CATCH RURAL Falls

Coordinated Action Toward Community Health: RedUce Risk And Limit Falls

Screening for Fall Risk

University of Nebraska Medical Center

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Introductions and Contact Information

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- Expertise in quality improvement, teamwork, and organizational science
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Educational Objectives

- Differentiate fall risk screening and fall risk assessment
- Describe strategies to screen for fall risk

- The identification of patients at increased risk of falling to determine if additional in-depth assessment of risk factors is needed
- Intended to be quick

Fall Risk Screening

- The identification of specific risk factors to guide intervention
- More thorough and therefore more time-consuming

Fall Risk Assessment

Screening: Who/When/Why?

Who	When	Why
• Adults ≥ 65 years old	• At least annually (e.g. Welcome to Medicare or Medicare Wellness Visits) • Can also be done during office visits for reasons other than annual physicals • Consider screening over the phone or via secure online patient portal in advance of appointment	• Most patients won't mention a fall themselves unless prompted

Centers for Disease Control Algorithm for Fall Risk Screening, Assessment, and Intervention

STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention among Community-Dwelling Adults 65 years and older

START HERE

1 SCREEN for fall risk yearly, or any time patient presents with an acute fall.

Available Fall Risk Screening Tools:

- **Stay Independent: a 12-question tool** [at risk if score ≥ 4]
  - **Important:** If score < 4, ask if patient fell in the past year (if **YES** → patient is at risk)
- **Three key questions** for patients [at risk if **YES** to any question]
  - Feels unsteady when standing or walking?
  - Worries about falling?
  - Has fallen in past year?
    - » If **YES** ask, "How many times?" "Were you injured?"

SCREENED NOT AT RISK

PREVENT future risk by recommending effective prevention strategies.

- Educate patient on fall prevention
- Assess vitamin D intake
  - If deficient, recommend daily vitamin D supplement
- Refer to community exercise or fall prevention program
- Reassess yearly, or any time patient presents with an acute fall

SCREENED AT RISK

2 ASSESS patient's modifiable risk factors and fall history.

Common ways to assess fall risk factors are listed below:

Evaluate gait, strength, & balance
Common assessments:
- Timed Up & Go
- 30-Second Chair Stand
- 4-Stage Balance Test

Identify medications that increase fall risk
(e.g., Beers Criteria)

Ask about potential home hazards
(e.g., throw rugs, slippery tub floor)

Measure orthostatic blood pressure
(Lying and standing positions)

Check visual acuity
Common assessment tool:
- Snellen eye test

Assess feet/footwear

Assess vitamin D intake

Identify comorbidities
(e.g., depression, osteoporosis)

3 INTERVENE to reduce identified risk factors using effective strategies.

Reduce identified fall risk
- Discuss patient and provider health goals
- Develop an individualized patient care plan (see below)

Below are common interventions used to reduce fall risk:

Poor gait, strength, & balance observed
- Refer for physical therapy
- Refer to evidence-based exercise or fall prevention program (e.g., Tai Chi)

Medication(s) likely to increase fall risk
- Optimize medications by stopping, switching, or reducing dosage of medications that increase fall risk

Home hazards likely
- Refer to occupational therapist to evaluate home safety

Orthostatic hypotension observed
- Stop, switch, or reduce the dose of medications that increase fall risk
- Educate about importance of exercises (e.g., foot pumps)
- Establish appropriate blood pressure goal
- Encourage adequate hydration
- Consider compression stockings

Visual impairment observed
- Refer to ophthalmologist/optometrist
- Stop, switch, or reduce the dose of medication affecting vision (e.g., anticholinergics)
- Consider benefits of cataract surgery
- Provide education on depth perception and single vs. multifocal lenses

Feet/footwear issues identified
- Provide education on shoe fit, traction, insoles, and heel height
- Refer to podiatrist

Vitamin D deficiency observed or likely
- Recommend daily vitamin D supplement

Comorbidities documented
- Optimize treatment of conditions identified
- Be mindful of medications that increase fall risk

2 options

FOLLOW UP with patient in 30-90 days.

Discuss ways to improve patient receptiveness to the care plan and address barrier(s)

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Screening Option #1

3 Key Questions*

Have you fallen in the past year?#	Do you feel unsteady when standing or walking?	Are you worried about falling?

*"Yes" to ANY question = at risk → assess for specific risk factors

#If yes, seek more details. How many times? Were you injured? Could also have the patient elaborate on the circumstances of the fall.

Screening Option #2

CDC's Stay Independent Brochure

- 12 item questionnaire

Score ≥ 4	Score < 4 but report a fall within the last year	Score < 4 and report no fall within the last year
• At risk • Assess for specific risk factors	• At risk • Assess for specific risk factors	• Not at risk • Consider recommendations to prevent patient from becoming at risk in the near future (e.g. general fall prevention education, exercise program, etc.

Check Your Risk for Falling

Circle "Yes" or "No" for each statement below			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.

Total _____

Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.

To check your risk online, visit: www.bit.ly/3o4RIW8

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011: 42(6)493-499). Adapted with permission of the authors.

Screening Option #1 – 3 Key Questions

Short and fast compared to Stay Independent Brochure

Can be answered by the patient in the waiting room, and/or administered via secure online patient portal

A “yes” to any question prompts follow-up, so it may trigger further assessment in many individuals

Not as useful for identifying an individual’s specific fall risk factors as the Stay Independent Brochure

Screening Option #2 – Stay Independent Brochure

Some questions begin to identify specific fall risk factors

Can be answered by the patient in the waiting room, and/or administered via secure online patient portal

Takes longer to complete than answering the 3 key questions

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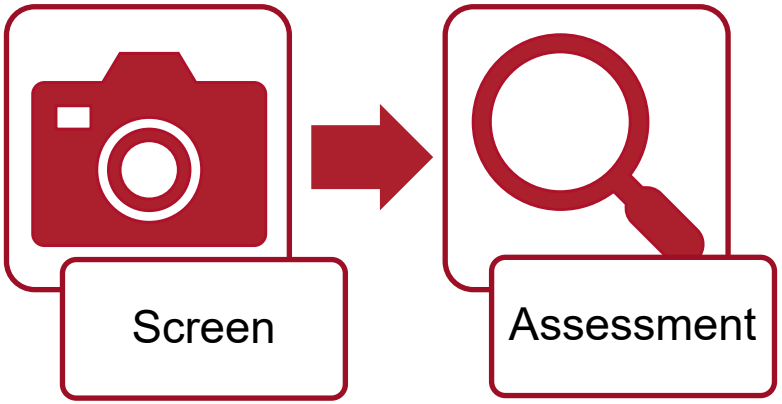
Summary: Review of Objectives

Differentiate fall risk screening and fall risk assessment



Describe strategies to screen for fall risk

STEADI Suggests Using One of Two Options	
3 Key Questions	Stay Independent Brochure

References and Resources

- Center for Disease Control (CDC) Stopping Elderly Accidents, Deaths, and Injuries (STEADI) Home Page
- CDC STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention
- CDC STEADI Stay Independent Brochure
- CDC STEADI Coordinated Care Plan to Prevent Older Adult Falls

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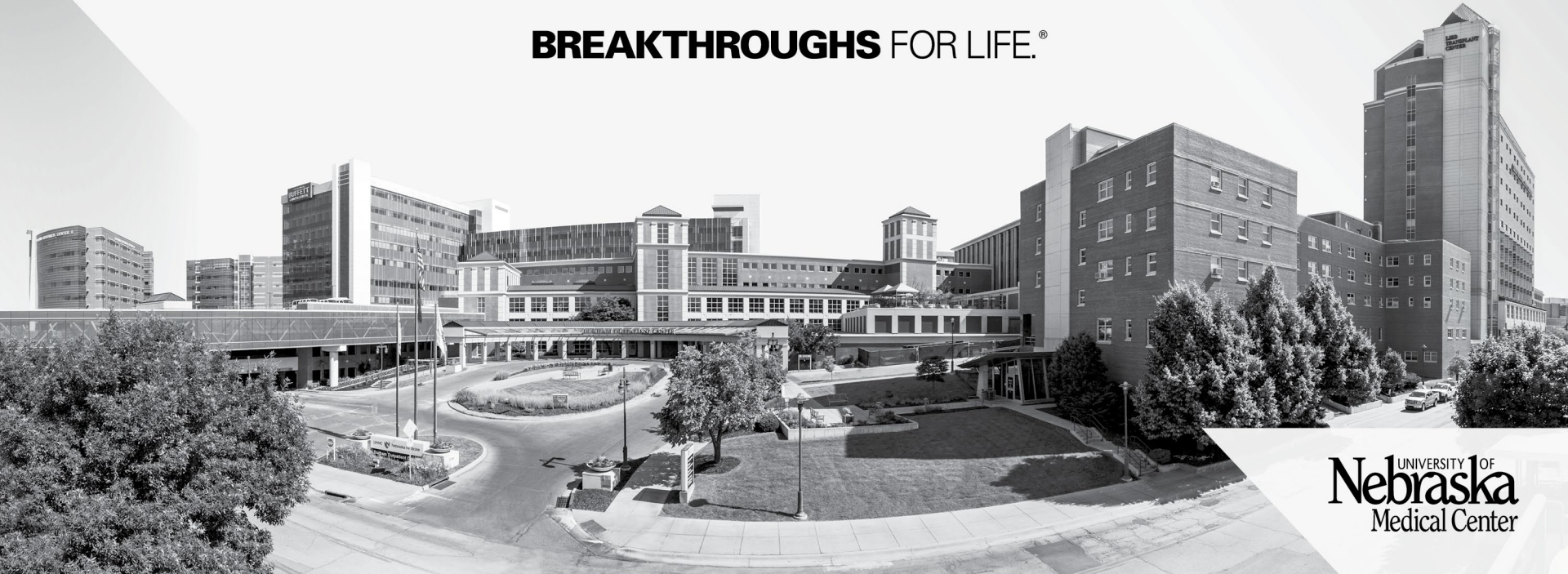

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