

***Department of Human Services
Rural and Regional Health
and Aged Care Services***

**Falls Prevention Program
Rationale and Funding Submission Guidelines**

**Whole of Community
Falls Prevention Projects
Phase 2**

July 2005

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1 Whole of Community Project Definition

This document, *Whole of Community Project Rationale and Funding Submission Guidelines*, provides the overall rationale to guide Primary Care Partnerships (PCPs) intending to develop a submission to implement a 'Whole of Community' Falls Prevention project.

The PCP strategy provides an unprecedented opportunity to build the ongoing capacity of the human services system in Victoria to plan and deliver effective, integrated health promotion. This falls prevention funding provides opportunities for PCPs to work with a range of partners across multiple settings, including public sector residential aged care services and other not for profit agencies within a designated local catchment area.

1.1 Falls Prevention Program Goals

The goal of the Falls Prevention Program is to implement multi-strategy falls prevention projects within an integrated health promotion framework to reduce the risk and incidence of falls, and the severity of fall-related injuries among older people.

The intended long-term benefits to municipalities and regions are improvements in the health, wellbeing and mobility of older people enabling them to live with greater confidence, independence and security.

1.2 Project Objectives

The objectives of falls prevention projects are to:

- Increase community recognition of falls as a '*whole of community*' responsibility.
- Increase community understanding that falls are not an inevitable part of growing older.
- Increase community understanding of the multifactorial risk factors that contribute to falls and benefits of falls prevention interventions.
- Increase the proportion of older people who actively participate in reducing their risk of falling, and as a consequence enjoy an independent and healthy lifestyle.
- Increase the safety of local environments for current and future generations.
- Integrate falls prevention interventions within the PCP Integrated Health Promotion Catchment Plan and Municipal Public Health Plan.

1.3 Contractual Arrangements, Funding and Resources

DHS Funding

Funding for *Whole of Community* Falls Prevention projects will be available from financial year 2005-2006 for a total of three years subject to Ministerial approval and available funding.

The amount of funding for each project will be in the vicinity of \$210,000 over three years. The funds will be structured to provide up to \$60,000 in Year 1 and \$75,000 in each of the following two years of the project on condition that satisfactory progress is achieved towards objectives and targets, and reported to DHS Regional and Central Office on a quarterly basis.

The exact amount per project may vary to accommodate innovative larger and/or smaller projects. However, given the program goals of supporting multi-strategic projects, it is not the intention to fund very small projects.

DHS Regional Officers will be responsible for administering contractual and funding arrangements, monitor and receive progress reports from the project. These multi-setting projects will be funded through PCPs. PCPs will be required to nominate the name of the Organisation/Agency that will receive and be responsible for the funding allocated for the project and DHS Service Agreement. This organisation may not necessarily be the lead Organisation/Agency for the project.

PCPs and collaborating agencies that are currently receiving other DHS funding to implement a falls prevention project, or are receiving funding from another source, for example the Australian Government or Metropolitan Health & Aged Care Services, will not be given a high priority.

However, where PCPs are receiving funding for a *Foothold on Safety (FOS)* project they may be eligible to apply for *Whole of Community* funding. PCPs must demonstrate that the size of the aged population, physical and/or geographical distance between key agencies, have impacted on the capacity of the FOS project to provide key falls prevention interventions for older people in their community.

Support and Resources for Quality Integrated Health Promotion Action

Applicants should identify how the funding will be spent within the three-year time frame including administrative overheads and operating costs.

- DHS acknowledges that PCPs may wish to nominate a Lead Organisation/Agency to implement the *Whole of Community* project.
- Funding can be used to establish ongoing, sustainable programs or for *further development and enhancement* of established programs.

The PCPs and collaborating agencies should:

- Identify the roles and responsibilities of the key stakeholders, including nominating the lead organisation/agency (if this option is decided upon), community, consumer and carer representatives.
- Provide (if known), contact details for the person/s responsible for:
 - o Implementing the project
 - o Managing the service agreement, and
 - o Liaising with DHS Regional Officers.
- Identify how resources will be allocated.
- Specify if necessary, any non-recurrent establishment costs.
- Demonstrate how links will be established between the project, the PCP management group and the *Whole of Community* falls project advisory group, and
- Identify how the benefits of the project will be sustained beyond the life of the existing project within each PCP integrated health promotion catchment planning area.

Note:

This funding is not to cover depreciation or used for capital works. It is principally for integrated health promotion purposes.

The Department of Human Services (DHS) looks to PCPs and collaborating agencies to demonstrate a willingness to show a shared financial or '*in kind*' commitment to supplement the funding provided by DHS.

1.4 Participation in Falls Prevention Network

There is an expectation that a representative from the PCP or Lead Organisation/Agency will participate in quarterly Falls Prevention Network Meetings held at DHS Central Office, Melbourne. Sufficient funds should be allocated within the budget to cover this requirement.

The Falls Prevention Network provides opportunities for meeting and networking with other project representatives, and to encourage shared learning and practice change.

2 Background

Falls are a major cause of injury for older people. They are the leading cause of injury-related hospital admissions in people aged 65 years and over and, as such, are a major public health problem in terms of social, health and economic costs for both individuals and the general community. However, many older people experience numerous falls that do not result in hospital admission or death but they are a cause for concern as likely markers of proneness to future falling, perhaps with worse outcomes, and as indicators of deteriorating health status.

The Falls Prevention Program is an initiative of the Aged Care Branch of Rural & Regional Health and Aged Care Services Division of the Department of Human Services. The Department has identified falls prevention as a priority area for promoting health, safety and independence and looks to PCPs and collaborating public sector residential aged care services and *not for profit* agencies to incorporate falls prevention into the PCP's integrated health promotion strategy.

The Department understands and supports older people's desire to remain active and independent. It believes it is in the community's interest to find long-term solutions to preventing falls and reducing the injury toll among older people. A commitment between older people and a range of agencies to promote safer living environments will benefit *all* people as they age.

Fostering a positive attitude to growing older will assist the community to view the ageing process as a natural part of living. Involving and encouraging older people to remain connected with the community, will contribute to their overall health, wellbeing and independence.

To assist communities in this work, DHS provides falls prevention project grants to reduce the number of falls and the severity of injuries from falls.

To prevent falls a partnership approach is vital because of the complex personal and environmental factors known to contribute to falls. No single group can solve the problem. Local government planners, architects and builders, community health centres, hospitals, general practitioners, pharmacists, older people's organisations, service clubs, public and private transport companies, media, shopping centres, voluntary organisations and health, sport and recreation clubs are just a few examples of agencies that can collaborate to bring about a safe environment and address intrinsic risk factors for older people to live confidently and go about their business.

To be successful, older people, local government and health professionals must share in the design of the project and the development of the various strategies from the commencement of any falls prevention project. DHS recognises that older people are not always free to make healthy choices and that health education, in isolation, is not an effective strategy to modify behaviour.

The Aged Care Branch of the Victorian Department of Human Services provides program and policy direction for the delivery of DHS-purchased aged care programs and services and works closely with the other program areas of the Department to ensure the provision of a coordinated health and support system for older Victorians.

Aged Care has developed a comprehensive program to prevent falls among older people that will be implemented over several years. In previous years the Program has funded projects in the following areas:

- *Foothold on Safety* projects for older people living in their own homes
- Public sector Residential Aged Care Facilities
- Sub-Acute Services, and
- Acute Hospitals.

In recognition of the way older people move between and across settings, DHS has decided to fund *Whole of Community* falls prevention projects. By agencies working together there are opportunities for organisations to effect long-term change.

2.1 Defining falls

The Aged Care Falls Prevention Program considers it is important that a standard definition of a fall is consistently used. For the purposes of this document the definition developed for the Victorian Quality Council Guidelines for Minimising the Risk of Falls & Fall-related Injuries 2004¹ will be used.

DEFINITION OF A FALL

A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, the ground or other surface. (Abbreviated)

This includes:

- *Slips*
- *Trips*
- *Falling into other people*
- *Being lowered*
- *Loss of balance, and*
- *Legs giving way.*

If a patient/resident is found on the floor, it should be assumed that they have fallen unless they are cognitively unimpaired and indicate that they put themselves there on purpose.

2.2 The Case for Preventing Falls

Falls are a major public health problem and an unnecessary toll on older people's health, vitality and independence. The following statistics attest to the current size of the issue and provide a projection of trends over the next century:

- About one in three older people living in their own homes fall each year.
- Even where no injury occurs, older people who have sustained a fall may develop a fear of falling. It should be noted that falling is not a prerequisite for fear of falling to occur. It becomes problematic when it immobilises or creates debilitating anxiety and interferes with daily activities. Any restriction of activities is itself a risk factor for falls because it can lead to muscle weakness and deconditioning, and reduced functioning. Up to a quarter of older persons with fear of falling report avoiding everyday activities either because of fear of injury (most commonly a fractured hip) and/or fear of being unable to get up from the ground following a fall².

Self-imposed activity limitations due to a fear of falling again are an additional challenge to promoting exercise among older people. The quality of life of older women, who have exceeded average life expectancy, is profoundly threatened by falls and hip fractures. Older women place a high value on their health. Any loss of ability to live independently in the community has a considerable detrimental effect on their quality of life (Salkeld et al 2000) and can lead to increased anxiety and loss of confidence, decreased activity and social interaction, and increased dependence on family and community services (Poulstrup, 2000). It can also increase the risk of falling.

- Falls are the leading cause of injury-related hospital admissions of older Victorians. In 2002-2003 Victorian Admitted Episodes Dataset (VAED) statistics

¹ on the definition devised by Tinetti, M., Baker, D., Dutcher, J., Vincent, J., Rozett, R. 1997. *Reducing the risk of falls among older adults in the community*. Berkeley, C.A.: Peaceable Kingdom Press.

Also see: Minimising the Risk of Falls & Fall-related injuries Based
http://www.health.vic.gov.au/qualitycouncil/plans/falls_5d.htm

² Tennstedt, S., Howland, J., Lachman, M., Peterson, E., Kasten, L. & Jette, A. (1998). A randomized controlled trial of a group intervention to reduce fear of falling and associated activity restriction in older adults. *Journal of Gerontology: Psychological Sciences* 53B (6): pp 384-92.

indicate the average length of stay for older persons with an injury-related neck of femur (hip) fracture was 11.93 days. In total there were 9,625 episodes with an injury as a principal diagnosis resulting from an accidental fall among people aged 65 years and over.

- A recent report to the Australian Government of projected costs of fall related injury suggests: The cost of fall related injury is not just driven by the total proportion of people over 65 years but by the distribution mix of ages within this group. An increasing proportion of people over 65 will reach the age of eighty or ninety, resulting in an increased need for service over time if the current rate of fall injury continues³.
- Approximately 47.1% of older people who fall at home and require hospital admission are subsequently discharged to a nursing home (Hazard Edition No. 45 December 2000). The probability of permanent admission to an aged care facility for community dwelling older people who fracture their hips is 28% in the year after fracture (MUARC 2002).
- The direct medical care cost of all fall injuries in older Victorians (aged 65 years and over) is estimated at \$323 million per year in 2002-2003⁴. People aged 65 years and over account for 12% of the Victorian population but 22% of the direct cost of injuries (mostly due to falls) because of their long recovery time from trauma⁵.

2.3 Falls are Preventable

Contrary to popular belief, falls are not inevitable among the older population. The risk factors for falls are amenable to change and where falls do occur, the severity of injuries can be reduced.

The belief that falling is an inevitable consequence of growing older is an ageist perspective and is counterproductive to the preventive measures that organisations and individuals can implement to minimise falls.

Falls (and injuries generally) are the culmination of a set of circumstances and pre-existing conditions that may best be understood as a chain of events. There are three main factors that contribute to injury: the person at risk, the activity being undertaken, and the environment. These factors may interact in various ways to result in an injury.

By viewing falls, not as accidents that are inevitable or the fault of individuals but by considering the factors contributing to injury and intervening, injuries can be prevented or reduced in severity.

2.4 Profile of People Who Fall

Falling is not peculiar to older people; it occurs at all ages, among children and athletes. The special significance of falls by older people is the high incidence rate, increased susceptibility to injury and a prolonged recovery period.

Falls can also lead to death among older people. MUARC reported that there were approximately 250 fall-related deaths among Victorians aged 65+ years, 12,000 fall-related hospital admissions and at least 12,000 hospital emergency department presentations for fall-related injuries⁶.

Fractures are a major cause of mortality and morbidity in older people, particularly hip fractures (the most serious fall-related injury) that contribute to an increase of 10-20% in the mortality rate⁷.

³ Moller, J. (2003). Projected costs of fall related injury to older persons due to demographic change in Australia. Report to the Commonwealth Department of Health and Ageing under the National Falls Prevention for Older People Initiative.

⁴ Monash University Accident Research Centre (2005). Unpublished report to DHS Public Health Branch.

⁵ (Watson, W. & Ozanne-Smith, J. 1997, MUARC November 2002).

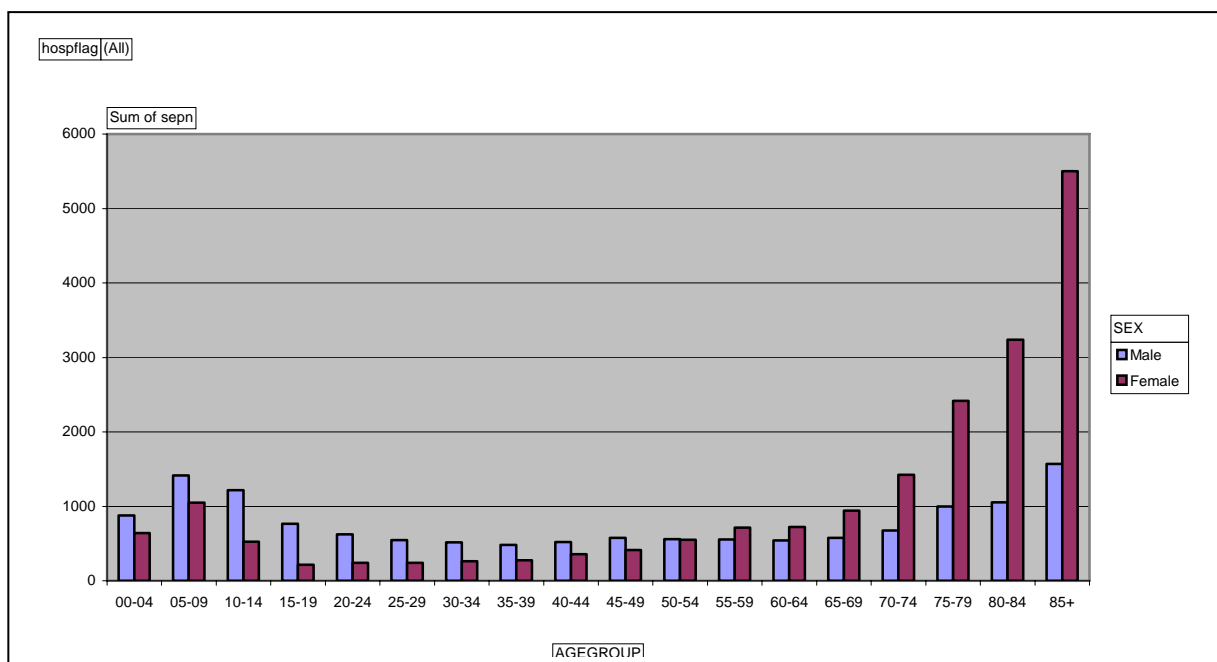
⁶ <http://www.monash.edu.au/muarc/VISAR/falls/fallfact.pdf>

⁷ Francis, R.M. (2001). Falls and fractures. *British Geriatrics Society, Age and Ageing* **30-S4**: 25-8.

There is no 'typical faller' but there are a number of attributes common to a large proportion of the older people who fall. These people are more likely to be:

- Advanced age group (over 80)
- Female
- Living alone
- Taking a number of medications (prescribed, in particular psychotropic drugs, or self-prescribed and administered)
- Ill or disabled
- With poor vision
- Using a walking aid
- Someone who has fallen recently and/or has had several slips or trips
- Socially isolated
- Depressed
- Cognitively impaired
- Experiencing a greater degree of:
 - postural sway
 - range of gait disorders
- Suffering from several chronic disabilities that increase the risk of falling

The following table based on Victorian Admitted Episodes Database (VAED) 2002-2003 statistics shows the difference between male/female fall-related hospital admissions:



Falls groups: vigorous, transitional and frail

Research has demonstrated that fall experiences of people living at home vary with levels of well-being⁸. Older people can be divided into three functional groups: vigorous, transitional (in transition from vigorous to frail) and frail, requiring different preventive approaches for each identified group. Speechley and Tinetti's study classified falls groups as follows:

Vigorous group

Averaged 78 years of age, were more active, had the highest alcohol and medication use (apart from sedatives) and the lowest rate of depression. Of this group 17% fell, usually when away from home and significantly, 22% of these falls resulted in serious injury.

⁸ Speechley, M. & Tinetti, M. (1991). Falls and injuries in frail and vigorous community elderly persons. *Journal of American Geriatrics Society* 39: 46-52.

Transitional group

Transitional from vigorous to frail. Spanned a wider age range, with an average age of 81 years, and a fall rate of 32% with 11% of the falls causing serious injury.

Frail group

Older, averaging over 86 years, with multiple disabilities and 52% falling at home during the year with 6% of those falls resulting in serious injury.

The above findings confirm that a higher percentage of frail, older people fall. However, falls by vigorous older people incur a higher percentage of serious injury and occur mainly when they are involved in more active, potentially hazardous activities such as climbing ladders or playing sport. They are also more likely to be in more hazardous environments.

It must also be recognised there are some older people, for a range of reasons including personal choice, who may 'fit' into the above groups but do not have, or wish to have regular contact with services or their peers. It is this group that may prove to be the most difficult to locate and encourage to join in activities/interventions.

Applicants are asked to specify how their interventions target the various 'at risk' sub-groups as well as the general population of people 65 years and over.

Note:

In considering the activities you may wish to include in a falls prevention project, older people attending activities have a right to expect that the people providing all services possess the necessary skills and knowledge to provide that service.

Consideration should be given to ensure all services that promote physical activity are provided, or supervised by, appropriately qualified health professionals. Service providers must ensure reasonable care is provided to individuals to avoid harm and to protect individuals from foreseeable risk of injury.

To enhance sustainability of falls prevention projects both in terms of personnel and service provision, Aged Care Branch is interested in workforce development, primarily through staff training. This is particularly important where skills, and the expertise needed to implement projects are not available locally or through other services.

3 *Submission Requirements*

Joint submissions for *Whole of Community* Falls Prevention projects are invited from PCPs and collaborating agencies to implement an innovative falls prevention project designed by, and for, the local community.

Each PCP and collaborating agencies will decide which organisations will participate in their project. The falls prevention project will be more effective if it actively involves a number of key stakeholders and representatives such as:

- Local government
- Community Health Services
- Falls and mobility clinic
- Local sport and recreation sector
- Organisations that represent older people or where older people are the majority of the membership
- Psychiatric disability support
- Psychogeriatric Assessment and Treatment Teams
- Aged Care Assessment Services (ACAS)
- Aboriginal community controlled health services
- Carer Agencies/Services
- Community drug treatment services
- Local ethno-specific health services, and
- Other integrated health promotion initiatives such as:
 - Well for Life
 - Active Script
 - Health and Active Living
 - Walk and Talk

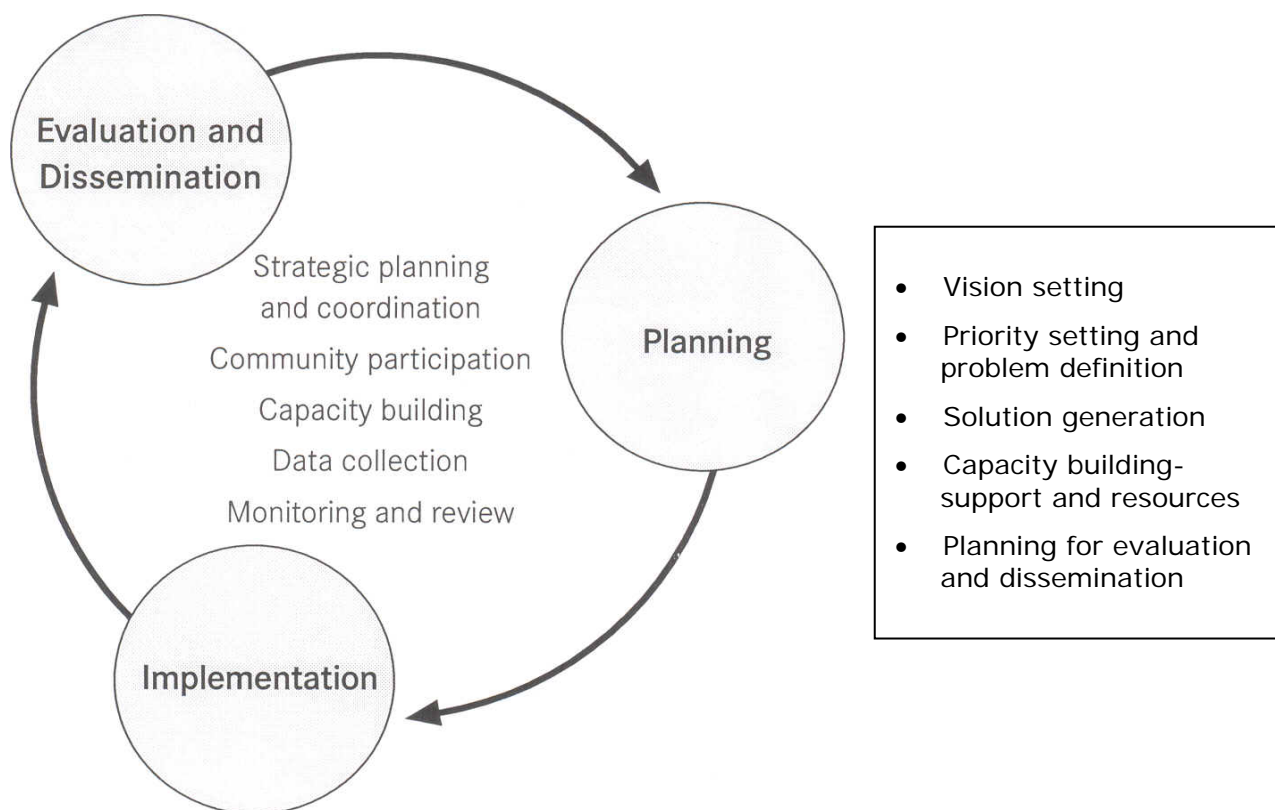
Local partnerships should encourage the active participation of consumers, carers and the broader community. PCPs and collaborating agencies are required to:

- Respond, in order, to each of the submission headings.
- Provide a short narrative that includes:
 - The number and proportion of the population of older people 65 + years in the designated local catchment area
 - The numbers and nature of fall-related injuries, eg. The number of people 65+ who are admitted to hospital for a fractured neck of femur. The settings where the falls are occurring, eg. In or outside of the home, residential aged care facility or acute hospital.
 - What services are available to assist older people who fall, and
 - Suggest the differences you consider this funding will make to the health and well being of older people, their families and carers.

In this brief narrative identify key features or special needs of the local population or particular groups within the community. PCPs should refer to the community health and well-being profile from their Community Health Plan or investigate additional data sources, where necessary, to assist in planning an appropriate falls prevention project.

- Describe how the PCP will link the falls prevention project with the catchment planning for integrated health promotion, as reflected in the PCP Integrated Health Promotion Catchment Plan and the Municipal Public Health Plan.
- Nominate a representative of the PCP (or Lead Organisation/Agency) to liaise with DHS.

Whole of Community projects should also consider the collaboration's vision, priority issues and how the goal, aims and objectives, and outcomes for the falls prevention project fits within a defined template. Specifically:



Note:
DHS reserves the right to review funding to organisations if the strategies identified in the initial project submission are significantly varied. Any variations will require DHS Regional and Central Office agreement.

4 Submission Headings

Applicants must address the selection criteria (5.1 – 5.6) and present their submissions under headings in the following order:

4.1 Contact Information:

- Contact details including name/address/telephone numbers and email addresses for:
 - o Executive Officers of the PCP and collaborating Agencies
 - o Executive Officer responsible for the submission.
- Provide (if known) contact details for:
 - o The lead agency
 - o Person(s) responsible for implementing the project, managing the service agreement, and liaising with DHS Regional Officers.
- Other PCP Member Organisations.
- Links with Other Organisations.

4.2 Understanding of the Issues (Criterion 5.1). (In providing understanding of the issues PCPs are required to provide a brief narrative that demonstrates how the falls prevention funding will impact upon the health and well being of the designated local catchment area.)

4.3 Detailed integrated health promotion implementation plan for a *Whole of Community* Falls Prevention Project (Criterion 5.2).

4.4 Consultations with all relevant stakeholders (Criterion 5.3). PCPs and collaborating agencies should also identify the roles and responsibilities of the key stakeholders, community, consumer and carer representatives.

4.5 Demonstrate how links will be established between the PCP and the *Whole of Community* falls prevention working group and their project advisory group.

4.6 Long-Term Strategy/ies (Criterion 5.4). Identify how the benefits of the project will be sustained beyond the life of the existing project. This includes identifying how community sector disability services, local Government, recreation services and private sector services will either be established and or enhanced to assist in the implementation of this initiative.

This includes the capacity to leverage existing locally based initiatives already taking place within PCP catchment planning for integrated health promotion.

4.7 Successful age-related integrated health promotion programs (Criterion 5.5).

4.8 Budget

- Resource Allocation - Identify how resources will be allocated
- Specify if necessary, any non-recurrent establishment costs
- Staff costs (including staff on-costs)
- Consumables
- Infrastructure costs
- Non-salary costs
- Financial or '*in kind*' contributions.

Additional information about preventing falls among older people, setting specific information and literature references can be accessed through the DHS Falls Prevention website:

<http://www.health.vic.gov.au/agedcare/maintaining/falls/index.htm>

5 Selection Criteria

Submissions will be assessed against the following selection criteria specifically in relation to your designated local catchment area.

- 5.1 Demonstrated, comprehensive and detailed level of **understanding of the issues** relevant to preventing falls and injuries from falls among older people in a range of settings within a discrete local community environment.
- 5.2 Evidence of a **planning process** identifying: project goal, project aims and objectives, mix of interventions, timelines and impacts.
- 5.3 Evidence-based rationale for the mix of interventions chosen to support a **multi-strategy falls prevention plan** for your designated local catchment area that addresses the major falls risk factors and includes a focus on:
 - Screening, individual risk assessment (falls prevention related services)
 - Health education and skill development
 - Social Marketing/Health Information (including awareness raising activities)
 - Community action
 - Settings and supportive environments (including home, hospital, residential aged care facility and public place audits)⁹.
- 5.4 Demonstrate appropriate **capacity building strategies** to ensure falls prevention initiatives will become an intrinsic part of the PCP catchment planning for integrated health promotion, and **sustained** beyond the period of project funding.
- 5.5 Documented evidence that **all relevant stakeholders** have been involved in the planning, design and development of the *Whole of Community* project.
- 5.6 Documented evidence of **recent successfully implemented aged related integrated health promotion programs** within the designated local catchment area.

⁹ Integrated Health Promotion – A practice guide for service providers:
<http://www.health.vic.gov.au/healthpromotion/>

6 Evaluation, Reporting and Review

Plan for Review and Evaluation

Monitoring, audit and review arrangements will apply uniformly to all service providers in line with Department of Human Services and State Government practice.

In planning for Review and Evaluation, PCPs and collaborating agencies should include the following:

- Process – the planning process and the strategies and processes that will be used to implement the project.
- Impact – Identifying how the immediate effect(s) of the implementation of a falls prevention intervention or plan will be measured. For example, have objectives been met, changes in knowledge, attitudes and practices of people, stakeholders and settings (as stated in Project Aims and Objectives).
- Outcome – the long-term effects of the project. For example, the health and social outcomes such as the incidence of falls and injuries from falls (as stated in the Falls Prevention Program Goals).

Note:

Raised awareness and improved reporting of falls can lead to an apparent increase in incidents. Over time there should be a more accurate view of outcomes of the project.

Quality evaluation that is more fully integrated with the planning and implementation of projects will ensure a sound, secure and sustainable improvement in integrated health promotion practice.

Information relating to fall-related injury data in discrete local government areas and postcode areas can be obtained from the Victorian Injury Surveillance System at the Monash University Accident Research Centre (MUARC).

<http://www.monash.edu.au/muarc/VISAR/contact.html>

For additional information about evaluation, please see:

- *Measuring Health Promotion Impacts: A Guide to Impact Evaluation in Integrated Health Promotion* – June 2003
http://www.health.vic.gov.au/healthpromotion/hp_practice/eval_dissem.htm
- *Integrated Health Promotion – A practice guide for service providers* – June 2003
http://www.health.vic.gov.au/healthpromotion/what_is/index.htm
- *Planning for effective health promotion evaluation* - May 2005
http://www.health.vic.gov.au/healthpromotion/downloads/planning_may05.pdf

7 Closing Date for Submissions

Submissions are to reach the Department of Human Services Regional Office **by 5.00 p.m. on July 2005.**

- Late or facsimile submissions will **not** be accepted.
- Submissions received after the closing time will be recorded as such, with the date and time of receipt, and the documentation returned to the applicant.
- Submissions forwarded through Australia Post should be posted to ensure receipt no later than the closing time (registered post preferred).
- The original and six copies of the *Whole of Community Falls Prevention Project* submission are required to be submitted.
- While invitations have been extended to PCPs and collaborating agencies, it does not follow that the lowest priced or any submissions will necessarily be accepted. Post selection negotiations may be required to finalise specifications and before the finalisation of a Service Agreement.

8 Reporting

The Department is required to report to Treasury for all budget allocations in the Budget Paper No. 3 by demonstrating funds have been appropriately used. To enable the Aged Care Branch to comply with this accountability requirement, PCPs will be required to provide a quarterly report to DHS Regional and Central Offices.

Reporting and feedback mechanisms will be available electronically for successful applicants to provide:

- Quarterly reports in January, April and October of each year; (Appendix 1)
- Annual report in June/July of each year. (Appendix 2)

These reports substantially provide information about progress on project implementation and achievement of objectives.

Reports will be returned to your contact at the DHS Regional Office and Aged Care Branch on dates to be advised.

PCPs must comply with the Financial Accountability Requirements and reporting requirements established from a Service Agreement.

9 Audit

PCPs and collaborating agencies should note that DHS might authorise an audit of a PCP/Lead Organisation/Agency:

- If the financial returns of the service provider indicate concern about the nature of expenditure of funds provided by the Department.
- To establish or investigate the financial viability of the PCP or the Lead Organisation/Agency where funds provided by the Department comprise a significant proportion of the organisation's total budget.
- To establish whether the grant of funds has been applied for the purposes for which it was made and whether the money has been applied economically, efficiently and effectively.

10 Conditions

10.1 General Conditions

PCPs and collaborating agencies wishing to make a submission should submit their submission in accordance with the Department of Human Services requirements set out in this document. The conditions under which a response must be made are indicated in this section. Agencies should familiarise themselves with this brief and ensure submissions conform. Agencies submitting submissions are deemed to have:

- Examined the Submission document and other information made available in writing by the Department of Human Services to agencies for the purpose of preparing a submission.
- Examined all information relevant to risks, contingencies, and other circumstances having an effect in their application and which is obtainable by the making of reasonable enquires.
- Examined statutory requirements and satisfied themselves they are not participating in any anti-competitive, collusive, deceptive or misleading practices in structuring and submitting their submission.

Satisfied themselves as to the correctness and sufficiency of their application and that prices included in their submission will be sufficient to meet the requirements of the service as outlined in the submission brief.

10.2 Legal Entity

PCPs and collaborating agencies making a submission must provide proof of their legal status. The Department of Human Services can only enter into a legal agreement/contract with an individual (a person at least 18 years of age) or an Organisation/Agency established under:

- Associations Incorporation Act
- Co-operatives Act
- Corporations Act
- Health Services Act
- An Individual Act of Parliament

10.3 Consortia

There are three legal and management options available to consortia within to make a submission. Each of these types of arrangements is acceptable to the Department of Human Services:

- Incorporate as a single body.
- Each Member signs as part of a Non Incorporated Consortium.
- Subcontracting by the Lead Organisation/Agency to other members of the Consortium.

If a consortium makes the submission the document must indicate the name of the Organisation/Agency assuming lead responsibility, which parts of the service it is proposed that each entity comprising the Consortium would provide. The submission should also indicate how the agencies would relate to each other to ensure cooperation and full provision of the required service across the PCP catchment area.

10.4 Form and Application of Agreement

The PCP and collaborating agencies will be required to nominate an Organisation/Agency to coordinate and assume lead responsibility for the project. This Organisation/Agency will be required to enter into a formal Service Agreement or agree to a Variation to an existing Agreement with the Department of Human Services.

A contract for delivery or provision of goods or services described in this document does not exist until both parties have executed the applicable standard Department of Human Services agreement.

10.5 Conflicts of Interest

Applicants must declare to the Department of Human Services any matter or issue that is, or may be perceived to be or may lead to, a conflict of interest regarding their submission or participation in supply of the services described. Agencies must describe a strategy so that any conflict of interest will be avoided.

10.6 GST (Goods and Services Tax)

All quotations must include GST (where applicable).

Appendix 1 – Progress Report

Please note the Progress Report will be due in October, January and April of each year

**DHS Aged Care Branch Falls Prevention Program
Local Initiatives for
Whole of Community Phase 2 Project**

Date:

| |
|----------------------------------|
| Project name: |
| Primary Care Partnership: |
| Project start date: |
| Project finish date: |
| Local government area/s: |

Progress reports outline the progress and activities undertaken in relation to the objectives and targets outlined in the Service Agreement and its timelines. Please feel free to use this outline to inform your progress report.

Progress reports need to be completed at three monthly intervals to coincide with the Falls Prevention Program Network Meetings and should be less than one page (500 words).

Each project can use the progress reports to provide an update of your project at the meeting. (If you are unable to attend the Network Meeting please forward this report electronically to your DHS region and Central Office.) In addition to this, the progress reports may be used to inform your final report.

The following are a guide to inform your Progress Report.

- Are the project objectives and targets being achieved? Description of activities undertaken in order to achieve the objectives/targets. Refer to the tasks outlined in your Service Agreement. For example:
 - Consultation with health professionals and/or agencies.
 - Participation of older people in the implementation of the project as distinct from participating in planned activities.
 - Development of project material. It's appropriateness and quality.
 - Education and awareness-raising activities
 - Training – professional development
 - Screening sessions undertaken
- Are any objectives not being achieved at this stage and why? Plans to remedy this.
- How well the project is reaching the target group/s?
- Any issues that have arisen during the course of the project?
 - Barriers that have been faced and how have these been addressed.
- Evaluation of project activities – progress to date (Refer to your Evaluation Plan).
- Learnings from this phase of the project.
- Plans for the next three months of the project.

DHS Regional Office:

DHS Central Office: 9616 7391

Email:

Email: margaret.thomas@dhs.vic.gov.au

Appendix 2 – PCP Reporting Requirements

Please note this Annual Report will be due in July

DHS Aged Care Branch Falls Prevention Program Annual Reporting Requirements

Introduction

Falls Prevention Program

The Falls Prevention Program is funded through the Aged Care Branch, Department of Human Service. The goal of the Falls Prevention Program is to improve in the health, wellbeing and mobility of older people who are able to live in the home of their choice with greater confidence, independence and security.

The goal of the Falls Prevention Program is to implement falls prevention projects within an integrated health promotion framework to reduce the risk and incidence of falls, and the severity of injuries from falls among older people living in their own homes.

Project Aims and Objectives

The aims and objectives of falls prevention projects are to:

1. Increase community recognition of falls as a *'whole of community'* responsibility.
2. Increase community understanding that falls are not an inevitable part of growing older.
3. Increase community understanding of the multifactorial risk factors that contribute to falls and benefits of falls prevention interventions.
4. Increase the proportion of older people who actively participate in reducing their risk of falling, and as a consequence enjoy an independent and healthy lifestyle.
5. Increase the safety of local environments for current and future generations.
6. Integrate falls prevention interventions within the PCP Integrated Health Promotion Catchment Plan and Municipal Public Health Plan.

Falls Prevention Performance Measures

1. Number of people accessing health information and resources
2. Number of people participating in education, counselling and skill development including physical activity
3. Number of people participating in screening or individual and/or home risk assessment.

Reporting requirements

The Falls Prevention Project lead agency is required to provide an annual report to DHS, Aged Care Branch, Falls Prevention Program Area at 10/555 Collins Street, Melbourne or email: margaret.thomas@dhs.vic.gov.au with quarterly reports provided to the DHS Regional Office.

There are two key elements to the reporting by the PCP Falls Prevention Project lead agency:

1. A progress report to DHS regions on a **quarterly** basis will be required in each January, April and October. Each DHS region will provide details on quarterly reporting requirements. Quarterly reports will coincide with the Falls Prevention Program Network meetings.
2. CHPIA reporting on an annual basis (end of June each year). The Falls Prevention Project lead agency is required to provide the following information:
 - o A summary table of KPR indicators using the Aged Care Falls Prevention KPR template.
 - o Case study using the Aged Care Falls Prevention case study template.A progress report will not be required in June.

- 1a. Complete the table below for the PCP Falls Prevention Project funded through the DHS Aged Care Falls Prevention Program. Please respond according to the 3 Key Performance Requirements (KPRs) below for each of the identified project objectives.
- i. What AGENCIES/ORGANISATIONS are actively involved in the planning and/or implementation (**REACH**)?
 - ii. How many CONSUMERS are involved in the planning, implementation and/or participating (**REACH**)?
 - iii. What proportion (%) of consumers and/or agencies participating, report a CHANGE in relevant key organisational policies, environments, access, knowledge, attitude and/ or behaviour (**IMPACT**)?

| | | |
|---|---|---|
| PROGRAM AREA: Aged Care Falls Prevention Program | | |
| Name of PCP: Name/s of collaborating agencies <ul style="list-style-type: none"> • Hospital: • Residential Aged Care Facility/Facilities: • Other: Lead agency: | | |
| PRIORITY ISSUE: Falls Prevention | | |
| Project Objective 1: | | |
| KPR 1 Name of Agencies involved in planning and/or implementation (REACH) ¹ | KPR 2 Number of consumers involved in the planning, implementation and/or participating (REACH) ² | KPR 3 Brief statement of achieved IMPACTS ³ |
| Project Objective 2: | | |
| KPR 1 Name of Agencies involved in planning and/or implementation (REACH) ¹ | KPR 2 Number of consumers involved in the planning, implementation and/or participating (REACH) ² | KPR 3 Brief statement of achieved IMPACTS ³ |
| Project Objective 3: | | |
| KPR 1 Name of Agencies involved in planning and/or implementation (REACH) ¹ | KPR 2 Number of consumers involved in the planning, implementation and/or participating (REACH) ² | KPR 3 Brief statement of achieved IMPACTS ³ |
| Continue for each of your Falls Prevention Project objectives. | | |

Explanatory Notes

1. In listing the Agencies/organisations, distinguish those that have been involved in the planning and of these, which have been involved in the implementation (if they are different).
2. In listing the numbers of consumers, distinguish who have been involved in the planning and who actually participated.
3. If quantitative information is available, report actual percentage change or numbers, rather than statements like 'more x', 'greater x', etc. Where it is too early to provide this, please indicate the intended measures and results. All programs should have an evaluation strategy from commencement. See *Measuring health promotion impacts- A Guide to Impact Evaluation in Integrated Health Promotion* (DHS June, 2003). See: http://www.health.vic.gov.au/healthpromotion/hp_practice/eval_dissem.htm

1b. Please provide a **case study** (ie. report) of the PCP **Falls Prevention Project** funded through the DHS Aged Care Falls Prevention Program. Elaborate on the information tabulated above, illustrating integrated health promotion practice facilitated through the PCP platform (Page limit 2 A4 pages). Please use the guide below.

| |
|---|
| DHS Aged Care FALLS PREVENTION PROGRAM |
| Name of PCP : |
| Lead agency: |
| TITLE: |
| 1. INTRODUCTION |
| <i>Summary description of problem definition, project goal and objectives.</i> |
| 2. WHO (and how many) are the key stakeholders (agencies/organisations and consumers)? |
| <i>Eg: Links to Key Performance Requirements 1 and 2 (REACH) in table above.</i> |
| 3. HOW was the Falls Prevention Project implemented? |
| <i>Please provide summary of solution generation ie. describe mix of interventions¹⁰ and identify any service co-ordination activities. Please include the stage of implementation (eg. Early Implementation, Advanced Implementation, Completed).</i> |
| 4. WHAT was revealed? |
| <i>Eg: Successes and unexpected outcomes, enablers and barriers, and lessons learned. Links to Key Performance Requirement 3 (IMPACTS) in table above.</i> |

¹⁰ Health promotion interventions are the actions undertaken to achieve program objectives. A mix of interventions (applied to individuals and populations) as specified in the health promotion plan include: Screening/risk assessment – health educations/skill development – social marketing/health information – community action – settings/supportive environments, as well as capacity building strategies: workforce development, organisational development, resources (Refer to DHS, IHP Resource Kit 2003, section 5).

5. HOW will elements of the project be sustained beyond the period of specific funding?

Eg:

1. *Age-appropriate or modified exercise program – from client fees a fitness instructor is employed two mornings per week to conduct a modified Tai Chi session for two groups of 10 people.*
2. *PCP involvement in falls prevention activities associated with April Falls Day or Community Safety Month.*
3. *Processes set up for continuation of medication reviews.*

6. CONCLUSION

Eg: Summarise the difference made for consumers and agencies as a result this Falls Prevention Project and its links into PCP integrated health promotion.

7. BUDGET

Identify Falls Prevention Project funds expended/allocated to-date. (Optional: include other sources of funds and in-kind resources)

Appendix 3 – General Contacts for Information

The following agencies/organisations have considerable experience in falls prevention program implementation and are willing to discuss submissions with PCPs and collaborating agencies. The list is by no means exhaustive and there are many other agencies/organisation available to share information and resources.

Aged Care Branch, Department of Human Services

Margaret Thomas

Department of Human Services, Aged Care
Level 10, 555 Collins Street, Melbourne Vic 3000.

Tel. (03) 9616 7391 Fax (03) 9616 8682

Email: margaret.thomas@dhs.vic.gov.au

Website: <http://www.health.vic.gov.au/agedcare/maintaining/falls/index.htm>

Australian Injury Prevention Network (AIPN)

The Australian Injury Prevention Network's mission is to act as a national networking channel for injury prevention practitioners, researchers and policy makers.

AIPN Secretariat

Xenia Consulting

PO Box 3379

NORMAN PARK Q 4170

Fax: 07 3847 2148

Email: secretariat@aipn.com.au

Website: <http://www.aipn.com.au/>

2005

Think Safe, Act Safe, Feel Safe, Be Safe

Contact: Ahmed Fasi Community Safety Month Coordinator on (03) 9651 7404,

Email: ahmed.fasi@justice.vic.gov.au

<http://www.communitysafetymonth.com.au/index.asp>

Monash University Accident Research Centre (MUARC)

Wellington Road, Clayton Vic 3168.

Tel. 9905 4371, Fax (03) 9905 4363.

Website: <http://www.monash.edu.au/muarc/>

HAZARD

<http://www.monash.edu.au/muarc/VISAR/hazard/>

VISAR

<http://www.monash.edu.au/muarc/VISAR/contact.html>

National Ageing Research Institute (NARI)

Dr Keith Hill

Poplar Road, Parkville Vic 3052.

Tel. (03) 8387 2639, Fax (03) 8387 2153

Email: k.hill@medicine.unimelb.edu.au

Website: <http://www.mednwh.unimelb.edu.au/>

Safety Centre

Royal Children's Hospital

Flemington Road, Parkville Vic 3052.

Tel. (03) 9345 5786 Fax (03) 9345 5086.

Appendix 4 – Falls Prevention and Other Contacts

A list of currently funded projects can be downloaded from the DHS Aged Care website:
<http://www.health.vic.gov.au/agedcare/maintaining/falls/projects.htm>

Transport Connections Projects

Commenced July 2003

| DHS Region/Project | Contact | Email/Phone |
|--|-----------------|---|
| Barwon Southwestern <i>Two Rivers Transport –</i> Western District Health Service | Becky Morton | Rebecca.morton@wdhs.net 5551 8461 |
| Gippsland <i>Bass Coast Transport Solutions -</i> Bass Coast Shire Council | Gill Heal | g.heal@basscoast.vic.gov.au 5671 2705 |
| Let's GET Connected – Gippsland East Transport Project | Glenys Butler | glenysb@wellington.vic.gov.au 5142 3326 |
| Grampians <i>Wimmera Transport Connections –</i> Wimmera Volunteers Inc. | Debbie Coyle | wimmvol@netconnect.com.au 5382 5607 |
| <i>Golden Connections –</i> Golden Plains Shire Council | Lenny Jenner | ljenner@gplains.vic.gov.au 5220 7116 |
| Hume <i>Valley to City efficiently –</i> Upper Hume Community Health Service | Nicki Melville | nmelville@uhchs.vic.gov.au 6022-8888 |
| Loddon Mallee <i>Southern Mallee Transport</i> <i>Connections Project</i> Gannawarra Shire Council | Pauline Thorson | pt@gannawarra.vic.gov.au 5450 9333 |
| <i>Getting Around – A Sustainable</i> <i>Transport System</i> Macedon Ranges Shire Council | Anne McLennan | annem@macedon-ranges.vic.gov.au 5427 8224 |
| Northern Metropolitan <i>Hume Transport Links –</i> Northern Care and Share Inc. | Narelle Staub | nstaub@hcs.org.au 9355 8484 |

DHS Regional Office contacts

| DHS Region | Contact | Phone |
|---------------------------|---|-------------------------------------|
| Barwon Southwestern | Marcia Webb | 5226 4790 |
| Gippsland | Jennifer Newling | 5177 2587 |
| Grampians | Kathleen Teggerth Jeannie Howard | 5333 6080 5333 6049 |
| Hume | Veronica Buchanan Mary Stapleton | 5722 0916 5722 0907 |
| Loddon Mallee | Maggie Fernie | 5434 2338 |
| Eastern Metropolitan | Christine Farnan Anita Thomas | 9843 6106 9843 6698 |
| North & West Metropolitan | Michelle Hollingworth Stephanie McAdam Guy Pianella | 9412 5316 9412 5316 9275 7392 |
| Southern Metropolitan | Ann Fitts | 8710 2812 |