

Identifying Barriers to Fall Prevention for Community-Dwelling Older Adults in Delaware:

A Qualitative Study

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Abstract

Objective. Falls are a major public health concern among older adults in the United States, and Delaware reflects this growing burden. Fall-related mortality increased steadily from 2012 to 2021, coinciding with a rapidly aging population. Despite the availability of effective evidence-based fall-prevention programs, adoption remains limited among high-risk populations. Grounded in implementation science, this study aimed to identify barriers and facilitators influencing the uptake of fall-prevention interventions among community-dwelling older adults and healthcare providers in Delaware. This project began November 2024 with data collection and analysis concluding March 2026. **Methods.** A qualitative descriptive, multi-method design was employed including semi-structured interviews with nineteen older adults and focus groups of nine healthcare providers in southcentral Delaware. Interviews and focus groups were audio recorded, transcribed, and analyzed using inductive and deductive coding. Themes were analyzed using Theoretical Domains Framework and Behavior Change Wheel to categorize barriers and facilitators affecting fall prevention participation. **Results.** Barriers to fall prevention spanned multiple domains, including limited awareness of programs, financial and transportation challenges, provider gatekeeping, time constraints, and inconsistent referral practices. Older adults frequently underestimated their fall risk, underreported falls, and demonstrated low adherence to preventive behaviors, often compounded by social isolation. Facilitators included willingness to adopt prevention strategies, individualized fall action plans, family and social support, use of emergency alert technologies, and strong provider motivation to address fall risk. **Conclusion.** Gaps in fall prevention reflect implementation challenges rather than a lack of available evidence-based programs. Interconnected behavioral, structural, and system-level barriers influence both older adults and healthcare providers. Coordinated, evidence-informed implementation strategies are needed to expand program reach and improve outcomes for Delaware's growing older adult population. **Policy Implications.** Standardized fall risk screening, interprofessional referral pathways, and population-specific implementation strategies for Delaware communities may help reduce fall-related morbidity and mortality among the state's rapidly aging population.

Introduction

Falls are the leading cause of injury-related death among older adults in the United States. According to the Centers for Disease Control and Prevention (CDC) 2023 data, approximately one in four adults aged 65 and older experiences a fall, accounting for more than 36 million falls annually, over 14 million of which require medical attention.¹ Falls result in approximately 3 million emergency department visits and 1 million hospitalizations annually, and fall-related deaths increased by 11% between 2021 and 2024.¹ The direct medical cost of falls exceeds \$50 billion annually in the United States, with Medicare absorbing approximately 75% of these expenditures.²

Delaware is particularly vulnerable to this growing public healthcare burden. As of 2025, adults aged 65 years and older comprised 21.8% of the state's population, ranking Delaware fifth nationally, with this population projected to increase by 40% by 2040.^{3,4} In 2020, Delaware recorded 46,119 falls among older adults, resulting in 88 fall-related deaths at a rate of 48.2 per 100,000 population.¹ According to the most current data provided by the CDC, in 2023, Delaware ranked ninth nationally in fall prevalence, with 67.7% of fall incidents among adults aged 65 years and older classified as traumatic.¹ More recently, the Delaware Trauma Registry within the Delaware Trauma System of Care documented 5,234 falls in 2024, resulting in 611 head injuries and traumatic brain injuries (TBIs) and 84 deaths statewide.⁵ Of these incidents, 3,652 falls (69.8%) occurred among adults aged 65 years and older, accounting for 70 deaths and 471 head injuries and TBIs.⁵ Beyond TBIs, falls contribute to fractures, functional decline, loss of independence and reduced quality of life, negative outcomes that evidence-based fall prevention programs are specifically designed to mitigate.⁶⁻⁸ These Delaware-specific findings underscore the disproportionate burden of fall-related injury among older adults in Delaware and highlight the urgent need for targeted, statewide prevention strategies. They reinforce the urgency in understanding why eligible older adults do not consistently participate in available fall prevention interventions.

Multiple organizations have developed clinical guidelines supporting a multifactorial approach to fall prevention, commonly recommending routine screening, medication review, balance assessment and intervention, exercise, and home safety evaluation.^{6,7,9} In 2011, the American Geriatrics Society (AGS) published clinical practice guidelines that were subsequently adopted by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS). These guidelines recommend annual fall risk screening, exercise interventions, home modification strategies, clinical management, and multifactorial prevention programs.⁶ Several evidence-based fall prevention programs are available in Delaware for community-dwelling older adults, including A Matter of Balance, Stepping On, the Otago Exercise Program, Enhance Fitness, and Healthy Steps for Older Adults. Many of these programs are offered through senior centers, health departments, Area Agencies on Aging, and community organizations,^{8,10-14} such as Modern Maturity in Dover which costs Bingocise, A Matter of Balance classes, and Tai Chi, to name a few.¹⁵

Despite the availability of these evidence-based resources, fall rates continue to increase nationwide. Studies suggest that limited participation in fall prevention programs may contribute to this trend, with accessibility remaining a persistent barrier, particularly among high-risk and underserved populations.⁶⁻⁸ Disparities in access are further influenced by race and ethnicity, socioeconomic status, educational attainment, insurance coverage, and proximity to primary

care services, all of which affect engagement with fall prevention resources.⁶⁻⁷ Evidence-based interventions are readily available in Delaware, so the challenge was to understand why existing programs have not achieved reductions in falls. For example, there are 30 senior community centers across all three counties offering a range of fall prevention classes and activities.¹⁶ Volunteer Delaware 50+ offered 28 classes of A Matter of Balance in 2025 throughout the state.¹⁷ ChristianaCare offers multiple community-based fall prevention programs, including Safe Steps, ThinkFirst to Prevent Falls, caregiver seminars, and fall prevention bingo.¹⁸

Implementation science addresses the persistent gap between evidence-based interventions and consistent adoption in clinical and community practice.¹⁹ Within fall prevention, this reflects the disconnect between the availability of effective prevention strategies and routine implementation among older adults and healthcare providers. The continued gap between research and practice highlights the need to better understand the structural, behavioral, and systemic factors that influence participation in fall prevention programs. Identifying barriers and facilitators affecting implementation is essential for developing targeted strategies to expand the reach of evidence-based fall prevention interventions to populations most at risk. Accordingly, this study was guided by the following research question: What barriers and facilitators influence the adoption of evidence-based fall prevention guidelines and strategies among older adults and healthcare providers in Delaware?”

Prior qualitative and mixed-methods studies have identified barriers and facilitators influencing participation in fall prevention programs among older adults. Vincenzo and colleagues²⁰ conducted focus groups interviews using constructs from the Health Belief Model and found that cues to action included financial incentives, printed educational materials, audiovisual reminders, and daily prompts. Shankar and colleagues²¹ interviewed 63 older adults presenting to emergency departments following fall-related visits and identified varying levels of concern about falls, uncertainty about prevention strategies, and greater provider interest in prevention than patient interest. A scoping review by Sibley and colleagues²² examined 22 publications and identified 293 factors influencing implementation of community-based fall prevention exercise programs. They concluded that insufficient evidence exists to determine the most effective implementation strategies for fall prevention, further supporting the need for the present study. Guirguis-Blake and colleagues⁷ similarly confirmed in a systematic review conducted for the U.S. Preventive Services Task Force that exercise and multifactorial interventions reduce fall risk; however, barriers related to access and adherence persist. To date, no known fall prevention intervention study has simultaneously examined these barriers across community-active and homebound older adults alongside healthcare and social service providers within a Delaware-specific context to gain perspective from various viewpoints and triangulate responses.

Methods

Study Design

This study employed a qualitative descriptive, multi-method design. Qualitative description was selected because it is well suited to exploring participant experiences, perceptions, and contextual factors influencing fall prevention. A multi-method approach incorporating individual semi-structured interviews and interprofessional focus groups was used to enable triangulation across data sources and participant perspectives.

Participants and Recruitment

Older Adult Cohort. Nineteen community-dwelling older adults were enrolled between April and October 2025, comprising ten community-active and nine homebound individuals. Community-dwelling older adults were defined as individuals residing in noninstitutional settings and included both community-active and homebound participants. Community-active participants were recruited through convenience sampling at informal outreach tables at the Modern Maturity Senior Center in Dover, Delaware. Homebound participants were recruited through flyers distributed by Meals on Wheels outreach volunteers. The participants were primarily African American, with four Caucasian, and one participant identified as Hispanic. Of the nineteen participants, eleven were women and eight were men with ages ranging from 60 to 99 years (median age range 70-79). Most of the participants (73.3%) lived alone and all were insured through Medicare and Medicare advantage.

Healthcare Professional Cohort: Nine healthcare providers participated in interprofessional focus groups conducted between July to October 2025. Participants were recruited through mass email invitations distributed to clinical staff at Bayhealth Medical Center in Dover, Delaware. Bayhealth was selected because it serves as a major healthcare system for Kent and Sussex counties, which include large rural populations within central and southern Delaware. Participants included two physicians, one nurse practitioner, two registered nurse case managers, one social worker, one occupational therapist, and two physical therapists. All participants were female, with clinical experience ranging from 4 to 39 years (mean of 14.6 years).

Data Collection

Sociodemographic data, including age, sex, race and ethnicity, health insurance status, and living situation, were collected using a demographic questionnaire. Additional information regarding professional role, clinical specializations, and years of experience were collected from healthcare provider participants. Older adult participants were interviewed in settings of their choosing, including private homes, the Modern Maturity Center, and the Delaware State University Library in Dover, Delaware, to promote participant comfort and engagement.

Interprofessional focus groups were conducted at Bayhealth Medical Center facilities with a multidisciplinary group of healthcare providers and were designed to facilitate discussion across professional roles and perspectives. Semi-structured interview and focus group guides were developed to elicit perspectives regarding awareness of fall prevention programs, perceived barriers and facilitators to participation, experiences with healthcare providers, and personal or professional motivation to engage in fall prevention activities. All interviews and focus groups were audio-recorded and transcribed using Microsoft Teams on laptop computers and mobile devices.

Data Analysis

All interviews and focus groups were initially transcribed using Microsoft Teams automated transcription and subsequently reviewed manually against the original audio recordings to verify verbatim accuracy. Transcripts were managed and organized using Atlas.ti qualitative analysis software.

Data analysis proceeded through two complementary analytic approaches. Inductive analysis

involved open coding of transcripts to identify emergent themes grounded in participants’ experiences and language. Deductive analysis subsequently mapped these themes to predefined implementation science constructs aligned with the study aims, enabling structured comparison across participant groups.

To align the findings with established implementation science frameworks, deductive coding was guided by the Theoretical Domains Framework (TDF)²³ and the COM-B (Capability, Opportunity, Motivation, Behavior) model (Figure 1).²⁴ Participant-identified barriers and facilitators were mapped to the 14 domains of the TDF, and subsequently synthesized within the broader COM-B behavioral dimensions to characterize determinants influencing fall prevention implementation.

Figure 1. The Capability, Opportunity, Motivation, Behavior Model



 Based on Michie, van Stralen, & West (2011). Image developed by The Center for Implementation, © 2023 | V2024.01 | For full citation: <https://thecenterforimplementation.com/toolbox/com-b-tdf>

Members of the research team independently coded transcripts and subsequently convened consensus meetings to discuss coding interpretation and resolve discrepancies. Analytical rigor and confirmability were enhanced through a multi-layered verification process, incorporating independent reviewer analysis, consensus coding procedures, and structured analytical comparison across participant groups. The AI-assisted analytic tool embedded in Atlas.ti was used to support organization and comparison of coding patterns; all final coding decisions and thematic interpretations were performed by the research team.

Results

Themes representing barriers and facilitators to fall prevention participation emerged across multiple domains of the TDF among older adult and healthcare provider participants. Representative quotations are presented to illustrate key findings.

Knowledge and Program Awareness

Limited awareness of available fall prevention programs emerged as one of the most prominent barriers identified among both older adults and healthcare providers. Older adults across community-active and homebound settings frequently reported little to no awareness of specific fall prevention resources, with one participant stating, *"Didn't never know I had such a thing."* Healthcare providers similarly acknowledged gaps in knowledge regarding available community-based programs. One nurse practitioner observed that *"you can't make a recommendation for what you don't know,"* while a physical therapist described uncertainty regarding available community resources and referral options.

Facilitators within this domain centered on accessible and engaging educational approaches. Participants expressed strong preferences for visual and experiential learning formats, with one participant stating, *"I'm a visual and a program.... If I can't get a program, give me a visual, a book, a paper, a handout. Something to look at."* These findings suggest that dissemination efforts should prioritize accessible, visually engaging educational materials alongside systematic provider education regarding available fall prevention resources and referral pathways.

Physical Capacity and Skills

Barriers related to physical capacity and functional skills reflected the cumulative effects of aging. Participants frequently described progressive balance impairment, reduced mobility, and declining physical function as central contributors to fall risk. One participant described a rapid deterioration in balance over several months resulting in 40 to 45 falls within a single year. Another reported that *"I also noticed I could tell my balance was Depreciating. Or whatever we call it."* Facilitators within this domain included active information seeking, proactive home modifications such as grab bars and ramps, and the use of mobility aids to support safety and independence. One participant stated, *"... I use a walker when I leave (home) 'cause, the knee gives way sometimes, so I have to. I don't try to take no chances"* Participants demonstrating greater awareness of fall risk also reported more frequent discussions regarding falls across healthcare settings, including repeated screening and follow-up by multiple providers.

Behavioral Regulation and Adherence

Low adherence to recommended preventive behaviors emerged as a significant barrier. Participants described inconsistent use of recommended safety equipment, including shower chairs, canes, and other assistive devices. One participant stated *"The cane just got in my way."* These findings suggest that resistance to assistive devices and avoidance of preventive behaviors were often influenced by concerns related to independence, identity, and perceived functional ability.

Facilitators within this domain included cautious self-management behaviors, regular engagement in physical activity, and development of individualized safety strategies. One participant described careful attention to footwear as a key component of her fall prevention strategy, including the use of shoes with grip soles and avoidance of slippery surfaces.

Social Influences and Isolation

Social isolation emerged as a significant barrier to participation in fall prevention strategies.

Multiple homebound participants described living alone, lacking nearby family support, and having limited access to assistance during emergencies.

Conversely, strong family relationships and social support networks functioned as important facilitators. Participants described maintaining regular communication with family or spouses, and benefitting from shared accountability and support related to safety and daily activities. As a participant stated “... yes, *'cause I keep my phone on me at all times so that if I need to call somebody, I can. But I live with my daughter and her husband, so there's always somebody else. There's always somebody around*” This created a sense of safety and security for those older adults who lived with other people.

Environmental Context and Structural Barriers

This domain reflected the greatest concentration of barriers affecting participation in fall prevention related activities. Participants described delays in seeking care or reporting falls, financial constraints, inadequate clinical follow-up, limited access to home modifications, low self-efficacy, provider communication gaps, and transportation challenges. Transportation barriers were particularly prominent, with participants stating, *"No, I don't drive anymore"* and *"My other problem is transportation."* A social worker described the compounded challenges faced by homebound individuals who were unable to leave their homes due to architectural barriers such as front and back steps yet lacked the financial resources necessary to install ramps or other accessibility modifications.

Emergency alert technologies emerged as important fall prevention strategies within this domain. Participants described the use of the Life Alert button and Apple Watches that automatically contacted emergency services following a fall, home camera systems used for safety monitoring, and personal emergency response devices. These technologies were perceived as practical, accessible strategies that enhanced safety and supported independent living. In their study, Lin and colleagues found that older adults who use technology are open to new experiences and more open to seeking help if needed.²⁵

Professional Role, Identity, and Provider Relationships

Several older adult participants described feeling dismissed or unheard by healthcare providers, particularly in relation to age and gender. One participant stated, *"I hate to say it, but I also think when you're a woman of a certain age, they stop listening to you. He treated me like, oh, you're just a dumb woman."* These experiences of perceived invalidation reduced participants' willingness to disclose falls, discuss safety concerns, and seek additional support or care.

Facilitators within this domain related to participation in fall prevention activities included trusting relationships with healthcare providers and proactive engagement from community organizations. Participants who expressed confidence in their healthcare teams were more likely to participate in fall risk discussions and seek preventive support. One participant praised the Modern Maturity Center as an example of effective community outreach, citing its use of printed newsletters, posted signage, and verbal announcements during meals to promote awareness of available programs and resources.

Fall Risk Perception and Consequence Beliefs

Complacency and underestimation of fall risk were common themes among older adult participants. Participants frequently describe awareness of potential safety concerns without consistently adopting preventative behaviors. For example, some individuals acknowledged difficulty getting out of the bathtub while continuing to use it without adaptive equipment or safety modifications with one participant stating, *“there’s a shower chair in there, I don’t use it”*. Fear and anxiety related to falling also contributed to avoidance behaviors and reluctance to disclose falls, rather than engagement in preventive strategies with one stating that *“And I have a fear of falling every day when I take my dogs for a walk because if they were to jump or whatever, I fear I fall every time”*

Facilitators within this domain included increased personal awareness of fall risk, recognition of functional limitations associated with falling, and behavior adjustments intended to improve safety and reduce vulnerability to future falls. A participant stated that *“Basically, being careful and mindful of the fact when in a situation, where they might fall. You know, there's certain things you don't do when you get to a certain age. Why would I go across a floor that's been waxed? So you know you have to remember your surroundings and make sure that you have proper equipment or the proper dress so that you don't fall.”* Self-awareness may improve overall safety and enhance behavioral modification to reduce fall risk.

Healthcare Provider-Specific Findings

All providers expressed strong motivation to address fall prevention; however, time constraints within primary care and clinical practice settings often resulted in falls being deprioritized when competing medical concerns were present. Physicians and nurse practitioners consistently identified physical and occupational therapy as primary referral resources for fall prevention. However, referral practices varied and were frequently influenced by assumptions regarding patients’ financial resources, transportation access, and ability to participate in services, with one provider stating that *‘I think a big thing is affordable transportation...Yes, I identified you could benefit from this service, but short of me physically putting them in my vehicle and taking them, that I think is it's the cost and the transportation...It just that's the reality’*

Provider gatekeeping emerged as a notable barrier, with some clinicians limiting recommendations or referrals based on perceived patient limitations rather than patient preferences or goals. As a result, some older adults who may have benefited from fall risk prevention services did not receive referrals to available programs or interventions. A case manager reported her reluctance to refer patients for community-based fall prevention programs due to the long wait list. She reported that *“I haven't actually referred anybody because when I look it's always so far out, so I don't really have an answer to that question.”*

Physical and occupational therapists were the only provider groups to consistently emphasize physical activity and exercise as primary fall prevention strategies, consistent with established evidence-based guidelines.

Summary of Themes

The findings converged around three overarching themes: (1) knowledge and perception gaps, including limited awareness of fall prevention programs among both older adults and

healthcare providers; (2) socioeconomic and structural barriers, including financial constraints, transportation limitations, and provider gatekeeping; and (3) professional roles and motivations, including strong provider motivation tempered by time constraints and inconsistent referral practices.

Discussion

The findings of this study highlight a complex and interconnected set of barriers that influence participation in fall prevention screening and interventions among community-dwelling older adults in Delaware. These barriers were not isolated to a single domain, but instead operated across individual, interpersonal, and systemic-level factors.

Knowledge gaps emerged as a foundational barrier among older adults and healthcare providers, consistent with findings reported by Vincenzo and colleagues,¹⁶ who similarly identified limited cues to action and insufficient awareness of available fall prevention resources within social and healthcare environments. Importantly, provider knowledge gaps often mirrored those of patients. When clinicians lacked awareness of available programs and referral resources, opportunities for fall prevention intervention were limited regardless of provider motivation. Shankar and colleagues²¹ similarly reported that older adults presenting to emergency departments following falls were frequently uncertain about how to prevent future falls, even when receptive to preventive interventions.

The underestimation of fall risk and underreporting of falls observed in this study are consistent with patterns previously described in gerontological literature. Concerns related to personal identity, particularly fears of being perceived as frail, dependent, or losing independence appeared to contribute to resistance toward assistive devices and reluctance to disclose falls to healthcare providers.²⁶ These findings underscore the importance of person-centered approaches that support older adult autonomy while addressing stigma associated with aging, fall risk, and functional decline.

Transportation and financial barriers emerged as important structural determinants that cannot be addressed through individual motivation alone. Delaware's geographic distribution and limited rural transportation infrastructure may prevent even highly motivated older adults from accessing center-based fall prevention programs. Expanding home-based service delivery, telehealth integration, and strengthened partnerships with organizations such as Meals on Wheels and senior centers may provide scalable approaches for improving access among transportation-limited and homebound populations.

Provider gatekeeping emerged as a modifiable systemic barrier with significant equity implications. When clinicians limit referrals based on assumptions of a patient's financial resources, transportation access, or ability to participate, rather than actual individual preferences and goals, older adults who may benefit from preventive services may not receive appropriate referrals. Standardizing fall risk screening within clinical workflows and establishing clear interprofessional referral pathways may help reduce variability in referral practices and improve equitable access to fall prevention services.

The strong motivation to address fall risk observed across healthcare provider groups represents an important implementation asset. Education, peer support, interprofessional collaboration, and clinical decision support tools may help strengthen existing motivation and support more

consistent integration of fall prevention practices into routine care. In addition, the expanding efforts of the Delaware Coalition for Injury Prevention, including the designation of September 2025 as Falls Prevention Awareness Month and the provision of more than 120 free community fall risk assessments demonstrate the feasibility of coordinated, statewide fall prevention initiatives.

Limitations

Several limitations should be acknowledged. The sample was recruited through convenience methods within two of Delaware's three counties, limiting broader generalizability. Although the inclusion of racially diverse participant samples strengthens understanding of barriers affecting populations historically underrepresented in implementation research, the homebound cohort, recruited through Meals on Wheels may not represent the full diversity of homebound older adults across the state. Provider recruitment through a single hospital system may also have introduced selection bias toward clinicians already engaged in fall prevention efforts. In keeping with the qualitative inquiry, these findings are intended to provide contextualized insight into participant experiences rather than broad population-level generalization. Future research should include larger, more geographically diverse samples and longitudinal designs to assess the persistence of identified barriers and the effectiveness of tailored intervention strategies.

Public Health Implications

Falls among older adults are preventable, and substantial evidence supports the effectiveness of fall risk screening and multifactorial prevention interventions. However, these evidence-based resources do not consistently reach the populations at greatest risk. Findings from this study demonstrate that barriers to fall prevention programs span individual, interpersonal, and system level factors. These barriers impact both community-dwelling and homebound older adults, as well as healthcare and social service providers.

Addressing these gaps will require coordinated, person-centered implementation strategies that: (1) increase awareness of available fall prevention resources through targeted education for older adults and healthcare providers; (2) reduce structural barriers to access by expanding home-based services and transportation support; (3) standardize fall risk screening and interprofessional referral pathways within clinical workflows, consistent with AGS and CDC guidelines;⁶⁻⁸ (4) incorporate emergency alert technologies and home-based safety monitoring strategies; and (5) build upon the strong provider motivation already present within Delaware's healthcare workforce.

Development of a Delaware-specific fall prevention and implementation model grounded in the qualitative findings of this study represents an important next step toward improving equitable and sustainable access to fall prevention services. As Delaware's older adult population continues to grow, implementation efforts focused on accessibility, coordination, and engagement will be essential to reducing preventable fall-related injury, disability, and mortality.

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