Falls: Screening for Future Fall Risk

**eCQM Title:** Falls: Screening for Future Fall Risk

**eCQM Identifier (Measure Authoring Tool):** 139

**eCQM Version Number:** 9.2.000

**NQF Number:** Not Applicable

**GUID:** bc5b4a57-b964-4399-9d40-667c896f31ea

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

**Measure Steward:** National Committee for Quality Assurance

**Measure Developer:** National Committee for Quality Assurance

**Measure Developer:** American Medical Association (AMA)

**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

**Risk Adjustment:** None

**Rate Aggregation:** None

**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, along with 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/AAGOS 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/AAGOS 2010)

**Improvement Notation:** A higher score indicates better quality

**Reference:**


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.

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.

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.

Transmission Format
TBD

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

Denominator
Equals Initial Population

Exclusions
Exclude patients whose hospice care overlaps the measurement period.

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

Exclusions
Not Applicable

Denominator Exceptions
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"

Exclusions
Hospice."Has Hospice"

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

Exclusions
None

Exceptions
None

Stratification
None

Definitions

Denominator
"Initial Population"

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
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.birthDatetme, 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-Individual Counseling"]
union ( ["Encounter, Performed": "Discharge Services - Nursing Facility"]
union ( ["Encounter, Performed": "Care Services in Long-Term Residential Facility"]
union ( ["Encounter, Performed": "Audiology Visit"]
union 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" (2.16.840.1.113883.3.464.1003.101.12.1008)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice care ambulatory" (2.16.840.1.113883.3.526.3.1285)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.464.1003.101.12.1026)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services - Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1013)
- valueset "Preventive Care Services-Individual Counseling" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Nursing Facility Visit" (2.16.840.1.113883.3.464.1003.101.12.1012)

Data Criteria (QDM Data Elements)

- ["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: Office Visit"] using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
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

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<thead>
<tr>
<th>Measure Set</th>
<th>None</th>
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