

The Role of the Physician in Promoting Fall Prevention for Older Adults

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“We are all one fall away from medical treatment, from hospitalization, from disability, from forced retirement, or a nursing home.”¹

Fernando Torres-Gil, Ph.D., Associate Dean for Academic Affairs, School of Public Policy and Social Research, University of California, Los Angeles

As the proportion of older adults increases in the population, the number of patients over 65 years of age who fall will increase dramatically. These falls can be just as devastating to patients as myocardial infarctions, strokes, and pneumonia, yet relatively little attention has been paid to this syndrome in common everyday practice. Since it has been shown that falls, in many instances, can be prevented with an aggressive prevention program, it makes sense that much more awareness, education, and involvement of physicians in fall prevention needs to become reality. In fact, proper assessment, management and referral could—and should—become the standard of practice.

Falls in the older adult patient population present unique challenges to physicians and other caregivers, since the etiology of these falls in most cases involves a multitude of known risk factors. To even *have* the knowledge of these risk factors, let alone sort out these individual risk factors in every patient who falls, can be very difficult, frustrating and time-intensive for any practitioner. Coupled with the normal challenges in dealing with older adult patients—such as poor historical reliability and the need to confirm established home support systems—it is clear why the average physician has little success in preventing falls in older adults.



Physicians often deal with older adult patients who have fallen or fall regularly, yet there are no specific tools readily available to primary practitioners to identify and treat those patients who are at risk for future falls. With the availability of a fall prevention clinic or program, the physician has assistance in managing these challenging patients. Throughout the fall prevention literature, the most successful programs are those that include a comprehensive risk assessment and involve multiple interventions.² This type of resource management is most likely too complex and time-consuming for the average practitioner, and this struggle could lead to failure

¹ *Creating a California Blueprint for Fall Prevention: Proceedings of a Statewide Conference*. Sacramento California. February 5-6, 2003. Page 21.

² RAND. *Fall Prevention Interventions in the Medicare Population*. Prepared for Centers for Medicare and Medicaid Services. 2003.

and perhaps medical liability. Relief from this diagnostic and therapeutic burden can therefore come by virtue of a fall prevention clinic.

Everybody wins when patients are referred to established fall prevention clinics and programs. Patients receive comprehensive evaluation of their risk factors, and multi-disciplinary, targeted interventions in a cohesive, organized manner not available in any other venue. Doctors are offered an excellent resource for assistance with these complex patients who repeatedly come to their offices after falling, and these doctors will be gratified that a solution is perhaps finally at hand. And with the refinement of reimbursement by third party payers, hospitals can offer a unique community service while becoming fiscally stronger with these programs. These advantages for all should be stressed when developing fall prevention clinics.



Since many interventions involve physical and occupational therapy, on-site clinics in the physical therapy or rehabilitation department make sense. Holding the clinic at an outpatient clinic site at the hospital could work also, as long as appointments with physical/occupational therapy staff are readily available. One individual or a small team of individuals needs to function as the clinic case manager(s), providing coordination of assessment and appropriate intervention. Also, a clinic case manager will need to follow-up with subsequent interventions and act as a liaison between the clinic, the primary physician, the pharmacist and other fall prevention clinic staff. Training staff for the fall prevention clinic will also be necessary. Some extra equipment, such as balance assessment machines, is ideal but optional. Adequate public relations for the clinic are needed as well to introduce the medical staff and community to this unique entity.

In summary, fall prevention clinics make perfect sense. The science of falls has evolved enough to offer more definitive solutions to a daunting epidemiological problem. Prevention of falls saves bones, brains and lives; spares physicians countless hours of frustration; and makes hospitals stronger partners in their communities.

For more information on development of hospital-based fall prevention clinics including referral and reimbursement guidelines, contact the Michigan Department of Community Health Injury and Violence Prevention Section at (517) 335-9517 or esdalea@michigan.gov for a manual *Comprehensive Fall Prevention for Community-Dwelling Older Adults: Planning for Success in Identifying and Referring Older Adults Through Hospital-Based Programs*. The manual is also available for download at www.michigan.gov/injuryprevention.

Three comprehensive interdisciplinary fall prevention clinics in Michigan offer evidence-based assessment and treatment services for community-dwelling older adults:

StrongSteps Program
Generation Care
945 E. Sherman Blvd.
Muskegon, Michigan 49444
231-737-4374
hollyld@generationcare.org

Staying Safe and Independent Fall Prevention Program
Crittenton Hospital Medical Center
1720 S. Livernois
Rochester, Michigan 48307
(248) 652-5380

Genesys Fall Prevention Program
Genesys Regional Medical Center
Grand Blanc Therapy Services
8423 North Holly Road
Grand Blanc, Michigan 48439
(810) 695-1200

Recreational exercise offers fall prevention activities ideal for older adults at low risk of falls.³ Recreational exercise programs include Tai Chi, walking clubs, and *EnhanceFitness*, a national evidence-based exercise program for older adults offered through diverse healthcare, senior and fitness settings. All of these exercise programs help older adults to build strength, balance and endurance to prevent falls.

Matter of Balance is an evidence-based community program led by lay leaders that helps older adults reduce their fear of falling and increase their activity levels.

For information on these programs, contact hospitals, fitness programs, Area Agencies on Aging and senior groups in your geographic area.

³ *Creating a California Blueprint for Fall Prevention: Proceedings of a Statewide Conference.* Sacramento California. February 5-6, 2003. Page 8.

The Role of the Physician in Fall Prevention: Clinical Practice Guidelines

Clinical practice guidelines on the prevention of falls in older persons were developed in 2001 by a panel of health care professionals as a joint project of the American Geriatrics Society (AGS), the British Geriatrics Society and the American Academy of Orthopaedic Surgeons.⁴

The purpose of these guidelines is to assist health care professionals in assessing fall risk in older persons and in managing older persons who have fallen or are at increased risk for falling. An updated version of these guidelines will be available on the AGS website in late 2006.

(<http://www.americangeriatrics.org>). The following will be included:

- ❑ A pocket card algorithm for community older adult services and primary care providers.
- ❑ Tools for consumers to help them identify fall risks.
- ❑ Support for a multi-factorial assessment and tailored/customized prescription.
- ❑ A recommendation that physical therapy be included in treatment to help address balance, gait, mobility and safety deficits.

The recommendations of this expert panel regarding fall prevention assessment and treatment are presented here:

Fall Risk Assessment

- I. As part of the routine care for older persons not presenting after a fall:
 - **Ask patients or caregivers yearly about falls:** Persons who report a single fall should be observed as they stand up from a chair without using their arms, walk several paces, turn, return to the chair and sit down. This test (the Timed Up and Go Test) is an important predictor of falls. For more detail, see page 7, guideline #3.)
 - Those demonstrating no difficulty need no further assessment.
- II. For older persons presenting after one or more falls, those who have abnormal gait and/or balance or who report recurrent falls:
 - Perform a fall evaluation, consisting of: history of fall circumstances, medications, medical problems, and mobility levels; examination of vision, gait, balance, lower extremity function, neurological function, cerebellar function and cardiovascular status.

Multi-factorial Interventions to Manage Falls

- I. For persons living in their own homes:

⁴American Geriatrics Society. *Guideline for the Prevention of Falls in Older Persons*. JAGS. 2001; 49:664-672.

- Provide gait training and advice on assistive devices; review/modify medications; provide exercise programs with balance training; treat postural hypotension; modify environmental hazards; and treat cardiovascular disorders/arrhythmias.
- II. For persons in long-term or assisted living settings:
- Provide staff education programs, gait training and advice on assistive devices and review/modify medications.
- III. For persons in acute hospital settings:
- Evidence is insufficient to recommend interventions.

Although multi-factorial interventions are more effective, single interventions to manage falls are also beneficial. Exercise programs that promote balance and muscle strength have the strongest evidence base.

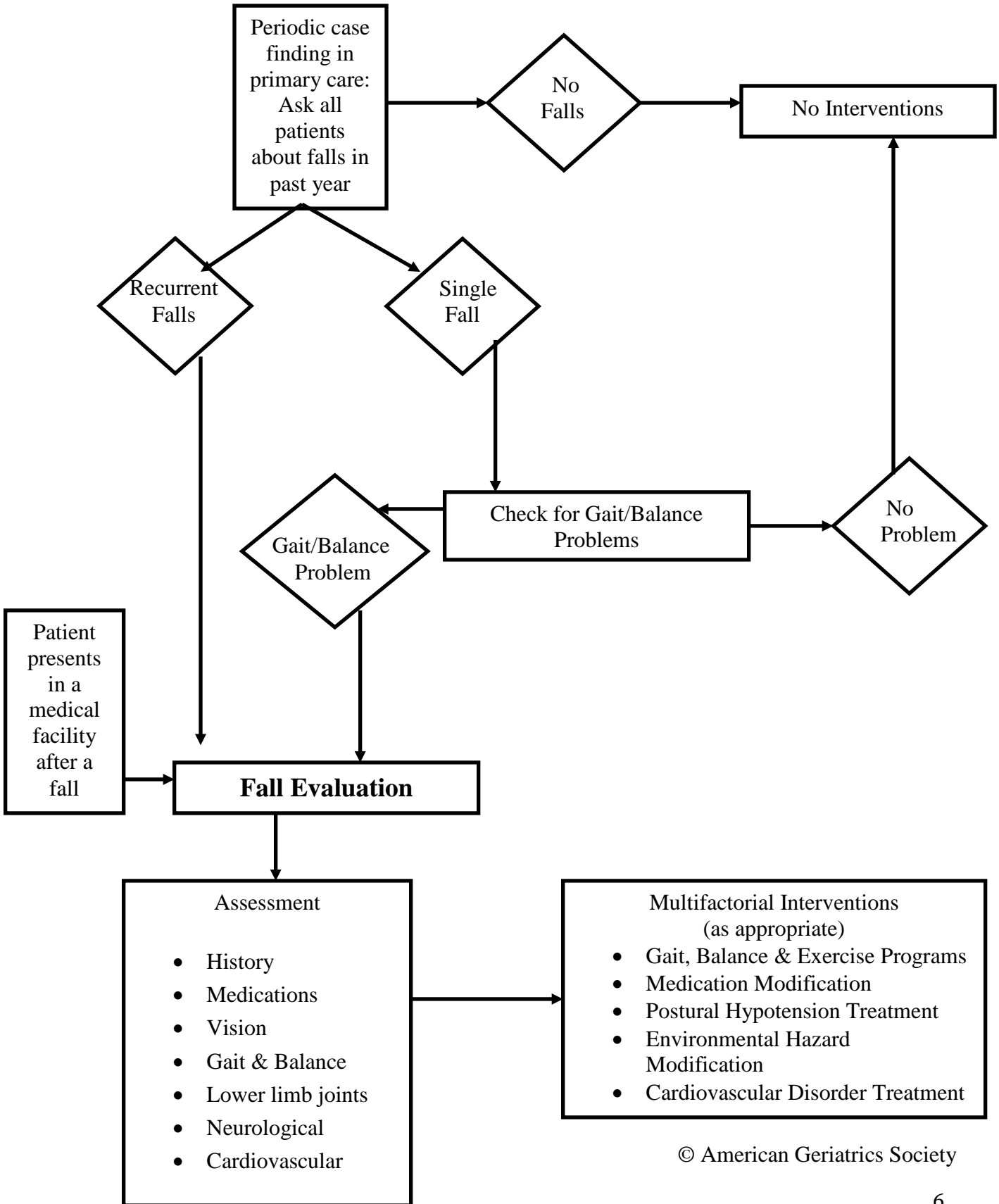
- I. Exercise programs, especially those incorporating balance training, are beneficial for persons with recurrent falls.
- II. Perform home environmental assessment/modifications for persons returning home after hospitalizations.

The AGS algorithm summarizing the assessment and management of falls is presented on the following page.

Reimbursement Tip

Medicare will pay for a fall risk assessment in physical therapy if the physician uses the ICD code for history of falling. **Physicians can use an ICD-9 diagnosis code V15.88 (or ICD-10 code Z91.81 after 10/1/14) that is “other specified personal history representing hazards to health.”** This code is not payable to therapists, but can be included as a physician note.

Algorithm Summarizing the Assessment and Management of Falls



Why Should Physicians Talk to Their Older Adult Patients About Falling?

Physicians do not consistently ask older adult patients about their falls. Studies conducted by Mary E. Tinetti, M.D. of the Yale School of Medicine, a leading fall prevention practitioner and researcher, have identified several of the reasons. Reasons include that physicians may not know that falling is a preventable health condition, may not be aware of the evidence-based and reimbursable interventions to treat falls and may be burdened by the increasing number of prevention and disease management guidelines that they are expected to follow.^{5 6} Physicians may also accept falls as part of aging.

Focus groups conducted by the Michigan Department of Community Health's (MDCH) Injury and Violence Prevention Section in 2004 revealed that older adults generally do not mention their falls to their physician, families or caregivers. There are many reasons for this, among them that older adults regard falls as an "inevitable part of aging" and they may be fearful of being placed in a nursing home.

At a minimum, the physician should ask the older adult patient about their falls. This could be a powerful motivator for behavior change such as attending a balance or fall prevention clinic, changing medications that contribute to fall risk or starting an exercise program.

The Michigan Fall Prevention Partnership recommends the following guidelines to assist physicians in talking to their older adult patients about falls:

1. Ask patients or caregivers yearly about falls by asking if they have ever had a fall with or without injury or had a "near fall," where they almost fell down.
2. Provide simple, yet powerful, messages to patients and families about how falls can be prevented or managed so that older adults can live independently and safely in their own homes.
3. One simple yet effective screening tool is to have the patient perform a Timed Up and Go test. Observe the patient as they get up from a chair, walk 10 feet, return and sit down. If the patient takes greater than **19 seconds**, then refer for further assessment in physical therapy. The typical order is "gait assessment," with the diagnosis of "difficulty walking."
4. Consider having a standing order referral pad for all patients needing to be referred to exercise programs or to physical therapy for fall assessment. Medicare will pay for a fall risk assessment in physical therapy if the physician uses the ICD-9 code for history of falling.
5. Refer patients to exercise programs—especially those programs incorporating balance training—which are beneficial for persons with recurrent falls.
6. To enhance patient education, use fall prevention brochures and posters such as *What YOU Can Do to Prevent Falls* and *Check for Safety* that can be downloaded from the Centers for Disease Control and Prevention web site (<http://www.cdc.gov/ncipc/pub-es/toolkit/brochures.htm>)

⁵ American Geriatrics Society. *Where is the Vision for Fall Prevention?* JAGS 49:676-677. 2001.

⁶Baker, D.I., et.al. *Dissemination of an Evidence-Based Multicomponent Fall Risk Assessment and Management Strategy Throughout a Geographic Area.* JAGS 53:675-680. 2005.

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