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ELDER CARE

A Resource for Interprofessional Providers

Assessing and Intervening in Fall Risk in Older Adults

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Falls from an upright position are the leading cause of fatal and nonfatal injuries among adults aged 65 years and older. Nearly one-third of older adults report falling each year, resulting in an estimated 29 million falls that cause nearly 7 million injuries. Over three million of these older adults are treated in U.S. emergency rooms each year; 25% of them are hospitalized and nearly 1% die. Despite the frequency of falls, half of older adults who fall do not discuss the fall with their health care providers, resulting in lost opportunities for fall prevention.

Reducing fall risk in older adults is an important primary care objective, and primary care provider (PCP) skills in assessing and ameliorating fall risk are needed. Effective fall prevention, including assessment and intervention, has the potential to reduce functional decline, fall-related injuries, emergency visits, hospitalization, and institutionalization. Despite this, while most PCPs are cognizant of older adult fall risk, many are unsure about how, in the course of a busy office schedule, to best assess and support older adults at high fall risk.

The U.S. Preventive Services Task Force (USPSTF) does not recommend a specific tool or approach for primary care fall assessment. But, both the American Geriatrics Society/ British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons, and the CDC's Stopping Elder Accidents, Deaths and Injuries (STEADI) tool kit provide clinicians with an approach to assessing a patient's fall risk, intervening to reduce risk, and providing follow-up. For care settings with the time and resources to fully implement these programs, these resources are ideal, and their free patient materials are easily accessible. However, many clinicians lack the time and/or resources to fully incorporate these recommendations. For these providers, a shortened approach as discussed in this edition of Elder Care, still offers substantial fall risk benefit.

Assessing Fall Risk

All community dwelling adults aged 65 and older should be assessed annually for fall risk. This can be done at the Welcome to Medicare, Annual Medicare, or other visit. Fall etiology involves both factors intrinsic to the patient and also environmental factors. It is important to important to focus on those factors that can be modified (Table 1).

Table 1. Potentially Reversible Risks for Falls	
Balance problems	Muscle weakness
Fear of falling	Postural hypotension
Foot and shoe problems	Psychoactive medications
Home hazards	Vision problems

In lieu of a more formal Timed Up-and-Go test or other assessment, simply watching your patient walk into the exam room and sit or rise from a chair can quickly give you a sense is there are problems with weakness, deconditioning, gait, balance, and stability.

Medical assistants can be trained to assess fall risk at patient check in by performing the observations just noted and asking questions about falls. Furthermore, design and implementation of an electronic health record fall template, with triggered referrals based on clinical findings can help to guide fall risk encounters. Importantly, if found to be at risk of falling, "Fall Risk" should be added to the patient's problem list, so that all care providers can consider this risk in their care of the patient.

The most predictive question to assess fall risk is: "Have you fallen in the past year?" Additional questions may include: If yes, "How often?" "Were you injured?" "Do you feel unsteady when standing or walking?" and, "Do you worry about falling?" This last question is of special importance.

TIPS

- "Have you fallen in the past year?" is the most predictive question for detecting high fall risk.
- Ask about fear of falling. It can affect even high-functioning older adults, causing them to decrease their physical activity and creating a downward spiral of deconditioning and a still higher risk of falling.
- Refer deconditioned elders for physical therapy rather than initially recommending a gym or exercise program.
- Many communities have robust fall resources – check your local health department, fire department, Fall Prevention Consortium, or Area Agency on Aging to find out about local resources.

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Fear of falling becomes more common as people age, surprisingly even among those who have not fallen. Fear of falling often leads older adults to avoid activities that require walking in unknown areas or participating in physical recreation. The latter, in turn, can lead to further deconditioning and subsequently, an even higher risk of falling.

Interventions to Reduce Fall Risk

Medication Review. A first step in reducing fall risk is a medication review to identify medications that can contribute to falls including sedative hypnotics, anxiolytics, antidepressants) and antipsychotics (including typical or atypical antipsychotics). Such medications should be withdrawn or doses reduced if at all possible, with appropriate tapering if indicated.

Address Environmental Hazards. Home environmental hazards, which are common, should also be addressed. Many fire departments now have programs to assist in home environmental assessment and adaptation or modification of the environment as needed. In addition, many older adults qualify for an in-home home health safety check to assist in alleviation of home hazards. Your local Area Agencies on Aging may have such a program and may be able to assist with installation of safety equipment for those with low incomes. Further, patient education materials on home hazards and a do-it-yourself home safety check are available on the CDC's STEADI website (www.cdc.gov/steadi).

Address Fear of Falling. For patients who express a fear of falling, many communities (check with your Area Agency on Aging, Health Department, or Health Care System) have community-based fall prevention courses such as "A Matter of Balance," which have been shown to decrease the fear of falling through fall risk education and support, and are very helpful in teaching strategies to avoid falling.

Physical Therapy and Exercise Programs. The aforementioned courses often lack an exercise program incorporating balance, gait, and strength training, so be sure to refer the patients for physical therapy (PT) or an exercise program in addition to these community-based courses. PT referral should be made when an older adult is deconditioned and not otherwise able to participate in an exercise program. Further, new evidence on poor balance indicates that a combined "dual task" balance training regimen such as Tai Chi, or ballroom dancing, is superior in improving balance over more static balance training.

Other Interventions. Other fall interventions to consider include annual eye exams; management of foot problems and footwear; assessment of postural blood pressure, heart rate and rhythm; assessment of osteoporosis risk; assessment of cognitive impairment and neurological examination; examination of neurological function, muscle strength, proprioception, reflexes, and tests of cortical, extrapyramidal, and cerebellar function; assessment of urinary incontinence; screening for depression; and vitamin D supplementation of at least 800 IU per day to older persons with proven or suspected vitamin D deficiency.

Patient Education

For those patients with high health literacy and good computer skills, or who are accompanied by engaged caregivers with those skills, you can refer them directly to the sites listed in Table 2. In addition, provide an information sheet with local resources for patient referrals to community fall prevention support programs.

Table 2. Fall Resources for Patients
STEADI Fall Prevention Program https://www.cdc.gov/STEADI/
National Council on Aging https://www.ncoa.org/healthy-aging/fallsprevention/
The Fall Prevention Center of Excellence www.stopfalls.org

Primary care providers can make a big difference in the care of older adults at high fall risk. A fall risk assessment and intervention need not take too much time if helpful tools are kept on hand and a template is used. Further, there are now codes for reimbursement of this work by PCPs and their teams.

References and Resources

Final Update Summary: Falls Prevention in Older Adults: Counseling and Preventive Medication. U.S. Preventive Services Task Force. September 2016. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/falls-prevention-in-older-adults-counseling-and-preventive-medication

American Geriatrics Society/British Geriatrics Society Fall Guideline http://www.americangeriatrics.org/files/documents/health_care_pros/Falls.Summary.Guide.pdf

Centers for Disease Control and Prevention. Stopping Elderly Accidents, Deaths and Injuries (STEADI). www.cdc.gov/steadi

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