Falls: Screening for Future Fall Risk

Measure Title: Falls: Screening for Future Fall Risk

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<th>eCQM Title</th>
<th>eCQM Identifier (Measure Authoring Tool)</th>
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<td>139</td>
<td>9.2.000</td>
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<th>NQF Number</th>
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<tr>
<td>Not Applicable</td>
<td>January 1, 20XX through December 31, 20XX</td>
<td>National Committee for Quality Assurance</td>
<td>American Medical Association (AMA)</td>
<td>PCPI(R) Foundation (PCPI[R])</td>
<td>None</td>
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**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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**Rationale**

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).

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/AAGS 2010)

**Clinical Recommendation Statement**

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/AAGS 2010)

**Improvement Notation**

A higher score indicates better quality

**Reference**


**Definition**

Screening for Future Fall Risk: Assessment of whether an individual has experienced a fall or problems with gait or

Fall: A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

This eCQM is a patient-based measure.

Transmission Format TBD

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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

Hospice."Has Hospice"

▲ Numerator

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

▲ Numerator Exclusions

None

▲ Denominator Exceptions

None

▲ Stratification

None

Definitions

▲ Denominator

"Initial Population"

▲ Denominator Exclusions

Hospice."Has Hospice"

▲ Hospice.Has Hospice

- exists ( ["Encounter, Performed": "Encounter Inpatient"] DischargeHospice where ( DischargeHospice.dischargeDisposition ~ "Discharge to home for hospice care (procedure)" or DischargeHospice.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)" ) )
- and DischargeHospice.relevantPeriod ends during "Measurement Period"

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

Guidance

This version of the eCQM uses QDM version 5.5. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
where HospiceOrder.authorDatetime during "Measurement Period"
)
or exists ( ["Intervention, Performed": "Hospice care ambulatory"] HospicePerformed
where HospicePerformed.relevantPeriod overlaps "Measurement Period"
)

▲ Initial Population
exists ( ["Patient Characteristic Birthdate": "Birth date"] BirthDate
where Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 65
) and exists "Qualifying Encounter"

▲ Numerator
exists ["Assessment, Performed": "Falls Screening"] FallsScreen
where FallsScreen.relevantDatetime 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, 0, timezoneoffset 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 "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)
- 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 "Hospital 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 "Payer" (2.16.840.1.114222.4.11.3951)
- 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: Falls Screening" using "Falls Screening (2.16.840.1.113883.3.464.1003.118.12.1026)"
- "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: EncountertimeP" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "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 (2.16.840.1.113883.3.464.1003.101.12.1026)"
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