

## Fall-Risk Evaluation and Management: Challenges in Adopting Geriatric Care Practices

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One third of older adults fall each year, placing them at risk for serious injury, functional decline, and health care utilization. Despite the availability of effective preventive approaches, policy and clinical efforts at preventing falls among older adults have been limited. In this article we present the burden of falls, review evidence concerning the effectiveness of fall-prevention services, describe barriers for clinicians and for payers in promoting these services, and suggest strategies to encourage greater use of these services. The challenges are substantial, but strategies for incremental change are available while more broad-based changes in health care financing and clinical practice evolve to better manage the multiple chronic health conditions, including falls, experienced by older Americans.

*Key Words: Falls interventions, Falls prevention, Fall-risk evaluation, Medicare, Preventive approaches*

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Despite the high prevalence and adverse effect of falls among older adults, prevention receives little attention in clinical practice. This neglect reflects, in part, a health care system focused on the episodic diagnosis and treatment of individual diseases rather than ongoing evaluation and management of the multiple simultaneous conditions experienced by many older adults (Berenson & Horvath, 2003; Tinetti & Fried, 2004; Wagner, Austin, & von Korff, 1996). The widespread incorporation of fall-prevention services into practice would require the adoption of new or modified services on the part of health care providers, payers, and older adults. The perspective of older adults, including the lack of a common language concerning falls and fall consequences, has recently been described in the literature (Zecevic, Salmoni, Speechley, & Vandervoort, 2006). In this article, we focus on the perspectives of providers and payers.

Our objectives are to (a) summarize the evidence revealing the burden of falls and supporting the effectiveness of fall-prevention services for older Americans living in the community; (b) delineate the barriers to promoting fall-prevention services from the perspectives of health care providers and payers in the United States; and (c) present strategies that could be implemented in the near term to improve the delivery and financing of care for

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community-living older Americans at risk for falls. The key groups of health care providers relevant to fall-risk evaluation and management include physicians, nurses, rehabilitation providers (i.e., physical and occupational therapists), and home care agencies. Our focus is on the fee-for-service component of Medicare, which covered 87% of Medicare beneficiaries in 2002.

## **The Burden of Falls**

### *Prevalence and Morbidity of Falls*

One third, or approximately 30%, of community-living adults who are older than 65 years of age fall each year; the proportion increases to 50% among those aged 80 years and older (Bergland & Wyller, 2004; Burt & Fingerhut, 1998; Hornbrook et al., 1994; Sattin, 1992). Approximately 10% of these falls result in a serious fall injury such as a fracture, serious soft-tissue injury, or head injury (Finkelstein, Fiebelkorn, & Binder, 2004; Nevitt, Cummings, & Hudes, 1991; Sattin; Tinetti, Doucette, Claus, & Marottoli, 1995). More frequent falling is an independent predictor of the likelihood of experiencing a serious injury such as a hip fracture (Schwartz, Nevitt, Brown, & Kelsey, 2005). Epidemiological studies suggest that fall events are direct and independent contributors to restricted activity, functional decline, and skilled nursing facility placement, rather than merely markers of poorer health status (Gill, Desai, Gahbauer, Holford, & Williams, 2001; Kosorok, Omenn, Diehr, Koepsell, & Patrick, 1992; Tinetti & Williams, 1997, 1998). Fear and poor self-confidence are probable mechanisms explaining the loss of function following falls without serious injury (Tinetti & Williams, 1998; Yardley & Smith, 2002). Recognizing falls' frequency, morbidity, and effect on functioning, quality of life, and health care utilization, the Department of Health and Human Services declared injury prevention, including fall prevention, one of the 10 leading health indicators in Healthy People 2010 (Department of Health and Human Services, 2005).

### *Etiology of Falls*

Conditions known to increase the risk of falling among community-living older adults include impairments in balance, gait, cognition, vision, and muscle strength; the use of four or more prescription medications, particularly psychoactive medications; depressive symptoms; postural hypotension; and arthritis (Bergland & Wyller, 2004; Sattin, 1992; Tinetti, Speechley, & Ginter, 1988; Tinetti et al., 1995). Environmental hazards such as stairs and obstacles in the walking path and unsafe behaviors

such as rushing further increase the risk of falling and experiencing a serious injury (Studenski et al., 1994). The risk of falling increases as the number of these factors increases, suggesting that falling is a multifactorial health condition that results from the accumulated effects of coexisting conditions and their treatment (Nevitt et al., 1991; Tinetti et al., 1988).

### *Cost Estimates of Falls and Fall Injuries Among Older Americans*

Falls account for approximately 10% of visits to an emergency department and 6% of hospitalizations among Medicare beneficiaries (Englander, Hodson, & Terregrossa, 1996). Rizzo and colleagues (1998) reported that, relative to the cost for community-living older adults of similar health status who had not fallen, the average additional health cost of experiencing a fall-related injury requiring hospitalization was \$16,000 (\$24,330 in 2002 dollars), after adjustment for age and other comorbidities such as heart disease associated with hospitalization (see also Bishop et al., 2002). This estimate included Medicare-covered hospital, home health care, emergency department, and subsequent nursing home costs. According to data from the National Electronic Injury Surveillance System—All Injury Program (Centers for Disease Control and Prevention [CDC], 2003), in 2002, approximately 388,200 people aged 65 years and older were hospitalized after being treated in emergency departments for fall-related injuries. Multiplying this number by the cost estimate derived by Rizzo and colleagues provides a \$9.4 billion estimate in additional fall-related health care costs to the system in that year. The CDC similarly estimated the added health costs at \$3,560 for the 1.6 million adults aged 65 years and older who required fall-related care in an emergency department but were not hospitalized (CDC, 2005b), resulting in an additional \$5.7 billion in health care costs. This gives a total of \$15.1 billion in fall-related health care costs to the system that year. In an economic analysis conducted by the CDC using incidence data and actual medical payments, the direct cost of fatal and nonfatal fall injuries in 2000 was estimated at 19.5 billion dollars (Finkelstein, Chen, Miller, Corso, & Stevens, 2005). The CDC findings extended the earlier estimates by adding outpatient and physician visits to emergency department and hospital treatments. These figures are of necessity based only on those falls that came to medical attention. Furthermore, existing estimates do not include caregiver time, nonmedical expenditures, decreased quality of life, or loss of functional capacity, all of which are potentially avoidable fall-related costs.

## **Effectiveness of Fall-Risk Evaluation and Management as a Preventive Approach**

### *Effectiveness at Reducing Falls*

A compelling body of evidence, including more than 60 randomized trials, supports the effectiveness of various health-care-based and community-based approaches at reducing the prevalence of falls, although most of the trials have not been large enough to assess the effect on the most serious fall injuries such as hip fracture (Gillespie et al., 2003). A methodologically rigorous review of clinical trials concluded that, although some interventions are of unknown effectiveness, the evidence supporting health-care-based multifactorial strategies among community-living older adults was convincing (Gillespie et al.). Evaluation and management, involving assessment of the multiple known risk factors for falls followed by treatment strategies targeting the identified risk factors, has proved to be the most consistently effective strategy among community-living older adults. It is associated with a 37% reduction in the rate of falls per person-month (Chang et al., 2004). Components of effective evaluation and management strategies studied in the clinical trials included reducing psychoactive medications; reviewing and reducing other medications; using home- or facility-based physical or occupational therapy, including progressive balance, gait, and strength training, and instruction in the proper use of mobility assistive devices such as canes and walkers; management of blood pressure drops on standing, referred to as postural hypotension; attention to visual impairment and other medical conditions; and home safety environmental adaptation and modifications.

Complementing these effectiveness studies, there have been a limited number of cost-effectiveness studies of fall-prevention services (Englander et al., 1996; Gillespie et al., 2003; Miller & Levy, 2000). Although the determination of net savings from fall-prevention services is sensitive to multiple assumptions about the prevalence of risks, effect sizes, and service-related costs, studies have uniformly indicated that such services have net-cost savings for older adults at high risk of falls.

Evidence-based clinical guidelines recommend that community-living older adults who present for medical attention because of a fall, who demonstrate difficulty with balance or walking, or who report recurrent falls in the past year receive fall-risk evaluation and management performed by clinicians with appropriate skills and experience (American Geriatrics Society, British Geriatrics Society, & American Academy of Orthopaedic Surgeons Panel on Falls Prevention, 2001). The guidelines did not specify which groups of health care providers should perform the various components of the fall-risk evaluation or management, although in practice the

components are variously under the purview of physicians, advanced practice registered nurses, rehabilitation specialists, and home care providers.

### **The Evidence–Practice Gap**

Despite the existing evidence and guidelines, the proportion of at-risk Medicare beneficiaries who presently receive fall-risk evaluation and management is unknown; it has not been a topic of beneficiary surveys and no traceable billing code exists. A survey conducted in primary care practices in several areas of the country found that most older adults are not even asked about falls (Wenger et al., 2003), suggesting that fall prevention, including fall-risk evaluation and management, remains largely ignored in clinical practice.

### **Barriers to Providers Offering Fall-Risk Evaluation and Management Services**

The challenges and barriers described here have been reported in the literature by individuals who have attempted to disseminate fall-related evidence (Baker et al., 2005; Reuben, Roth, Kamberg, & Wenger, 2003), or they are consistent with the authors' clinical and research experience with providers and payers concerning the adoption of evidence-based fall-prevention services (see Table 1). The barriers and challenges to diffusing any evidence-based service or innovation into practice have been well chronicled (Berwick, 2003; Bradley, Webster, Baker, Schlesinger, & Inouye, 2005; Institute of Medicine, 2001; Rogers, 1995; Timmermanns & Mauck, 2005). Some of the challenges facing fall-risk evaluation and management, such as time constraints and competing demands, are similar to those facing other services, although they are perhaps of a greater magnitude for fall prevention because of the personnel-intensive nature of the services. Other challenges and barriers, such as knowledge and skills deficits, are somewhat unique to geriatric conditions that do not fit the disease model of clinical care and reimbursement.

### *Time Limitations and Competing Demands*

The time required to perform the total package of currently recommended preventive services in primary care is prohibitive (Yarnall, Pollak, Ostbyte, Krause, & Michener, 2003). In clinical encounters, pressing problems, such as exacerbation of congestive heart failure, usually take precedence over preventive issues. Fall-related interventions such as checking and managing postural blood pressure and medication review and adjustment are particularly time consuming. Fall-risk evaluation and management is not yet a focus of quality assurance initiatives

that encourage or mandate attention to specific health conditions even in the face of limited time and competing demands in clinical encounters (National Committee for Quality Assurance, 2003).

### *Knowledge and Skills Deficits*

Fall-risk evaluation and management, like all multifactorial geriatric health conditions, involves complex decision making and behavioral interventions. Neither traditional professional education nor practice patterns among the relevant provider groups includes sufficient attention to these geriatric health conditions. Many providers thus lack the necessary knowledge, skills, or experience to care for older adults with these conditions. Knowledge of the types of balance exercises known to improve stability and prevent falls, for instance, has not yet widely permeated clinical practice. Furthermore, when making clinical decisions, many providers who are used to diagnosing and treating individual conditions separately are not accustomed to weighing several competing morbidities simultaneously. Decision making for medications, for example, presently is predicated on attaining disease-specific outcomes rather than on weighing the benefits and harms of medications to reduce fall risk without compromising other health conditions.

### *Fragmentation and Lack of Coordination*

Even when providers are willing and able to perform fall-risk evaluation and management, the fragmentation of care among providers and across settings is a barrier to effective patient care. Fall-risk evaluation and management requires coordination and referral among several providers with complementary skills, including physicians, home care nurses, physical therapists, and occupational therapists. The more components and providers involved, however, the harder it is and the longer it takes for practice changes to diffuse (Bradley et al., 2004). Inadequate awareness of the skills of other provider groups exacerbates the difficulty; the roles of physical therapists and occupational therapists, in particular, are poorly understood by some providers. As a result, for instance, home care nurses may not recognize that some individuals might benefit from rehabilitation, and medical providers may fail to prescribe these services.

The challenge of coordinating patient care among health care providers is compounded by the need to coordinate such care between health care and non-health-care settings. Some components of fall-risk management are within the purview of medical care, such as medication reduction and physical therapy, whereas others, such as environmental safety outside the home, and physical activity or exercise, are not. The straddling of responsibility within and outside

**Table 1. Provider and Payer Barriers in Promoting Fall-Risk Evaluation and Management for Older Americans**

Health care providers
Time limitations
Competing demands from coexisting conditions
No mandate to address falls
Lack of knowledge and skills
Geriatric conditions not part of professional training or practice; providers not familiar with multifactorial geriatric health conditions
Complexity caused by the multifactorial nature of fall evaluation and management
Focus is on diagnosing and treating individual diseases; providers not skilled in weighing tradeoffs among multiple health conditions
Fragmentation and lack of coordination
Need to coordinate and refer across settings and provider groups
Provider groups do not understand each other's roles and skills
Components within and outside of the health care system
Reimbursement and financial concerns
Perceived lack of, or inadequate, reimbursement
Provider confusion concerning what is prevention of falls (not covered) versus management of the risk conditions (covered)
Coordination services not covered by Medicare
Health care payers – Medicare (fee for service)
Potential cost of services
Concern about fraud and abuse
Statutory limitations on coverage (Medicare was developed for acute episodes of care)
Complex financing structure
Centers for Medicare and Medicaid Services not accustomed to multiprovider, multisetting model of fall-risk evaluation and management
Component services are processed by different types of Medicare contractors
Variable interpretation of Medicare policies among carriers and intermediaries

*Notes:* Health care providers = physicians, nurses, rehabilitation specialists, and home care agencies; health care payers = Medicare (fee for service).

the health care setting further compromises coordination and limits accountability.

### *Reimbursement and Financial Concerns*

Whether accurate or not, reimbursement for fall-related clinical activities is perceived by the relevant health care provider groups as inadequate; inadequate reimbursement is considered a disincentive for providing fall-risk evaluation and management (Baker et al., 2005).

In addition to the perceived inadequacy of reimbursement, there is confusion among providers of what is or is not covered. This confusion results, in part, from the fact that Medicare covers treatment but not preventive services. On the one hand, fall-risk

evaluation and management could be considered a preventive service for which coverage must be specified by changes in the Medicare statute. These changes would require legislation. On the other hand, although fall prevention per se is not covered, the evaluation and management of contributing conditions and the treatment of individuals who have already fallen are services covered at least to some extent.

Even when the issue of prevention versus treatment is resolved, there are still financial barriers. For instance, most of the physician-provider components of fall evaluation and management (e.g., counseling about medications) are covered by Evaluation and Management (E and M) codes, used for documenting the nonprocedural components of the visit. Criteria for assigning E and M codes are vague; some providers consider documentation cumbersome; and coverage decisions are open to variable interpretation among local health insurance carriers.

Furthermore, Medicare specifically provides no additional payments for coordination among providers as a covered service. Although the components of fall-risk evaluation and management may be allowable under Medicare, there is no incentive for the multiple providers involved in the delivery of these services to coordinate their care. As a consequence, components may be duplicated, omitted, or performed inadequately (see Table 1).

## **Barriers to Fee-for-Service Medicare Coverage for Fall-Risk Evaluation and Management Services**

### *Potential Cost of Services*

The cost benefit of fall-risk evaluation and management theoretically provides an incentive to the Centers for Medicare and Medicaid Services (CMS) to ensure adequate reimbursement (Miller & Levy, 2000). Given the prevalence of fall risk among Medicare beneficiaries and the multiple providers who would require payment, however, the costs of fall-risk evaluation and management services could be substantial. From the perspective of the CMS, there is no guarantee that these costs will be offset by the reduced CMS expenditures for treating fall-related consequences.

### *Concern About Fraud and Abuse*

The CMS has a long-standing concern about fraud and abuse in the evaluation and treatment of conditions that are difficult to define and may be relatively common. Relevant to fall-risk evaluation and management, for instance, is that home care and rehabilitative services, both of which often entail multiple visits in nonmedical settings, have come under careful scrutiny. At least in part to control the potential for abuse, the Balanced Budget Act of 1997 required payment under a prospective payment

system for home health care. The act also imposed caps on outpatient rehabilitation services; these caps have recently been reinstated after a period of moratorium. The CMS is also concerned about possible billing for nonevidence-based methods to evaluate falls, such as the use of expensive machines to assess equilibrium. Fall-risk evaluation and management services will have to address concerns about fraud and abuse, perhaps by setting up outcome-driven criteria for eligibility or by limiting the duration of services, such as the existing cap on outpatient rehabilitation services.

### *Statutory (Legislative) Limitations*

The complexity of Medicare payment and coverage policies contributes to the barriers facing not only providers but also the CMS itself in financing fall evaluation and management services. Fall risk is a recurrent problem with predictable and frequent use of services. Medicare, created in 1965, has its historic roots in indemnity insurance. It was developed primarily for unpredictable and infrequent use of acute services and not for frequent use of chronic services (Radovsky, 1968). Legislative barriers, resulting from the limits on what decisions the CMS can make on its own, make it challenging to address chronic conditions and geriatric conditions such as falls. These conditions require ongoing, coordinated approaches across multiple providers, settings, and payment systems.

### *Complex Financing Structure*

Fee-for-service Medicare is more accustomed to the single-provider, single-setting model than to the multiprovider, multisetting approach necessary for optimal fall-risk evaluation and management. Different providers deliver fall-risk evaluation and management services in a variety of settings and bill Medicare Part A or B, depending on the circumstances. Insurers that process Medicare hospital claims, generally under Part A, are called *intermediaries*, whereas those that process Medicare physician claims, generally under Part B, are called *carriers*. However, the situation is more complex than that. Home health care, for instance, may be covered under either Part A or B. Hospital-based outpatient rehabilitation services are financed under Part B, although the bills are sent to fiscal intermediaries. Outpatient physician and freestanding outpatient rehabilitation services, in contrast, are paid for under Part B, with the bills sent to carriers. The CMS contracts with private insurers to process claims for Medicare beneficiaries. Adding to the complexity and confusion, different models of payment are used in different settings. This complexity is illustrated by home health payments, which are generally provided under the prospective payment system, rather than fee-for-service reimbursement.

## Near-Term Strategies That Could Promote Fall-Risk Evaluation and Management

Many of the systems, infrastructure, training, and health care financing changes needed to fully integrate management of multifactorial geriatric health conditions into practice require long-term solutions. In the meantime, several strategies could be employed to address one or more of the barriers, thus encouraging both providers and payers to incrementally adopt and promote fall-risk evaluation and management services (see Table 2).

### *Explain Medicare Policies and Procedures to Providers*

A near-term strategy for improving the delivery of fall-risk evaluation and management services is provider education aimed at explaining the complexities of Medicare coverage and payment policies and procedures. The CMS could elucidate Medicare policy regarding coverage and payment policies for fall-risk evaluation and management services and distribute this information to all carriers and intermediaries while simultaneously releasing provider-education materials on the CMS Web site and carrier and intermediary local Web sites (CMS, 2005b). These materials could include a combination of existing information, such as the American Geriatrics Society clinical practice guideline (American Geriatric Society et al., 2001), and newly developed materials on Medicare coverage and payment.

In explaining coverage and payment, language is important. Medicare does not cover services labeled as preventing or controlling *risk* but rather covers services labeled as treating *symptoms*. For instance, Medicare pays to *treat* balance or gait impairment, but not to *prevent* falls that are due to balance or gait risk. Thus, a person who has a symptom, such as balance or gait impairment, that predisposes him or her to a fall could receive Medicare-reimbursed services. Many known fall-risk factors can be linked to a symptom-specific diagnostic code or an evaluation and management visit.

Beneficiaries can now get a one-time preventive physical examination, including fall-risk assessment, within 6 months of enrolling in Medicare Part B coverage. Approximately 1 million beneficiaries will be eligible for this benefit each year. Initiating fall-risk evaluations in this select population could influence provider practice patterns for older adults more generally.

### *Enhance Providers' Clinical Knowledge and Skills*

Professional education is beginning to incorporate geriatric principles into the training of physicians, nurses, and rehabilitation specialists. It is hoped that this training will result in increased knowledge of the evaluation and management of geriatric con-

Table 2. Near-Term Strategies That Facilitate Provider–Payer Adoption of Fall-Risk Evaluation and Management for Older Americans

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Explain Medicare coverage and payment to providers
Enhance providers' clinical knowledge and skills (e.g., professional education and training; professional behavioral change strategies; disseminate fall evaluation and management evidence and guidelines)
Create fall-specific International Classification of Diseases and Current Procedural Terminology codes (e.g., V code 15.88)
Enlist professional leadership (e.g., American Board of Internal Medicine)
Include falls in public reporting of quality (e.g., Physician Voluntary Reporting Program; National Committee for Quality Assurance; Outcome and Assessment Information Set mandates functional outcomes in home care)
Include falls in accreditation standards (e.g., Joint Commission on the Accreditation of Health Care Organizations)
Explore Medicare Demonstration Projects (e.g., link falls to mandated chronic disease management program)
Create new Medicare benefit (Centers for Medicare and Medicaid Services mandate or legislative mandate)

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ditions such as falls and in enhanced skills in balancing tradeoffs among competing conditions.

For providers in practice, multiple strategies may improve knowledge of, skills in, and, subsequently, behaviors related to new practices such as fall-risk evaluation and management (Berwick, 2003; Oxman, Thomson, Davis, & Haynes, 1995). Commonly employed strategies include continuing education, outreach visits to providers' practice sites, medical record prompts to encourage performance, enlistment of local opinion leaders, and consumer demand for the services. Local and national efforts are underway that use these strategies (Baker et al., 2005; Fortinsky et al., 2004; Reuben et al., 2003). The effects of these efforts on provider practices are not yet known, although they are usually most effective for those who are ready to change their practices.

### *Create a New V Code for History of Falls*

The CDC and CMS recently developed a new V code for history of falls (V15.88) that was implemented in October 2005. This code could be used to identify individuals at risk, measure quality of care, and justify a provider's decision to order or perform certain services. A V code describes a status rather than a specific condition (CDC, 2005a); the specific conditions and diseases that predispose a person to falling already have diagnostic codes. The V code would denote that the person has the status of having fallen (over a designated time frame, likely to be 1 year), is at risk for recurrent falls so that the status is relevant to current care, and could benefit from fall-risk evaluation and management. Depending on the situation, the code could serve as a justification for further evaluation and management such as referral to rehabilitation or performance of

time-intensive activities such as medication review and adjustment. Without this code, there is no existing diagnosis or condition code that conveys such information. With a specific code, reviewers may be willing to accept services such as prolonged counseling time or outpatient rehabilitation gait-and-balance evaluation and management without the need for time-consuming manual review. Medicare contractor medical directors could add the V code to local medical review policies. To be effective, providers must be made aware of the new code and its proper use, through avenues such as the CMS Web site and communications from their professional organizations. A specific fall code might heighten the awareness of providers of the importance of falling as a manageable medical problem. It would also enhance the likelihood that providers would perform fall-risk evaluation and management, understanding that these services would be covered. In addition to a V code, consideration should be given to developing appropriate Current Procedural Terminology (CPT) codes indicating specific fall-related procedures. Current Procedural Terminology codes, developed by the American Medical Association, provide uniform terms and codes to describe medical, surgical, and diagnostic services. These codes are used by insurers, including the CMS, for processing claims.

### *Enlist Professional Leadership*

Professional leadership, particularly through highly respected national provider specialty organizations, is a potent force for creating greater awareness and improved norms of fall-risk evaluation and management and increasing attention to geriatric health conditions in practice. In illustration, the American Board of Internal Medicine (2005) created an evidence-based fall-related practice improvement module for its diplomates.

### *Implement Public Reporting of and Payment for Quality*

Given the multiple competing time demands on providers, fall-risk evaluation and management is best framed within the context of something providers view as important or feel they need to do, such as adhere to performance measures. In January 2006, the CMS launched the Physician Voluntary Reporting Program, which encourages physicians to report data on the quality of care they provide to Medicare beneficiaries. The Physician Voluntary Reporting Program will inform the development of pay-for-performance systems that aim to reward clinicians for better care, rather than simply paying based on the volume of services. Through a set of newly established codes, which are similar to procedural codes, physicians can report on

a starter set of 16 performance measures, including falls assessment (CMS, 2006). The CMS will provide feedback to participating physicians on their performance on these measures. In addition, the National Committee on Quality Assurance has developed a Health Plan Employer Data and Information Set measure on falls, based on the fall-related quality indicators developed through the Assessing Care of Vulnerable Elders project (Rubenstein et al., 2004), that will result in public performance reporting, giving health plans an incentive to do well (National Committee on Quality Assurance, 2003). These two efforts should help promote fall-risk evaluation and management among both fee-for-service and Medicare Advantage beneficiaries.

CMS mandates a focus on functional outcomes, monitored through the Outcome and Assessment Information Set (known as OASIS), for home care agencies (CMS, 2005c). Home care agencies' performance on these functional outcomes is listed on the CMS Web site, offering an incentive for agencies to improve the functional outcomes of their clients. Home care agencies can improve their performance by adopting fall-risk evaluation and management strategies. Educational efforts will likely be required to ensure awareness of the connection between fall-prevention efforts and patient function. Furthermore, the Medicare Payment Advisory Commission, an independent federal organization established to advise Congress on issues affecting the Medicare program, is developing measures related to falls as part of the Pay for Performance initiative for home care (Medicare Payment Advisory Commission, 2006). These pay-for-performance measures should also foster interest in implementing fall-prevention programs among home care agencies.

### *Incorporate Fall-Related Practices Into Accreditation Standards*

The accreditation process also encourages providers to adopt new practices. For example, the Joint Commission on the Accreditation of Health Care Organizations (2005), the nation's oldest and largest standards-setting and accrediting body in health care, recently added fall measures to its accreditation process for the ambulatory, home care, and assisted living settings. Providers must now show evidence of fall-prevention programming with measurable outcomes.

### *Explore Other Medicare Coverage Options*

A Medicare demonstration and a new Medicare benefit are two other potential strategies for improving the delivery of fall evaluation and management services. The CMS conducts demonstrations to test and identify methods to improve the delivery, financing, and coverage of health care

services. Demonstrations may be mandated through legislation or be initiated by the CMS. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, for example, mandated the phasing in of the Chronic Care Improvement Program, a population-based disease-management program, targeting congestive heart failure, diabetes mellitus, and chronic obstructive pulmonary disease (CMS, 2005a).

It can take many years, if at all, for demonstrations to have an effect on health care policy and practice. Furthermore, fall-risk evaluation and management requires coordinated and integrated decision making across multiple providers and disease categories that is generally beyond the purview and scope of disease management. Nevertheless, it might be worth it to explore ways to incorporate the evaluation and management of falls within the context of other demonstrations.

Another potential option is to explore the creation of a new benefit, such as a limited number of visits per year per beneficiary, to appropriate providers for components presently not covered or covered inadequately. Examples of such components include repeated physician visits for medication review and reduction; rehabilitation for balance, strength, and gait reevaluations; and progressive training. If these services are defined as treatment, then the CMS could craft the new benefit. If they are defined as prevention, then coverage of these services would require Congressional legislation.

### Broad-Based Changes in Financing and Clinical Practice Systems

The near-term strategies for encouraging providers and payers to adopt the fall-risk evaluation and management services recommended by guidelines, and supported by evidence, are predicated on the existing health care organization and financing. As noted by the Institute of Medicine (Institute of Medicine, 2001; Rogers, 1995), if the fundamental problem is the design of the system, then improvements in care cannot be achieved merely by stressing the current systems of care. Our care and payment systems were organized to respond to individual acute illness and injury, not to the multiple chronic conditions, diseases, and impairments typically experienced by the Medicare population.

Systems-based interventions are needed to handle the complexity, and reduce the time and administrative costs, of the evaluation and management of conditions such as falls that coexist with other health conditions. One example of such interventions is the enhanced use of information technologies that could aggregate the fall-risk evaluation and management information from multiple sources and facilitate referral among providers (see Table 3). Additional systems changes include better coordination across provider groups and a shift in clinical practice from its present single-disease focus toward integrated

**Table 3. Broad-Based Changes in Health Care and Financing Systems To Benefit the Chronic Health Care Needs of Older Americans**

Information technology solutions for efficiently aggregating and processing information related to the evaluation and management of multifactorial conditions such as falls
Coordination across provider groups with complementary skills
Shifts in provider education and practice toward integrated clinical decision making that weighs all health conditions rather than diagnosing and treating individual diseases
Financing system suited to preventing and managing multiple chronic health care needs

clinical decision making that weighs all health conditions. From a clinical and financing perspective, the current interest in chronic disease management is a step in the right direction, but the focus must be on integrated care across conditions, not on treatment of separate diseases (Berenson & Horvath, 2003).

In summary, the need for fall-risk evaluation and management in the clinical care of older adults is great; the evidence of its effectiveness is strong. There is a large gap between this evidence and the delivery of fall-prevention services. Fall-risk evaluation and management illustrates the need to evolve both financing and clinical practice systems better suited to the care of the multiple chronic health conditions experienced by the rapidly growing Medicare population.

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