

**STEPPING ON EVALUATION PROTOCOL**  
**DIRECTIONS AND MATERIALS FOR STEPPING ON LEADERS**  
**JUNE 2016**



# CONTENTS

DEFINITIONS.....3

INTRODUCTION AND REQUIREMENTS .....4

INSTRUCTIONS .....6

EVALUATION TIMELINE/CHECKLIST .....8

EVALUATION MATERIALS .....9

# 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 Sally Aerts at the Utah Department of Health for assistance:

Email: [saerts@utah.gov](mailto:saerts@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 Sally Aerts 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:

| Participant ID   | S 0 | S 1 | S 2 | S 3 | S 4 | S 5 | S 6 | S 7 | Total |
|--|-----|-----|-----|-----|-----|-----|-----|-----|-------|
| <b>Name:</b> Dan Johnson<br><b>ID:</b> DAJO49 <b>Zip:</b> 84101    | ✓   | ✓   | ✓   |     | ✓   | ✓   |     | ✓   | 6     |
| <b>Name:</b> Trudy Brothers<br><b>ID:</b> TRBR38 <b>Zip:</b> 84770 | ✓   | ✓   | ✓   | ✓   |     |     |     |     | 4     |

### 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 Sally ([saerts@utah.gov](mailto:saerts@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 [saerts@utah.gov](mailto:saerts@utah.gov) with subject line “[Agency name]\_Submitted Stepping On Evaluation” (preferred) or mail copies to:**

Stepping On Evaluation  
c/o Sally Aerts  
PO Box 142106  
SLC, UT 84114-2106
  - Step 5: Retain all original paperwork in a safe place until completion of the grant period (8/31/2016), 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 [saerts@utah.gov](mailto:saerts@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!)

## EVALUATION TIMELINE/CHECKLIST FOR ALL-PAPER VERSION

|  |   |
|--|---|
| <b>Session 1</b>                         | <input type="checkbox"/> Distribute and collect Participant Information Forms at the beginning of the class session<br><input type="checkbox"/> Take attendance   |
| <b>Session 2</b>                         | <input type="checkbox"/> Take attendance  |
| <b>Session 3</b>                         | <input type="checkbox"/> Take attendance  |
| <b>Session 4</b>                         | <input type="checkbox"/> Take attendance  |
| <b>Session 5</b>                         | <input type="checkbox"/> Take attendance  |
| <b>Session 6</b>                         | <input type="checkbox"/> Take attendance  |
| <b>Session 7</b>                         | <input type="checkbox"/> Distribute and collect Participant Post-Program Surveys<br><input type="checkbox"/> Take attendance  |
| <b>After final session has concluded</b> | <input type="checkbox"/> Fill out the Falls Prevention Information Cover Sheet<br><input type="checkbox"/> Fill out the Host Organization Information Form, if you have not previously turned one in for that host organization<br><input type="checkbox"/> Assemble copies of materials as described on page 7 of this protocol<br><input type="checkbox"/> Within two weeks of workshop completion, submit copies as instructed on page 7 of this protocol<br><input type="checkbox"/> Retain originals materials |
| <b>Booster Session</b>                   | <input type="checkbox"/> Distribute and collect Participant Booster Session Surveys<br><input type="checkbox"/> Within two weeks of Booster Session, submit copies as instructed on page 7 of this protocol<br><input type="checkbox"/> Retain original materials   |

## EVALUATION TIMELINE/CHECKLIST FOR COMPASS USERS\*

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

|                  |   |
|------------------|---|
| <b>Session 1</b> | <input type="checkbox"/> Distribute and collect Participant Information Forms at the beginning of the class session<br><input type="checkbox"/> Take and record attendance in compass |
| <b>Session 2</b> | <input type="checkbox"/> Take and record attendance in compass  |
| <b>Session 3</b> | <input type="checkbox"/> Take and record attendance in compass  |
| <b>Session 4</b> | <input type="checkbox"/> Take and record attendance in compass  |
| <b>Session 5</b> | <input type="checkbox"/> Take and record attendance in compass  |
| <b>Session 6</b> | <input type="checkbox"/> Take and record attendance in compass  |
| <b>Session 7</b> | <input type="checkbox"/> Take and record attendance in compass<br><input type="checkbox"/> 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

# Stepping On Group Leader Talking Points

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*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

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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. 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. In general, how would you rate your health? (Choose only one)

Excellent       Very good       Good       Fair       Poor

3. How old are you today? \_\_\_\_\_ years

4. Do you live alone?

Yes       No

5. What is your gender?

Male       Female

6. Are you of Hispanic, Latino, or Spanish origin?

Yes       No

7. 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

8. What is the highest grade or level of school that you have completed?

Less than high school

Some high school

High school graduate or GED

Some college or vocational school

College graduate or higher

9. Are you limited in any way in any activities because of physical, mental, or emotional problems?

Yes       No

# Stepping On Participant Information Form

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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.

10. 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

11. How fearful are you of falling?

Not at all       A little       Somewhat       A lot

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

|   | Very sure             | Sure                  | Somewhat sure         | Not at all sure       |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| a. I can find a way to get up if I fall | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. I can find a way to reduce falls     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. I can protect myself if I fall       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. I can increase my physical strength  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. I can become more steady on my feet  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

13. 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

14. 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.)

|  |   |
|--|---|
| <input type="checkbox"/> Arthritis or other bone/joint disease | <input type="checkbox"/> Heart disease or blood circulation problem                   |
| <input type="checkbox"/> Breathing/lung disease                | <input type="checkbox"/> Glaucoma/other chronic eye problem                           |
| <input type="checkbox"/> Depression                            | <input type="checkbox"/> Other:<br>_____  |
| <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> None (I have not been diagnosed with any chronic conditions) |

**The form is complete! Thank you for your participation.**

**Please return this completed form to your instructor.**

# Attendance Log

Workshop: \_\_\_\_\_ Start Date: \_\_\_ / \_\_\_ / \_\_\_\_ End Date: \_\_\_ / \_\_\_ / \_\_\_\_

| Participant Information           | Session Zero | Session 1 | Session 2 | Session 3 | Session 4 | Session 5 | Session 6 | Session 7 | Total |
|-----------------------------------|--------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-------|
| Name:<br>ID:            Zip code: |              |           |           |           |           |           |           |           |       |
| Name:<br>ID:            Zip code: |              |           |           |           |           |           |           |           |       |
| Name:<br>ID:            Zip code: |              |           |           |           |           |           |           |           |       |
| Name:<br>ID:            Zip code: |              |           |           |           |           |           |           |           |       |
| Name:<br>ID:            Zip code: |              |           |           |           |           |           |           |           |       |
| Name:<br>ID:            Zip code: |              |           |           |           |           |           |           |           |       |
| Name:<br>ID:            Zip code: |              |           |           |           |           |           |           |           |       |

*Use additional pages if needed.*

*If there was not a Class 0 for this workshop, write n/a in the corresponding column.*

# Stepping On Participant Post-Program Survey

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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:                  | Very<br>sure          | Sure                  | Somewhat<br>sure      | Not at all<br>sure    |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| a. I can find a way to get up if I fall | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. I can find a way to reduce falls     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. I can protect myself if I fall       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. I can increase my physical strength  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. I can become more steady on my feet  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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

# Stepping On Participant Post-Program Survey

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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...  | Strongly Agree        | Agree                 | Disagree              | Strongly Disagree     |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. I feel more comfortable talking to my family and friends about falling   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. I feel more comfortable increasing my activity   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. I plan to continue exercising  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. I feel more satisfied with my life   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. I would recommend this program to a friend or relative   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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

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*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):

- |   |   |
|---|---|
| <input type="radio"/> Municipal Government                        | <input type="radio"/> Recreational organization |
| <input type="radio"/> Area Agency on Aging                        | <input type="radio"/> Residential Facility      |
| <input type="radio"/> County Health Department                    | <input type="radio"/> Senior Center             |
| <input type="radio"/> Educational Institution                     | <input type="radio"/> Other Community Center    |
| <input type="radio"/> Faith-based organization                    | <input type="radio"/> Tribal Center             |
| <input type="radio"/> Health Care Organization                    | <input type="radio"/> Workplace                 |
| <input type="radio"/> Library                                     | <input type="radio"/> Other (please specify):   |
| <input type="radio"/> Multi-purposes social services organization |   |

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):

- |  |   |
|--|---|
| <input type="radio"/> State Unit on Aging      | <input type="radio"/> Multi-purposes social services organization |
| <input type="radio"/> Municipal Government     | <input type="radio"/> Recreational organization                   |
| <input type="radio"/> Area Agency on Aging     | <input type="radio"/> Residential Facility                        |
| <input type="radio"/> State Health Department  | <input type="radio"/> Senior Center                               |
| <input type="radio"/> County Health Department | <input type="radio"/> Other Community Center                      |
| <input type="radio"/> Educational Institution  | <input type="radio"/> Tribal Center                               |
| <input type="radio"/> Faith-based organization | <input type="radio"/> Workplace                                   |
| <input type="radio"/> Health Care Organization | <input type="radio"/> Other (please specify):                     |
| <input type="radio"/> Library                  |   |

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

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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:

|   | Very<br>sure          | Sure                  | Somewhat<br>sure      | Not at<br>all sure    |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| a. I can find a way to get up if I fall | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. I can find a way to reduce falls     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. I can protect myself if I fall       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. I can increase my physical strength  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. I can become more steady on my feet  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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

# Stepping On Participant Booster Session Survey

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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.

| <b>Since completing Stepping On...</b>  | <b>Strongly Agree</b> | <b>Agree</b>          | <b>Disagree</b>       | <b>Strongly Disagree</b> |
|---|-----------------------|-----------------------|-----------------------|--------------------------|
| a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>    |
| b. I feel more comfortable talking to my family and friends about falling   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>    |
| c. I feel more comfortable increasing my activity   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>    |
| d. I plan to continue exercising  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>    |
| e. I feel more satisfied with my life   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>    |
| f. I would recommend this program to a friend or relative   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>    |

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? \_\_\_\_\_

- 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.**

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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.**

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

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**The survey is complete! Thank you for your participation.**

**Please return this completed survey to your instructor.**