet and exercise)

APPENDIX 5.72 OPIOIDS DE-ESCALATION

Opioids

Prescribing caveats:

- Avoid Codeine- more injuries than other opioids
- Avoid Meperidine- more delirium
- In patients with renal failure, consider opioid other than morphine
- Watch acetaminophen dose when using combination products

1. Alternative treatments:

Non-pharmacological: ice/heat; PT,TENS, acupuncture, relaxation techniques

Pharmacological: acetaminophen, topical products;

☐ If Neuropathy:
  - topicals (lidocaine,[Lidoderm], capsaicin)
  - low dose gabapentin or pregabilin

☐ Preferred drugs if patient has specific adverse events but requires opioid
  - Constipation: Fentanyl

2. Drug Tapering

• Acute pain use: decrease by 20% daily.

• Chronic use: 10% every three to five days; clonidine may be useful adjunct.

3. Withdrawal symptoms and risk factors

• Runny nose, tearing, chills, myalgia, vomiting, diarrhea, cramps, anxiety, agitation, hostility, insomnia.

APPENDIX 5.73 SKELETAL MUSCLE RELAXANTS AND ANTISPASMODICS DE-ESCALATION

Skeletal Muscle Relaxants and Antispasmodics

Prescribing Caveats:

☐ Should be avoided in older adults (Beers Criteria)
☐ Use for over one month is risk factor for delirium.

Baclofen:

• Taper over one to two weeks.

Withdrawal symptoms :

Hallucinations, delusions, confusion, agitation, anxiety, insomnia, altered consciousness, hyperthermia, spasticity, tachycardia, seizures

Carisoprodol (Soma):

"Taper recommendations:

• Long taper (for patients with renal or liver impairment, age >65 years, or total daily dose >1400 mg): 350 mg three times daily for three days, then twice daily for three days, then once daily for three days.

• Short taper: 350 mg three times daily for one day, then twice daily for two days, then once daily for one day.

Withdrawal symptoms :

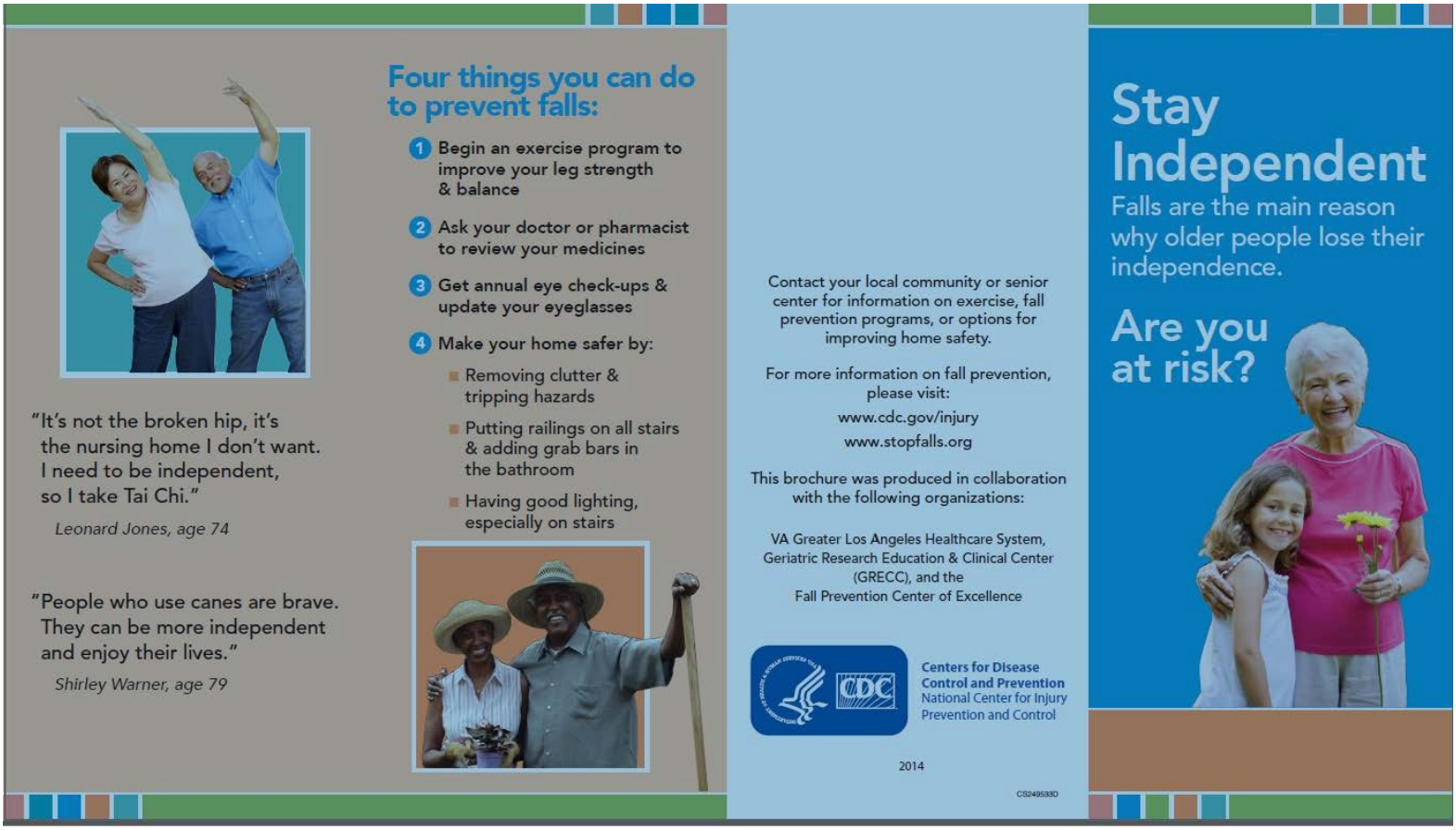
Body aches, sweating, palpitations, sadness, anxiety, restlessness, insomnia.

APPENDICES CHAPTER 6 - THE CONTROL INTERVENTION

6.1 CDC STEADI STAY INDEPENDENT BROCHURE

6.2 COMMUNICATION TEMPLATES FOR PCPS RE: CONTROL

APPENDIX 6.1 CDC STEADI STAY INDEPENDENT BROCHURE



"It's not the broken hip, it's the nursing home I don't want. I need to be independent, so I take Tai Chi."

Leonard Jones, age 74

"People who use canes are brave. They can be more independent and enjoy their lives."

Shirley Warner, age 79

Four things you can do to prevent falls:

1. Begin an exercise program to improve your leg strength & balance
2. Ask your doctor or pharmacist to review your medicines
3. Get annual eye check-ups & update your eyeglasses
4. Make your home safer by:
   - Removing clutter & tripping hazards
   - Putting railings on all stairs & adding grab bars in the bathroom
   - Having good lighting, especially on stairs

Contact your local community or senior center for information on exercise, fall prevention programs, or options for improving home safety.

For more information on fall prevention, please visit:

www.cdc.gov/injury

www.stopfalls.org

This brochure was produced in collaboration with the following organizations:

VA Greater Los Angeles Healthcare System, Geriatric Research Education & Clinical Center (GRECC), and the Fall Prevention Center of Excellence

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

2014

CS249533D

Stay Independent

Falls are the main reason why older people lose their independence.

Are you at risk?

APPENDIX 6.2 COMMUNICATION TEMPLATES FOR PCPS RE: CONTROL GROUP

1. Statement to communicate with Control PCPs about STEADI webinar

On behalf of the STRIDE study, we want to make you aware of a new webinar that the CDC has produced about fall prevention for health care providers. The webinar is available to view at http://www.cdc.gov/steadi/webinar.html

2. Templated message to PCPs about patient's enrollment in STRIDE control group

Your patient has recently enrolled in the STRIDE fall-injury prevention trial. During the study screening, your patient reported that they have one or more risk factors for falls. Your practice is a control practice in this study. Your patient has been mailed an information booklet about fall prevention and they will be tracking their falls and injuries using a calendar. If you have any questions, please feel free to contact (*site coordinator, site clinical director and/or site PI*) at XXX-XXX-XXXX or by email at XX@XXX.XXX.

We also wanted to make you aware of a new webinar that the CDC has produced about fall prevention. The webinar is available to view at http://www.cdc.gov/steadi/webinar.html

APPENDICES CHAPTER 7 – STUDY OUTCOMES

APPENDIX 7.1 GUIDELINES FOR ASKING OPEN-ENDED INTERVIEW QUESTIONS

Guidelines for Asking Questions:

- Read slowly in a natural conversational rhythm and in a normal tone of voice.
- Always read the entire question before getting the participant's response.
- Be aware of the participant's comments, e.g., puzzled, confused.
- Repeat the question if it is answered inappropriately, but repeat it exactly as written.
- Offer to reread a question if you believe the participant did not understand what was asked.
- Ask questionnaire items in order and exactly as worded.
- Unless the instructions indicate otherwise, ask every question. Often a previous statement by the participant will partially answer another question, but rarely does it answer that question completely. Do not omit any questionnaire items. The RedCap system will automatically skip questions if they don't need to be asked.

Guidelines for Eliciting and Recording Responses:

- Learn The Purpose Of Each Questionnaire Item. You need to understand the information we are trying to obtain through each question. Unless you understand its purpose, you will not be able to judge when a response is adequate.
- Don't Attempt To Interpret/Explain The Question—Maintain Neutrality. If a participant does not seem to understand a question, repeat the question slowly and clearly. Unless you have other instructions about handling specific questions, the acceptable reply for a participant who wants to know what a question means is, "Whatever it means to you." Do not attempt to explain the purpose of a question unless the interviewer instructions specifically authorize you to do so.
- Don't Define Terms Used In Questions Unless The Standard Definition Is Included For The Question. Some participants may ask, "What is meant by a word used in a question?" Leave the matter of definition to the participant. For example, you might respond, "Whatever you think it means" or "However you use the term."
- Don't Leave A Question Item Until You Have An Adequate Response Or Have Determined That A Participant Can't Give A Clearer Response.
- Participants May Refuse To Answer Any Question. However, refusal to answer some questions, such as those determining study eligibility, can affect whether or not a person may participate in STRIDE.

Probing

The quality of the interview depends a great deal on the interviewer's ability to probe meaningfully and successfully.

What is probing and why is it necessary?

Probing is the technique used by the interviewer to obtain more information. We probe when a respondent's answer is not meaningful or is incomplete, that is, when it does not adequately answer the question. There are a number of reasons respondents sometimes do not answer the question to our satisfaction.

In every day social conversation people normally speak in vague terms. It is understandable that respondents may at first respond to our question in a way which is not clear or specific. It is important to encourage the respondent to express himself/herself more concretely and in very specific terms.

Sometimes respondents may think that they are answering a question when all they are doing is simply repeating an answer which was already given or simply repeating parts of the question.

Respondents may sometimes miss the point of the question. Many times they will give responses which appear to answer the question, but in reality are not to the point. In most cases, a respondent gives an irrelevant response because he/she has missed an important word or phrase in the question.

Probing, has two major functions. 1) probing motivates respondents to enlarge, clarify, or explain the reasons for their answers. 2) probing focuses the respondent's answer, so irrelevant and unnecessary information can be eliminated. All this must be done without introducing bias or antagonizing the respondent.

Below are some examples of answers that for different reasons fail to answer the question properly. Because of the answer given, each requires probing.

Question: How many weeks were you employed during the last 12 months?

Answer: I worked in a department store during the holiday rush.

Answer: I worked outside so I only worked in good weather.

Answer: I worked part-time until I hurt my leg last fall.

The best way to probe these kinds of answers is to repeat the question emphasizing "how many weeks".

Demeanor

The demeanor of the interviewer should be casual, yet professional. This is a difficult balance to maintain and requires a thorough familiarity with the questionnaires and procedures prior to interviewing the first participant. Although it is essential that the structured interview be followed verbatim, the interviewer should not sound like a recording. The interviewer should know the questions so well that it never sounds as if he or she is reading them formally. The interviewer should use a natural, conversational style. At the same time, the interviewer needs to "stay on track" and politely, but firmly, lead the participant through the interview.

Finally, the interviewer should be pleasant and friendly. As noted by Backstrom and Hursh-Cesar (1981), "A major objective is to put the respondent at ease. If the participant isn't relaxed, [the interviewer] can't make the participant talk." Similarly, "the burden of ignorance has to be lifted from the respondent's shoulders—that is, he or she must not be made to feel ashamed of his/her lack of information. [The interviewer's] attitude, therefore, must be sympathetic and understanding. Emphasize that there are no correct answers. Rather, [the participant] must realize that what he or she thinks really is what counts. An opinion can never be wrong."

APPENDIX 7.2 FALLS CALENDAR

STrategies to
Reduce
Injuries and
Develop confidence in
Elders

JUNE 2015

Please mark the calendar: **"N" on each day you did not fall**
"F" on each day you had a fall

SUN	MON	TUES	WED	THURS	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27

28	29	***30***				

On the last day of the month, please complete the questions on the back.

JUNE 2015

For each question, please consider all of the falls you marked on the calendar this month.

1. Were you injured in any fall this month?	YES ☐ ↓	☐ NO ↓ **STOP**
1a. What were your injuries? **Mark all that apply**		
☐ Broke or fractured a bone:		
☐ Dislocated a joint:		
☐ Injured my head:		
☐ Cut with bleeding:		
☐ Sprain or a strain:		
☐ Bruising or swelling:		
☐ Other injury:		

Please describe your injury or injuries:		
1b. What was the date of the injury? _ _ / _ _ / _ _ _ _	If more than 1 injury, please provide additional dates _ _ / _ _ / _ _ _ _ _ _ / _ _ / _ _ _ _	
1c. Did you see a doctor or other health care professional for the injury?	YES ☐ ↓	☐ NO ↓
1d. Where did you go for care? **Mark all that apply and write the name and the location of the facility in the space provided**		**STOP**

	Name	**Location**
☐ Emergency room		
☐ Stayed overnight in the hospital		
☐ Doctor's office or other facility		

APPENDIX 7.3 INSTRUCTIONS FOR CALENDAR

STrategies to Reduce Injuries and Develop confidence in Elders

STRIDE

Instructions for Calendar

"You" refers to the person who is participating in the STRIDE study

Enclosed you will find the calendar discussed during your recent telephone call with STRIDE staff. Please post the calendar someplace where it is in full view, perhaps on the refrigerator. Enclosed is a clip with magnet which will hold the calendar to the refrigerator door.

Please use the calendar each day to record whether you had a fall or not. Please mark each day with either an "F" or "N". "F" indicates that Yes, a fall occurred and "N" indicates no fall occurred.

A fall is considered any time that you fall to the ground, floor, or surface including a fall out of bed, a fall from a ladder, a fall from a "trip" ("I just tripped"), or any time you involuntarily ended up on the floor.

On the last day of the month, please complete the questions on the back page of the calendar. After you answer the questions on the back of the calendar, start recording any falls for the next month.

Please save the monthly calendars, we will review them with you when we call every 4 months to ask about any falls or other changes in your health.

Thank you for your important contribution to this study.

APPENDIX 7.4 BASELINE INTERVIEW

STRIDE BASELINE QUESTIONNAIRE

QOL MEASURES SUB-SET

NOTE: THE FOLLOWING IS TEXT FOR THE BASELINE QUESTIONNAIRE WHICH WILL BE PUT INTO THE DATA MANAGEMENT SYSTEM AND WILL NOT BE ADMINISTERED VIA A HARD COPY

STUDY ID: ☐☐☐☐☐☐☐☐

INTERVIEWER ID: ☐☐☐

DATE OF INTERVIEW: M M D D Y Y Y Y ☐☐ ☐☐ 2 0 ☐☐

TIME OF INTERVIEW: ☐☐ : ☐☐ am pm

TYPE OF INTERVIEW:
☐ Participant
☐ Surrogate

INTERVIEW DISPOSITION:
☐ Complete and ENROLLED IN STRIDE
☐ Interview not completed: Participant refusal
☐ Interview not completed: Surrogate refusal
☐ Interview not completed: Too ill
☐ Interview not completed: Died
☐ Interview not completed: Unable to contact
☐ Interview not completed: Other (specify)

_____

☐ INELIGIBLE FOR STUDY

(Hospice, Nursing Home, Age, Practice, Language, Moving)

CALL RECORD

TEMPORARY DELAYS: CALL BACK IN ONE MONTH

AT TIME OF CONTACT ANY OF THE FOLLOWING CONDITIONS:

Surrogate is needed, but not immediately available	☐
Participant wants to discuss study with family	☐
Recruitment packet not received, re-send	☐
CONFIRM ADDRESS: _____	
Speech/communication problem, surrogate may be needed	☐
_____ (SPECIFY)	
Too busy right now	☐
_____ (SPECIFY)	
Currently in a hospital or rehab facility	☐
_____ (SPECIFY)	
Illnesses/Not a good time (cancer treatments, scheduled for surgery, not feeling well today, etc.)	☐
_____ (SPECIFY)	
Death in family	☐
Other	☐
_____ (SPECIFY)	

FOR ALL TEMPORARY EXCLUSIONS, NOTES:

Call back date: __ __/__ __/ __ __ __ __, Time window (e.g., 9-11am): _____

TRAVEL PLANS

Do you currently plan to be out of the area for more than one month in the next two months?	
[IF YES, END INTERVIEW] Yes	☐
No	☐
Refused	☐
DK	☐
IF YES, WHERE, SPECIFY: _____	
Call back date: __ __/__ __/ __ __ __ __, Time window (e.g., 9-11am): _____	

STUDY EXCLUSIONS

Death reported: Yes ☐ No ☐

I am so sorry to hear of your loss. I was referred to [PATIENT'S NAME] by their [PRACTICE] about a fall prevention study. May I ask when [PATIENT'S NAME} passed away?

____ ____/ ___ ___/ ___ ___

Thank you for your time and once again, I am sorry for your loss.

Currently receiving care at [PRACTICE NAME AND PRACTICE ADDRESS?

Yes ☐

IF NO, END INTERVIEW, NOT ELIGIBLE FOR STUDY No ☐

Patient speaks English or Spanish

English ☐

Spanish ☐

IF OTHER, END INTERVIEW, NOT ELIGIBLE FOR STUDY Other ☐

_____ (SPECIFY)

When were you (he/she) born? ____ ____/ ___ ___/ ___ ___

Month Day Year

IF PARTICIPANT < 70 YEAR OF AGE, NOT ELIGIBLE FOR STUDY

Do you plan to move out of the area within the next year?

IF NO, END INTERVIEW, NOT ELIGIBLE FOR STUDY Yes ☐ No ☐

INELIGIBLE FOR STUDY:

Thank you for this information. You do not qualify for this study because (tell the reason, e.g. people must be over age 70, people must be members of the practice, etc.) Thank you very much for taking the time to talk to me today.

Gender		
Are you (he/she):	Male	☐
	Female	☐
Race		
Do you consider yourself to be:	White	☐
SURROGATE: Would he/she consider himself/herself to be:	Black/ African American	☐
	American Indian/Alaskan Native	☐
	Asian	☐
	Native Hawaiian/ Other Pacific Islander	☐
	More than 1 race	☐
	_____Other	☐
	Refused	☐
	DK	☐
Ethnicity		
Do you consider yourself to be:	Hispanic/Latino	☐
SURROGATE: Would he/she consider himself/herself to be:	Non-Hispanic/Latino	☐
	Refused	☐
	DK	☐
Living situation:		
Do(es) you (he/she) currently live alone?	Yes	☐
	No	☐
	Refused	☐
	DK	☐
What type of housing do you (he/she) **live in?**		
	Single family home	☐
	Apartment/town house, not age restricted	☐
	Senior housing/ 55+ community	☐
	Assisted living	☐
	Other (mobile home, boat)	☐
	Refused	☐
	DK	☐

	DK	☐
Physical Activity		
How would you (he/she) describe your leisure time physical activity over the past month?	I did no regular physical activity	☐
	I did some regular physical activity like light walking, nonstrenuous cycling or gardening approximately once a week	☐
	I regularly did physical activity like brisk walking, bicycling or sports more than one time per week.	☐
	Refused	☐
	DK	☐

SELF-RATED HEALTH (SRH)		
Would you (he/she) say your (his/her) health is excellent, very good, good, fair, or poor?	Excellent	☐
	Very good	☐
	Good	☐
	Fair	☐
	Poor	☐
	Refused	☐

Monitoring Device

Do you have a medical alert system or personal emergency button you can push if you fall and need help? Sometimes people wear them around their neck or on their wrist.

Yes ☐
No ☐

If YES, Have you had to use the system in the past 12 months (or year)?

Yes ☐
No ☐

DK ☐

CHRONIC CONDITIONS (CC)

1. Has a doctor ever told you (him/her) that you have high blood pressure or hypertension?	Yes	☐
Go to Question 2	No	☐
	Refused	☐
	DK	☐
1a. Are you (he/she) currently taking any medicine for your (his/her) high blood pressure?	Yes	☐
	No	☐
	Refused	☐
	DK	☐
	NA	☐

2. Has a doctor ever told you (him/her) that you (he/she)

	Yes	Suspect or possible	No	Refused	DK
had a heart attack, or coronary, or myocardial infarction and you (he/she) had to be hospitalized?	☐	☐	☐	☐	☐
had heart failure or congestive heart failure?	☐	☐	☐	☐	☐
had a stroke or brain hemorrhage and had to be hospitalized?	☐	☐	☐	☐	☐
had cancer or a malignant tumor, excluding minor skin cancers?	☐	☐	☐	☐	☐
diabetes?	☐	☐	☐	☐	☐
have Parkinson's Disease?	☐	☐	☐	☐	☐
have chronic lung disease such as chronic bronchitis, COPD, asthma, or emphysema?	☐	☐	☐	☐	☐
had a broken or fractured hip and had to be hospitalized?	☐	☐	☐	☐	☐

Since the age of 50, have you (he/she) ever been told by a doctor, nurse, therapist, or medical assistant that you (he/she) had broken or fractured any other bones?		
	Yes	☐
	Suspect or possible	☐
	No	☐
	Refused	☐
	DK	☐
During the last 12 months, have you (he/she) seen a doctor specifically for arthritis or rheumatism?	Yes	☐
	Suspect or possible	☐
	No	☐
	Refused	☐
	DK	☐
Do you (he/she) usually use a cane, walker or other device when walking inside your (his/her) home?	No, walks without device	☐
	No, doesn't walk (i.e., uses wheelchair)	☐
	Yes, cane	☐
	Yes, walker	☐
	_____Yes, Other	☐
	Refused	☐
	DK	☐

Do you (he/she) usually use a cane, walker or other device when walking outside your (his/her) home?	No, walks without device	☐
	No, doesn't walk (i.e., uses wheelchair)	☐
	Yes, cane	☐
	Yes, walker	☐
	_____Yes, Other	☐
	Refused	☐
	DK	☐

Falls

1. Have you (he/she) fallen in the past year?

Yes	☐
No	☐
Refused	☐
DK	☐

[SKIP TO NEXT SECTION]

[IF YES, ASK]:

1a. How many times have you (he/she) fallen? ___ ___

1b. For any fall, did you (he/she) land on the floor, ground, or other lower level when you (he/she) fell?

Yes	☐
No	☐
Refused	☐
DK	☐

[SKIP TO NEXT SECTION]

2. Do you use any devices that can tell if you have fallen and/or send a signal for help if you fall?

Yes	☐
No	☐
Refused	☐
DK	☐

[SKIP TO NEXT SECTION]

SURROGATE INTERVIEWS: SKIP Modified Falls Efficacy

Modified Falls Efficacy – 10 ITEM

I have some questions about common daily activities. For each of the following activities, please tell me how concerned you are about the possibility of falling.

FIRST PROBE IF RESPONDENT SAYS "I DON'T DO THAT": I know you don't (are unable to)...but think about if you did (could), how concerned are you that you might file while...?

SECOND PROBE IF RESPONDENT AGAIN SAYS "I DON'T DO THAT": I understand that you don't (can't) do that but please try to think about if you did (could), how concerned are you that you might fall while...?
DO NOT PROBE A THIRD TIME FOR AN ITEM, INSTEAD SELECT "DK" FOR DON'T KNOW NEXT TO THE ITEM.

NOTE: RESPONSES ONLY REPEATED AS THE CALLER FEELS THE PARTICIPANT NEEDS TO BE REMINDED.

How concerned are you that you might fall while .....? Are you:

	Not at all concerned	Somewhat concerned	Fairly concerned	Very concerned	REF	DK
cleaning the house (doing things like sweeping or dusting)?	☐	☐	☐	☐	☐	☐
getting dressed or undressed?	☐	☐	☐	☐	☐	☐
preparing simple meals?	☐	☐	☐	☐	☐	☐
taking a bath or shower?	☐	☐	☐	☐	☐	☐
doing simple shopping?	☐	☐	☐	☐	☐	☐
getting in and out of a chair?	☐	☐	☐	☐	☐	☐
going up and down stairs?	☐	☐	☐	☐	☐	☐
walking around in your neighborhood?	☐	☐	☐	☐	☐	☐
reaching into cabinets or closets?	☐	☐	☐	☐	☐	☐
going to answer the telephone before it stops ringing?	☐	☐	☐	☐	☐	☐

SURROGATE INTERVIEWS: SKIP PROMISE

PROMISE: Emotional Distress - Depression – Anxiety - Short Form B

Please respond to each item by marking one box per row.
NOTE: RESPONSES ONLY REPEATED AS THE CALLER FEELS THE PARTICIPANT NEEDS TO BE REMINDED.

Now I'd like to ask you some questions about how you have been feeling over the last week.

In the past 7 days.....

	Never	Rarely	Sometimes	Often	Always	Refused	DK
I felt worthless	☐	☐	☐	☐	☐	☐	☐
I felt that I had nothing to look forward to	☐	☐	☐	☐	☐	☐	☐
I felt helpless	☐	☐	☐	☐	☐	☐	☐
I felt sad	☐	☐	☐	☐	☐	☐	☐
I felt like a failure	☐	☐	☐	☐	☐	☐	☐
I felt depressed	☐	☐	☐	☐	☐	☐	☐
I felt unhappy	☐	☐	☐	☐	☐	☐	☐
I felt hopeless	☐	☐	☐	☐	☐	☐	☐
I felt fearful	☐	☐	☐	☐	☐	☐	☐
I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐	☐	☐
My worries overwhelmed me	☐	☐	☐	☐	☐	☐	☐
I felt uneasy	☐	☐	☐	☐	☐	☐	☐
I felt nervous	☐	☐	☐	☐	☐	☐	☐
I felt like I needed help for my anxiety	☐	☐	☐	☐	☐	☐	☐
I felt anxious	☐	☐	☐	☐	☐	☐	☐
I felt tense	☐	☐	☐	☐	☐	☐	☐

Late Life FDI

BE SURE TO CLICK SAVE AND CONTINUE BEFORE LOADING LLFDI SOFTWARE

Load software for administration of LLFDI.
NOTES:

TIMEFRAME: NO SPECIFIC TIME FRAME. THE BACKGROUND TO THE INSTRUMENT SAYS THAT THEY WOULD LIKE

PEOPLE TO THINK ABOUT "A TYPICAL DAY".

"WHEN ANSWERING QUESTIONS ABOUT LIMITATIONS IN ACTIVITIES, YOU (HE/SHE) MIGHT FEEL LIMITED BECAUSE OF (HIS/HER) YOUR HEALTH OR BECAUSE IT TAKES A LOT OF PHYSICAL OR MENTAL ENERGY. YOU (HE/SHE) MAY ALSO FEEL LIMITED BY FACTORS OUTSIDE OF YOURSELF (HIS/HERSELF). YOUR ENVIRONMENT COULD RESTRICT YOU FROM DOING THINGS, FOR INSTANCE YOU

MIGHT FEEL LIMITED DUE TO OF TRANSPORTATION ISSUES OR PHYSICAL ACCESSIBILITY. THINK OF ALL THESE FACTORS WHEN YOU ANSWER THE QUESTIONS."

PERSON DOESN'T DO SOMETHING (WORK AS A VOLUNTEER, TAKE THE BUS):

IF POSSIBLE, YOU SHOULD TRY TO PROBE FOR THEM TO THINK ABOUT HOW MUCH DIFFICULTY THEY WOULD HAVE IF

THEY DID IT.

PLEASE NOTE: The Late Life Disability and Late Life Function Instrument questions will be asked using a computer adaptive program. Only 10 of the items listed for each of the measures will be asked. The 10 items each person are asked will depend on the individual person's responses to each previous item. The full set of potential items are listed here.

Late-Life FDI: Disability Component (10 items will be asked)

To what extent do you feel (do you think he/she feels) limited in…?

D1. Keeping in touch with others through letters, phone, or email.

D2. Visiting friends and family in their homes.

D3. Providing care or assistance to others.

D4. Taking care of the inside of your home.

D5. Working at a volunteer job outside your home.

D6. Taking part in active recreation.

D7. Taking care of household business and finances.

D8. Taking care of your own health.

D9. Traveling out of town for at least an overnight stay.

D10.Taking part in a regular fitness program. T

D11. Inviting people into your home for a meal or entertainment.

D12. Going out with others to public places such as restaurants or movies.
D13. Taking care of your own personal care needs.

D14. Taking part in organized social activities.

D15. Taking care of local errands.

D16. Preparing meals for yourself.

Response options:

- Not at All
- A Little
- Somewhat
- A Lot
- Completely

Late-Life FDI: Function Component (10 items will be asked)

How much difficulty do you have…?

F1. Unscrewing the lid off a previously unopened jar without using any devices

F2. Going up and down a flight of stairs inside, using a handrail

F3. Putting on and taking off long pants (including managing fasteners)

F4. Running 1/2 mile or more

F5. Using common utensils for preparing meals (e.g., can opener, potato peeler, or sharp knife)

F6. Holding a full glass of water in one hand

F7. Walking a mile, taking rests as necessary

F8. Going up & down a flight of stairs outside, without using a handrail

F9. Running a short distance, such as to catch a bus

F10. Reaching overhead while standing, as if to pull a light cord

F11. Sitting down in and standing up from a low, soft couch

F12. Putting on and taking off a coat or jacket

F13. Reaching behind your back as if to put a belt through a belt loop

F14. Stepping up and down from a curb

F15. Opening a heavy, outside door

F16. Rip open a package of snack food (e.g. cellophane wrapping on crackers) using only your hands
F17. Pouring from a large pitcher

F18. Getting into and out of a car/taxi (sedan)

F19. Hiking a couple of miles on uneven surfaces, including hills

F20. Going up and down 3 flights of stairs inside, using a handrail

F21. Picking up a kitchen chair and moving it, in order to clean

F22. Using a step stool to reach into a high cabinet

F23. Making a bed, including spreading and tucking in bed sheets

F24. Carrying something in both arms while climbing a flight of stairs (e.g. laundry basket)

F25. Bending over from a standing position to pick up a piece of clothing from the floor

F26. Walking around one floor of your home, taking into consideration thresholds, doors, furniture, and a variety of floor coverings

F27. Getting up from the floor (as if you were laying on the ground)

F28. Washing dishes, pots, and utensils by hand while standing at sink

F29. Walking several blocks

F30. Taking a 1 mile, brisk walk without stopping to rest

F31. Stepping on and off a bus

F32. Walking on a slippery surface outdoors

Response options:

- None
- A Little
- Some

- Quite a Lot
- Cannot do

Recent Health Care Utilization

ER Visits

1. In the past year, did you (he/she) go to the emergency room for any reason? Yes ☐
   No ☐
   Refused ☐
   DK ☐

[SKIP TO HOSPITAL ADMISSIONS]

[IF YES, ASK]:

1a. How many times did you (he/she) to go to the emergency room in the past year? — —

Hospital Admissions

1. In the past year, were you (he/she) admitted for an overnight stay, or longer, in the hospital for any reason? Yes ☐
   No ☐
   Refused ☐
   DK ☐

[SKIP TO ~~HOMECARE~~ NURSING HOME, CONVALESCENT HOME, OR REHAB]

[IF YES, ASK]:

2a. How many times were you (he/she) admitted to the hospital in the past year? — —

Nursing Home, Convalescent Home, Rehab Facility

1. In the past year, have you (he/she) stayed overnight in a nursing home, convalescent home, or rehab facility? Yes ☐
   No ☐
   Refused ☐
   DK ☐

[SKIP TO HOMECARE]

[IF YES, ASK]:

2a. How many times were you (he/she) admitted to a nursing home,

convalescent home, or rehab facility in the past year?	___

Home Care

1. In the past year, have you (he/she) had a visit from a home care worker such as a visiting nurse, homemaker, home health aide, etc.?	Yes	☐
[SKIP TO TRANSPORTATION]	No	☐
	Refused	☐
	DK	☐

[IF YES, ASK]:

3a. Are you (he/she) currently receiving any of the following home care services?

	Yes	No	REF	DK
Visiting Nurse	☐	☐	☐	☐
Physical Therapist	☐	☐	☐	☐
Occupational Therapist	☐	☐	☐	☐
Home Health Aide	☐	☐	☐	☐
Homemaker	☐	☐	☐	☐
Other	☐	☐	☐	☐

Other (specify): _____

Transportation

1. How do(es) you (he/she) travel to Doctor's appointments?	Drive Self	☐
	Driven by family member, friend, or other	☐

Public Transportation	☐
_____Other	☐
Refused	☐
DK	☐

NOTES: _____

2. When you (he/she) attend doctor appointments, does a family member or friend usually sit with you (him/her) during the visit?

Yes	☐
No	☐
Refused	☐
DK	☐

2a. [IF YES], who attends doctor appointments with you (him/her)?

Spouse	☐
Son or Daughter	☐
Niece or Nephew	☐
Grandchild	☐
Brother or Sister	☐
Friend/Neighbor	☐
Brother or Sister	☐
_____Other relative (please specify):	☐

Health Insurance

I'd like to ask you about your (his/her) health insurance:

1. Do you (he/she) have traditional Medicare or a Medicare Advantage plan?
   [NEED TO ADD DETAILS INTERVIEWERS COULD USE IF A SUBJECT IS HAVING TROUBLE FIGURE IT OUT]

[SKIP TO QUESTION 2]	Traditional	☐
[SKIP TO QUESTION 3]	Advantage	☐
	No	☐
~~[SKIP TO QUESTION4]~~	Refused	☐
	DK	☐

2. Part A of Medicare covers most hospital expenses. Part B covers many Doctor expenses, and the premium may be deducted from Social Security. Are you (he/she) covered under Part B of Medicare?

	Yes	☐
	No	☐
	Refused	☐
	DK	☐

3. Some people have chosen a Medicare Advantage plan (for example, a Medicare HMO or PPO health plan) instead of traditional Medicare. Are you (he/she) currently covered by a Medicare Advantage plan such as (***provide interviewers a list of 2-3 for each state we are calling)***

Essentia: Medicare Advantage
Healthcare Partners:
Johns Hopskins:
Mount Sinai:
Partners Healthcare: Medicare Advantage Plan
Reliant:
University of Iowa:
University of Michigan:
University of Pittsburgh:
University of Texas:

Yes ☐
No ☐
Refused ☐
DK ☐

[GO TO QUESTION 4]

3a. IF YES, What is the name of your (his/her) Medicare Advantage plan?

_____

4. Are you (he/she) covered by your (his/her) State's medical assistance (Medicaid) program? This is also called Title 19.

Essentia: Medical Assistance (or MA) or Medicaid
Healthcare Partners: Medi-Cal
Johns Hopkins: Medicaid/Medical Assistance or 8 HealthChoice Managed Care Organizations (most Medicaid participants mandated to join)
Mount Sinai: Medicaid
Partners Healthcare: MassHealth
Reliant: MassHealth
University of Iowa: Iowa Medicaid or Title 19
University of Michigan: Medicaid
University of Pittsburgh: *PENDING*
University of Texas: *PENDING*

Yes ☐
No ☐
Refused ☐
DK ☐

5. Are you (he/she) covered by any other public assistance program that pays for Medical Care?		
	Yes	☐
[GO TO QUESTION 6]	No	☐
	Refused	☐
	DK	☐
5a. IF YES, what is the name of that program?		
_____		

6. Not counting Medicare and the other programs we just talked about, do you (he/she) have any other health insurance or medical insurance that pays for hospital or doctor bills, such as VA or Medi-gap, or a Medicare Supplemental?		
	Yes	☐
	No	☐
	Refused	☐
	DK	☐

Financial Strain		
How difficult is it for you (his/her) / (your family) to meet monthly payments on your (his/her) (your family's) bills?	Not at all difficult	☐
	Not very difficult	☐
	Somewhat difficult	☐
	Very difficult	☐
	Completely difficult	☐
	Refused	☐
	DK	☐

INTERVIEWER ONLY: **Do you feel you were unblinded?**		Yes ☐ No ☐
PATIENT CONTACT INFORMATION		
We would like to be sure we have accurate contact information for you so that we can reach you again for a follow-up phone call.		
1.	When our staff contact or interact with you, what name do you prefer that they use? [*For example: Sally, Bill, Mr. or Mrs. Smith, Dr. Smith, etc.*]	_____
2.	When is the best time to reach you? [check all that apply] Morning ☐ Afternoon ☐ Evening ☐	
3.	Do you live at more than one address during the year?	Yes ☐ No ☐
	3a. If 'Yes', Secondary Address	_____
	3b. If 'Yes', City, State, Zip	_____
	3c. If 'Yes', Telephone	___-___-_____
	3d. If 'Yes', When do you live at this address?	_____

APPENDIX 7.5 SURROGATE QUESTIONNAIRE

7-5 Surrogate/Other Contact Information Script from Baseline Interview

SURROGATE INFORMATION

IF PARTICIPANT INTERVIEW: Please provide the name, address, and telephone number of someone who could provide information and answer questions for you in the event that you are unable to answer yourself.
IF SURROGATE INTERVIEW, Please provide your name, address, and telephone number.

1. What is the name of the surrogate / your name (prefix, first name, last name)?

   _____

2. What is the address of the surrogate / your address (address, city, state, zip code)?

   _____

IF SURROGATE INTERVIEW, Should study materials such as calendars be mailed to the participant's address or your address? ☐ Participant ☐ Surrogate

3. What is the primary telephone number of the /surrogate / for you?
   (__ __ __) __ __ __ - __ __ __ __

4. What is the cell phone number of the surrogate/ for you?

   (__ __ __) __ __ __ - __ __ __ __

IF PARTICIPANT INTERVIEW ASK QUESTIONS 5-7.
IF SURROGATE INTERVIEW, SKIP QUESTIONS 5-7.

5. What is the relationship of the surrogate to you?

Spouse	☐
Son or Daughter	☐
Niece or Nephew	☐
Grandchild	☐
Brother or Sister	☐
Friend/Neighbor	☐
Brother or Sister	☐
_____ Other relative (please specify):	☐

6. How long has the surrogate known you?

   Months Years

7. How many days per week (0-7) does the surrogate see you and/or talk with you?
   Face-to-Face contacts: ____ Telephone contacts: ____

8. Gender of surrogate

Male	☐
Female	☐

9. Race of surrogate

- White ☐
- Black ☐
- Hispanic ☐
- _____ Other ☐
- _____ Other ☐

OTHER CONTACTS INFORMATION

Please provide the name, address, and telephone number of two close friends or relatives who do not live with you (him/her) and who would know how to reach you (him/her) in case you (he/she) move. They do not have to be local:

OTHER CONTACT #1

1. What is the name of other Contact #1 (prefix, first name, last name)?

   _____

2. What is the address of other Contact #1 (address, city, state, zip code)?

   _____

3. What is the primary telephone number of other Contact #1?

   (__ __ __) __ __ __ - __ __ __ __

4. What is the cell phone number of the other Contact #1?

   (__ __ __) __ __ __ - __ __ __ __

5. What is the relationship of other Contact #1 to the participant?

- Spouse ☐
- Son or Daughter ☐
- Niece or Nephew ☐
- Grandchild ☐
- Brother or Sister ☐
- Friend/Neighbor ☐
- Brother or Sister ☐
- _____ Other relative (please specify): ☐

OTHER CONTACT #2

1. What is the name of other Contact #2 (prefix, first name, last name)?

   _____

2. What is the address of other Contact #2 (address, city, state, zip code)?

   _____

3. What is the primary telephone number of other Contact #2?

   (__ __ __) __ __ __ - __ __ __ __

4. What is the cell phone number of the other Contact #2?

   (__ __ __) __ __ __ - __ __ __ __

5. What is the relationship of other Contact #2 to the participant?

Spouse	☐
Son or Daughter	☐
Niece or Nephew	☐
Grandchild	☐
Brother or Sister	☐
Friend/Neighbor	☐
Brother or Sister	☐
_____ Other relative (please specify):	☐

APPENDIX 7.6 THANK YOU NOTE

STrategies to Reduce Injuries and Develop confidence in Elders
STRIDE

«Street address»
«City», «State» «Zipcode»
«Date»

Dear «Salutation» «LastName»,

On behalf of the STRIDE Study, I would like to express my sincere thanks for the time you have given and the interest you have shown. You are one of 6,000 older adults from across the country who decided to work with us to better understand how falls might be prevented.

Enclosed with this letter you will find the calendar we discussed. Please use it each day to record whether you have a fall or not. At the end of each month, please complete the questions about any falls you had. In 4 months, we will call you to ask about any falls or other changes to your health.

The information that you share with us is held in strict confidence; your name is never disclosed. Knowledge gained from this study is being used to develop new programs to prevent falls.

Let me close by thanking you again for your important contribution to this study. Research such as ours cannot be done without the cooperation and goodwill of many individuals like yourself. I hope that we will continue working together to promote the health and well-being of older people.

Please feel free to contact the STRIDE study staff at Yale University with any questions at toll-free number 1-844-978-7433 (STRIDE) or by email at STRIDE@yale.edu.

Sincerely,

Thomas Gill, M.D.
STRIDE Assessment Center on behalf of the STRIDE research team

APPENDIX 7.7 SCRIPT FOR TRAINING SUBJECTS IN USE OF FALL CALENDARS

"Mr./Mrs. _____, please pull out the calendar that was mailed to you. As the instructions at the top state, you are asked to record on this calendar at the end of each day:

PLEASE MARK THE CALENDAR AS FOLLOWS:

- "F" ON EACH DAY YOU (PATIENT's NAME)HAD A FALL
- "N" ON EACH DAY YOU (PATIENT'S NAME) DID NOT FALL

- **A fall is an unexpected event in which you involuntarily ended up on the ground, floor, or lower level, including falls that occurs on stairs or out of bed or a fall from a ladder.**

- At the end of each month, please complete the questions on the back of the calendar.

Question 1 asks: "Were you injured in any fall this month?" a. If NO, check the box. You do not need to answer the remaining questions.

Question 1a. If you were injured in a fall this month, please indicate the type of injury under Mark all that apply. The injury might be:

i. Broke or fractured a bone
ii. Dislocated a joint
iii. Injured my head
iv. Cut with bleeding
v. Sprain or a strain
vi. Bruising or swelling
vii. Other injury

Please describe your injury or injuries in the space provided.

Question 1b asks, "What was the date of the injury?" "If more than 1 injury, please provide additional dates." Please record the date(s) of injury.

Question 1c asks, "Did you see a doctor or other health care professional for the injury?"

If NO, check the box. You do not need to answer the last question.

Question 1d asks, "Where did you go for care?" If you saw a doctor or other health care professional for the injury, please mark all that apply and write name and location of facility in the space provided to the right. The choices include:

i. Emergency room
jj. Stayed overnight in the hospital

iii. Doctor's office or other facility

- After you have answered the questions on the back of the calendar, you can start recording any falls for the next month. Please save your monthly calendars, since you will need to refer to them when we call you in 4 months.

- Please mark an "X" on yesterday to indicate that you will begin the recording today.

- As you can see, the calendar you received is for [XX] month and [YY] month. . This is only a sample, so you can begin recording today. We will send you a larger calendar in the mail. That calendar will go through the next 5 months. It will also have a clip with a magnet so you can place it on your refrigerator if you like.

- Do you have any questions about the calendar?"

APPENDIX 7.8 4-MONTHLY FOLLOW-UP INTERVIEW

STRIDE 4-Month FOLLOW-UP TELEPHONE QUESTIONNAIRE

STUDY ID: ☐☐☐☐☐☐☐☐

INTERVIEWER ID: ☐☐☐

DATE OF INTERVIEW: M M D D Y Y Y Y ☐☐ ☐☐ 2 0 ☐☐

TYPE OF INTERVIEW:
- ☐ Participant
- ☐ Surrogate

INTERVIEW DISPOSITION:
- ☐ Complete
- ☐ Partial Interview: Participant refusal
  - end at question number ☐
- ☐ Partial Interview: Surrogate refusal
  - end at question number ☐
- ☐ Interview not completed: Participant refusal
- ☐ Interview not completed: Surrogate refusal
- ☐ Interview not completed: Requests dropout
- ☐ Interview not completed: Too ill
- ☐ Interview not completed: Died
- ☐ Interview not completed: Unable to contact
- ☐ Interview not completed: Other (specify)

_____

SURROGATE SCRIPTS IF NEEDED:

1. Established SURROGATE

Hello, may I please speak with _____.

Hello, my name is _____. I am with the STRIDE Study. You may recall that you assisted _____ [PATIENT's NAME when s/he enrolled in the study about 4months ago. At this time, we are calling to see how _____ [PATIENT's NAME] has been.

I have a few questions to ask you over the phone. Is this a good time for you?

2. New surrogate (complete a surrogate information sheet)

Hello, may I please speak with _____.

Hello, my name is _____. I am with the STRIDE Study, working with _____ [PRACTICE NAME] . Mr/s. _____ is a participant in the study and s/he had given us your name as a person to call if we were not able to reach him/her (or if s/he were not able to answer for him/herself).

At this time, we are calling to see how _____ [PATIENT's NAME] has been.

I have a few questions to ask you over the phone. Is this a good time for you?

Hello, my name is **[INTERVIEWER NAME]** from the STRIDE Study. How are you today?

I am calling to ask you some questions about your(his/her) activities during the past 4 months (since enrollment date or last contact).

I would like you to refer to your (his/her) responses on the fall calendars from the past four months. Can you please try to locate these calendars?

Do you have fall calendars to review?	☐ Yes
	☐ No
If YES, have you (he/she) been recording information about falls (daily yes/no and end of the month questions)?	☐ Yes
	☐ No
IF PARTICIPANT <u>DOES NOT</u> HAVE CALENDARS OR <u>HAS NOT</u> BEEN USING THEM, ASK WHY AND RECORD THEIR RESPONSES VERBATIM:	
IF PARTICIPANT <u>HAS</u> THE CALENDARS AND <u>HAS</u> BEEN USING THEM, ASK HOW THEY HAVE BEEN USING THEM AND RECORD THEIR RESPONSES VERBATIM:	

Have you (he/she) fallen in the past 4 months (or since last contact)? ☐ Yes ☐ No

1a. How many times have you (he/she) fallen?					**GO TO PAGE 10**
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5 or more	
1b. Were you (he/she) injured in any fall in the past 4 months (or since last contact)? ☐ Yes ☐ No					
1c. IF YES, How many falls did you (he/she) have that led to an injury: ☐					**GO TO PAGE 10**

[IF ONLY ONE FALL INJURY EPISODE:]

I am going to ask you some questions about your (his/her) fall injury. **[GO TO PAGE 5, QUESTION 1.]**

[IF MORE THAN ONE FALL INJURY EPISODE:]

I am going to ask you a series of questions about each fall injury that you (he/she) reported. First, I would like to ask you some questions about your (his/her) most recent injury. **[GO TO PAGE 5, QUESTION 1.]**

QUESTIONS 1 THROUGH 10 WILL BE REPEATED FOR EACH REPORTED INJURY

FALL INJURY #: _____

1. What was the date of this fall injury?	M M D D Y Y Y Y ☐☐ ☐☐ 2 0 ☐☐
Could you please describe to me what happened when you (he/she) fell on **[DATE OF INJURY] [RECORD R'S RESPONSE VERBATIM.]**	

Next, I'd like to ask you a few more specific questions about your (his/her) fall and injury. You may already have told me some of this, but I need to make sure that I have everything.

2. Did you (he/she) land on the floor, ground or other lower level when you (he/she) fell?	☐ Yes Participant landed on the ground, floor or other lower level
	☐ No Participant did not land on the ground, floor or other lower level
	☐ Refused
	☐ DK
3. Did you (he/she) faint, pass out, blackout or lose consciousness?	☐ Yes
	☐ No
	☐ Refused
	☐ DK

4. Were you (he/she) knocked down by someone or something?	☐ Yes
	☐ No
	☐ Refused
	☐ DK
5. When you (he/she) fell, did you break or fracture a bone?	☐ Yes
[IF NOT SURE, PROBE: "WERE YOU TOLD BY A DOCTOR, OR OTHER HEALTH PROFESSIONAL, THAT YOU FRACTURED A BONE?]	☐ No **[GO TO Q6 OTHER INJURY]**
	☐ Refused **[GO TO Q6 OTHER INJURY]**
	☐ DK **[GO TO Q6 OTHER INJURY]**
5a. [IF YES] What bone(s) did you (he/she) break or fracture?	
[DO NOT READ LIST, BUT CHECK ALL THAT PARTICIPANT MENTIONS THAT DOCTOR SAID FRACTURED]	

☐ Head/skull	☐ Shoulder/Upper arm	☐ Hip	
☐ Face	☐ Shoulder blade	☐ Upper leg/femur	
☐ Neck	☐ Elbow	☐ Knee	
☐ **C**ollar bone	☐ Lower arm	☐ Lower leg	
☐ Ribs	☐ Wrist	☐ Foot/toes	
☐ Tailbone	☐ Hand/fingers	☐ Ankle	
☐ Back/Spine Vertebrae (non-neck and non-tailbone)	☐ Pelvis		
☐ Other (specify):			

6. Now I am going to read a list of some injuries you (he/she) may have had from your (his/her) fall. Can you tell me, yes or no, if you (he/she) had a....?				
[READ ALL RESPONSES AND CHECK ANY THAT R RESPONDS YES]				
Dislocated joint?	☐ Yes	☐ No	☐ Refused	☐ DK
Injury to your head?	☐ Yes	☐ No	☐ Refused	☐ DK
Cut with bleeding?	☐ Yes	☐ No	☐ Refused	☐ DK
	If yes, were stitches, staples or some type of glue used to close the cut?		☐ Yes ☐ No ☐ Refused ☐ DK ☐ NA	
Sprain or a strain? Includes a pulled or torn muscle, tendon or ligament	☐ Yes	☐ No	☐ Refused	☐ DK
Bruising or swelling?	☐ Yes	☐ No	☐ Refused	☐ DK
Other injury [SPECIFY BELOW]?	☐ Yes	☐ No	☐ Refused	☐ DK

6a. Can you describe the injury (circumstances of fall/injury and location of injury)?
[RECORD VERBATIM]

7. Did you (he/she) see a doctor or other health care professional for the injury?	☐ Yes
	☐ No **[GO TO Q9)**
	☐ Refused **[GO TO Q9)**
	☐ DK **[GO TO Q9)**
7a. **[IF YES, PROBE:]** Did you (he/she) go to the emergency room, doctor's office or other facility? [IF YES, ASK: What was the name and location of the (emergency room / doctor's office / other facility) you (he/she) went to? What was the date you (he/she) went there?]	

☐ Yes, Emergency Room	M M D D Y Y Y Y ☐☐ ☐☐ 2 0 ☐☐	Name and location of facility:
☐ Yes, Doctor's Office	M M D D Y Y Y Y ☐☐ ☐☐ 2 0 ☐☐	Name and location of doctor:
☐ Yes, Other facility	M M D D Y Y Y Y ☐☐ ☐☐ 2 0 ☐☐	Name and location of facility:
☐ Refused		
☐ DK		

8. Were you (he/she) admitted for an overnight stay, or longer, in the hospital following your injury? [IF YES, ASK: What was the name and location of the hospital where you (he/she) stayed overnight? What was the date you (he/she) were admitted to the hospital?]		☐ Yes
[IF YES]:	M M D D Y Y Y Y ☐☐ ☐☐ 2 0 ☐☐	☐ No
	Name and location of facility:	☐ Refused
		☐ DK

9. Did the injury from your (his/her) fall cause you (him/her) to stay in bed for a least half a day or to cut down on your (his/her) usual activities?	☐ Yes
	☐ No
	☐ Refused
	☐ DK
10. Did the injury from your (his/her) fall lead to pain that lasted for more than a day?	☐ Yes
	☐ No
	☐ Refused
	☐ DK

[IF MULTIPLE FALL INJURY EPISODES REPORTED, REPEAT QUESTIONS 1 THROUGH 10 FOR <u>EACH</u> EPISODE]

We are now finished with the questions for this most recent fall injury…
You indicated that you (he/she) had more than one fall that led to an injury ….

[IF <u>ONLY 1</u> FALL INJURY REPORTED OR <u>LAST</u> FALL INJURY]

We are now finished with the questions related to your (his/her) fall injury(ies).

Health Care Utilization and Administrative Questions

Before we end, I have a few additional questions that I would like to ask you.

IF PARTICIPANT WAS HOSPITALIZED FOR A FALL INJURY, ASK: ☐ Yes ☐ No

Other than for a fall injury, were you (he/she) admitted for an overnight stay, or longer, in the hospital any other reason in the past 4 months (since enrollment date or last contact)?

IF PARTICIPANT WAS NOT HOSPITALIZED FOR A FALL INJURY, ASK:

Were you (he/she) admitted for an overnight stay, or longer, in the hospital for any reason in the past 4 months (since enrollment date or last contact)?

If Yes, number of times: ☐

GO TO PAGE 12

Hospitalization #1:

If Yes, where were you (he/she) hospitalized:

Name of hospital: _____

Location of hospital: _____

If Yes, what dates were you (he/she):

Admitted: ____ ____ / ____ ____ / ____ ____ ____ ____

Discharged: ____ ____ / ____ ____ / ____ ____ ____ ____

If Yes, what was the major reason you (he/she) were hospitalized?

Hospitalization #2 (IF APPLICABLE):

If Yes, where were you (he/she) hospitalized:

Name of hospital: _____

Location of hospital: _____

If Yes, what dates were you (he/she):

Admitted: ____ ____ / ____ ____ / ____ ____ ____ ____

Discharged: ____ ____ / ____ ____ / ____ ____ ____ ____

If Yes, what was the major reason you (he/she) were hospitalized?

2. Have you (he/she) stayed overnight in a nursing home, convalescent home or rehab facility in the past 4 months (since enrollment date or last contact)? ☐ Yes ☐ No

If Yes, number of times: ☐

GO TO PAGE 13

Facility #1:

If Yes, specify facility name, location, and dates:

Name of facility: _____

Location of facility: _____

If Yes, what dates were you (he/she) in the facility:

Admitted: ____ ____ / ____ ____ / ____ ____ ____ ____

Discharged: ____ ____ / ____ ____ / ____ ____ ____ ____

If Yes, what was the major reason for being in the facility?

_____

Facility #2:

If Yes, specify facility name, location, and dates:

Name of facility: _____

Location of facility: _____

If Yes, what dates were you (he/she) in the facility:

Admitted: ____ ____ / ____ ____ / ____ ____ ____ ____

Discharged: ____ ____ / ____ ____ / ____ ____ ____ ____

If Yes, what was the major reason for being in the facility?

3. I would like to confirm that we have your correct contact information. Is this correct? ☐ Yes ☐ No

[Display both patient and surrogate current address and phone number]

If No, specify the changes:

4. In the next 4 months, do you or [PATIENT NAME] plan to change your (his/her) address and/or phone number? ☐ Yes ☐ No

If Yes, specify the changes:

Who provided the answers for this questionnaire? (please select the best option)

☐ Participant

☐ Surrogate (provided consent for STRIDE participation)

☐ Other (complete next page before ending interview):

That was our last question. Thank you for answering these important questions for the STRIDE study.

Do you have any questions before we hang-up?
Great, be well, and thank you for participating in this important study.

INTERVIEWER ONLY:
Do you feel you were unblinded? Yes ☐ No ☐

OTHER SURROGATE INFORMATION

1. What is your name (prefix, first name, last name)?

_____

2. What is your the address (address, city, state, zipcode)?

_____

3. What is your primary telephone number?

(__ __ __) __ __ __ - __ __ __ __

4. What is your cell phone number?

(__ __ __) __ __ __ - __ __ __ __

5. What is your relationship to the participant?

Spouse ☐
Son or Daughter ☐
Niece or Nephew ☐
Grandchild ☐
Brother or Sister ☐
Friend/Neighbor ☐
Brother or Sister ☐
_____ Other relative (please specify): ☐

6. How long have you known the participant? Months ___

7. How many days per week (0-7) do you see and/or talk with [PATIENT'S NAME]?

Face-to-Face contacts: _____ Telephone contacts: _____

8. Gender

Male ☐
Female ☐

9 . **Race of Surrogate**

Do you consider yourself to be:

- White ☐
- Black/ African American ☐
- American Indian/Alaskan Native ☐
- Asian ☐
- Native Hawaiian/ Other Pacific Islander ☐
- More than 1 race ☐
- _____Other ☐
- Refused ☐
- DK ☐

10. Ethnicity of Surrogate

Do you consider yourself to be:

- Hispanic/Latino ☐
- Non-Hispanic/Latino ☐
- Refused ☐
- DK ☐

IF HEALTH CARE PROVIDER – END HERE

9. How old are you? Years __

10. What was the last grade you completed in school? Grade __

No formal education = 00 High School = 09-12

Elementary school = 01-08 College = 13-17

APPENDIX 7.9 LIST OF QUALIFYING CLAIMS/ENCOUNTER CODES

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
1. Hip Fracture						
Hip fracture	820.xx	79.05, 79.15, 79.25, 79.35, 79.65	S72.0xx, S72.1xx, S72.2xx	0QS6xxx, 0QS7xxx	27230-27248, 27267-27269	
2. Other Fracture						
Cervical spine	805.0x-805.1x		S12.0xx, S12.1xx, S12.2xx, S12.3xx, S12.4xx, S12.5xx, S12.6xx, S12.9xx		22326	CPT codes 22318 and 22319 are for "odontoid fracture and/or dislocation." I did not include them since the use of the code does not necessarily indicate a fracture.
Sacrum/coccyx	805.6x-805.7x		S32.1xx, S32.2xx		27200, 27202	
Rib	807.0x-807.1x		S22.3xx, S22.4xx		21805-21813	
Pelvis	808.xx		S32.3xx, S32.4xx, S32.5xx, S32.6xx, S32.8xx		27193-27194, 27215-27228	
Clavicle	810.xx		S42.0xx		23500-23515	
Scapula	811.xx		S42.1xx		23570-23585	

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
Humerus	812.xx	79.01, 79.11, 79.21, 79.31, 79.61	S42.2xx, S42.3xx, S42.4xx, S49.0xx, S49.1xx	0PSCxxx, 0PSDxxx, 0PSFxxx, 0PSGxxx	23600-23630, 23665-23680, 24500-24587	
Radius & ulna	813.xx	79.02, 79.12, 79.22, 79.32, 79.62	S52.xxx, S59.0xx, S59.1xx, S59.2xx	0PSHxxx, 0PSJxxx, 0PSKxxx, 0PSLxxx	24586, 24587, 24620, 24635, 24650-24685, 25500-25609, 25650-25652	
Carpals (including scaphoid)	814.xx	79.03, 79.13, 79.23, 79.33, 79.63	S62.0xx, S62.1xx	0PSMxxx, 0PSNxxx	25622-25645, 25680, 25685	
Hand - metacarpal	815.xx	79.03, 79.13, 79.23, 79.33, 79.63	S62.2xx, S62.3xx	0PSPxxx, 0PSQxxx	26600-26615, 26645, 26650, 26665, 26740, 26746	
Hand - phalanges	816.xx	79.04, 79.14, 79.24, 79.34, 79.64	S62.5xx, S62.6xx	0PSRxxx, 0PSSxxx, 0PSTxxx, 0PSVxxx	26720-26765	
Hand - multiple fractures	817.xx	See comment	See comment	See comment	same as for metacarpals and/or phalanges	No functional match for dx -- consider S62.9xx

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
4. Joint Dislocation						
a. Shoulder	831.xx	79.71, 79.81	S43.0xx, S43.1xx	0RSJxxx, 0RSKxxx	23650-23680	
b. Elbow	832.xx	79.72, 79.82	S53.0xx, S53.1xx	0RSLxxx, 0RSMxxx	24600, 24605, 24620, 24635	Excluded 24615 because dislocation could be acute or chronic
c. Wrist	833.xx	79.73, 79.83	S63.0xx	0RSQxxx, 0RSRxxx	25660-25695	
d. Knee	836.xx	79.76, 79.86	S83.0xx, S83.1xx, S83.2xx, S83.3xx	0SSCxxx, 0SSDxxx	27550-27566	ICD-9 code 836.0 - 836.2 (meniscal tear) corresponds to S83.2xx-S83.3xx
5. Laceration requiring closure						

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
Laceration closure	n/a	86.5, 86.59	n/a	0HQ0XZZ, 0HQ1XZZ, 0HQ2XZZ, 0HQ3XZZ, 0HQ4XZZ, 0HQ5XZZ, 0HQ6XZZ, 0HQ7XZZ, 0HQ8XZZ, 0HQ9XZZ, 0HQAXZZ, 0HQBXZZ, 0HQCXZZ, 0HQDXZZ, 0HQEXZZ, 0HQFXZZ, 0HQGXZZ, 0HQHXZZ, 0HQJXZZ, 0HQKXZZ, 0HQLXZZ, 0HQMXZZ, 0HQNXZZ, 0HQQXZZ, 0HQRXZZ, 0HQTXZZ, 0HQUXZZ, 0HQVXZZ, 0HQWXZZ, 0HQYXZZ	12001-12018, 12031-13153	
6. Sprains/Strains						

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
Femur, tibia, fibula	821.xx, 823.xx	79.05, 79.06, 79.15, 79.16, 79.25, 79.26, 79.35, 79.36, 79.65, 79.66	S72.3xx, S72.4xx, S72.8xx, S72.9xx, S82.1xx, S82.2xx, S82.3xx, S82.4xx, S82.81x, S82.82x, S82.83x, S82.86x	0QS8xxx, 0QS9xxx, 0QSBxxx, 0QSCxxx, 0QSGxxx, 0QSHxxx, 0QSJxxx, 0QSKxxx	27500-27514, 27530-27540, 27750-27759, 27780-27792, 27824-27828	
Patella	822.xx		S82.0xx		27520, 27524	
Ankle	824.xx		S82.5xx, S82.6xx, S82.84x, S82.85x, S82.87x, S82.89x		27760-27769, 27808-27823, 28430-28445	
Foot and toes	825.xx, 826.xx	79.07, 79.08, 79.17, 79.18, 79.27, 79.28, 79.37, 79.38, 79.67, 79.68	S92.xxx	0QSLxxx, 0QSMxxx, 0QSNxxx, 0QSPxxx, 0QSQxxx, 0QSRxxx	28400-28420, 28450-28531	
3. Head Injury						
a. Head and face fracture	800.xx-804.xx	21.71, 21.72, 76.7x,	S02.xxx	See comment	21310-21423, 21440-21470, 62000-62010	Not clear that ICD-10 procedure codes are specific for fracture
b. Head trauma	850.xx-854.xx		S06.xxx		see comment	difficult to determine which procedures apply to these

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
Neck	847.0		S13.4xx, S13.5xx, S13.8xx, S13.9xx, S16.1xx			
Back, lumbar spine, lower back, sacroiliac, coccyx	846.xx, 847.2, 847.3, 847.4, 847.9		S33.5xx, S33.6xx, S33.8xx, S33.9xx, S39.012			
Shoulder, rotator cuff, upper arm	840.xx		S43.4xx, S43.5xx, S43.6xx, S43.8xx, S43.9xx, S46.01x, S46.11x, S46.21x, S46.31x, S46.81x, S46.91x			
Elbow, forearm	841.xx		S53.4xx, S56.01x			

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
Wrist, Finger(s), Hand	842.xx		S63.5xx, S63.6xx, S63.8xx, S63.9xx, S56.11x, S56.21x, S56.31x, S56.41x, S56.51x, S56.81x, S56.91x, S66.01x, S66.11x, S66.21x, S66.31x, S66.41x, S66.51x, S66.81x, S66.91x			
Hip, thigh	843.xx		S73.1xx, S76.01x, S76.11x, S76.21x, S76.31x, S76.81x, S76.91x			

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
Knee, leg, lower leg	844.xx		S83.4xx, S83.5xx, S83.6xx, S83.8xx, S83.9xx, S86.11x, S86.21x, S86.31x, S86.81x, S86.91x,			
Ankle, Achilles tendon, toe, foot	845.xx		S93.4xx, S86.01x, S93.5xx, S93.6xx, S96.01x, S96.11x, S96.21x, S96.81x, S96.91x			
7. Bruising						

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
Scalp, face, head, neck	910.0, 910.1, 910.8, 910.9, 920.xx		S00.00x, S00.01x, S00.03x, S00.30x, S00.31x, S00.33x, S00.40x, S00.41x, S00.43x, S00.50x, S00.51x, S00.53x, S00.80x, S00.81x, S00.83x, S00.90x, S00.91x, S00.93x, S10.90x, S10.91x, S10.93x			

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
Torso, trunk	911.0, 911.1, 911.8, 911.9, 922.xx		S20.0xx, S20.10x, S20.11x, S20.2xx, S20.30x, S20.31x, S20.40x, S20.41x, S20.90x, S20.91x, S30.0xx, S30.1xx, S30.2xx, S30.3xx, S30.81x, S30.9xx			

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
Shoulder, arm, elbow, wrist, hand, fingers	912.0, 912.1, 912.8, 912.9, 913.0, 913.1, 913.8, 913.9, 914.0, 914.1, 914.8, 914.9, 915.0, 915.1, 915.8, 915.9, 923.xx		S40.0xx, S40.21x, S40.81x, S40.9xx, S50.0xx, S50.1xx, S50.31x, S50.81x, S50.9xx, S60.0xx, S60.1xx, S60.2xx, S60.31x, S60.39x, S60.41x, S60.51x, S60.81x, S60.9xx			

Body site or type of injury	ICD-9 Diagnosis	Tentative ICD-9 Procedure	Tentative ICD-10 Diagnosis	Tentative ICD-10 Procedure	CPT Repair procedure	Comment
Hip, thigh, leg, ankle, foot, toes	916.0, 916.1, 916.8, 916.9, 917.0, 917.1, 917.8, 917.9, 924.0x, 924.1x, 924.2x, 924.3, 924.4, 924.5		S70.0xx, S70.1xx, S70.21x, S70.31x, S70.9xx, S80.0xx, S80.1xx, S80.21x, S80.81x, S80.9xx, S90.0xx, S90.1xx, S90.2xx, S90.3xx, S90.41x, S90.51x, S90.81x, S90.9xx			
8. Swelling						
Limb	729.81		R22.3xx, R22.4xx			
Localized superficial swelling	782.2		R22.9xx			
Head and neck	784.2		R22.0xx, R22.1xx			
Trunk, Chest, Abdomen or pelvis	786.6, 789.3x		R22.2xx			

APPENDICES CHAPTER 8 – SAFETY MONITORING AND PROCEDURES FOR ADVERSE EVENTS AND SERIOUS ADVERSE EVENTS

8.1 UNANTICIPATED PROBLEM EVENT REPORT

APPENDIX 8.1 UNANTICIPATED PROBLEM EVENT REPORT

I. PROTOCOL INFORMATION:

IRB Protocol Number: Protocol Name:

II. SITE PRINCIPAL INVESTIGATOR INFORMATION:

Name (first, middle, last, degree(s):	
Dept/service:	Division/unit:
Address:	
Phone:	Beeper:
Fax:	Email:

III. RESEARCH SUBJECT IDENTIFICATION:

Subject's Initials:	DOB:
Study ID:	Gender:

IV. UNANTICIPATED PROBLEM INFORMATION:

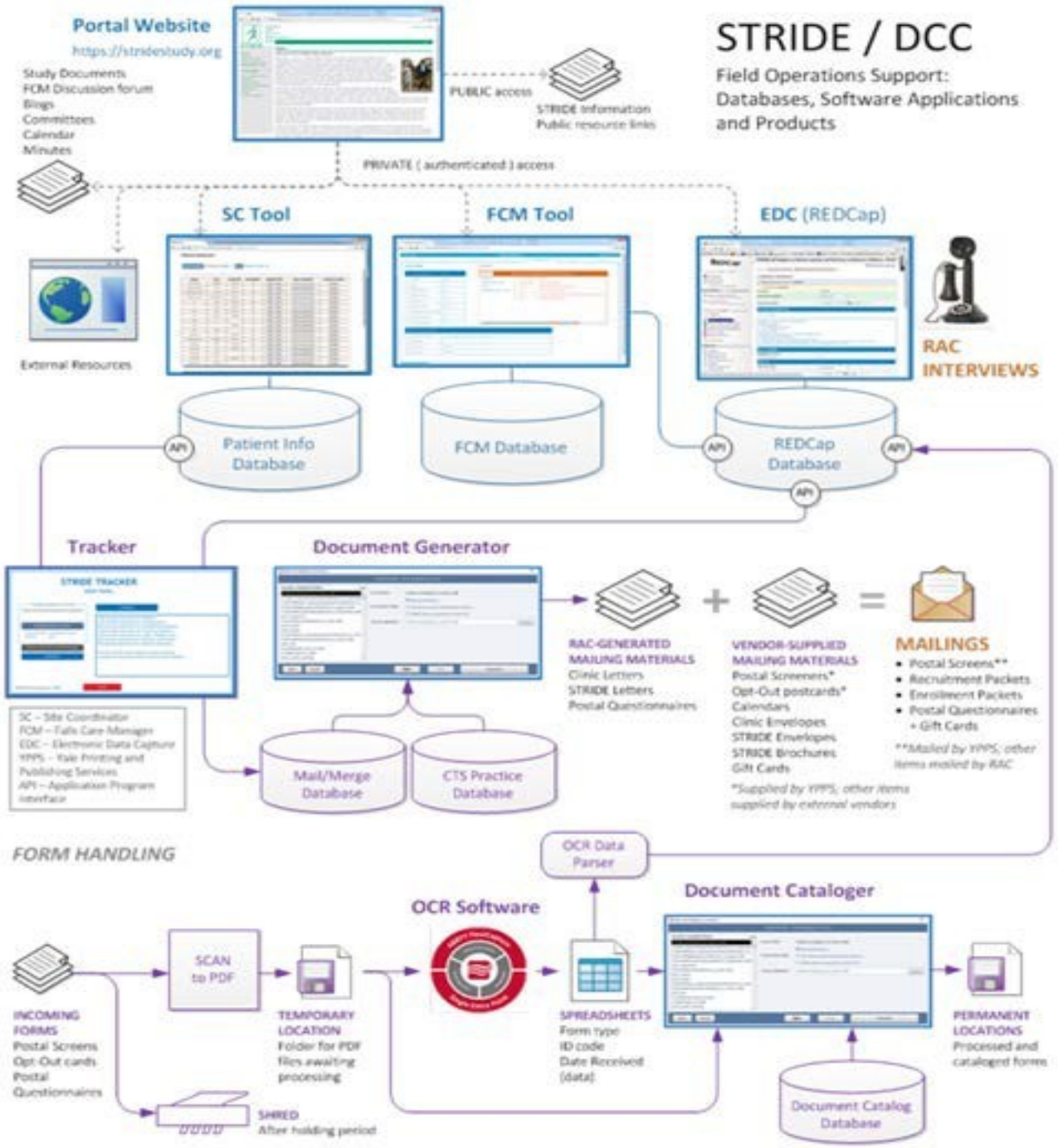
Date of event:	Time of event:
Location of event:	
Description of event:	

V. REPORT PREPARATION INFORMATION:

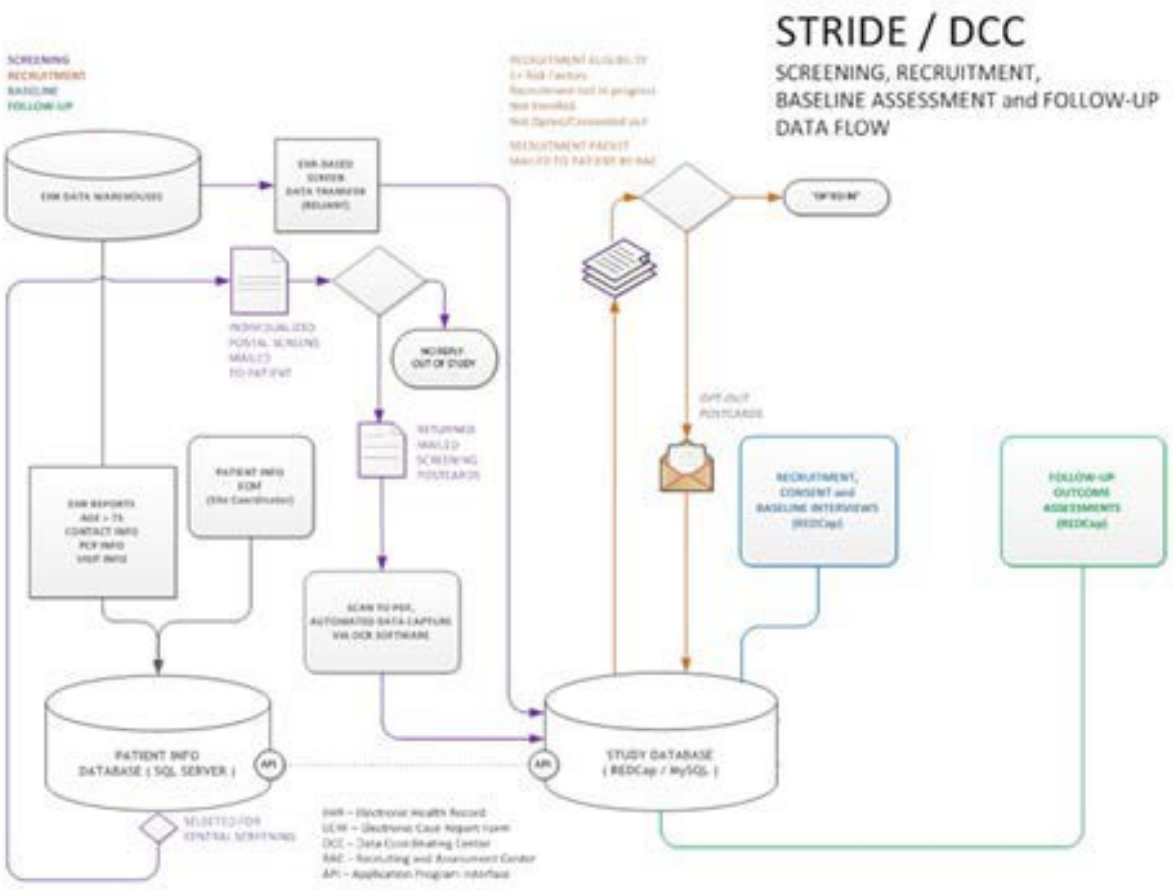
Person Preparing Report (if different from Principal Investigator): . Title: Phone: Email:
Signature of Principal Investigator:
Date of this report: (mm/dd/yyyy)

APPENDICES CHAPTER 9 - DATA MANAGEMENT

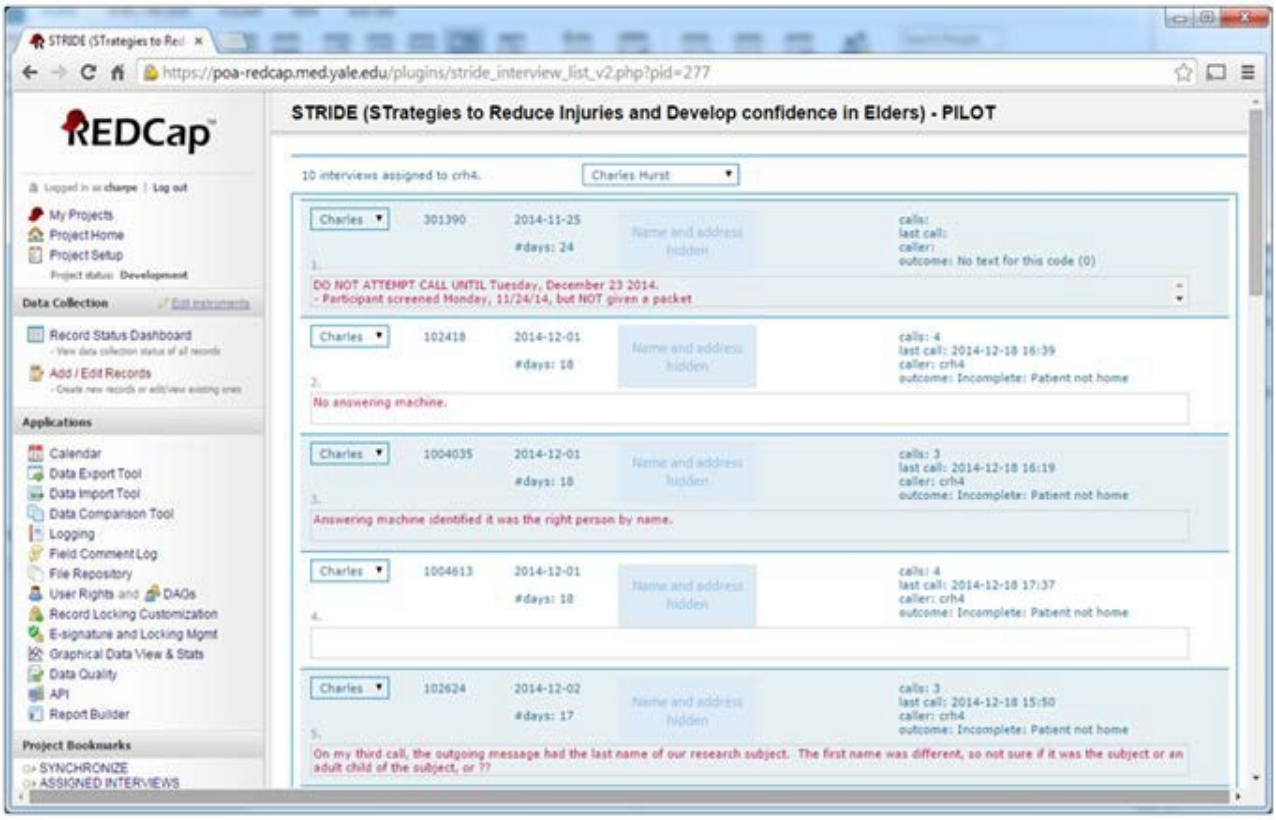
APPENDIX 9.1 STRIDE DCC FIELD OPERATIONS SUPPORT



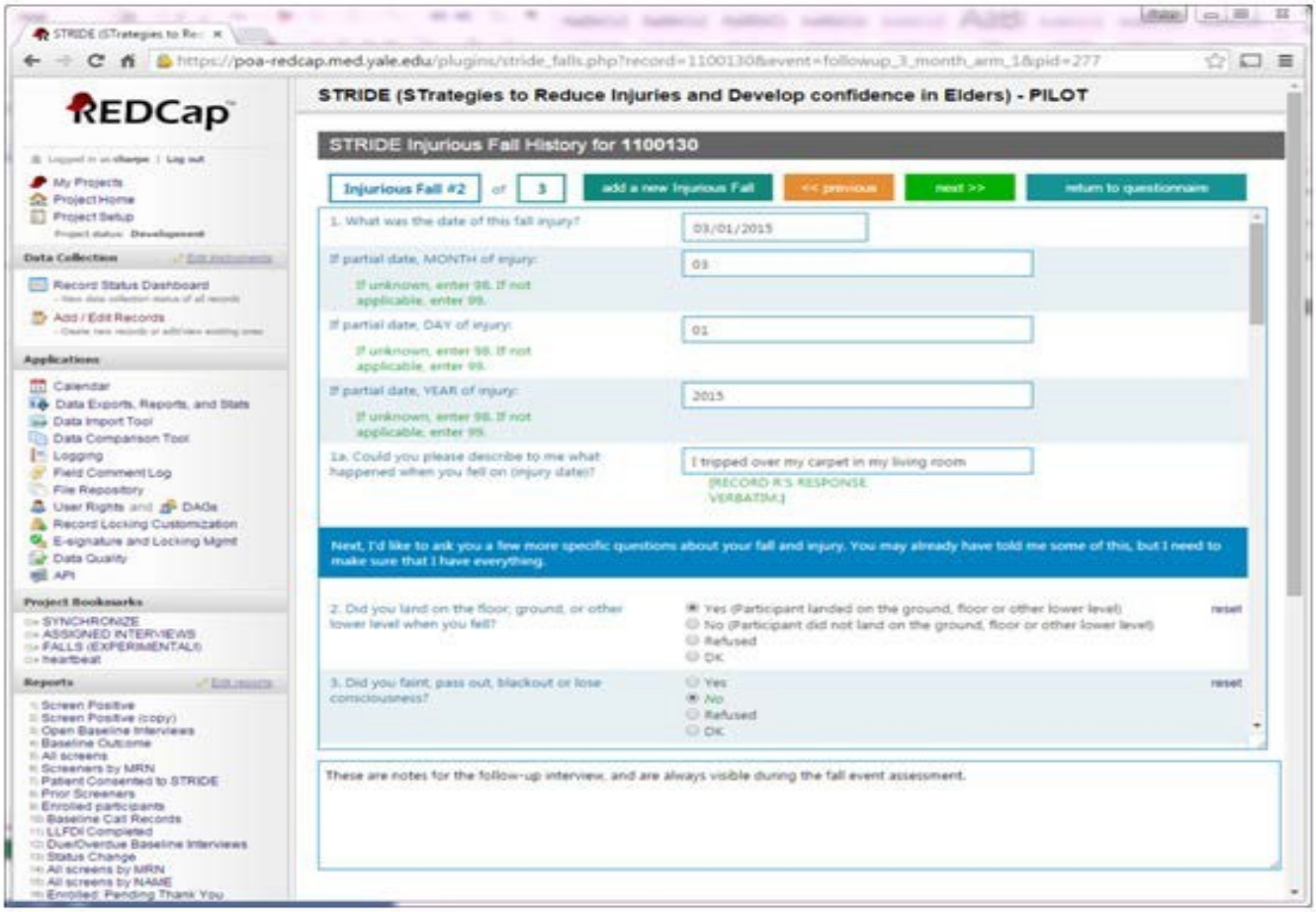
APPENDIX 9.2 OVERVIEW DCC STRIDE WORK FLOW



APPENDIX 9.3 OVERVIEW REDCAP SUPPORT STRIDE WORKFLOW

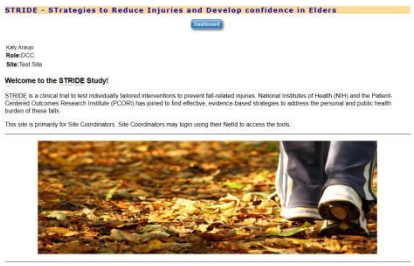


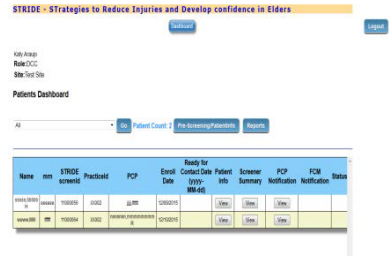
APPENDIX 9.4 FALL EVENTS PLUG-IN

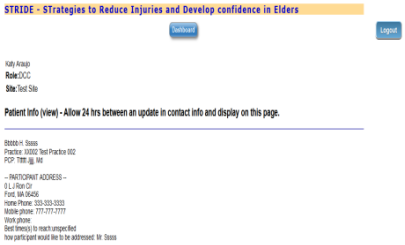


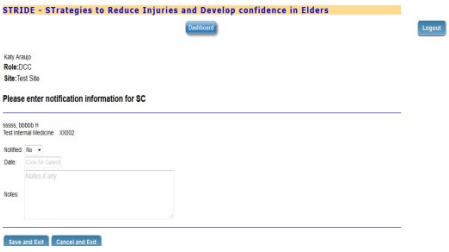
APPENDIX 9.5 THE STRIDE SC WEBSITE

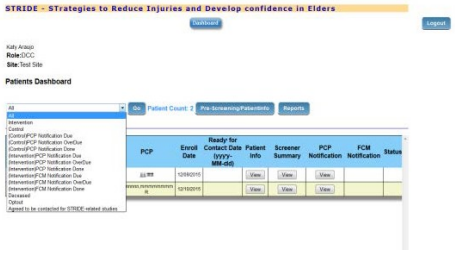
https://stride.med.yale.edu/STRIDE/











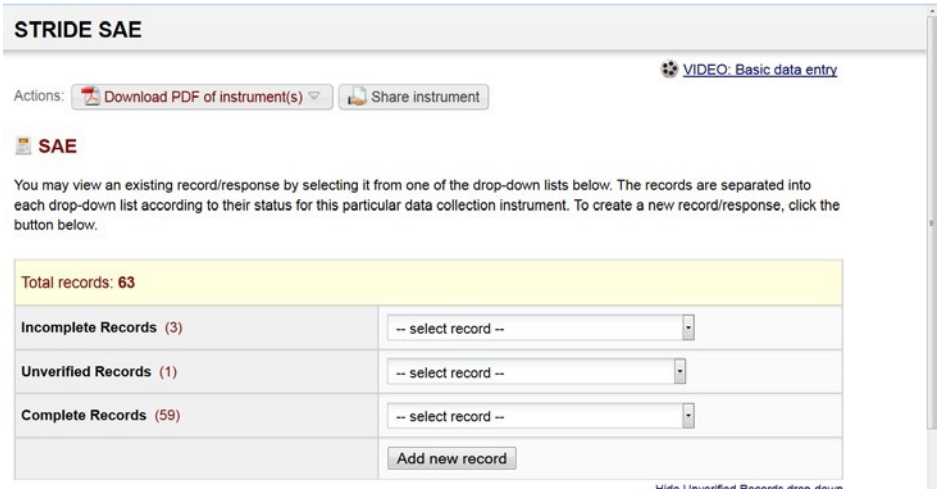
APPENDIX 9.6 STRIDE SERIOUS ADVERSE EVENTS

LOGIN TO YALE REDCAP USING YALE NETID: HTTPS://POA-REDCAP.MED.YALE.EDU

SELECT STRIDE SAE PROJECT.

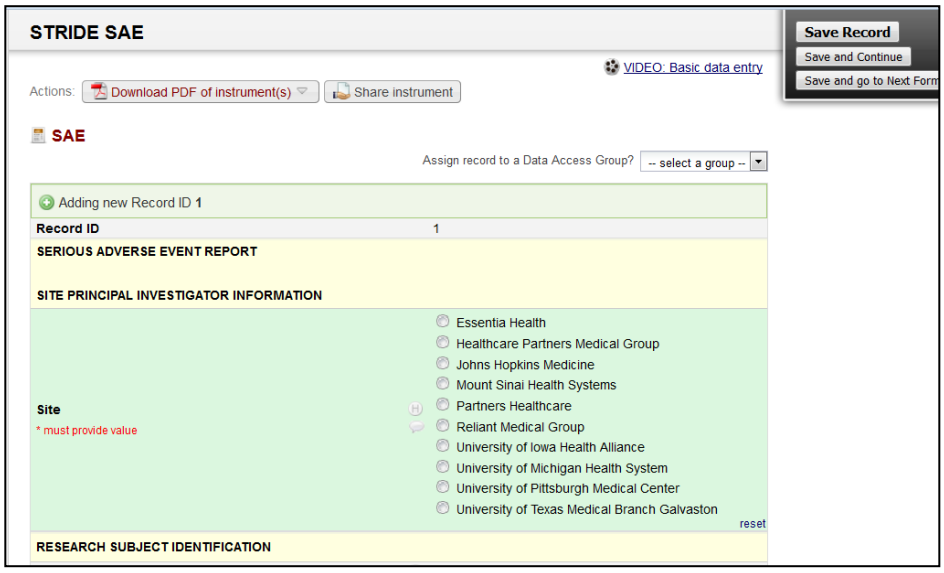
SELECT ADD/EDIT RECORDS UNDER DATA COLLECTION TAB

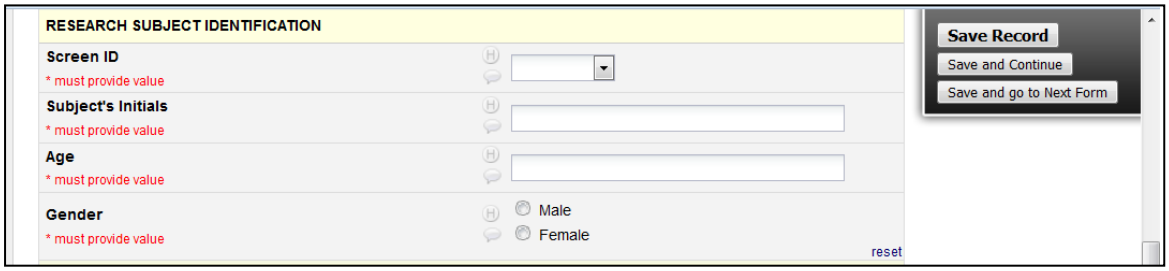
SELECT ADD NEW RECORD

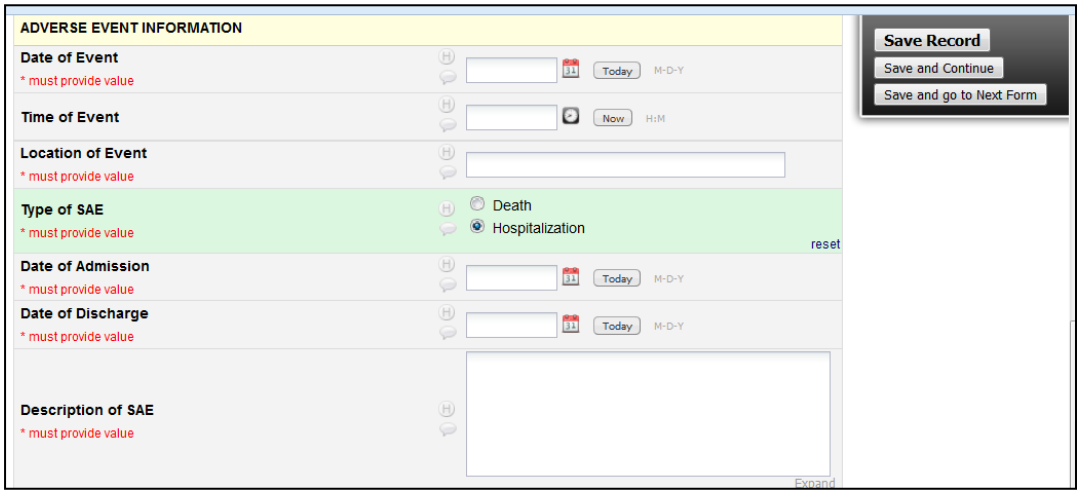


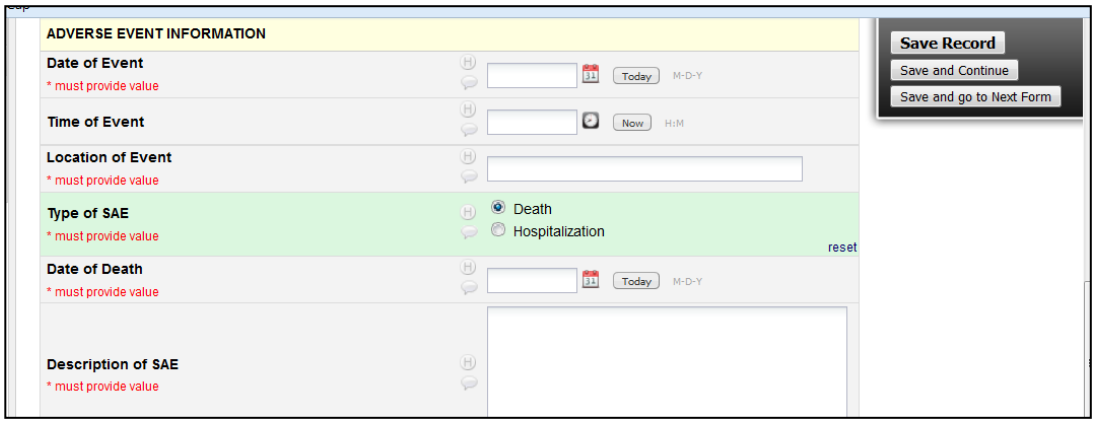
Completing SAE Form:

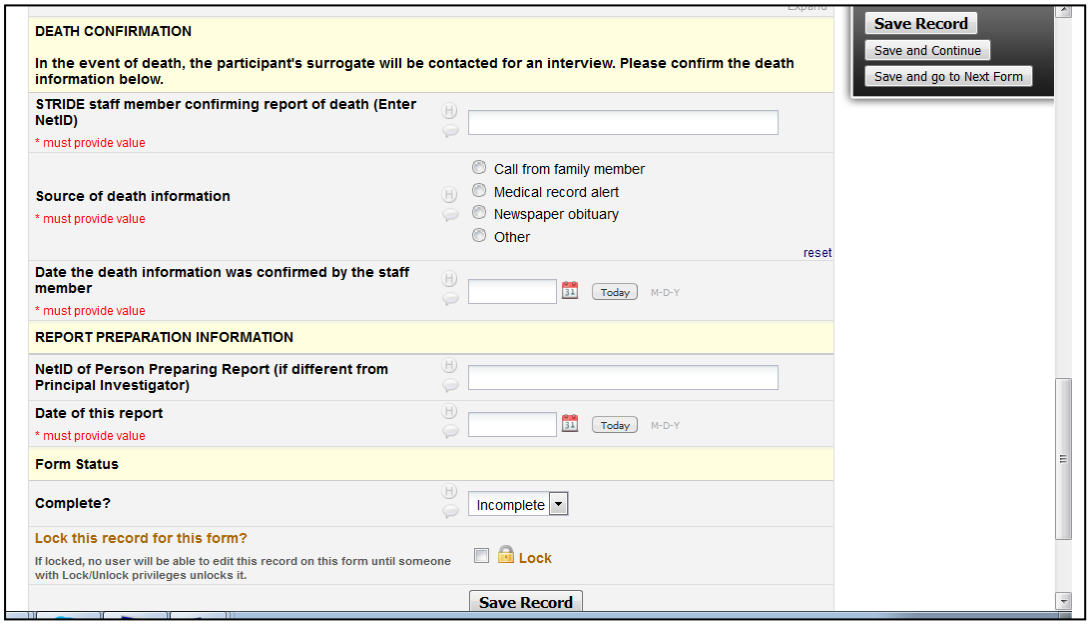
- Select Site and enter participant information (ID, participant initials, age, and gender). For screenid field a list of enrolled participants at the site are displayed.
- Enter Adverse Event Information
    - Date of event, time of event (if available), location of event (e.g., home), type of SAE (hospitalization or death)
        - For hospitalization enter date of admission and discharge, description of SAE.
        - For deaths enter date of death and description of SAE, confirmation of death information (staff member confirming report, source of death information such as family member, date death information was confirmed by site staff)
- Enter Report preparation information
    - Site staff preparing the report (enter NetID)
    - Date of report
- Enter Form Status
    - Enter complete (all information complete and verified) or incomplete (pending/in-process)


STRIDE SAE
Save Record
Save and Continue
Save and go to Next Form
VIDEO: Basic data entry
Actions:
Download PDF of instrument(s)
Share instrument
SAE
Assign record to a Data Access Group?
-- select a group --
Adding new Record ID 1
Record ID 1
SERIOUS ADVERSE EVENT REPORT
SITE PRINCIPAL INVESTIGATOR INFORMATION
Site
* must provide value
Essentia Health
Healthcare Partners Medical Group
Johns Hopkins Medicine
Mount Sinai Health Systems
Partners Healthcare
Reliant Medical Group
University of Iowa Health Alliance
University of Michigan Health System
University of Pittsburgh Medical Center
University of Texas Medical Branch Galvaston
reset
RESEARCH SUBJECT IDENTIFICATION

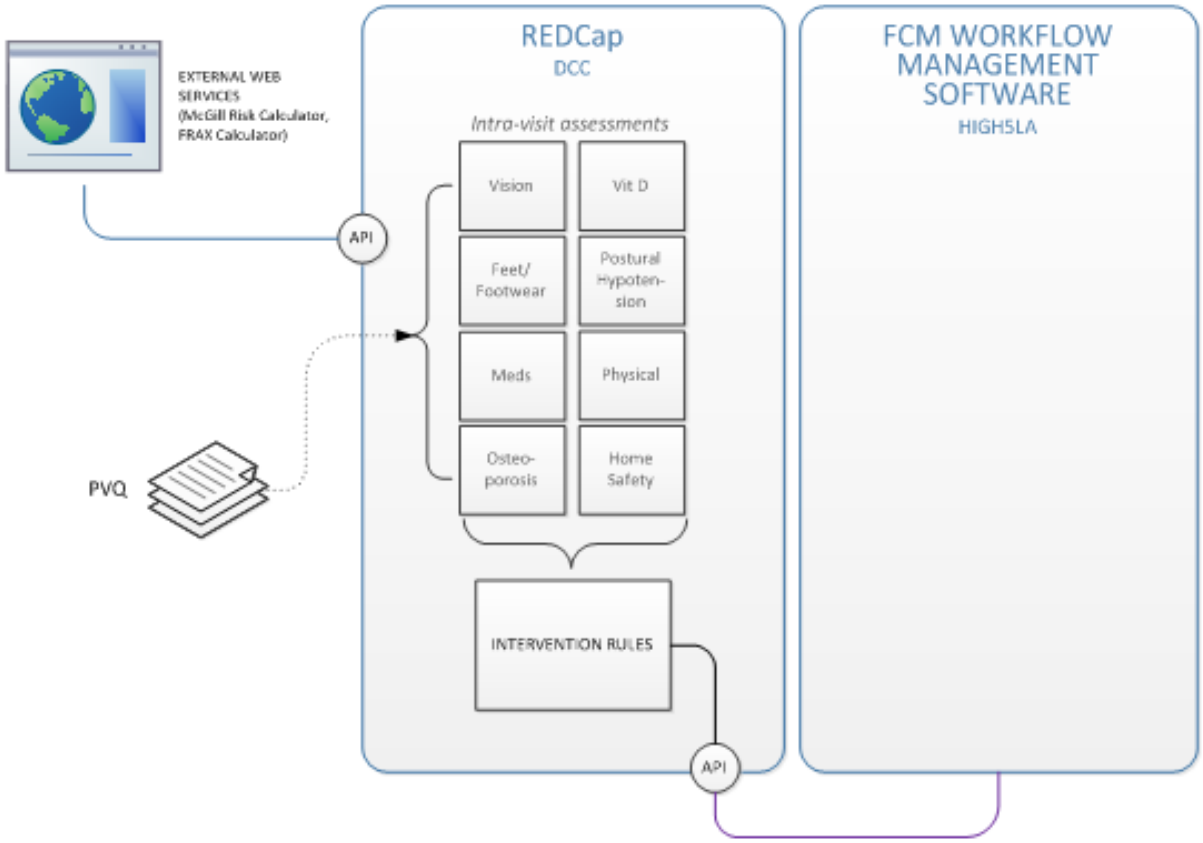

RESEARCH SUBJECT IDENTIFICATION
Screen ID
* must provide value
Subject's Initials
* must provide value
Age
* must provide value
Gender
* must provide value
Male
Female
reset
Save Record
Save and Continue
Save and go to Next Form


ADVERSE EVENT INFORMATION
Date of Event
* must provide value
Today
M-D-Y
Time of Event
Now
H:M
Location of Event
* must provide value
Type of SAE
* must provide value
Death
Hospitalization
reset
Date of Admission
* must provide value
Today
M-D-Y
Date of Discharge
* must provide value
Today
M-D-Y
Description of SAE
* must provide value
Expand
Save Record
Save and Continue
Save and go to Next Form

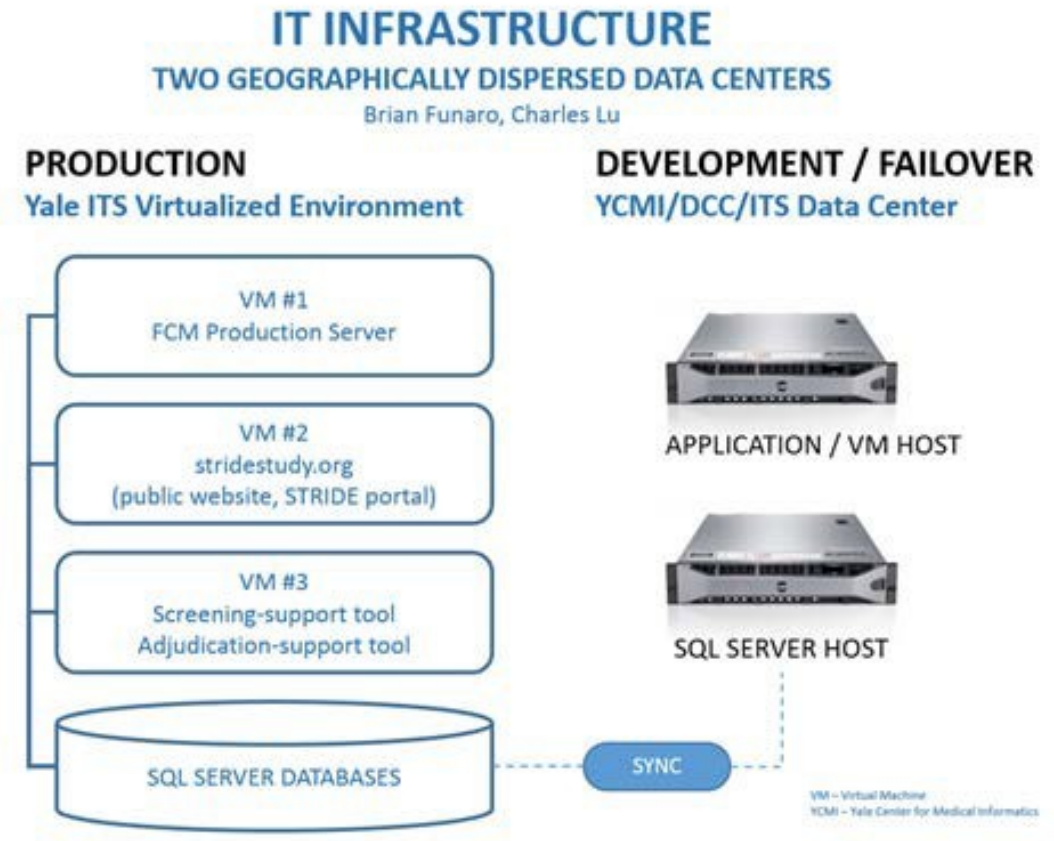

ADVERSE EVENT INFORMATION
Date of Event
* must provide value
Today
M-D-Y
Time of Event
Now
H:M
Location of Event
* must provide value
Type of SAE
* must provide value
Death
Hospitalization
reset
Date of Death
* must provide value
Today
M-D-Y
Description of SAE
* must provide value
Save Record
Save and Continue
Save and go to Next Form


DEATH CONFIRMATION
In the event of death, the participant's surrogate will be contacted for an interview. Please confirm the death information below.
STRIDE staff member confirming report of death (Enter NetID)
* must provide value
Source of death information
* must provide value
Call from family member
Medical record alert
Newspaper obituary
Other
reset
Date the death information was confirmed by the staff member
* must provide value
Today
M-D-Y
REPORT PREPARATION INFORMATION
NetID of Person Preparing Report (if different from Principal Investigator)
Date of this report
* must provide value
Today
M-D-Y
Form Status
Complete?
Incomplete
Lock this record for this form?
If locked, no user will be able to edit this record on this form until someone with Lock/Unlock privileges unlocks it.
Lock
Save Record
Save Record
Save and Continue
Save and go to Next Form

APPENDIX 9.7 THE STRIDE FCM WORKFLOW SUPPORT APPLICATION



APPENDIX 9.8 IT INFRASTRUCTURE

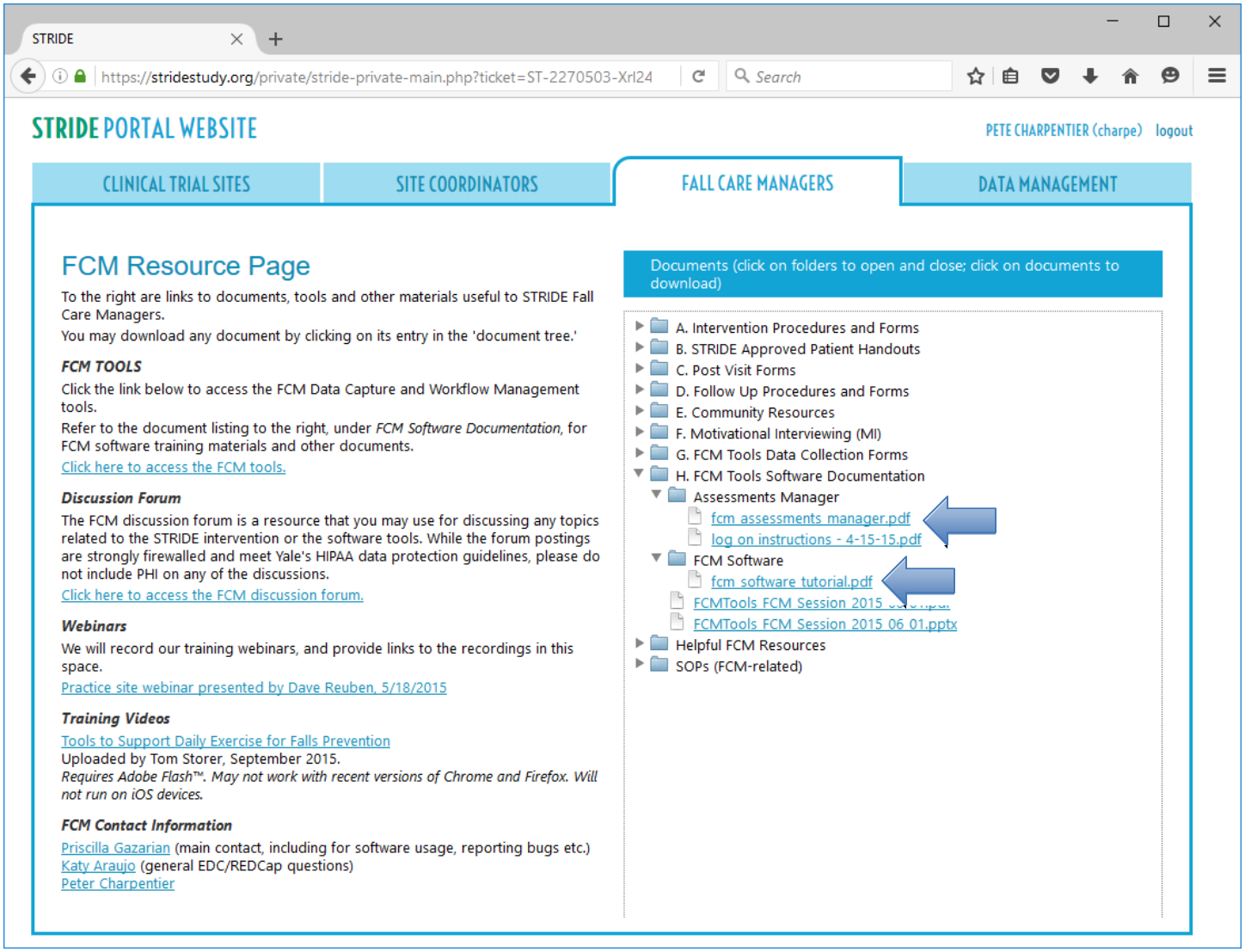


APPENDIX 9.9 DOWNLOADING FCM USER DOCUMENTS

DCC has prepared two software guides for FCMs. They are both available for download on the Portal Website. The documents are:

- fcm_assessments_manager.pdf – A User Guide for the Assessments Manager
- fcm_software_tutorial.pdf – A training document that covers the basic steps of creating an Initial Visit, managing tasks and performing data entry.

To download these files, navigate to the portal website (https://strideportal.med.yale.internal), log in using your Yale netid and password, and open the FCM tab. You will find the documents in the "document tree" as shown below on the right, in *H. FCM Tools Software Documentation*.



APPENDICES CHAPTER 10 - PROCEDURES FOR HANDLING EARLY WITHDRAWAL, EARLY TERMINATION, OR PROTOCOL DEVIATIONS

APPENDIX 10.1 RESEARCH FOLLOW UP STATUS CHANGE FORM

ENROLLED STRIDE Participants: Research Follow Up Status Change Form	
QUESTIONS 1-10 TO BE COMPLETED BY STRIDE CTS STAFF:	
1. STRIDE ID #	Click here to enter text.
2. Date of Status Change	Click here to enter a date.
3. NETID Of STRIDE Staff Completing Form	Click here to enter text.
4. At What Point Did Participant/ Surrogate Request Research Follow Up Change **(Select Category that Applies)**	☐ 1. Participant/Surrogate Called Site Staff and Requested Research Follow up Change after Receiving Enrollment Materials ☐ 2. Participant/Surrogate Decided During First In-Person Appointment with FCM ☐ 3. Other If other, specify: Click here to enter text.
5. Name Of Site Staff That Spoke With Participant /Surrogate:	Click here to enter text.

6. Document Conversation With Participant In Detail: **(MANDATORY)**	Click here to enter text.
7. RAC Will Contact Participant/ Surrogate	☐ Yes ☐ No IF NO, STRIDE Site Staff that Made the Decision that RAC Should NOT Re-Contact The Person **(Provide Rationale for Decision)**: Click here to enter text.
SKIP Section 8 & 9 if you answered YES to Question 7 8. Participant/Surrogate Request OR Site Action **(Select All That Apply)**	☐ 1. Change/ Stop RAC Follow-Up (e.g., calendars, 3 times a year follow-up calls) **a.** Did you explain that the calendars are not required. They are provided as a help. ☐ Yes ☐ No **b.** Did you explain that calls could be made fewer than 3 times a year? ☐ Yes ☐ No **c.** Was a once a year call acceptable? ☐ Yes ☐ No ☐ 2. Medical Record Follow-Up Opt-out (participant was asked if medical record could be accessed and said NO), **a.** Did you explain that it would be helpful if we can still look at their medical record, even if we don't contact them again? ☐ Yes ☐ No ☐ 3. Other, Please Specify in detail:

	Click here to enter text.
9. Reason For Research Follow up Change: **(Select All That Apply)**	☐ 1. Illness ☐ 2. Too Busy ☐ 3. Illness Of Other Person ☐ 4. Work/ Caregiving Responsibilities ☐ 5. Do Not Think Study Is Useful ☐ 6. Do Not Like Providing Information Over The Phone ☐ 7. Didn't Understand What Study Involved ☐ 8. Patient No Longer Able and Surrogate Refuses Click here to enter text. ☐ 9. Other, please specify: Click here to enter text.
10. Date Form Sent To Un-Blinded STRIDE Staff	Click here to enter a date.

Other comments:

Click here to enter text.

QUESTIONS 11-15 TO BE COMPLETED BY UNBLINDED RAC STAFF:	
11. Form Reviewed By:	Click here to enter text.
12. Date Form Reviewed/Approved:	Click here to enter a date.
13. Status	☐ Reviewed/Approved ☐ Other
14. Comments	Click here to enter text.
15. Date Status Change Form Entered Into Research Database	Click here to enter a date.

APPENDIX 10.2 INTERVENTION PARTICIPATION STATUS CHANGE FORM

ENROLLED STRIDE Participants: Intervention Participation Status Change Form	
QUESTIONS 1-10 TO BE COMPLETED BY STRIDE CTS STAFF PLEASE NOTE COMPLETING THIS FORM DOES NOT WITHDRAW PARTICIPANT FROM RAC FOLLOW UP CALLS	
1. STRIDE ID #	Click here to enter text.
2. Date of Status Change	Click here to enter a date.
3. NETID Of STRIDE Staff Completing Form	Click here to enter text.
4. At What Point Did Participant/ Surrogate Request Participation Change **(Select Category that Applies)**	☐ 1. Participant/Surrogate Called Site Staff and Requested Participation Change after Receiving Enrollment Materials ☐ 2. Participant/Surrogate Requested Participation Change when STRIDE Staff Called Prior to First In-Person Visit. ☐ 3. Participant/Surrogate Decided During First In-Person Appointment with FCM ☐ 4. Participant/Surrogate Decided After First Visit with FCM ☐ 5. Other If other, specify: Click here to enter text.
5. Name Of Site Staff That Spoke With Participant /Surrogate:	Click here to enter text.

6. Document Conversation With Participant In Detail: **(MANDATORY)**	Click here to enter text.
7. Participant/ Surrogate Request OR Site Action **(Select All That Apply)**	☐ 1. Full Intervention Opt-Out **(document in section 6)** ☐ 2. Other, Please Specify: Click here to enter text.
8. Reason For Participation Change: Participant No Longer Associated with Assigned Baseline Practice (Changed: PCP, etc) **(Select All That Apply)**	☐ 1. Illness ☐ 2. Too Busy ☐ 3. Upcoming Travel ☐ 4. Upcoming Change In Housing ☐ 5. Illness Of Other Person ☐ 6. Work/ Caregiving Responsibilities ☐ 7. Do Not Think Study Is Useful ☐ 8. Do Not Like Providing Information Over The Phone ☐ 9. Transportation Is A Problem ☐ 10. Didn't Understand What Study Involved ☐ 11. Patient No Longer Able and Surrogate Refuses Click here to enter text. ☐ 12. Other, please specify: Click here to enter text.
9. Date Form Sent To Un-Blinded STRIDE Staff	Click here to enter a date.

Other comments:

Click here to enter text.

QUESTIONS 10-15 TO BE COMPLETED BY UNBLINDED RAC STAFF:	
10. Form Reviewed By:	Click here to enter text.
11. Date Form Reviewed/Approved:	Click here to enter a date.
12. Status	☐ Reviewed/Approved ☐ Other
13. Comments	Click here to enter text.
14. Date Status Change Form Entered Into Research Database	Click here to enter a date.

APPENDIX 10.3 PRACTICE OR HEALTH SYSTEM PARTICIPATION STATUS CHANGE FORM

ENROLLED STRIDE Participants: Practice or Health System Participation Status Change Form

QUESTIONS 1-11 TO BE COMPLETED BY STRIDE CTS STAFF	
1. STRIDE ID #	Click here to enter text.
2. Date of Status Change	Click here to enter a date.
3. NETID Of STRIDE Staff Completing Form	Click here to enter text.
4. At What Point Did Practice/Healthsystem Change Occur **(Select Category that Applies)**	☐ 1. Participant/Surrogate Called Site Staff after receiving Study materials ☐ 2. Participant/Surrogate Informed STRIDE staff during first call to schedule Appointment with FCM ☐ 3. Participant/Surrogate notified Site Staff After First Visit with FCM ☐ 4. Other If other, specify: Click here to enter text.
5. Name Of Site Staff Who Spoke With Participant /Surrogate:	Click here to enter text.
6. Document Conversation With Participant In Detail: **(MANDATORY)**	Click here to enter text.
7. Type of Practice/Health System Status Change	☐ 1. Practice Change: **(Initial Practice Change--Patient was not in assigned**

	practice at time of enrollment) Did Participant receive Modified Intervention and/or Intervention Materials as outlined in Appendix 5.4.2 ☐ Yes ☐ No ☐ 2. Practice Change (**Mid Study Practice Change--Participant no longer associated with assigned practice**) Did Participant receive Modified Intervention and/or Intervention Materials as outlined in Appendix 5.4.2 ☐ Yes ☐ No ☐ 3. Health System Change (Participant no longer associated with Health System) Did Participant receive Intervention Materials as outlined in Appendix 5.4.2 ☐ Yes ☐ No ☐ 4. Other, Please Specify: Click here to enter text.
REMINDER: Practice/Healthsystem Change Does NOT Remove a Participant from the STRIDE Study: RAC Follow-up Calls and/or Medical Record Review **COMPLETE THIS NEXT SECTION ONLY IF Participant/ Surrogate Request Research Follow Up Change** **IF patient is NOT changing their research follow up status, please skip to section 11**	

8. RAC Will Contact Participant/ Surrogate	☐ Yes ☐ No IF NO, Name of STRIDE Site Staff who Made the Decision that RAC Should NOT Re-Contact The Person (Please provide Rationale for the decision): Click here to enter text.
Skip Sections 9 and 10 if you answered YES to Question 8 **9. COMPLETE THIS SECTION ONLY IF:** Participant/ Surrogate Request Research Follow Up Change **(select all that apply)** IF patient is NOT changing their research follow up status, please skip to section 11	☐ 1. Change/ Stop RAC Follow-Up (e.g., calendars, 3 times a year follow-up calls) a. Did you explain that the calendars are not required. They are provided as a help. ☐ Yes ☐ No b. Did you explain that calls could be made fewer than 3 times a year? ☐ Yes ☐ No c. Was a once a year call acceptable? ☐ Yes ☐ No ☐ 2. Medical Record Follow-Up Opt-out (participant was asked if medical record could be accessed and said NO), a. Did you explain that it would be helpful if we can still look at their medical record, even if we don't contact them again? ☐ Yes ☐ No ☐ 3. Other, Please Specify in detail: Click here to enter text.
10. Reason For Research Follow up Change: **(Select All That Apply)**	☐ 1. Participant did not want to proceed when informed they would not receive the in person Intervention ☐ 2. Illness ☐ 3. Too Busy ☐ 4. Illness Of Other Person ☐ 5. Work/ Caregiving Responsibilities

	☐ 6. Do Not Think Study Is Useful ☐ 7. Do Not Like Providing Information Over The Phone ☐ 8. Didn't Understand What Study Involved ☐ 9. Patient No Longer Able and Surrogate Refuses Click here to enter text. ☐ 10. Patient/Surrogate displeased with baseline practice error correction ☐ 11. Other, please specify: Click here to enter text.
11. Date Form Sent To Un-Blinded STRIDE Staff	Click here to enter a date.

Other comments:

Click here to enter text.

QUESTIONS 11-15 TO BE COMPLETED BY UNBLINDED RAC STAFF:	
12. Form Reviewed By:	Click here to enter text.
13. Date Form Reviewed/Approved:	Click here to enter a date.
14. Status	☐ Reviewed/Approved ☐ Other
15. Comments	Click here to enter text.
16. Date Status Change Form Entered Into Research Database	Click here to enter a date.

APPENDICES CLINICAL TRIAL SITE CLOSE-OUT DOCUMENTS

PART A – INTERVENTION CLOSE-OUT

PART B – FINAL SITE CLOSE-OUT

PART A – INTERVENTION CLOSE-OUT

STRIDE Clinical Trial Site (CTS) Close-out Checklist

PART A – INTERVENTION CLOSE OUT – Please return to Central Project Management (CPM) by July 1, 2019

Clinical Trial Site: _____

Site Principal Investigator: _____

Please list below all study documents or electronic files relating to the STRIDE intervention that have been retained that have participant names or ID numbers. Examples could include pre-visit questionnaires (PVQs), care plans, notes in the electronic medical records (EMR) etc. If documents are no longer retained because data were entered into the FCM software, this can be noted under "Where it is stored."

Name of Document or Electronic File	Where it is Stored	Name of person who can access file	Email address for person with access
PVQ			
Care plans			
Other:			

Study records are considered medical records and should be stored under the applicable guidelines of federal, state and local regulations. CTSs should consult their institutional records retention policy. Taking into account NIA, HIPAA, cIRB, and site-specific records retention requirements applicable for a given study, the policy with the longest period of required record retention should be followed. The minimum storage period for study records is **7 years** from the time of study closure.

Equipment and Consumables:

Any hardware and consumables related to the study intervention are considered property of the clinical trial site.

Name of staff member completing form:

Name: _____ Email Address: _____ Telephone Number:_____

Principal Investigator Signature: _____ Date: _____

Email a PDF of this completed and signed form to CPM at lagoehring@bwh.harvard.edu

For CPM Use Only:

☐ All required items submitted to CPM

_____ _____

CPM Personnel Signature Date

PART B – FINAL SITE CLOSE-OUT

STRIDE Clinical Trial Site (CTS) - Final Close-out Checklist

PART B – FINAL SITE CLOSE OUT. Please complete and send to Central Project Management (CPM) by Jan 15 2020.

Clinical Trial Site: _____

Site Principal Investigator: _____

In order to execute phase-out of STRIDE involvement, please consider/complete all actions below. Please put an "X" beside completed tasks.

Participant Records

__ Review and ensure all essential/regulatory documents are current, complete, accurate, and filed appropriately in a regulatory binder.
__ Review and ensure all research records are complete, accurate, and filed appropriately.
__ Ensure notes-to-file exist for any violations/exceptions that require additional explanation.

Document Collation and Storage

Email PDF of items marked * below to CPM:
__ Final delegation log/signature pages*

__ Create and file written inventory of all items to be stored. The inventory should include:
- __ STRIDE Registry binder
- __ All study documents bearing participant names
- __ All study documents bearing participant ID numbers

Indicate long-term storage information, location and contact information

Study records are considered medical records and should be stored under the applicable guidelines of federal, state and local regulations. CTSs should consult their institutional records retention policy. Taking into account NIA, HIPAA and cIRB guidelines, study records must be retained for a minimum of **7 years** from the time the project ends. If the retention requirements of the clinical trial site or local IRB are greater than 7 years, the policy with the longest period of required record retention should be followed. Project end is defined as after final reporting to the sponsor OR final publication of research results, whichever is later.

Should local storage limitations require original paper-format source documents to be converted to electronic format (i.e. compact disc or PDF) before the relevant federal regulatory retention periods above have expired, the CTS must first send its Standard Operating Procedure (SOP) for creating certified electronic copies to the Data Coordinating Center (DCC) Principal Investigator for review and approval.

☐ Check to confirm that Intervention Close-out Document (Part A) which includes information about the storage of all intervention materials with patient information was sent to CPM.

Please complete this section only if your site is storing any non-intervention documents or files with patient information that were not previously listed in the Intervention Close-out Document:

Describe the type of record: _____

Record storage location: _____

Contact information re: record storage:

_____

_____

Equipment and Consumables

Any hardware and consumables are considered to be property of the clinical trial site.

Data Management and Query Resolution

Please identify at least one individual who will maintain access to the site data for query resolution (include name, phone number and email address).

Name: _____

Role: _____

Phone Number: _____

Email Address: _____

Other Comments: _____

_____

_____

_____

Signature indicating this form has been considered and/or completed as directed, and documentation with asterisk (*) above have been emailed to Central Project Management.

_____ _____

Principal Investigator Signature Date

_____ _____

Email Address Telephone Number

Email a PDF of this completed and signed form to CPM at lagoehring@bwh.harvard.edu

For CPM Use Only:

☐ All required items submitted to CPM

_____ _____

CPM Personnel Signature Date