STEPPING ON EVALUATION PROTOCOL

DIRECTIONS AND MATERIALS FOR STEPPING ON LEADERS

2018
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DATA COLLECTION PROTOCOL FOR STEPPING ON EVALUATION

DEFINITIONS

**Program**: An evidence-based falls prevention intervention (e.g. Stepping On)

**Workshop**: A series of classes or group meetings through which a program is delivered to participants

**Session**: A meeting of a workshop (e.g. an hour-long class period or encounter)

**Participants**: The people who enroll in the programs

**Leaders**: The people who are trained to deliver the falls-prevention programs and who conduct the workshops

**Host organization**: The agency that sponsors the workshop (e.g. Utah County Health Department, Salt Lake County Aging and Adult Services, Intermountain Healthcare)

**Implementation site**: The physical location where the workshop is held (e.g. Cache County Senior Center, Lehi Fire Station 82, Holladay Library)
INTRODUCTION AND REQUIREMENTS

As one of the funding requirements from the Stepping On Falls Prevention Grant, Stepping On Leaders (individuals who have completed the Stepping On Leadership training) are responsible for collecting data from workshop participants. This is done in order to evaluate participant satisfaction with the program as well as the program’s effectiveness in helping participants develop the awareness, knowledge, and skills that they need in order to prevent falls.

While filling out surveys or release forms is voluntary for participants (i.e., it is not required of them in order for them to participate in the workshop), **you are required to collect the following data within your Stepping On workshops** in order to fulfill your obligation as a grant awardee.

Please read the directions included in this packet carefully and follow them exactly! If you have questions, contact Sheryl Gardner at the Utah Department of Health for assistance:

Email: sagardner@utah.gov  
Phone: 801-538-6592

Note: The following forms are listed in the order in which they should be completed. All forms are to be retained by the Leader until completion of the seven-week program, at which point copies should be submitted to Sheryl Gardner at the Utah Department of Health by email or mail. Please submit within two weeks of completing a workshop. Additionally, please maintain the original forms.

**Attendance Log**: Each class session, the Stepping On Leader will record those present.

**Participant Information Form**: This form collects demographic information as well as baseline data about participants’ health and their views and experiences related to falls. This form is to be filled out by Stepping On participants **prior to the start of instruction**.

**Participant Post-Program Survey**: This survey collects data about participants’ status after completing the program. This form is to be filled out by participants **at the last session** and collected by the Leader before they leave.

**Host Organization Information Form**: This form provides information about where Stepping On is being hosted. This form is to be filled out by the Leader **upon completion** of the seven-week course. (Note: One Host Organization Form must be filled out by each Leader who conducts
Stepping On sessions affiliated with that Host Organization. However, only one Host Organization Form needs to be completed per Leader—a new form is not necessary for each workshop.)

**FALLS PREVENTION PROGRAM INFORMATION COVER SHEET:** This form will serve as the cover sheet when the Leader submits the materials described above. This form is to be filled out by the Leader upon completion of the seven-week workshop. (Note: This form must be completed for each new workshop. Also note, if your agency is a Local Health Department, please mark “Other” under “Type of Agency” and specify the name of your Local Health Department.)

**STEPPING ON PARTICIPANT BOOSTER SESSION SURVEY:** This survey collects data about participants’ status three months after completing the program. It also provides Leaders with feedback on logistical details related to the convenience of the workshop location, meeting time, etc. This survey is to be filled out by participants in person OR to be administered to participants via phone OR by mail *three months after* a workshop is completed.
INSTRUCTIONS

1. Before instruction begins, Leader may choose to use the “Talking Points” to explain the program and evaluation process to participants.

2. Next, participants need to fill out a brief PARTICIPANT INFORMATION FORM, which also serves as a baseline survey for the workshop.
   
   **Step 1:** Make a copy of the Participant Information Form for each class participant.
   
   **Step 2:** Give the Participant Information Form to participants and read or summarize the “Talking Points” to the class, if you choose to do so. Have class participants fill out the forms. Some instructors have found it helpful to hold a “Class Zero” orientation meeting prior to the first official session. This is an excellent time for participants to meet the instructors, learn about what to expect from the program, and fill out the Participant Information Form. If you do not hold a Class Zero, you will need to distribute and collect the Participant Information Form at the beginning of the first class session.
   
   **Step 3:** Collect the completed surveys from class participants and retain them someplace safe. You will be required to submit copies of these forms to the Utah Department of Health upon completion of the workshop.

3. ATTENDANCE LOG must be completed during each class session to record those present.
   
   **OPTION 1 – PAPER VERSION**
   
   **Step 1:** Take attendance at each class session. While filling out the Participant Information Form, each person will create a Personal ID. Please make sure these IDs, as well as participants’ home zip codes, are included on the Attendance Log.
   
   **Step 2:** At the end of the workshop, add up the number of sessions attended for each participant, as shown in the example below. If you do not hold a “Class 0,” just mark “n/a” in the corresponding column
   
   **Step 3:** Once it has been filled out, store the Attendance Log with the Participant Information Forms until the next session.

   **Example:**

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>S 0</th>
<th>S 1</th>
<th>S 2</th>
<th>S 3</th>
<th>S 4</th>
<th>S 5</th>
<th>S 6</th>
<th>S 7</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Name: Dan Johnson</td>
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<td>ID: DAJO49 Zip: 84101</td>
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<td>ID: TRBR38 Zip: 84770</td>
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</tbody>
</table>

   **Option 2 – Online through Compass**

   **Step 1:** Log into portal
   **Step 2:** Make sure all participants are registered
   **Step 3:** Go to the schedule table for the workshop, open the attendance log and mark participant as “present” or “absent”
   **Step 4:** At end of workshop, email Sheryl (sagardner@utah.gov) that attendance log is in the portal.
4. At the last session, have participants fill out the Participant Post-Program Survey.
   **Step 1:** Make a copy of the Participant Post-Program Survey for each class participant and have participants fill out the surveys.
   **Step 2:** Collect completed Participant Post-Program Surveys from participants before they leave.
   **Step 3:** Store Participant Post-Program Surveys with the Attendance Log and the Participant Information Sheets from the beginning of the workshop.

5. When the previous steps have been completed, you will need to submit all forms to the Utah Department of Health.
   **Step 1:** Copy and complete the Host Organization Information Form (Note: Only one Host Organization Form need be completed per Leader per host organization—a new form is not necessary for each workshop)
   **Step 2:** Copy and complete the Falls Prevention Information Cover Sheet (Note: If your agency is a Local Health Department, please mark “Other” under “Type of Agency” and specify the name of your Local Health Department.)
   **Step 3:** Assemble COPIES of the materials as follows:
   - Falls Prevention Information Cover Sheet (on top)
   - Host Organization Information Form
   - Completed Attendance Log
   - Completed Participant Information Forms
   - Completed Participant Post-Program Surveys
   **Step 4:** Within two weeks of workshop completion, scan and mail a PDF of the materials listed above to sagardner@utah.gov with subject line “[Agency name]_Submitted Stepping On Evaluation” (preferred) or mail copies to:
     Stepping On Evaluation
     c/o Sheryl Gardner
     PO Box 142106
     SLC, UT 84114-2106

Step 5: Retain all original paperwork in a safe place until completion of the grant period (7/31/2020), at which point all material should be shredded.

6. Schedule a three month Booster Session with all willing participants to occur in person, by phone, or by mail.
   **Step 1:** For in-person Booster Sessions, make a copy of the Stepping On Participant Booster Session Survey for each class participant, have participants fill out the surveys, and collect the surveys before they leave. For surveys by phone, call participants at their scheduled time and record their survey responses. For surveys by mail, give participants a deadline by which to return the forms to the Leader.
   **Step 2:** Assemble copies of the surveys and, within two weeks of the Booster Session, scan and mail a PDF of the surveys to sagardner@utah.gov with the subject line “[Agency name]_Submitted Stepping On Booster Session Surveys” (preferred) or mail copies to the address listed in Step 5. (Note: Be sure to indicate the name and date of the workshop the surveys correspond with!)
| Session 1 | □ Distribute and collect Participant Information Forms at the beginning of the class session  
□ Take attendance |
<table>
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<tbody>
<tr>
<td>Session 2</td>
<td>□ Take attendance</td>
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<tr>
<td>Session 3</td>
<td>□ Take attendance</td>
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<tr>
<td>Session 4</td>
<td>□ Take attendance</td>
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<tr>
<td>Session 5</td>
<td>□ Take attendance</td>
</tr>
<tr>
<td>Session 6</td>
<td>□ Take attendance</td>
</tr>
</tbody>
</table>
| Session 7 | □ Distribute and collect Participant Post-Program Surveys  
□ Take attendance |
| After final session has concluded | □ Fill out the Falls Prevention Information Cover Sheet  
□ Fill out the Host Organization Information Form, if you have not previously turned one in for that host organization  
□ Assemble copies of materials as described on page 7 of this protocol  
□ Within two weeks of workshop completion, submit copies as instructed on page 7 of this protocol  
□ Retain originals materials |
| Booster Session | □ Distribute and collect Participant Booster Session Surveys  
□ Within two weeks of Booster Session, submit copies as instructed on page 7 of this protocol  
□ Retain original materials |
**EVALUATION TIMELINE/CHECKLIST FOR COMPASS USERS**

*WORKSHOP MUST BE LISTED IN COMPASS AND ALL PARTICIPANTS MUST BE REGISTERED IN COMPASS*

| Session 1 | □ Distribute and collect Participant Information Forms at the beginning of the class session  
□ Take and record attendance in compass |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Session 2</td>
<td>□ Take and record attendance in compass</td>
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<td>Session 3</td>
<td>□ Take and record attendance in compass</td>
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<td>Session 4</td>
<td>□ Take and record attendance in compass</td>
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<td>Session 5</td>
<td>□ Take and record attendance in compass</td>
</tr>
<tr>
<td>Session 6</td>
<td>□ Take and record attendance in compass</td>
</tr>
</tbody>
</table>
| Session 7 | □ Take and record attendance in compass  
□ Distribute and collect Participant Post-Program Surveys |

**EVALUATION MATERIALS**

STEPPING ON GROUP LEADER TALKING POINTS

STEPPING ON PARTICIPANT INFORMATION FORM

ATTENDANCE LOG IN COMPASS

STEPPING ON PARTICIPANT POST-PROGRAM SURVEY

STEPPING ON PARTICIPANT BOOSTER SESSION SURVEY
Read/paraphrase the following points to participants prior to their completion of the Participant Information Survey:

• This workshop is made possible by a grant from the U.S. Administration on Community Living (ACL) and the Administration on Aging (AOA) awarded to the Utah Department of Health Violence and Injury Prevention Program.

• We would like you to fill out a Participant Information Form today and then at the last class session we will again ask you to complete another brief survey.

• First we want to explain how your information will be used and protected.

• Your information is very valuable to us. We use it to learn who is being reached by this program and about how we can improve our services. It also helps our funding agencies show that they are spending their money wisely.

• At the top of the forms, we ask for the first two letters of your first and last name and the last two years of the year you were born. We will use this to match your information to an Attendance Log to track how many times you attend a class session and to the survey you will take at the end of the program. We do not share this information with anyone else. If you do not feel comfortable using your birth year digits, you may select two different digits of your choice. **If you do this please make sure these digits are consistent for each form you fill out.**

• The Survey also asks you to provide some personal information such as your birth year and gender. You may skip any questions that you do not want to answer. While doing the Survey, you may ask us to explain any questions that you find confusing.

• We follow very strict rules to protect all of your information and to keep it private. We will maintain these paper forms securely following standard practices for protecting private data. After a trained person enters your information into a secure computer database, we will destroy the paper forms.

• Completing the Survey is entirely voluntary. If you decide not to complete the Survey you can still participate in this program.

• Please take time now to read the Survey and let us know if you have any questions.
Stepping On Participant Information Form

Today’s date: _____ / _____ / _____ Zip Code of Residence:____________

Participant ID (First two letter of your first name, first two letters of your last name, last two numbers of your birth year): ___ ___ ___ ___ ___ ___

1. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program? ○ Yes ○ No
   a. If you answered “No,” how did you hear about this program?____________________________________________
   b. If you answered “Yes,” from which healthcare facility were you referred? (e.g. Intermountain Medical Center)__________________________

2. How old are you today? ______ years

3. Do you live alone?
   ○ Yes ○ No

4. What is your gender?
   ○ Male ○ Female

5. Are you of Hispanic, Latino, or Spanish origin?
   ○ Yes ○ No

6. What is your race? (Check all that apply)
   □ American Indian or Alaska Native
   □ Asian
   □ Black or African American
   □ Native Hawaiian or other Pacific Islander
   □ White

7. What is the highest grade or level of school that you have completed?
   ○ Less than high school ○ Some college or vocational school
   ○ Some high school ○ College graduate or higher
   ○ High school graduate or GED

8. Has a health care provider ever told you that you have any of the following chronic conditions (i.e., one that has lasted for three months or more)? (Please check all that apply.)
   □ Arthritis or other bone/joint disease
   □ Breathing/lung disease
   □ Depression
   □ Heart disease or blood circulation problem
   □ Glaucoma/other chronic eye problem
   □ Other:__________________________

1
Stepping On Participant Information Form

☐ Diabetes  ☐ None (I have not been diagnosed with any chronic conditions)

9. Are you limited in any way in any activities because of physical, mental, or emotional problems?
   ○ Yes  ○ No

10. In general, how would you rate your health? (Choose only one)
    ○ Excellent  ○ Very good  ○ Good  ○ Fair  ○ Poor

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

11. In the past three (3) months, how many times have you fallen?
    ○ None  ○ ________ times

   a. If you fell in the past three months, how many of these falls caused an injury?
      (By an injury, we mean the fall caused you to limit your regular activities for at least a day or you had to go to see a doctor.)
      _________ Number of falls causing an injury

12. How fearful are you of falling?
    ○ Not at all  ○ A little  ○ Somewhat  ○ A lot

13. Please mark the circle that tells us how sure you are that you can do the following activities:

   a. I can find a way to get up if I fall
      ○ Very sure  ○ Sure  ○ Somewhat sure  ○ Not at all sure

   b. I can find a way to reduce falls
      ○ Very sure  ○ Sure  ○ Somewhat sure  ○ Not at all sure

   c. I can protect myself if I fall
      ○ Very sure  ○ Sure  ○ Somewhat sure  ○ Not at all sure

   d. I can increase my physical strength
      ○ Very sure  ○ Sure  ○ Somewhat sure  ○ Not at all sure

   e. I can become more steady on my feet
      ○ Very sure  ○ Sure  ○ Somewhat sure  ○ Not at all sure

14. During the last four (4) weeks, to what extent has your concern about falling interfered with your normal social activities with family, friends, neighbors or groups? (Please choose only one)
    ○ Extremely  ○ Quite a bit  ○ Moderately  ○ Slightly  ○ Not at all

The form is complete! Thank you for your participation.

Please return this completed form to your instructor.
# Attendance Log

Workshop:______________________ Start Date: ___ / ___ / _____ End Date: ___ / ___ / _____

<table>
<thead>
<tr>
<th>Participant Information</th>
<th>Session Zero</th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
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<th>Session 5</th>
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</tbody>
</table>

*Use additional pages if needed.*

*If there was not a Class 0 for this workshop, write n/a in the corresponding column.*
Today's date: _____ / _____ / _____
Participant zip code (address of residence):________________________
Participant ID (First two letter of your first name, first two letters of your last name, last two numbers of your birth year):  ___ ___ ___ ___ ___ ___

1. In general, how would you say your health is? (Choose only one)
   ○ Excellent      ○ Very good      ○ Good      ○ Fair      ○ Poor

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

2. Since this program began, how many times have you fallen?
   ○ None          ○ _______ times

   a. If you fell since the program began, how many of these falls caused an injury? (By an injury, we mean the fall caused you to limit your regular activities for at least a day or you had to go to see a doctor.)
      _________ falls (Number of falls causing an injury)

3. How fearful are you of falling?
   ○ Not at all fearful     ○ A little       ○ Somewhat       ○ Very fearful

4. Has this program reduced your fear of falling?
   ○ Yes          ○ No

5. Please mark the circle that tells us how sure you are that you can do the following activities.

   How sure are you that:

   a. I can find a way to get up if I fall
      ○ Very sure      ○ Sure      ○ Somewhat sure      ○ Not at all sure
   b. I can find a way to reduce falls
      ○ Very sure      ○ Sure      ○ Somewhat sure      ○ Not at all sure
   c. I can protect myself if I fall
      ○ Very sure      ○ Sure      ○ Somewhat sure      ○ Not at all sure
   d. I can increase my physical strength
      ○ Very sure      ○ Sure      ○ Somewhat sure      ○ Not at all sure
   e. I can become more steady on my feet
      ○ Very sure      ○ Sure      ○ Somewhat sure      ○ Not at all sure

Please turn to the next page to continue filling out the survey.
6. During the last four (4) weeks, to what extent has your concern about falling interfered with your normal social activities with family, friends, neighbors or groups? (Please choose only one)

- Extremely
- Quite a bit
- Moderately
- Slightly
- Not at all

7. Please tell us your thoughts about this program. Mark one circle for each question.

As a result of this program...

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. I feel more comfortable talking to my family and friends about falling</td>
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<tr>
<td>c. I feel more comfortable increasing my activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. I plan to continue exercising</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. I feel more satisfied with my life</td>
<td></td>
<td></td>
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<tr>
<td>f. I would recommend this program to a friend or relative</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

8. Since this program began, what have you done to reduce your chance of a fall? Check all that apply.

- Talked to a family member or friend about how I can reduce my risk of falling
- Talked to a health care provider about how I can reduce my risk of falling
- Had my vision checked
- Had my medications reviewed by a health care provider or pharmacist
- Participated in another fall prevention program in my community
- Did exercises I learned in this program at home
- Made changes in my home to reduce my risk of falling (for example, secured rugs or improved lighting)

The survey is complete! Thank you for your participation.

Please return this completed survey to your instructor
Falls Prevention Program Information Cover Sheet

Please use this as a cover sheet for the completed data collection forms to return to the Utah Department of Health at the end of the program.

1. Site Name: _______________________________________________________________

2. Site Address:______________________________________________________________
   City: __________________________ State: ___________ Zip: _______________

3. Type of agency (select the type that best describes your agency):
   ○ Municipal Government
   ○ Area Agency on Aging
   ○ County Health Department
   ○ Educational Institution
   ○ Faith-based organization
   ○ Health Care Organization
   ○ Library
   ○ Multi-purposes social services organization
   ○ Recreational organization
   ○ Residential Facility
   ○ Senior Center
   ○ Other Community Center
   ○ Tribal Center
   ○ Workplace
   ○ Other (please specify):

4. Name of parent/host/sponsoring organization licensed to offer program:
   ________________________________________________________________

5. Leader/Coach/Instructor Names (Please provide your first and last names and provide the daytime phone number or email of the best person to contact about any questions on the forms.)
   Name: ________________________ Phone: _________________
   Email: ________________________
   Name: ________________________ Phone: _________________
   Email: ________________________

6. Program Start Date (mm/dd/yyyy): ____________ End Date: ____________

7. Did you offer a “Class 0” with the workshop? (Class 0 is an optional pre-workshop session provided by some agencies.)  ☐ Yes  ☐ No

8. What type of program is this?
   ☑ Stepping On

9. Number of participants enrolled (who attended at least one session): ________________
   Number of completers (who attended at least 4 of the possible sessions, excluding Class 0): _____
Host Organization Information Form

1. Agency Name: ________________________________________________________________
   Street Address: ________________________________________________________________
   City: __________________________ State: ______________ Zip code: _______________

2. Type of agency (select the type that best describes your agency):
   - [ ] State Unit on Aging
   - [ ] Municipal Government
   - [ ] Multi-purposes social services organization
   - [ ] Area Agency on Aging
   - [ ] State Health Department
   - [ ] Recreational organization
   - [ ] County Health Department
   - [ ] Other Community Center
   - [ ] Educational Institution
   - [ ] Residential Facility
   - [ ] Faith-based organization
   - [ ] Senior Center
   - [ ] Health Care Organization
   - [ ] Tribal Center
   - [ ] Library
   - [ ] Workplace
   - [ ] Other (please specify):

3. Which falls prevention program(s) are you licensed/authorized to offer?
   - [ ] A Matter of Balance
   - [ ] Stepping On
   - [ ] Otago
   - [ ] Stay Safe, Stay Active
   - [ ] Fallscape
   - [ ] Tai Chi—list name: _______________________________________________________
   - [ ] Other—list name: _______________________________________________________

4. Contact Person’s Name and Information:
   First and Last Name: __________________________________________________________
   Daytime Phone Number: _______________________________________________________
   Email address: _______________________________________________________________

   Optional Information:
   Title or role with organization: _______________________________________________
   Role with the falls prevention program(s): _______________________________________
   Date trained in Stepping On: ___________________________________________________
Stepping On Participant Booster Session Survey

Stepping On workshop location & start date:______________________________
Today’s date: _____ / _____ / _____
Participant zip code (address of residence):_______________
Participant ID (First two letter of your first name, first two letters of your last name, last two numbers of your birth year): ___ ___ ___ ___ ___ ___

1. In general, how would you rate your health? (Choose only one)
   ○ Excellent   ○ Very good   ○ Good   ○ Fair   ○ Poor

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

2. Since completing Stepping On, how many times have you fallen? If you can only remember the approximate number of falls, that is okay. Try to enter a number as close to your number of fall as you can remember. (Only enter one number.)
   ○ None   ○ _______ times   ○ I don’t know
   a. If you fell since completing the program, how many of these falls caused an injury? (By an injury, we mean the fall caused you to limit your regular activities for at least a day or you had to go to see a doctor.)
      _________ falls (Number of falls causing an injury)

3. How fearful are you of falling?
   ○ Not at all   ○ A little   ○ Somewhat   ○ A lot

4. Please mark the circle that tells us how sure you are that you can do the following activities:

   a. I can find a way to get up if I fall
   b. I can find a way to reduce falls
   c. I can protect myself if I fall
   d. I can increase my physical strength
   e. I can become more steady on my feet

<table>
<thead>
<tr>
<th>Very sure</th>
<th>Sure</th>
<th>Somewhat sure</th>
<th>Not at all sure</th>
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Please turn to the next page to continue filling out the survey.

5. During the last four (4) weeks, to what extent has your concern about falling interfered with your normal social activities with family, friends, neighbors or groups? (Please choose only one)

- Extremely
- Quite a bit
- Moderately
- Slightly
- Not at all

6. Please tell us your thoughts about this program.

Since completing Stepping On...

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling</td>
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<td></td>
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<tr>
<td>b. I feel more comfortable talking to my family and friends about falling</td>
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<tr>
<td>c. I feel more comfortable increasing my activity</td>
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<td>d. I plan to continue exercising</td>
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<td>e. I feel more satisfied with my life</td>
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<tr>
<td>f. I would recommend this program to a friend or relative</td>
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</tbody>
</table>

7. Since completing the Stepping On program, what have you done to reduce your chance of a fall? Check all that apply.

- Talked to a family member or friend about how I can reduce my risk of falling
- Talked to a health care provider about how I can reduce my risk of falling

If no, why not?

- Had my vision checked

If no, why not?
Stepping On Participant Booster Session Survey

○ Had my medications reviewed by a health care provider or pharmacist
  If no, why not?__________________________________________________________

○ Participated in another fall prevention or exercise program in my community
  If yes, which one?______________________________________________________

Please turn to the next page to continue filling out the survey.

8. Have you made changes in your home to reduce your risk of falling?

○ No ○ Yes

  a. If yes, what changes have you made? (Check all that apply.)

    ○ Secured or removed rugs
    ○ Improved lighting
    ○ Used night lights
    ○ Reduced clutter
    ○ Installed grab bars
    ○ Installed handrails on stairs
    ○ Applied nonskid strips on stairs
    ○ Other______________________________________________________________

9. Have you been doing the exercises you learned from the “Stepping On” classes?

○ No ○ Yes

10. How often do you do these exercises?

    ○ Less than twice a week
    ○ 2-5 times a week
    ○ 6 or more times a week

11. Do you participate in your community more since you began “Stepping On” classes?

    ○ No ○ Yes
12. What other suggestions do you have on how we can improve “Stepping On” for you and others? (e.g. role of lay leaders, class materials, location, etc.)

Please turn to the next page to continue filling out the survey.

13. Do you have a success story about how the Stepping On Program has helped you that you would like to share?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

The survey is complete! Thank you for your participation.

Please return this completed survey to your instructor.