Engaging community organizations in falls prevention for older adults: Moving from research to action

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ABSTRACT

OBJECTIVES: Falls prevention (FP) evidence abounds but falls rates remain relatively unaffected. This study aimed to explore community service providers' use of evidence-based FP interventions, attitudes toward implementation, knowledge and capacity for FP engagement, collaboration in FP, and organizational readiness to implement evidence. To our knowledge, this is the first study exploring the potential for broader integration of FP throughout communities.

METHODS: A purposive sampling of providers (n = 84), in varied roles within diverse senior-serving community organizations (both health and non-health sectors) across disparate geographies, completed a structured survey as part of a larger mixed methods study.

RESULTS: Nearly all (90%) reported already implementing at least one evidence-based FP practice. The majority indicated that falls were preventable (82%) and a top concern for older adults (75%), and that FP would be beneficial to their clients (75%). There were, however, notable differences between health and non-health sectors in their: confidence in providing FP activities (86% vs. 47%), desire for future collaboration (86% vs. 56%) and already knowing how best to provide FP activities (49% vs. 36%). Only some (21%) perceived that staff to a great extent had the necessary knowledge and skills, and few (10%) perceived that available resources could support FP activities.

CONCLUSION: Community service providers generally supported FP, but resources limited implementation, particularly in non-health sectors. Translating FP evidence to better fit community settings, and fostering collaboration to bridge resource gaps, suggest a public health role in the broader integration of FP within and across community sectors.

KEY WORDS: Fall prevention; community-dwelling; older adults; public health

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Evidence now exists that could reduce the number of falls among older people by at least 25%.[1] Falls rates, however, have remained unchanged for decades.[2] Proven interventions demand not only effective implementation, but also enabling contexts to create outcomes that benefit individuals and society.[3] Surprisingly, the role of communities as the context for falls prevention has been largely unrecognized.[4]

Falls prevention (FP) evidence requires individuals, providers and organizations to change the way they act, think and respond.[5] To date, research has focused on the perceived barriers to implementing FP strategies within health services for older adults[6] and on the acceptability of FP interventions among older adults.[7] Literature has focused on health care providers and interventions within single care settings or provider groups. Less is known about how promising practices are conveyed across organizations. There is a gap in our understanding of the attitudes, knowledge, and FP practices within and across sectors, settings and organizations serving seniors.[6]

Complex interplays of biological, environmental, social and psychological factors lead to falls. To be effective, population-level interventions must be comprehensive: in multiple settings, from multiple perspectives, through multiple strategies, at multiple times.[8] To reduce falls, population-based strategies must become embedded within the social and physical structures of community function.[9] Few FP interventions, however, are offered in communities.[10] Furthermore, little is known about the best way to encourage[11] or sustain[12] the broader use of FP interventions, particularly through public health practices. The Ottawa Model of Research Use recognizes this dynamic interplay of decisions and actions by various individuals mutually

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influencing and being influenced by FP practices, players, context, delivery, uptake and outcomes.[13] This model therefore has focussed our research first on the falls prevention evidence, specifying the evidence-based practices, assessing their use by community service providers, and identifying barriers and facilitators due to knowledge, attitudes and organizational environments.

Using a mixed methods approach (qualitative and quantitative), we address these gaps in knowledge by: 1) examining the use of, attitudes towards and knowledge of evidence-based falls prevention interventions among providers, managers and directors of diverse, senior-serving community-based organizations, and 2) identifying the perceived barriers and effective strategies for the adoption, implementation and sustainability of these strategies within and across diverse senior-serving community organizations.

This paper presents findings from the quantitative (survey) component of the study. Specific objectives of the quantitative research component were to describe: 1) use of evidence-based FP interventions; 2) attitudes towards implementation; 3) knowledge and capacity for engaging in FP; 4) collaboration in FP; and 5) organizational readiness to implement evidence. This paper includes a secondary exploratory analysis of survey responses by participants from the health versus non-health sectors.

METHODS

This study was conducted in accordance with the Tri-Council Policy Statement, *Ethical Conduct for Research Involving Humans*.[14] Ethics approval was obtained from the Hamilton Integrated Research Ethics Board (#11-621) and was renewed yearly as required. All participants provided written informed consent.

Setting and participants

Data were collected from front-line service providers, managers and directors working in a broad range of senior-serving community organizations, representing both health and non-health sectors (Table 1), in the catchment areas of three Public Health Units in Ontario: North Bay Parry Sound District Health Unit, Simcoe Muskoka District Health Unit, and York Region Community and Health Services. These settings differed by Health Region Peer Group,[15] land area, population density, percentage of population age 65+, and proportion of visible minorities.

Purposive sampling for maximum variation was used in the mixed methods study design.[16] A variety of community-based organizations known to public health and offering health, social or other services to older adults (>65 years) were invited to participate. Using a prepared script, Health Unit staff telephoned potential participants to obtain their verbal consent to participate. Upon arrival at the focus group or interview, participants provided informed written consent and completed the self-administered questionnaire.

The research team developed a questionnaire to assess knowledge, attitudes and use of evidence-based FP activities. The process included several steps using the methodological framework for tool development described by Streiner and Norman.[17] The research team, experienced in community-based FP among older adults, selected the items. Cumulative public health knowledge and research expertise was used to assess content validity and to determine whether items were relevant and appropriate to measure use, attitudes and knowledge of falls-preventing activities for community-dwelling older adults. The questionnaire was pretested with a convenience sample of five community service providers to assess face validity (question relevance to a layperson), clarity of wording, and correct interpretation. The final questionnaire included six sections, described below:

1. Participant characteristics
   Sixteen questions identified characteristics of the participants and their community organizations.
2. Use of evidence-based falls prevention (FP) practices
   Participants indicated whether or not their organization currently provided each of seven evidence-based FP activities for community-living older adults. The seven FP activities (shown in Table 2) were based upon findings of a Rapid Evidence Assessment (REA) conducted by the research team. The REA included three practice guidelines,[18–20] two meta-analyses[21,22] and one systematic review.[23]
3. Attitude toward implementing falls-related interventions
   Six questions were adapted from the Attitudes to Falls-Related Interventions Scale (AFRIS).[24] The AFRIS, originally designed to measure attitudes of older adults toward taking up specific FP interventions,[25] was adapted to reflect attitudes of community services staff toward *providing* falls-related interventions *in general*. The AFRIS is based upon the Theory of Planned Behaviour.
4. Knowledge and capacity to engage in falls prevention
   Five questions assessed knowledge/perceptions of impact and preventability of falls, self-rated general knowledge to provide FP activities, and capacity to engage in FP (perception of their role in deciding whether their organization provides FP activities, and potential to help others provide FP activities).

Table 1. Types of participating organizations

	n = 84	%
Type of community served		
Urban	34	40%
Rural	3	4%
Both urban and rural	47	56%
Type of organization		
Health sector		
Home health agency (e.g., personal support for bathing, toileting, respite care)	24	28%
Health care agency (e.g., care coordination, hospital, therapy services)	14	17%
Public health department (e.g., health promotion, community engagement)	9	11%
Primary care (e.g., medical assessment and treatment)	5	6%
Emergency medical services (i.e., paramedic services)	2	2%
	54	**64%**
Non-health sector		
Community support services (e.g., meal delivery, rides to appointments, companionship)	11	13%
Volunteer services (e.g., friendly visitors, service clubs)	4	5%
Police or fire department	4	5%
Other: business/retail, community foundations, government services, recreation services, social services	11	13%
	30	**36%**

5. Collaboration in falls prevention
   Two yes/no questions assessed the extent of current FP collaboration and openness to collaborate.
6. Organizational readiness to implement evidence
   The Environmental Readiness Assessment[26] questionnaire measured the participant's view of their organization's readiness to implement evidence.

Data analysis

Analyses were performed using SPSS version 21.0 for Windows. Descriptive statistics were expressed as the median and range for continuous variables and counts and percentages for categorical variables. Exploratory descriptive analyses were conducted to compare the responses of participants from organizations in the health sector versus other sectors. The sampling methods, based on the qualitative component of the study, were suitable only for descriptive, exploratory analyses; thus, tests for significant differences between groups were not conducted.

RESULTS

Participant characteristics

Participants (n = 84) were mostly women (87%), ranging from 23 to 68 years of age (median age = 50.5 years). The majority were either college (34%) or university (64%) graduates. More than half of the participants (53%) were direct service providers, and the remainder were supervisors, managers, directors, or had other roles. Participants worked in a wide range of community organizations with community-dwelling older adults for a median of 10 years. Almost two thirds of the participants (62%) worked for health sector organizations (i.e., home health agencies, health care agencies, public health departments, primary care, emergency medical services). The remainder (38%) worked for organizations in non-health sectors (i.e., community support services, volunteer services, police or fire services, foundations, recreation centres).

Use of evidence-based falls prevention (FP) practices

Most participants (90%) reported currently providing at least one of the seven evidence-based FP practices and commonly provided more than one: 39% used one or two, 25% used three or four, and 26% used five or more. Almost everyone (88%) indicated that they provided FP education, and 48% offered exercise programs. Medication reviews and comprehensive falls risk assessments were offered or facilitated by 42% and 39% of participants respectively, primarily from the health sector. Home safety assessments with modification were offered by 35% of participants, primarily by providers from the health sector. Approximately one fifth reported that they offered or facilitated vision assessments and promoted vitamin D supplementation with a calcium-enhancing diet. Table 3 compares the percentages of participants from the health sector and other sectors reporting use of each FP activity.

Attitude toward implementing falls-related interventions

Three quarters of participants strongly agreed that providing FP activities would be beneficial for their clients (Figure 1). Almost 60% of all participants also strongly agreed that they intended to provide FP activities if given the opportunity. Notably, 70% from the health sector strongly agreed with this statement compared to only 42% from other sectors. Moreover, 67% from the health sector strongly agreed that other people whose opinions mattered to them would think it was a good idea for them to provide falls-preventing activities, and only 34% from other sectors strongly agreed with this statement. Almost three quarters of health sector participants either agreed or strongly agreed that they were the kind of person who should be providing falls-preventing activities compared to only 53% of participants from other sectors. There was also a notable difference between the health sector and other sectors in the percentage of participants who agreed or strongly agreed that they were confident in providing falls-preventing activities (86% vs. 47%).

Table 2. Evidence-based falls-preventing activities

Comprehensive fall risk assessment[18–20,22]	A comprehensive fall risk assessment by a knowledgeable professional for clients who report more than one fall in the past year, an injurious fall, or difficulties with walking. The assessment includes a medical history, physical exam, functional and environmental assessments followed by interventions tailored to the individual.
Exercise programs[18–20,22]	Progressive, tailored exercise programs proven to improve strength, gait and balance (e.g., Tai Chi, physical therapy in either group exercise classes or home-delivered strength and balance retraining).
Vitamin D supplementation[18–20,22]	Vitamin D supplements of at least 800 IU per day along with high-calcium foods and fewer foods that limit calcium absorption.
Home safety assessment and modification[18–22]	A home safety assessment for clients at high risk of falls using a validated tool such as the HomeFAST screen, followed by environmental modifications prescribed by a trained professional.
Medication review[18–20,22]	A medication review including the adjustment of medications to reduce the total number of medications or dose of individual medications that may lead to increased risk of falls (e.g., sleeping pills, nerve pills and antidepressants).
Vision assessment[18–20,22]	Assessment for vision impairment (e.g., cataracts) and referral for correction (e.g., to an ophthalmologist).
Falls prevention education[18–20,23]	Falls prevention education at the individual or community level.

Table 3. Use of falls-preventing activities

Falls-preventing activity	Health sector		Non-health sectors		Total	
	n	%	*n*	%	*n*	%
Falls prevention education	51	98.0	23	71.9	74	88.1
Exercise programs	25	49.0	15	46.9	40	48.2
Medication review	28	56.0	6	18.8	34	41.5
Comprehensive falls risk assessment	28	53.8	5	15.6	33	39.3
Home safety assessment and modification	23	46.9	5	15.6	28	34.6
Vision assessment	13	26.5	4	12.5	17	21.0
Vitamin D supplementation	12	23.5	4	12.5	16	19.3

Data shown are the numbers and percentages of respondents within the health sector (n = 52), other sectors (n = 32) and total sample.

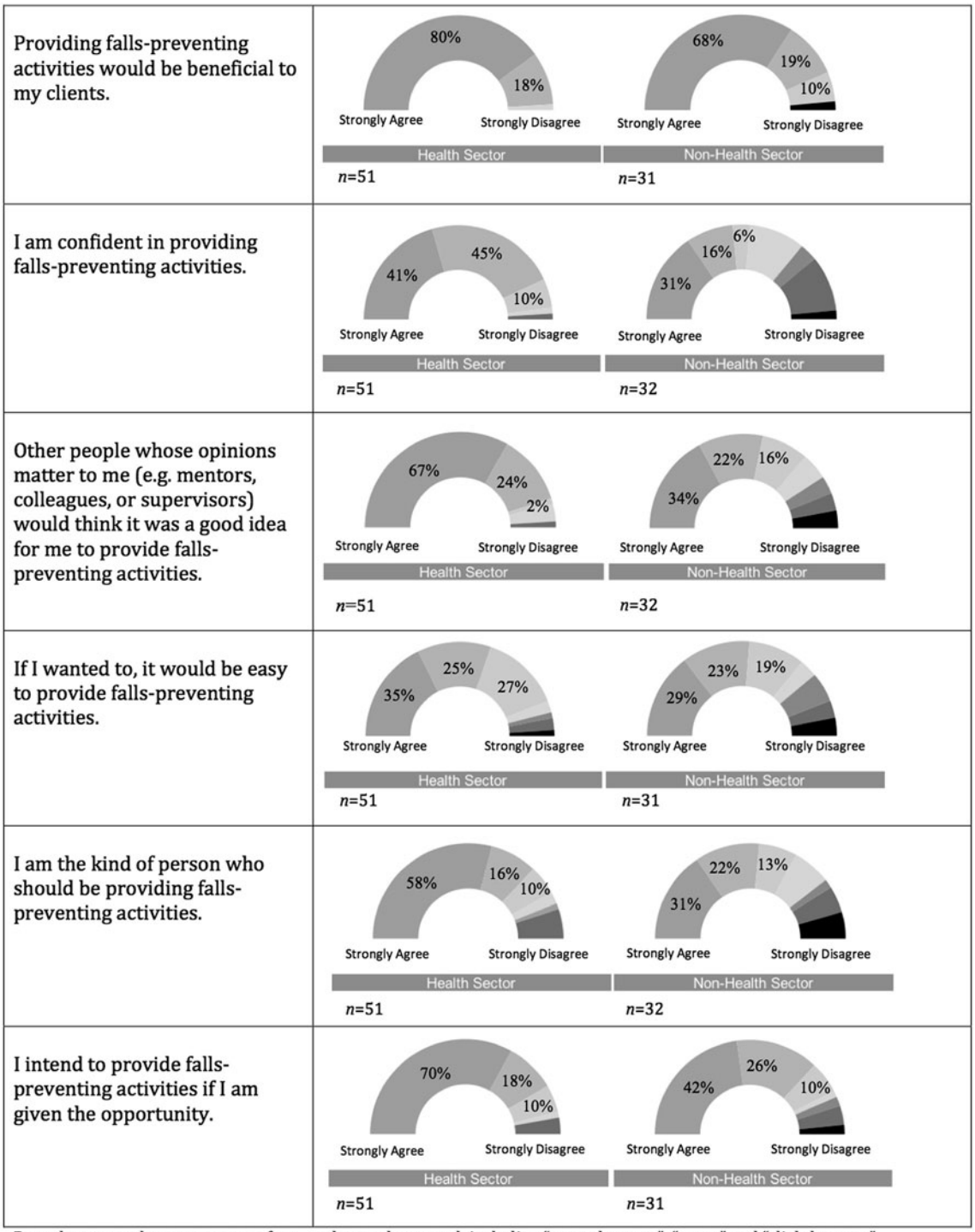

Figure 1. Attitudes toward providing falls-preventing activities

Knowledge and capacity to engage in falls prevention

Approximately three quarters of all participants agreed or strongly agreed that the risk of falling is the number one concern for older adults, and 82% agreed or strongly agreed that older adult falls are preventable (Figure 2). However, only 49% from the health sector and 35% from other sectors agreed or strongly agreed that they already knew how best to provide FP activities for older adults. Interestingly, 62% of participants in both categories agreed or strongly agreed that they had an important role in deciding whether their organization provides FP activities for older adults. Almost two thirds (64%) of participants from the health sector and half of participants from other sectors agreed or strongly agreed that they could help other organizations, agencies or individuals to provide FP activities for older adults.

Collaboration in falls prevention

Almost three quarters (73%) of all participants reported that they were already working with other agencies, organizations or

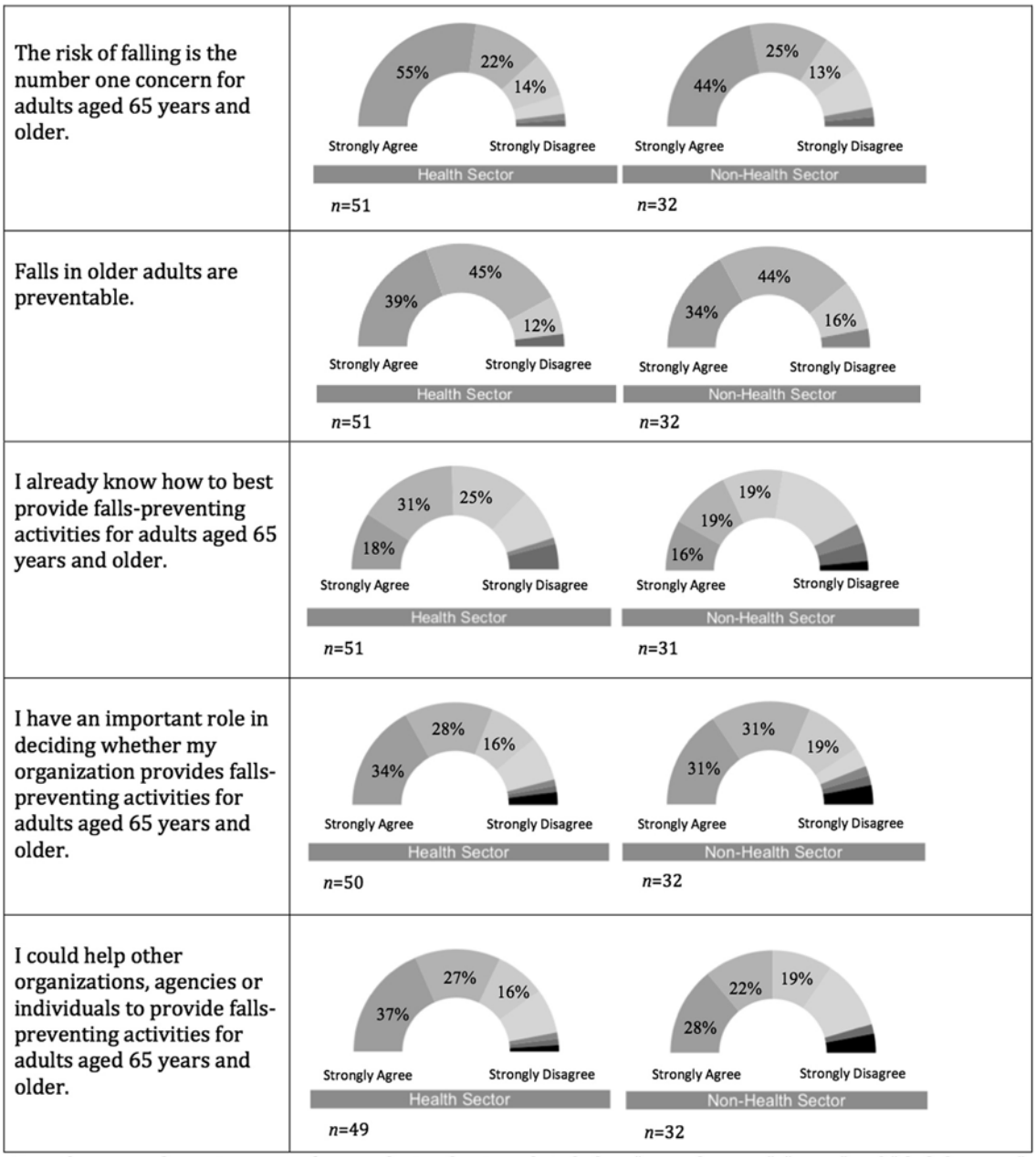

Figure 2. Knowledge and capacity to engage in falls prevention

professionals to provide FP activities. Slightly more participants from the health sector reported working with others, compared with the other sectors (75% vs. 69%). Three quarters of all participants indicated that they would like to work with other agencies, organizations or professionals in FP in the future. Again this percentage was higher in the health sector (86% vs. 56%) (data not shown).

Organizational readiness to implement evidence

Only 23% of all participants indicated that to a great extent, adequate communication systems existed to support the exchange of FP information. Furthermore, just 21% of all participants reported that to a great extent the staff in their organization had the necessary knowledge and skills to implement FP activities. Only 10% of all participants indicated that a great deal of the necessary human, physical and financial resources were available to support implementation of FP activities (data not shown).

More participants from the health sector reported a great deal of organizational support for quality improvement initiatives than those from other sectors (64% vs. 41%). Similarly, more participants in the health sector indicated there was a great deal of support from leaders in their organization for innovations to improve quality of care, compared with the non-health sectors (63% vs. 41%). In the two groups, a larger proportion in the health sector indicated that there was a great deal of support from staff in their organization for innovations to improve quality of care (57% vs. 38%) (data not shown).

DISCUSSION

This paper presented survey findings regarding community service providers' use of evidence-based FP interventions, attitudes towards implementation, knowledge and capacity for engaging in FP, collaboration in FP, and organizational readiness to implement evidence. Secondary exploratory analyses of survey responses by participants from the health versus non-health sectors were also presented.

To our knowledge, this is the first study to explore the readiness of such a wide range of community service providers to prevent falls among seniors, particularly beyond the health sector. Falls prevention has been challenged to go beyond a health sector approach and engage other sectors.[27] This study explores the unique perspectives of individuals in varied roles in diverse organizations (health and non-health sectors) across disparate geographies (rural, urban–rural mix, urban), but all providing community-based services to older adults.

The majority of participants reported providing at least one of the seven evidence-based falls-prevention interventions identified through a rapid evidence assessment. With the exception of the relatively equal provision of exercise, a greater proportion of health services providers reported offering the evidence-based interventions compared to non-health service providers. Poor fit of clinical interventions within non-health community services reflects a barrier to implementation noted elsewhere.[28] Of the reported evidence-based FP activities, education was most commonly provided (88%) but appeared to occur in conjunction with other interventions as supported by current evidence.[22]

Our findings describe varying degrees of intention to provide FP activities across settings and providers. As evidence-based interventions are only effective if implemented, knowing why community services might not provide these FP activities is important. Those trained in health professions or working in health sector organizations appear to have stronger intentions to provide FP activities. Both sectors viewed falls as a significant problem and interventions as beneficial, however role expectations of self and the organization, and confidence to provide FP activities were much stronger in the health sector. Organizational support for innovation, and leader and staff support of quality improvement suggest a culture in the health sector not seen in other sectors. The findings may reflect health sector drivers supporting implementation such as Required Organizational Practices (Accreditation Canada), Falls Prevention Best Practice Guidelines (American Geriatric Society) or pan-Canadian educational curriculum (Canadian Falls Prevention Curriculum). Consideration should be given to how similar implementation drivers might be created in other sectors, although some have questioned the suitability of clinical knowledge translation strategies for community-based organizations.[29] Despite these differences in competency supports, neither the health nor the non-health sector perceived more control, ease or expertise in being able to provide falls-preventing activities. Similarly, employee beliefs of self-efficacy, intervention fit, management support and personal benefit have been found to indicate individual readiness in organizational change across sectors.[30]

Effective FP interventions rely not only on competent implementation, but also enabling contexts. It is somewhat surprising that less than a quarter of participants perceived that their organizations had sufficient staff with the necessary knowledge and skills to implement FP, given the significant work that has been done in the health sector and its predominance in this sample. An even smaller fraction of organizations were seen to have the resources needed to implement FP activities. While surprising, these findings confirm both the barriers of inadequate knowledge and skills, and the lack of facilitators through suitable, simple strategies, noted previously.[6]

Effective collaboration also enables successful implementation,[6] but less than a quarter of participants perceived that their organization's communication systems supported the information exchange needed. Despite this, many participants reported that they were currently collaborating to provide FP and would like to work more with others. While most, particularly in the health sector, also indicated that they could help others to provide FP, it is unclear whether this reflects having knowledge to share or simply a willingness to work with others. Collaboration among administrators, providers, community members, and researchers to integrate FP activities in community settings has been found to mitigate resource challenges[6] and sustain efforts.[12]

The Ottawa Model of Research Use[13] suggests six steps to guide the integration of existing FP research knowledge into practice. This project 1) identified desired change, 2) specified evidence-based innovation, and 3) assessed the innovation, potential adopters and the environment for barriers and facilitators. Future projects will 4) tailor the strategies, 5) monitor innovation adoption, and 6) evaluate outcomes of the innovation.

Limitations

There are a number of limitations in this study. Purposive sampling prevents generalizing the findings beyond our participants, although it was effective in gathering divergent key insights. Recruitment by Health Unit staff may have influenced participants' representations of their organizations and the importance of FP. Our next steps include triangulating these quantitative results with the qualitative findings. The accuracy of self-reported interventions was not verified by independent means, and therefore may not reflect the numbers of evidence-based interventions actually being used. Findings are further limited to descriptive analyses as the methodology did not support hypothesis testing. Additional research is needed to confirm the validity of the adapted AFRIS to measure the acceptability of providing falls-related interventions.

CONCLUSION

Aging demographics will demand that promised falls reductions are realized among older adults. To be a purveyor of such change, Public Health must work together with more than the usual community sectors to not only identify evidence-informed interventions but also build the capacity for effective implementation and enabling environments needed to make falls prevention happen. Greater collaboration may harness collective knowledge for more innovative solutions to the

complexities of older adult falls. The current study adds to the evidence that communities have untapped potential to prevent falls. However, the best ways to either prevent falls through non-clinical interventions or integrate promising clinical interventions into a wider range of community services remain unclear. Further public health research is needed to capture the wisdom, gained from years of community-based falls prevention work, to inform these efforts.

To move evidence into action, Public Health partnerships must look beyond increasing awareness and knowledge of risk factors and focus on appropriately tailoring proven FP interventions for community settings. In this study, FP was viewed as important and beneficial, but participants perceived low organizational support and low personal knowledge and capacity to provide FP activities, particularly in non-health sectors. This study underscores a role for public health staff through both collaborative leadership and knowledge translation, vehicles to more enabling contexts. Engaging all community-based organizations in the effective implementation of fitting interventions can ultimately reduce falls among our growing aging population.

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RÉSUMÉ

OBJECTIFS : Les faits liés à la prévention des chutes (PC) abondent, mais le nombre de chutes demeure relativement le même. La présente étude explore le recours par les fournisseurs de services communautaires aux interventions et attitudes fondées sur les faits en matière de prévention des chutes pour la mise en œuvre, les connaissances et la capacité de mobilisation à la PC, de collaboration en matière de PC et la volonté des organisations de mettre ces faits en œuvre. À notre connaissance, il s'agit de la première étude qui explore la possibilité d'une intégration plus large de la PC dans les collectivités.

MÉTHODES : Un échantillon de fournisseurs choisis à dessein (n = 84), jouant divers rôles au sein des organisations qui servent les personnes âgées (des secteurs de la santé et autres) dans des endroits disparates, ont répondu à un sondage structuré dans le cadre d'une étude plus large sur les méthodes mixtes.

RÉSULTATS : Presque tous (90 %) ont déclaré mettre en œuvre au moins une pratique fondée sur les faits en matière de PC. La majorité a précisé que les chutes peuvent être évitées (82 %) et sont une préoccupation majeure chez les adultes plus âgés (75 %), et que la PC est bénéfique pour leurs clients (75 %). Mais il y a cependant des différences importantes entre les

secteurs de la santé et les autres pour ce qui est de leur confiance dans l'offre d'activités de PC (86 % c. 47 %), de leur désir de collaboration future (86 % c. 56 %) et de leur connaissance du meilleur moyen d'offrir des activités de PC (49 % c. 36 %). Seulement 21 % d'entre eux pensent que le personnel possède dans une grande mesure les connaissances et habiletés nécessaires et quelques-uns (10 %) pensent que les ressources disponibles pourraient soutenir les activités de PC.

CONCLUSIONS : Les fournisseurs de services communautaires appuient généralement la PC, mais les ressources limitent sa mise en œuvre, dans les autres secteurs en particulier. Ajuster les faits sur la PC pour mieux les adapter au cadre communautaire et promouvoir la collaboration pour combler le manque de ressources laisse penser que la santé publique a un rôle à jouer dans une intégration plus large de la PC au sein des secteurs communautaires.

MOTS CLÉS : prévention des chutes; vivant dans la communauté; adultes plus âgés; santé publique