

Community Care Hub Demonstration to Scale Evidence-Based Falls Prevention Interventions Through Clinical-Community Partnerships

Appendix B. Projected STEADI Screening and Referral Volume

For each key health care partner, provide cumulative projected numbers at the end of each six-month reporting period. Projections should reflect the expected scale-up of STEADI screening, referrals, and successful connections over the 30-month project period. The template below includes space for two health care partners for illustrative purposes; applicants are expected to identify additional key partners as appropriate to their proposed regional approach. Copy and add rows for each additional health care partner included in your proposal.

Health Care Partner	Projected Measure	End of Month 6	End of Month 12	End of Month 18	End of Month 24	End of Month 30
[Partner Name]	# of individuals screened using STEADI					
	# of individuals identified at risk for falls					
	# of referrals made to CCH/community partners					
	# of referrals to Stepping On					
	# of Successful connections/completed referrals					

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[Partner Name]	# of individuals screened using STEADI					
	# of individuals identified at risk for falls					
	# of referrals made to CCH/community partners					
	# of referrals to Stepping On					
	# of Successful connections/completed referrals					
TOTAL, ALL PARTNERS	# of individuals screened using STEADI					
	# of individuals identified at risk for falls					
	# of referrals made to CCH/community partners					



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	# of referrals to Stepping On					
	# of Successful connections/completed referrals					

Note: Figures should be cumulative. For example, the Month 12 projection should represent anticipated activity from Months 1–12, and the Month 30 projection should represent anticipated activity across the full 30-month project period.