eCQM Title: Falls: Screening for Future Fall Risk

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Measurement Period: January 1, 20XX through December 31, 20XX

Measure Steward: National Committee for Quality Assurance

Measure Developer: American Medical Association (AMA)

Measure Developer: National Committee for Quality Assurance

Measure Developer: PCPI(R) Foundation (PCPI[R])

Endorsed By: None

Description: Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period

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Measure Scoring: Proportion

Measure Type: Process

Stratification: None
As the leading cause of both fatal and nonfatal injuries for older adults, falls are one of the most common and significant health issues facing people aged 65 years or older (Schneider, Shubert and Harmon 2010). Moreover, the rate of falls increases with age (Dykes et al. 2010). Older adults are five times more likely to be hospitalized for fall-related injuries than any other cause-related injury. It is estimated that one in every three adults over 65 will fall each year (Centers for Disease Control and Prevention 2015). In those over age 80, the rate of falls increases to fifty percent (Doherty et al. 2009). Falls are also associated with substantial cost and resource use, approaching $30,000 per fall hospitalization (Woolcott et al. 2011). Identifying at-risk patients is the most important part of management, as applying preventive measures in this vulnerable population can have a profound effect on public health (al-Aama 2011). Family physicians have a pivotal role in screening older patients for risk of falls, and applying preventive strategies for patients at risk (al-Aama 2011).

Clinical Recommendation Statement

All older persons who are under the care of a health professional (or their caregivers) should be asked at least once a year about falls. (AGS/BGS/AAOS 2010)

Older persons who present for medical attention because of a fall, report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should have a fall evaluation performed. This evaluation should be performed by a clinician with appropriate skills and experience, which may necessitate referral to a specialist (e.g., geriatrician). (AGS/BGS/AAOS 2010)

Improvement Notation

A higher score indicates better quality

Reference


Reference


Reference


Reference


Reference


Reference


Reference


Definition

Screening for Future Fall Risk: Assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure, however potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test.

Guidance

None

Transmission Format

TBD

Initial Population

Patients aged 65 years and older with a visit during the measurement period

Denominator

Equals Initial Population

Denominator Exclusions

Exclude patients whose hospice care overlaps the measurement period.

Exclude patients who were non-ambulatory at some point in the measurement period.
Falls: Screening for Future Fall Risk

**Numerator**: Patients who were screened for future fall risk at least once within the measurement period

**Exclusions**: Not Applicable

**Denominator**: None

**Exclusions**: None

**Supplemental Data Elements**: For every patient evaluated by this measure also identify payer, race, ethnicity and sex

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### Population Criteria

#### Initial Population

- exists ( ["Patient Characteristic Birthdate": "Birth date"] BirthDate
  where Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period") >= 65 )

- and exists "Qualifying Encounter"

#### Denominator

- "Initial Population"

#### Denominator Exclusions

- "Assessed as Not Ambulatory During Measurement Period"
  
- or ( "Assessed as Not Ambulatory Prior to Measurement Period"
    and not exists ( "Ambulatory Status Assessment During Measurement Period" )
  )

- or Hospice."Has Hospice"

#### Numerator

- exists ["Assessment, Performed": "Falls Screening"] FallsScreen
  where FallsScreen.authorDatetime during "Measurement Period"

#### Numerator Exclusions

- None

#### Denominator Exceptions

- None

#### Stratification

- None
Definitions

**Ambulatory Status Assessment During Measurement Period**

`AmbulatoryStatusAssessment.authorDatetime during "Measurement Period" and AmbulatoryStatusAssessment.result is not null`

**Assessed as Not Ambulatory During Measurement Period**

`AmbulatoryStatusAssessed.result in "Patient not ambulatory"`

**Assessed as Not Ambulatory Prior to Measurement Period**

`PriorAmbulatoryStatus.authorDatetime before start "Measurement Period" sort by authorDatetime

`PriorAmbulatoryStatus.result in "Patient not ambulatory"`

**Denominator**

"Initial Population"

**Denominator Exclusions**

"Assessed as Not Ambulatory During Measurement Period"

or ( "Assessed as Not Ambulatory Prior to Measurement Period"

and not exists ( "Ambulatory Status Assessment During Measurement Period"

) or Hospice."Has Hospice"

**Hospice.Has Hospice**

`DischargeHospice.dischargeDisposition as Code ~ "Discharge to home for hospice care (procedure)"

or DischargeHospice.dischargeDisposition as Code ~ "Discharge to healthcare facility for hospice care (procedure)"

and DischargeHospice.relevantPeriod ends during "Measurement Period"

) or exists ( ["Intervention, Order": "Hospice care ambulatory"] HospiceOrder

where HospiceOrder.authorDatetime during "Measurement Period"

) or exists ( ["Intervention, Performed": "Hospice care ambulatory"] HospicePerformed

where HospicePerformed.relevantPeriod overlaps "Measurement Period"

)

**Initial Population**

`BirthDate.birthDatetime, start of "Measurement Period")>= 65`

and exists "Qualifying Encounter"

**Numerator**
exists ["Assessment, Performed": "Falls Screening"] FallsScreen
    where FallsScreen.authorDatetime during "Measurement Period"

▲ Qualifying Encounter

( ["Encounter, Performed": "Office Visit"]
    union ["Encounter, Performed": "Annual Wellness Visit"]
    union ["Encounter, Performed": "Preventive Care Services - Established Office Visit, 18 and Up"]
    union ["Encounter, Performed": "Preventive Care Services-Initial Office Visit, 18 and Up"]
    union ["Encounter, Performed": "Home Healthcare Services"]
    union ["Encounter, Performed": "Ophthalmological Services"]
    union ["Encounter, Performed": "Preventive Care Services-Individual Counseling"]
    union ["Encounter, Performed": "Discharge Services - Nursing Facility"]
    union ["Encounter, Performed": "Nursing Facility Visit"]
    union ["Encounter, Performed": "Care Services in Long-Term Residential Facility"]
    union ["Encounter, Performed": "Audiology Visit"] ) ValidEncounter
    where ValidEncounter.relevantPeriod during "Measurement Period"

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Functions

▲ Global.CalendarAgeInYearsAt(BirthDateTime DateTime, AsOf DateTime)

years between ToDate(BirthDateTime) and ToDate(AsOf)

▲ Global.ToDate(Value DateTime)

DateTime(year from Value, month from Value, day from Value, 0, 0, 0, timezone from Value)

Terminology

- code "Birth date" ("LOINC Code (21112-8)"
- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)"
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)"
- valueset "Ambulatory Status" (2.16.840.1.113883.3.464.1003.118.11.1219)
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Audiology Visit" (2.16.840.1.113883.3.464.1003.101.12.1066)
- valueset "Care Services in Long-Term Residential Facility" (2.16.840.1.113883.3.464.1003.101.12.1014)
- valueset "Discharge Services - Nursing Facility" (2.16.840.1.113883.3.464.1003.101.12.1013)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
**Falls: Screening for Future Fall Risk**

- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Falls Screening" (2.16.840.1.113883.3.464.1003.118.12.1028)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice care ambulatory" (2.16.840.1.113762.1.4.1108.15)
- valueset "Nursing Facility Visit" (2.16.840.1.113883.3.464.1003.101.12.1012)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Patient not ambulatory" (2.16.840.1.113883.3.464.1003.118.12.1009)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Preventive Care Services - Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services-Individual Counseling" (2.16.840.1.113883.3.464.1003.101.12.1026)
- valueset "Preventive Care Services-Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Race" (2.16.840.1.114222.4.11.836)

**Data Criteria (QDM Data Elements)**

- "Assessment, Performed: Ambulatory Status" using "Ambulatory Status (2.16.840.1.113883.3.464.1003.118.12.1219)"
- "Assessment, Performed: Falls Screening" using "Falls Screening (2.16.840.1.113883.3.464.1003.118.12.1028)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Care Services in Long-Term Residential Facility" using "Care Services in Long-Term Residential Facility (2.16.840.1.113883.3.464.1003.101.12.1014)"
- "Encounter, Performed: Discharge Services - Nursing Facility" using "Discharge Services - Nursing Facility (2.16.840.1.113883.3.464.1003.101.12.1013)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Encounter, Performed: Nursing Facility Visit" using "Nursing Facility Visit (2.16.840.1.113883.3.464.1003.101.12.1012)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services (2.16.840.1.113883.3.526.3.1285)"
- "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up" using "Preventive Care Services - Established Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1025)"
- "Encounter, Performed: Preventive Care Services-Individual Counseling" using "Preventive Care Services-Individual Counseling (2.16.840.1.113883.3.464.1003.101.12.1026)"
- "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up" using "Preventive Care Services-Initial Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Intervention, Order: Hospice care ambulatory" using "Hospice care ambulatory (2.16.840.1.113762.1.4.1108.15)"
- "Intervention, Performed: Hospice care ambulatory" using "Hospice care ambulatory (2.16.840.1.113762.1.4.1108.15)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Patient Characteristic Birthdate: Birth date" using "Birth date (LOINC Code 21112-8)"

**Supplemental Data Elements**

- **SDE Ethnicity**
  - "Patient Characteristic Ethnicity": "Ethnicity"

- **SDE Payer**
  - "Patient Characteristic Payer": "Payer"

- **SDE Race**
  - "Patient Characteristic Race": "Race"

- **SDE Sex**
[[Patient Characteristic Sex": "ONC Administrative Sex"]]

**Risk Adjustment Variables**

None

| Measure Set | None |