eCQM Title	**Falls: Screening for Future Fall Risk**		
eCQM Identifier (Measure Authoring Tool)	139	eCQM Version Number	13.1.000
CBE 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, & 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 four adults over 65 will fall each year (Centers for Disease Control and Prevention, 2023). 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).		
Clinical Recommendation Statement	All older persons who are under the care of a heath professional (or their caregivers) should be asked at least once a year about falls. (American Geriatrics Society/British Geriatric Society/American Academy of Orthopaedic Surgeons (AGS/BGS/AAOS), 2010) 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/AAOS, 2010)		
Improvement Notation	A higher score indicates better quality		
Reference	Reference Type: CITATION Reference Text: 'al-Aama, T. (2011). Falls in the elderly: spectrum and prevention. Can Fam Physician 57(7),771-6. Retrieved from https://pubmed.ncbi.nlm.nih.gov/21753098/'		
Reference	Reference Type: CITATION Reference Text: 'American Geriatrics Society and British Geriatrics Society. (2010). Prevention of Falls in Older Persons AGS BGS Clinical Practice Guideline 2010. Accessed December 8. 2023. Available at https://geriatricscareonline.org/toc/updated-american-geriatrics-societybritish-geriatrics-society-clinical-practice-guideline-for-prevention-of-falls-in-older-persons-and-recommendations/CL014/'		
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2023). "Facts about Falls" (May 12, 2023) https://www.cdc.gov/falls/facts.html'		
Reference	Reference Type: CITATION Reference Text: 'Doherty, M., and J. Crossen-Sills. (2009). Fall Risk: Keep your Patients in Balance. The Nurse Practitioner: The American Journal of Primary Health Care 34(12),46-51.'		
Reference	Reference Type: CITATION Reference Text: 'Dykes, P.C., Carrollf, D.L., Hurley, A., et al. (2010). Fall Prevention in Acute Care Hospitals: A Randomized Trial. JAMA, 304(17), 1912-1918.'		
Reference	Reference Type: CITATION Reference Text: 'Schneider, E.C., Shubert, T.E., & Harmon, K.J. (2010). Addressing the Escalating Public Health Issue of Falls Among Older Adults. NC Med J, 71(6), 547-52.'		
Reference	Reference Type: CITATION Reference Text: 'Woolcott, J.C., Khan, K.M., Mitrovic, S., et al. (2011). The Cost of Fall Related Presentations to the ED: A Prospective, In-Person, Patient-Tracking Analysis of Health Resource Utilization. Osteporos Int [Epub ahead of print].'		
Definition	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.		
Guidance	This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. 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 at the start of the measurement period with a visit during the measurement period		
Denominator	Equals Initial Population		
Denominator Exclusions	Exclude patients who are in hospice care for any part of the measurement period		
Numerator	Patients who were screened for future fall risk at least once within the measurement period		
Numerator Exclusions	Not Applicable		
Denominator Exceptions	None		
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex		

Table of Contents

Population Criteria

◢ Initial Population

```
AgeInYearsAt(date from start of "Measurement Period") >= 65
  and exists "Qualifying Encounter"
```

◢ Denominator

```
"Initial Population"
```

◢ Denominator Exclusions

```
Hospice."Has Hospice Services"
```

◢ Numerator

```
exists ( ["Assessment, Performed": "Falls Screening"] FallsScreening
    where Global."NormalizeInterval" ( FallsScreening.relevantDatetime, FallsScreening.relevantPeriod ) during day of "Measurement Period"
)
```

◢ Numerator Exclusions

None

◢ Denominator Exceptions

None

◢ Stratification

None

Definitions

◢ Denominator

```
"Initial Population"
```

◢ Denominator Exclusions

```
Hospice."Has Hospice Services"
```

◢ Hospice.Has Hospice Services

```
exists ( ["Encounter, Performed": "Encounter Inpatient"] InpatientEncounter
    where ( InpatientEncounter.dischargeDisposition ~ "Discharge to home for hospice care (procedure)"
        or InpatientEncounter.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"
    )
      and InpatientEncounter.relevantPeriod ends during day of "Measurement Period"
)
  or exists ( ["Encounter, Performed": "Hospice Encounter"] HospiceEncounter
      where HospiceEncounter.relevantPeriod overlaps day of "Measurement Period"
  )
  or exists ( ["Assessment, Performed": "Hospice care [Minimum Data Set]"] HospiceAssessment
      where HospiceAssessment.result ~ "Yes (qualifier value)"
        and Global."NormalizeInterval" ( HospiceAssessment.relevantDatetime, HospiceAssessment.relevantPeriod ) overlaps day of "Measurement Period"
  )
  or exists ( ["Intervention, Order": "Hospice Care Ambulatory"] HospiceOrder
      where HospiceOrder.authorDatetime during day of "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Hospice Care Ambulatory"] HospicePerformed
      where Global."NormalizeInterval" ( HospicePerformed.relevantDatetime, HospicePerformed.relevantPeriod ) overlaps day of "Measurement Period"
  )
or exists ( ["Diagnosis": "Hospice Diagnosis"] HospiceCareDiagnosis
      where HospiceCareDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
  )
```

◢ Initial Population

```
AgeInYearsAt(date from start of "Measurement Period") >= 65
  and exists "Qualifying Encounter"
```

◢ Numerator

```
exists ( ["Assessment, Performed": "Falls Screening"] FallsScreening
    where Global."NormalizeInterval" ( FallsScreening.relevantDatetime, FallsScreening.relevantPeriod ) during day of "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"]
  union ["Encounter, Performed": "Telephone Visits"]
  union ["Encounter, Performed": "Virtual Encounter"]
  union ["Encounter, Performed": "Physical Therapy Evaluation"]
  union ["Encounter, Performed": "Occupational Therapy Evaluation"] ) ValidEncounters
  where ValidEncounters.relevantPeriod during day of "Measurement Period"
```

◢ SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

◢ SDE Payer

```
["Patient Characteristic Payer": "Payer Type"]
```

◢ SDE Race

```
["Patient Characteristic Race": "Race"]
```

◢ SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

◢ Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- 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 "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)
- valueset "Hospice Diagnosis" (2.16.840.1.113883.3.464.1003.1165)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Nursing Facility Visit" (2.16.840.1.113883.3.464.1003.101.12.1012)
- valueset "Occupational Therapy Evaluation" (2.16.840.1.113883.3.526.3.1011)
- 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 Type" (2.16.840.1.114222.4.11.3591)
- valueset "Physical Therapy Evaluation" (2.16.840.1.113883.3.526.3.1022)
- 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)
- valueset "Telephone Visits" (2.16.840.1.113883.3.464.1003.101.12.1080)
- valueset "Virtual Encounter" (2.16.840.1.113883.3.464.1003.101.12.1089)

Data Criteria (QDM Data Elements)

- "Assessment, Performed: Falls Screening" using "Falls Screening (2.16.840.1.113883.3.464.1003.118.12.1028)"
- "Assessment, Performed: Hospice care [Minimum Data Set]" using "Hospice care [Minimum Data Set] (LOINC Code 45755-6)"
- "Diagnosis: Hospice Diagnosis" using "Hospice Diagnosis (2.16.840.1.113883.3.464.1003.1165)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Audiology Visit" using "Audiology Visit (2.16.840.1.113883.3.464.1003.101.12.1066)"
- "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: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Hospice Encounter" using "Hospice Encounter (2.16.840.1.113883.3.464.1003.1003)"
- "Encounter, Performed: Nursing Facility Visit" using "Nursing Facility Visit (2.16.840.1.113883.3.464.1003.101.12.1012)"
- "Encounter, Performed: Occupational Therapy Evaluation" using "Occupational Therapy Evaluation (2.16.840.1.113883.3.526.3.1011)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services (2.16.840.1.113883.3.526.3.1285)"
- "Encounter, Performed: Physical Therapy Evaluation" using "Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022)"
- "Encounter, Performed: Preventive Care Services Established Office Visit, 18 and Up" using "Preventive Care Services Established Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1025)"
- "Encounter, Performed: Preventive Care Services Individual Counseling" using "Preventive Care Services Individual Counseling (2.16.840.1.113883.3.464.1003.101.12.1026)"
- "Encounter, Performed: Preventive Care Services Initial Office Visit, 18 and Up" using "Preventive Care Services Initial Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Encounter, Performed: Telephone Visits" using "Telephone Visits (2.16.840.1.113883.3.464.1003.101.12.1080)"
- "Encounter, Performed: Virtual Encounter" using "Virtual Encounter (2.16.840.1.113883.3.464.1003.101.12.1089)"
- "Intervention, Order: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer Type" using "Payer Type (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"

Supplemental Data Elements

◢ SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

◢ SDE Payer

```
["Patient Characteristic Payer": "Payer Type"]
```

◢ SDE Race

```
["Patient Characteristic Race": "Race"]
```

◢ SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Risk Adjustment Variables

None

Measure Set	None