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BECOMING A TAI CHI FOR ARTHRITIS AND FALL PREVENTION INSTRUCTOR

OLDER ADULT FALLS PREVENTION PROGRAM

2026 UPDATE

WHAT IS TAI CHI FOR ARTHRITIS AND FALL PREVENTION?

- Mind-Body Exercise
- Improves Health
- “Easy” to Learn Safe and Effective (adapt to current state of health)
- Many layers of complexity suitable for life-long learning
- taichiforhealthinstitute.org

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EVIDENCE-BASED FALLS PREVENTION PROGRAMS

Solid Research

Packaged Programs

Form Community Partnerships

Benefits

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GUIDELINES TO MAINTAIN FIDELITY

TAI CHI FOR HEALTH INSTITUTE

- taichiforhealthinstitute.org
- Developed and oversees the program models
- Responsible for “certifying” instructors
- Must maintain membership with Institute

NATIONAL COUNCIL ON AGING/ ADMINISTRATION ON COMMUNITY LIVING

- ncoa.org
- Support Resources
- Grants to Expand Delivery
- Collects data on programs to report at National Level

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TAI CHI FOR ARTHRITIS AND FALL PREVENTION

FORMAT	Exercise Class
DELIVERY	≥ 16 one-hour sessions Twice/week for ≥ 8 weeks ≥ 1 Instructor Class size varies
APPROACH	Slow, intentional movements improve strength and balance Many health benefits beyond falls prevention
INSTRUCTOR CERTIFICATION	Must learn movements in advance No prior tai chi experience needed Biannual recertification required
EVIDENCE	Reduced recurring falls by nearly 70%

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BECOMING A TAI CHI FOR ARTHRITIS AND FALL PREVENTION INSTRUCTOR

Two Main Components: “Self-Paced” followed by “Live-Interactive”

- The **Self-paced Instructor Preparation Program** is a self-paced virtual program containing essential material to train effective and safe instructors. All you must do is to follow the sequence with Dr. Lam’s video guides for every step (15-50 hours)
- After completion of the Self-paced Instructor Preparation Program and the associated practice, you will be ready for the **1-day live interactive** Tai Chi for Arthritis and Fall Prevention Instructor Training Workshop to be eligible to become a Tai Chi for Health Institute Board Certified instructor

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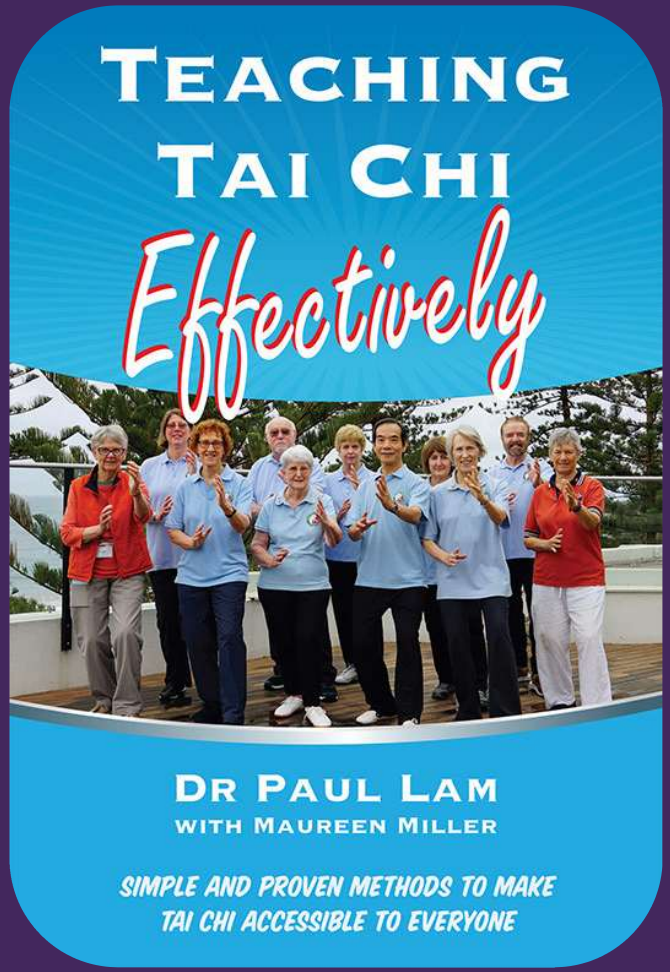
YOU CAN'T TEACH WHAT YOU DON'T KNOW



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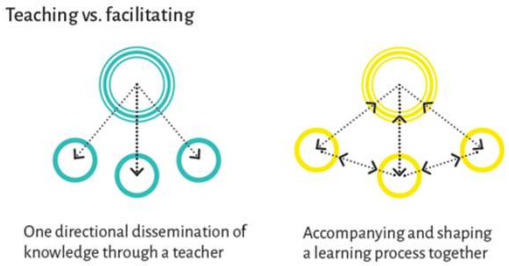
TEACHING VS. FACILITATING

TEACHING

- Comes from the teacher's knowledge
- Set curriculum
- Information flows teachers → students
- Teacher focused on students learning the “right” information
- Formal relationship

FACILITATING

- Starts with current knowledge of the group
- Heavily guided by interests of the group Information flows between facilitate or and group
- Value different views and beliefs
- Equal relationship and trust



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SELF-PACED INSTRUCTOR PREPARATION PROGRAM

1. Learn and Practice the Warmups, Basic 6, Advanced 6, and Cool Down Exercises
2. Read the “Teaching Tai Chi Effectively” book
3. Complete all the required modules in the Self-paced Instructor Preparation Program and pass quizzes/knowledge checks
4. Complete all required paperwork sent by Master Trainer
5. Record yourself demonstrating the Basic 6 and Advanced Movements

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LIVE-INTERACTION SESSION

- Eligible **AFTER** you complete Self-paced Instructor Preparation Program with **certificate** and send Master Trainer a recording of you demonstrating the form.
- Full 8-hour day on Zoom with a small group and the Master Trainer.
- Must be visible head to toes on your camera and have a microphone.
- The Master Trainer will work with you to answer your questions about the program and tai chi routine, help you refine your tai chi movements, and help to ensure you can teach the program safely and effectively using the Stepwise Progressive Teaching Method.
- Personal 1 Day Instructor Workshop Includes:
  - Discussions
  - Practice sessions
  - Sharing skill and knowledge
  - Question and Answer portions
  - Personal attention and feedback

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FINAL STEPS TO CERTIFICATIONS

- Successful 1-1 Zoom meetings with Master Trainer (~1hr)
  - Demonstrate movements
  - Refine technique
- Register with the Tai Chi for Health Institute
- Pay Annual Board Fees
- Schedule your first workshop!
- Recertify every two years

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GRANT FUNDING FOR CERTIFICATIONS

COVERED


All costs for certification materials


Recertification during grant periods


Support from grant team


Opportunities for co-teaching

NOT COVERED

- Time spent learning the movements and completing the required steps towards certification
- Time spent teaching after certification
- Annual Board Fees*

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2025-2028 ACL FALLS PREVENTION GRANT IN NEW YORK

The Bureau of Occupational Health and Injury Prevention (BOHIP) and key partners will expand the state's infrastructure for evidence-based falls prevention programs to reach older adults (60+) with greatest economic and social need and/or disabilities.

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2025-2028 ACL FALLS PREVENTION GRANT IN NEW YORK

Goal 1: Develop an innovative fall prevention method that increases statewide capacity to deliver in-person and virtual person-centered, trauma-informed evidence-based falls prevention programs to older adults with greatest economic and social needs (majority) and/or disabilities.

- A Matter of Balance
- Tai Chi for Arthritis and Fall Prevention
- Stay Active and Independent for Life

Goal 2: Evaluate impact on evidence-based falls prevention programs and delivery method on reducing falls and fall risk and meeting individuals' critical needs using results to develop and disseminate resources.

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IMPORTANCE OF COLLECTING DATA

- Determine program reach and participant demographics so we can better target our efforts to serve our community.
- Report participant outcomes to determine the impact and value of the programs.
- Show grant funding agency and legislators that they are spending their money wisely on these programs.
- Learn what technical assistance we can provide to better support you in implementing and sustaining programs.
- Inform future program needs.
- Conduct research to determine the reach and value of programs.

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DATA COLLECTION FORM TERMINOLOGY

Program: An evidence-based falls prevention program.

Workshop: A class or group meeting through which a program is delivered to participants.

Session: A single meeting of a workshop, e.g., an hour-long class period or an encounter.

Facilitators/Leaders: The people who are trained to deliver the falls prevention programs.

Participant: The people who enroll in the programs.

Host Organizations: The organizations that sponsor workshops, hold the license for a programs, train or employ leaders, and arrange for the use of implementation sites.

Implementation Sites: The physical locations where programs are delivered.

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DATA COLLECTION FORMS

- Host organization information form
- Program information cover sheet
- Participant attendance log
- Participant information form (pre-survey)
- Participant post-session survey
- All forms can be downloaded at the following webpage: ncoa.org/article/data-collection-tools-for-falls-prevention-programs or can be directly emailed to you

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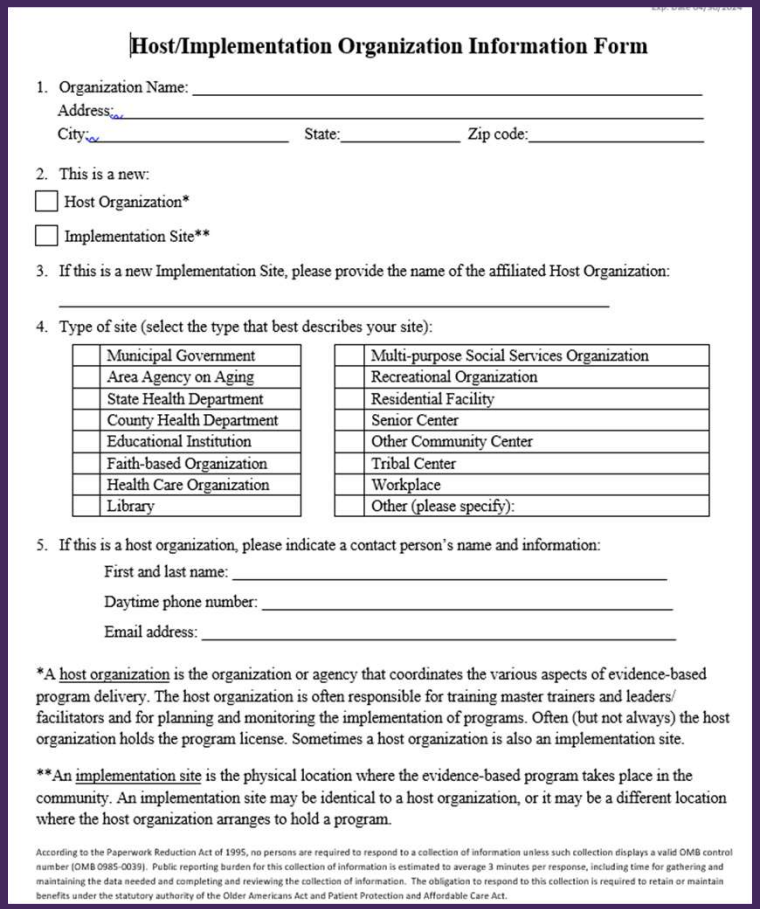
HOST/IMPLEMENTATION ORGANIZATION INFORMATION SHEET



Host/Implementation Organization Information Form

1. Organization Name: _____
   Address: _____
   City: _____ State: _____ Zip code: _____

2. This is a new:

☐ Host Organization*

☐ Implementation Site**

3. If this is a new Implementation Site, please provide the name of the affiliated Host Organization:

   _____

4. Type of site (select the type that best describes your site):

☐	Municipal Government	☐	Multi-purpose Social Services Organization
☐	Area Agency on Aging	☐	Recreational Organization
☐	State Health Department	☐	Residential Facility
☐	County Health Department	☐	Senior Center
☐	Educational Institution	☐	Other Community Center
☐	Faith-based Organization	☐	Tribal Center
☐	Health Care Organization	☐	Workplace
☐	Library	☐	Other (please specify):

5. If this is a host organization, please indicate a contact person's name and information:

   First and last name: _____

   Daytime phone number: _____

   Email address: _____

*A host organization is the organization or agency that coordinates the various aspects of evidence-based program delivery. The host organization is often responsible for training master trainers and leaders/ facilitators and for planning and monitoring the implementation of programs. Often (but not always) the host organization holds the program license. Sometimes a host organization is also an implementation site.

**An implementation site is the physical location where the evidence-based program takes place in the community. An implementation site may be identical to a host organization, or it may be a different location where the host organization arranges to hold a program.

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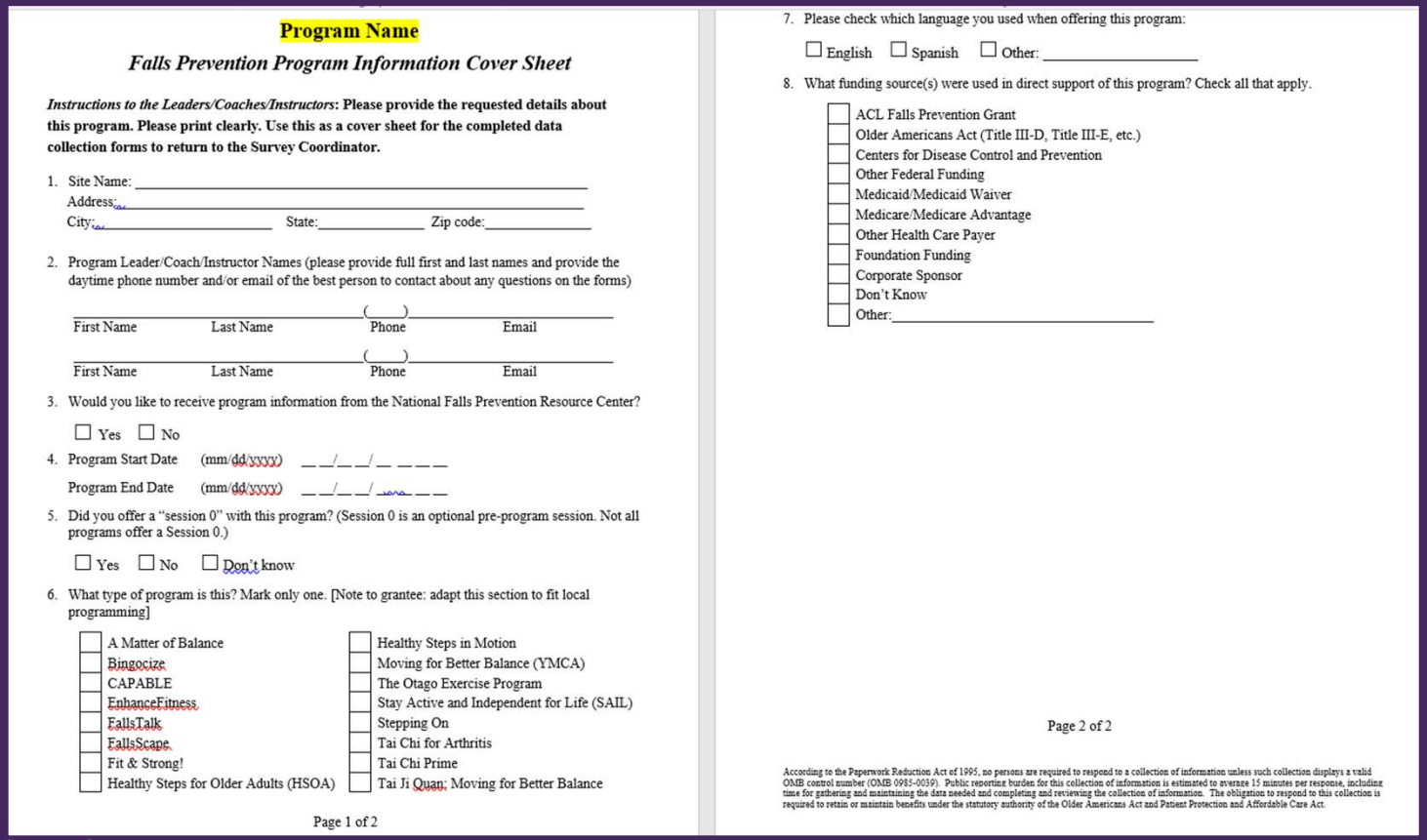
FALLS PREVENTION PROGRAM INFORMATION COVER SHEET



Program Name

Falls Prevention Program Information Cover Sheet

***Instructions to the Leaders/Coaches/Instructors*: Please provide the requested details about this program. Please print clearly. Use this as a cover sheet for the completed data collection forms to return to the Survey Coordinator.**

1. Site Name: _____
   Address: _____
   City: _____ State: _____ Zip code: _____

2. Program Leader/Coach/Instructor Names (please provide full first and last names and provide the daytime phone number and/or email of the best person to contact about any questions on the forms)

   _____ (____) _____
   First Name Last Name Phone Email

   _____ (____) _____
   First Name Last Name Phone Email

3. Would you like to receive program information from the National Falls Prevention Resource Center?

   ☐ Yes ☐ No

4. Program Start Date (mm/dd/yyyy) __ __/__ __/__ __ __ __
   Program End Date (mm/dd/yyyy) __ __/__ __/__ __ __ __

5. Did you offer a "session 0" with this program? (Session 0 is an optional pre-program session. Not all programs offer a Session 0.)

   ☐ Yes ☐ No ☐ Don't know

6. What type of program is this? Mark only one. [Note to grantee: adapt this section to fit local programming]

   ☐ A Matter of Balance
   ☐ Bingocize
   ☐ CAPABLE
   ☐ EnhanceFitness
   ☐ FallsTalk
   ☐ FallsScape
   ☐ Fit & Strong!
   ☐ Healthy Steps for Older Adults (HSOA)
   ☐ Healthy Steps in Motion
   ☐ Moving for Better Balance (YMCA)
   ☐ The Otago Exercise Program
   ☐ Stay Active and Independent for Life (SAIL)
   ☐ Stepping On
   ☐ Tai Chi for Arthritis
   ☐ Tai Chi Prime
   ☐ Tai Ji Quan: Moving for Better Balance

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7. Please check which language you used when offering this program:

   ☐ English ☐ Spanish ☐ Other: _____

8. What funding source(s) were used in direct support of this program? Check all that apply.

   ☐ ACL Falls Prevention Grant
   ☐ Older Americans Act (Title III-D, Title III-E, etc.)
   ☐ Centers for Disease Control and Prevention
   ☐ Other Federal Funding
   ☐ Medicaid/Medicaid Waiver
   ☐ Medicare/Medicare Advantage
   ☐ Other Health Care Payer
   ☐ Foundation Funding
   ☐ Corporate Sponsor
   ☐ Don't Know
   ☐ Other: _____

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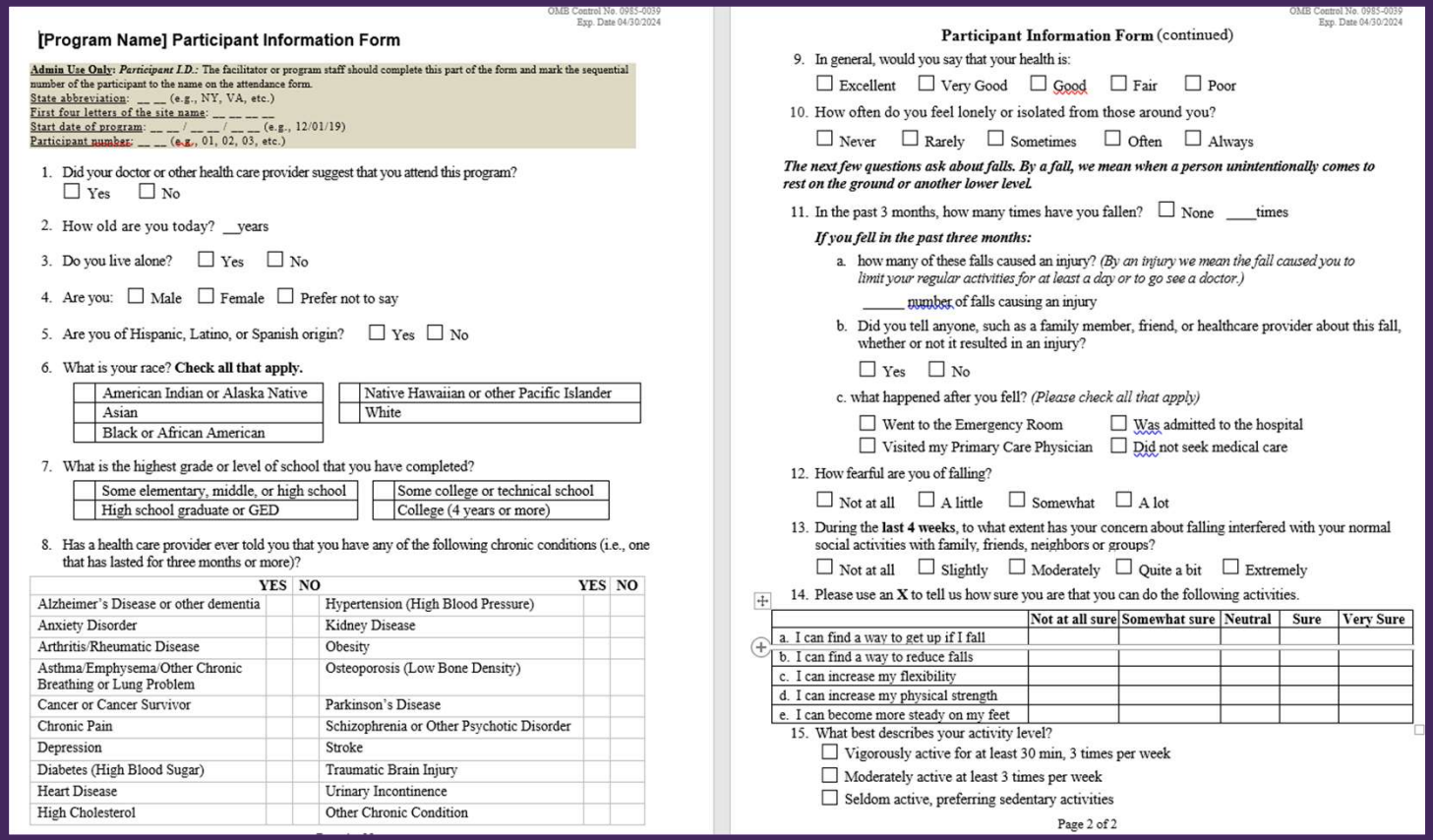
PARTICIPANT INFORMATION FORM (PRE-SURVEY)



OMB Control No. 0985-0039
Exp. Date 04/30/2024

[Program Name] Participant Information Form

Admin Use Only: ***Participant I.D.:*** The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.
State abbreviation: __ __ (e.g., NY, VA, etc.)
First four letters of the site name: __ __ __ __
Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/19)
Participant number: __ __ (e.g., 01, 02, 03, etc.)

1. Did your doctor or other health care provider suggest that you attend this program?
   ☐ Yes ☐ No
2. How old are you today? __years
3. Do you live alone? ☐ Yes ☐ No
4. Are you: ☐ Male ☐ Female ☐ Prefer not to say
5. Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No
6. What is your race? **Check all that apply.**

☐	American Indian or Alaska Native	☐	Native Hawaiian or other Pacific Islander
☐	Asian	☐	White
☐	Black or African American		

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

☐	Some elementary, middle, or high school	☐	Some college or technical school
☐	High school graduate or GED	☐	College (4 years or more)

8. Has a health care provider ever told you that you have any of the following chronic conditions (i.e., one that has lasted for three months or more)?

	YES	NO		YES	NO
Alzheimer's Disease or other dementia			Hypertension (High Blood Pressure)		
Anxiety Disorder			Kidney Disease		
Arthritis/Rheumatic Disease			Obesity		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Osteoporosis (Low Bone Density)		
Cancer or Cancer Survivor			Parkinson's Disease		
Chronic Pain			Schizophrenia or Other Psychotic Disorder		
Depression			Stroke		
Diabetes (High Blood Sugar)			Traumatic Brain Injury		
Heart Disease			Urinary Incontinence		
High Cholesterol			Other Chronic Condition		

OMB Control No. 0985-0039
Exp. Date 04/30/2024

Participant Information Form (continued)

9. In general, would you say that your health is:
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
10. How often do you feel lonely or isolated from those around you?
    ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

11. In the past 3 months, how many times have you fallen? ☐ None ____times

    If you fell in the past three months:

    a. how many of these falls caused an injury? *(By an injury we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor.)*
       _____ number of falls causing an injury

    b. Did you tell anyone, such as a family member, friend, or healthcare provider about this fall, whether or not it resulted in an injury?
       ☐ Yes ☐ No

    c. what happened after you fell? *(Please check all that apply)*
       ☐ Went to the Emergency Room ☐ Was admitted to the hospital
       ☐ Visited my Primary Care Physician ☐ Did not seek medical care

12. How fearful are you of falling?
    ☐ Not at all ☐ A little ☐ Somewhat ☐ A lot
13. During the **last 4 weeks**, to what extent has your concern about falling interfered with your normal social activities with family, friends, neighbors or groups?
    ☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely
14. Please use an **X** to tell us how sure you are that you can do the following activities.

	Not at all sure	Somewhat sure	Neutral	Sure	Very Sure
a. I can find a way to get up if I fall					
b. I can find a way to reduce falls					
c. I can increase my flexibility					
d. I can increase my physical strength					
e. I can become more steady on my feet					

15. What best describes your activity level?
    ☐ Vigorously active for at least 30 min, 3 times per week
    ☐ Moderately active at least 3 times per week
    ☐ Seldom active, preferring sedentary activities

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POST-SURVEY

OMB Control No. 0985-0039
Exp. Date 04/30/2024

[Program Name] Participant Post Program Survey

Admin Use Only: ***Participant I.D.***: The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.
State abbreviation: __ __ (e.g., NY, VA, etc.)
First four letters of the site name: __ __ __ __
Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/19)
Participant number: __ __ (e.g., 01, 02, 03, etc.)

1. In general, would you say that your health is:
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
2. How often do you feel lonely or isolated from those around you?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

3. Since this program began, how many times have you fallen? ☐ None ____times

   If you fell since the program began:

   a. how many of these falls caused an injury? *(By an injury we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor.)*

      _____number of falls causing an injury

   b. Did you tell anyone, such as a family member, friend, or healthcare provider about this fall, whether or not it resulted in an injury?
      ☐ Yes ☐ No

   c. what happened after you fell? *(Please check all that apply)*
      ☐ Went to the Emergency Room ☐ Was admitted to the hospital
      ☐ Visited my Primary Care Physician ☐ Did not seek medical care

4. How fearful are you of falling?
   ☐ Not at all ☐ A little ☐ Somewhat ☐ A lot
5. During the **last 4 weeks**, to what extent has your concern about falling interfered with your normal social activities with family, friends, neighbors or groups?
   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

OMB Control No. 0985-0039
Exp. Date 04/30/2024

Participant Post Program Survey (continued)

6. Please use an **X** to tell us how sure you are that you can do the following activities.

	Not at all sure	Somewhat sure	Neutral	Sure	Very Sure
a. I can find a way to get up if I fall					
b. I can find a way to reduce falls					
c. I can increase my flexibility					
d. I can increase my physical strength					
e. I can become more steady on my feet					

7. What best describes your activity level?
   ☐ Vigorously active for at least 30 min, 3 times per week
   ☐ Moderately active at least 3 times per week
   ☐ Seldom active, preferring sedentary activities
8. Please use an **X** to tell us your thoughts about this program.

As a result of this program:	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling.					
b. I feel more comfortable talking to my family and friends about falling.					
c. I feel more comfortable increasing my activity.					
d. I feel more satisfied with my life.					
e. I would recommend this program to a friend or relative.					
f. I have reduced my fear of falling.					
g. I plan to continue to exercise.					
h. I have made safety modifications in my home, such as installing grab bars or securing loose rugs.					

9. Since this program began, what have you done to reduce your chance of a fall? **Check all that apply**
   ☐ Talked to a family member or friend about how I can reduce my risk of falling
   ☐ Talked to a health care provider about how I can reduce my risk of falling
   ☐ Had my vision checked
   ☐ Had my medications reviewed by a health care provider or pharmacist
   ☐ Participated in or plan to participate in another fall prevention program in my community

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[Program Name] Participant Information Form

Admin Use Only: ***Participant I.D.:*** The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.

State abbreviation: __ __ (e.g., NY, VA, etc.)

First four letters of the site name: __ __ __ __

Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/19)

Participant number: __ __ (e.g., 01, 02, 03, etc.)

[Program Name] Participant Post Program Survey

Admin Use Only: ***Participant I.D.:*** The facilitator or program staff should complete this sequential number of the participant to the name on the attendance form.

State abbreviation: __ __ (e.g., NY, VA, etc.)

First four letters of the site name: __ __ __ __

Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/19)

Participant number: __ __ (e.g., 01, 02, 03, etc.)

A Matter of Balance - Attendance Log

Location: _____
(Please indicate if virtual)

Start Date: _ _/_ _/_ _ _ _ End Date: _ _/_ _/_ _ _ _

Day of the week: _____

Time of class: _____

Coaches: _____

		Sessions Attended								
Participant ID# & Name	Phone	1	2	3	4	5	6	7	8	TOTAL
#1.										
#2.										
#3.										
#4.										
#5.										
#6.										
#7.										
#8.										
#9.										
#10.										
#11.										
#12.										
#13										
#14										

Mark each session that a participant attends with an X.

Please write each participant's name on the individual lines above.

The corresponding # next to their name is their Participant ID#.

The Participant ID# should be written at the top of their PRE and POST surveys.*

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WHERE TO SUBMIT DATA

Via email directly to FallsFree@stonybrookmedicine.edu

OR via mail to:
Kristi Ladowski
Stony Brook University Hospital
HSC T18-040 (Mailing)
Stony Brook, NY 11794-8191

OR via electronic submission:
If you are interested in learning more about electronic data submission, please contact Kristi Ladowski (Kristi.Ladowski@stonybrookmedicine.edu).

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SUPPORT

- Bi-Monthly meetings for instructors
- Regular communication from BOHIP and Falls Free Long Island
- Co-Teaching
- Zoom/Virtual Workshops
- Data Reports

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NEXT STEPS *BEFORE* STARTING THE SIPP

Still have questions? Schedule a personal Q&A	calendly.com/kristi-ladowski/tca-new-candidate OR email injury@health.ny.gov
Complete the Tai Chi for Arthritis and Fall Prevention Instructor Certification and Recertification Application & Agreement	surveymonkey.com/r/2KC867T
Get comfortable with the Warmups and First Lesson	youtu.be/tAOuEpa01j4
Email a recording of you leading the warmups (head to toe with sound)	injury@health.ny.gov

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CONTACT

injury@health.ny.gov
Website: health.ny.gov/prevention/injury_prevention/falls
FallsFree@stonybrookmedicine.edu
Website: LongIslandFallsFree.com

Resources:
Program/Instructor Specific
taichiforhealthinstitute.org

Delivery Tips
ncoa.org/article/evidence-based-program-tai-chi-for-arthritis-and-falls-prevention

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