Clinician’s Guide to Fall Risk Assessments in Older Adults

Who Is At Risk?
(Source: CDC, 2012)

Annually, 1 in 3 adults over the age of 65 falls in the United States, causing moderate to severe injuries, such as hip fractures and head injuries; such injuries can increase the risk of early death. In addition:

- Falls are the leading cause of injury death among adults over age 65; falls are also the most common cause of nonfatal injuries and hospital admissions for trauma.
- In 2010, 2.3 million nonfatal fall injuries occurred among those over age 65 and were treated in emergency departments; over 662,000 were hospitalized. Direct medical costs of falls (adjusted for inflation) was $30.0 billion.

Injuries due to falls among those over age 75 are four to five times more likely than those age 65 to 74 to be admitted to a long-term care facility for a year or longer. Rates of fall-related fractures among older women are more than twice those for men. Over 95% of hip fractures are caused by falls – in 2009, there were 271,000 hip fractures (the rate for women was nearly three times the rate for men). Rates are higher among White women than Black women. In addition:

- Twenty to thirty percent of people who fall suffer moderate to severe injuries (e.g., lacerations, hip fractures, head traumas) – such injuries make it hard to live independently and increase the risk of early death.
- Falls are the most common cause of traumatic brain injuries; in 2000, they accounted for 46% of fatal falls.
- Most fractures among older adults are caused by falls; the most common are fractures of the spine, hip, forearm, leg, ankle, pelvis, upper arm, and hand.
- Many who fall, even if they are not injured, develop a fear of falling. This fear may cause them to limit their activities, which can lead to reduced mobility and loss of physical fitness, and in turn increases their risk of falling.

Deaths due to falls among older adults have risen sharply over the past decade. In 2009, approximately 20,400 died from unintentional fall injuries. Men are more likely than women to die from a fall; the fall death rate in 2009 was 34% higher for men than for women. Rates also differ by ethnicity - older non-Hispanics have higher fatal fall rates than Hispanics; older Whites are 2.4 times more likely to die from falls as their Black counterparts.

Prevention
(Source: CDC, 2012)

Providers can reassure members that falls are preventable and can be reduced with the following tips:

- **Regular Exercise.** Focus on increasing leg strength and improving balance, incorporating more challenging exercises over time. Tai Chi programs are recommended.
- **Medication Review.** Both prescription and over-the-counter medications may cause side effects or interactions.
such as dizziness or drowsiness.

- **Vision Exam.** Members should have an annual eye exam and update eyeglasses to maximize vision. Members should consider having a pair with single vision distance lenses for some activities such as walking outside.

- **Home Safety.** Providers can encourage members to reduce tripping hazards such as removing throw rugs, adding grab bars inside and outside the tub or shower and next to the toilet, adding railings on both sides of stairways and improving the lighting throughout their home.

To lower hip fracture risk, older adults should:
- Get adequate calcium and vitamin D from food and/or from supplements.
- Do weight bearing exercise.
- Get screened and, if needed, treated for osteoporosis.

The United States Preventative Services Task Force (USPSTF) (2012) recommends that exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls (Grade: B). Further, the USPSTF states that no single recommended tool or brief approach can reliably identify older adults at increased risk for falls, but several reasonable and feasible approaches are available for primary care clinicians. The USPSTF does not recommend automatically performing an in-depth multifactorial risk assessment in conjunction with comprehensive management of identified risks to prevent falls in community-dwelling adults aged 65 years or older because the likelihood of benefit is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of the circumstances of prior falls, comorbid medical conditions, and patient values (Grade: C).

**AGS / BGS Clinical Guideline**
(Source: AGS, 2010)

The American Geriatrics Society and the British Geriatrics Society (2010) recommend the following questions be asked when screening older adults for fall risk:

1. All older individuals should be asked whether they have fallen (in the past year).
2. An older person who reports a fall should be asked about the frequency and circumstances of the fall(s).
3. Older individuals should be asked if they experience difficulties with walking or balance.
4. Older persons who present for medical attention because of a fall, report recurrent falls in the past year, or report difficulties in walking or balance should have a multifactorial fall risk assessment.
5. Older persons presenting with a single fall should be evaluated for gait and balance.
6. Older persons who have fallen should have an assessment of gait and balance using one of the evaluations.
7. Older persons who cannot perform or perform poorly on a standardized gait and balance test should be given a multifactorial fall risk assessment.
8. Older persons who have difficulty or demonstrate unsteadiness during the evaluation of gait and balance require a multifactorial fall risk assessment.
9. Older persons reporting only a single fall and reporting or demonstrating no difficulty or unsteadiness during the evaluation of gait and balance do not require a fall risk assessment.
10. The multifactorial fall risk assessment should be performed by a clinician with appropriate skills and training.
11. The multifactorial fall risk assessment should include:

   **Focused History**
   - **Fall History.** Detailed description of the circumstances of the fall(s), frequency, symptoms at time of fall, injuries, other consequences.
   - **Medication Review.** All prescribed and over-the-counter medications with dosages.
   - **Relevant Risk Factors.** Review acute or chronic medical problems, (e.g., osteoporosis, urinary incontinence, cardiovascular disease).
**Physical Examinations**

- **Detailed Assessment.** Review of gait, balance, and mobility levels and lower extremity joint function.
- **Neurological Function.** Cognitive evaluation, lower extremity peripheral nerves, proprioception, reflexes, tests of cortical, extrapyramidal and cerebellar function.
- **Muscle Strength.** Specific attention should be paid to the lower extremities.
- **Cardiovascular Status.** Heart rate and rhythm, postural pulse, blood pressure, and, if appropriate, heart rate and blood pressure responses to carotid sinus stimulation.
- **Assessment of Visual Acuity.**
- **Examination of the Feet and Footwear.**

**Functional and Environmental Assessment**

- **Activities of Daily Living (ADL).** Review ADLs including use of adaptive equipment and mobility aids.
- **Functional Ability.** Review the individual’s perceived functional ability and fear related to falling.
- **Home Safety.** Review ways the individual can modify their home to decrease fall risk.

The following AGS / BGS guidelines for older adults received an A rating (for all interventions, refer to the link below):

**Older Adults Living in the Community**

1. The multifactorial fall risk assessment should be followed by direct interventions tailored to the identified risk factors, coupled with an appropriate exercise program.
2. A strategy to reduce the risk of falls should include multifactorial assessment of known fall risk factors and management of the risk factors identified.
3. The components most commonly included in efficacious interventions were:
   a. Adaptation or modification of home environment
   b. Exercise, particularly balance, strength, and gait training
4. Those at risk should be offered an exercise program incorporating balance, gait, and strength training. Flexibility and endurance training should also be offered, but not as sole components of the program.
5. The health professional or team conducting the fall risk assessment should directly implement the interventions or should assure that the interventions are carried out by other qualified healthcare professionals.
6. Exercise should be included as a component of multifactorial interventions for fall prevention.
7. An exercise program that targets strength, gait and balance, such as Tai Chi or physical therapy, is recommended as an effective intervention to reduce falls.
8. Vitamin D supplements of at least 800 IU per day should be provided to those with proven vitamin D deficiency.
9. Home environment assessment and intervention carried out by a health care professional should be included in a multifactorial assessment and intervention for those who have fallen or who have risk factors for falling.
10. The intervention should include mitigation of identified hazards in the home, and evaluation and interventions to promote the safe performance of daily activities.

**Older Adults Living in Long-Term Care Facilities**

1. Vitamin D supplements of at least 800 IU per day should be provided to older persons residing in long-term care settings with proven or suspected vitamin D insufficiency.

**CMS STAR METRIC**

**Discussing fall risk:** To increase the percentage of Medicare members 75 years of age and older or 65–74 years of age with balance or walking problems or a fall in the past 12 months, who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner.

**Managing fall risk:** To increase the percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who
received fall risk intervention from their current practitioner.

**NCQA HEDIS STANDARD**

NCQA has not published a metric for this condition.

**REFERENCES**


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**MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS**

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<th>Date</th>
<th>History and Revisions by the Medical Policy Committee</th>
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<tr>
<td>11/6/2014</td>
<td>• Approved by MPC. Inclusion of CMS STAR and NCQA HEDIS standards. No other changes.</td>
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<tr>
<td>11/1/2012</td>
<td>• Approved by MPC. New CPG.</td>
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