Documentation of Falls Screening in the Ralston Practice

Fellows CEQI Project
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Why we chose this topic?

- Fellowship year has made us realize the importance of falls as a syndrome
  - Often not given enough importance
    - Despite having severe long-term consequences
    - Despite a profound economic impact
- This project may help us signify the importance of improvement in documentation of falls in a Geriatric/primary care practice
  - Can be built upon in the future to target high risk populations
Falls: the need for screening

- Significant cause of morbidity and economic burden
  - Affects about 30-40% of community dwelling elders over 65
  - Up to 50% over 80
- Generally under-reported
- Elderly patients have the highest contact with primary care physicians
  - Higher chance of detection
Falls: the need for screening

- Falls lead to
  - Injury and fracture
    - May lead to pressure ulcers, incontinence, etc.
  - Reduced mobility
    - Decreased independence
  - Fear of falling
    - Depression
    - Psychological decline leading to accelerated functional decline
  - Admission to LTC (26%)
  - Decreased quality of life
  - Death
High Risk Populations

- Age >83
- Folstein MMSE score < 20
- CES-D score > 16
- Low BMI (Men < 23, Women < 22.4)
- Visual Impairment ( > 75%)
- Number of words missed on whisper test > 4.8
- Urinary incontinence ( > 1 time/wk)
- Score on Physical-performance battery ( < 3.9)
- Any disability in ADL
- Number of non-injury related hospitalizations ( > 2)
- History of > 1 fall with serious injury
Should there be targeted screening?

- Evidence to tailor fall-prevention programs in primary care
  - Leading to 9% lower fall-related injuries
  - Leading to 11% lower fall-related medical services use
    - Potential savings of $21 million in health care costs on the basis of an average acute care cost of $12,000 per event

A Serious Fall-Related Injuries

B Fall-Related Use of Medical Services

Potential Problems with Screening

- Unclear definition of falls across specialties
- In a smaller, community setting, inadequate access to a multi-disciplinary team leading to
  - Lack of or under-screening
- Under-reporting by the patient
  - Less importance given to falls
  - Lower rate of adherence to prevention strategies
Future Implications

- Quality of a Geriatric Practice judged on the basis of
  - Number of LTC admission and/or
  - Numbers of falls
  - Percentage of patients being screened
- Future projects looking at
  - Number of falls in our practice versus the national statistics
  - Number of admissions to LTC as a result of falls in the Penn system versus national statistics
Current Practice

- What is Ralston clinic doing?
  - MA screening
  - MA documentation
  - Yellow alert box
Methods

- Clinical question
  - Are providers screening for falls appropriately at Ralston clinic?
- Inclusion criteria
  - Age > 65
  - In practice for at least 3 yrs
  - Has to have been seen at least yearly
- Exclusion criteria
  - New patients
  - Osteoporosis clinic patients
Methods

- Audit charts
  - 10 charts for 6 attendings
  - Charted data onto table
- Survey with 4 questions
  - Are you aware MAs performing yearly fall assessment?
  - Are you aware of site of documentation?
  - Is fall assessment part of your yearly assessment?
  - Any suggestions for improvement in screening?
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<th>Age</th>
<th>Gender</th>
<th>Date seen within last year</th>
<th>How often were they screened for falls in past 3 years (include dates)</th>
<th>Assistive devices (if any)</th>
<th>Screened appropriately?</th>
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Demographics

Gender

- Male: 68%
- Female: 32%
Demographics

Age

- 65 - 70: 23%
- 71 - 75: 17%
- 76 - 80: 17%
- 81 - 85: 17%
- >85: 20%
Results/Analysis

Total Screened Appropriately

- Screened appropriately
- Not screened appropriately

50% 50%
Results/Analysis

% screened by gender

- Male
- Female

- 26
- 61
Results/Analysis

% screened by age

- 65 - 70
- 71 - 75
- 76 - 80
- 81 - 85
- >85

Counts:

- 20
- 30
- 58
- 64
- 64
Results/Analysis

- Survey results
  - 2/4 aware of screening by MAs
  - Documentation
  - All assess at least yearly
  - Suggestions for improvement
- Assistive devices
  - Documentation
Conclusions

- It is well established that screening for falls should be done at least annually
- Our review of 60 charts revealed only 50% documentation for screening of falls
- Females and older patients tend to have better documentation for screening of falls
- There does not seem to be a uniform approach to documenting screening of falls or the role of MAs in doing so
Limitations

- No dedicated section for falls screening in notes
- Small study of 60 charts and only 4 of 8 responses to the surveys
Discussion

- EPIC documentation
  - Musculoskeletal tab
  - Template
  - Copy note forward
  - Clinical reminders
  - Free typing
  - Any others?
Discussion

- Observations
  - Copy note forward phenomenon – helpful or deceptive?
    - Thoughts
    - Adaptations
  - “All review of systems negative”
Discussion

- What are some ways to improve alerts for screening for falls (or for any other screens for that matter)?

- What are some ways to help better document “routine health care maintenance” items?

- In a busy geriatric practice, should all HCM visits be scheduled separately with an NP? How do we go about selecting which patients best benefit from this?
Potential Future Projects

- Repeat of study post any intervention that can be proposed and undertaken by future fellows

- Repeat of study post having a dedicated NP to go through routine screening

- Follow patients longitudinally for adverse outcomes such as falls, osteoporotic fractures and NH placements
THANK YOU
References


• Tinetti et al. “Falls, Injuries due to Falls, and the Risk of Admission to a Nursing Home”, NEJM 1997; 337: 1279-84