Talking With Your Patients About Falls

- Help patients understand their own unique fall risk.
- Educate patients on their modifiable risk factors and corresponding fall prevention strategies.
- Emphasize that fall prevention can help them remain independent.
- Discuss with patients which strategies they might be willing to do.
- Work with patients and caregivers to develop a plan for fall prevention.

STEADI Resources for Your Patients

Available patient-friendly brochures:
- Stay Independent
- Postural Hypotension: What it is & How to Manage it
- Check for Safety
- What YOU Can Do to Prevent Falls

Key Facts About Falls

- One in four older adults age 65+ falls every year.
- Falls are the leading cause of injury deaths for older adults.
- Many patients who have fallen do not bring it up at medical appointments, so providers need to ask.

Each year, ask your older patients:

- Have you fallen in the past year?
- Do you feel unsteady when standing or walking?
- Do you worry about falling?

For more patient and provider resources, visit www.cdc.gov/steadi.
STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention among Community-Dwelling Adults 65 years and older

1. SCREEN for fall risk yearly, or any time patient presents with an acute fall.

Available Fall Risk Screening Tools:
- **Stay Independent**: a 12-question tool
  [at risk if score ≥ 4]
  *Important:* If score < 4, ask if patient fell in the past year
  (If **YES** patient is at risk)
- **Three key questions** for patients [at risk if **YES** to any question]
  Feels unsteady when standing or walking? 
  Worries about falling? 
  Has fallen in past year? 
  » If **YES** ask, “How many times?” “Were you injured?”

2. SCREENED AT RISK

Common ways to assess fall risk factors are listed below:

<table>
<thead>
<tr>
<th>Evaluate gait, strength, &amp; balance</th>
<th>Common assessments:</th>
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<td>Identify medications that increase fall risk</td>
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<td>Ask about potential home hazards</td>
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<td>Measure orthostatic blood pressure</td>
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<td>Check visual acuity</td>
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<td>Assess feet/footwear</td>
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<td>Assess vitamin D intake</td>
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<td>Identify comorbidities</td>
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Common assessment tools:
- **30-Second Chair Stand**
- **Timed Up & Go**
- **4-Stage Balance Test**
- **E.g., Beers Criteria**
- **E.g., throw rugs, slippery tub floor**
- **Lying and standing positions**
- **Snellen eye test**
- **Depression, osteoporosis**

3. INTERVENE to reduce identified risk factors using effective strategies.

Reduce identified fall risk:
- Discuss patient and provider health goals
- Develop an individualized patient care plan (see below)

Below are common interventions used to reduce fall risk:

- **Poor gait, strength, & balance observed**
  - Refer for physical therapy
  - Refer to evidence-based exercise or fall prevention program (e.g., Tai Chi)

- **Medication(s) likely to increase fall risk**
  - Optimize medications by stopping, switching, or reducing dosage of medications that increase fall risk

- **Home hazards likely**
  - Refer to occupational therapist to evaluate home safety

- **Orthostatic hypotension observed**
  - Stop, switch, or reduce the dose of medications that increase fall risk
  - Educate about importance of exercises (e.g., foot pumps)
  - Establish appropriate blood pressure goal
  - Encourage adequate hydration
  - Consider compression stockings

- **Visual impairment observed**
  - Refer to ophthalmologist/optometrist
  - Stop, switch, or reduce the dose of medications affecting vision (e.g., anticholinergics)
  - Consider benefits of cataract surgery
  - Provide education on depth perception and single vs. multifocal lenses

- **Feet/footwear issues identified**
  - Provide education on shoe fit, traction, insoles, and heel height
  - Refer to podiatrist

- **Vitamin D deficiency observed or likely**
  - Recommend daily vitamin D supplement

- **Comorbidities documented**
  - Optimize treatment of conditions identified
  - Be mindful of medications that increase fall risk

FOLLOW UP with patient in 30-90 days.

Discuss ways to improve patient receptiveness to the care plan and address barrier(s).