

# Don't Roll the Dice: Preventing Falls in Older Adults Sunday, December 4, 2016



Mollie Ashe Scott, Pharm.D., BCACP, CPP, FASHP Michelle A. Fritsch, Pharm.D., CGP, BCACP Melanie A. Dodd, Pharm.D., Ph.C., BCPS

### Disclosure

 The program chair and presenters for this continuing education activity have reported no relevant financial relationships.



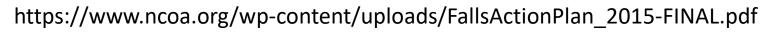
### **Goals and Objectives**

- Choose a therapeutic plan to decrease the risk of falls using recommendations from the 2015 American Geriatrics Society Beers Criteria.
- Evaluate clinical trials that examine the relationships between vitamin D and falls in high risk geriatric patients.
- Compare screening tools that identify seniors who are at risk for falls.
- Describe workflow strategies for incorporating falls reduction strategies into the Annual Wellness Visit for Medicare recipients.



# **Falls in Older Adults**

- Falls are the leading cause of death and emergency room visits from unintentional injuries in adults over 65
- 30% of community dwellers and up to 50% of nursing home patients fall each year
- Up to 1 million hospitalized patients fall each year
- The most serious injury associated with falls is hip fracture
- The US Preventive Task Force recommends exercise or physical therapy, and vitamin D supplementation to prevent falls (Grade B)
- AGS recommends withdrawal of psychoactive medications (Grade B) and withdrawal of other medications (Grade C)





### **2015 National Action Plan**

- Physical mobility
- Medication management
- Home safety
- Environmental safety in the community







# 2015 American Geriatrics Society Beers Criteria Update

#### Michelle A. Fritsch, Pharm.D., CGP, BCACP Founder & CEO, Meds MASH, LLC Monkton, MD



#### **Patient Case**

- Glipizide XL 10 mg po qam
- Glargine (Lantus) insulin 10 units SQ qpm
- Hydrochlorothiazide 25 mg po qam
- Lisinopril 40 mg po qam
- Clonidine 0.2 mg po tid
- Hydrocodone/Acetaminophen
   5/325 1 tab po q4h prn pain
- Diazepam 5 mg po tid
- Vitamin D 400 IU qam
- Vitamin C 1 g qday
- Multivitamin 1 tab po qam



- LL 80 year old woman
  - Diabetes
  - Osteoarthritis
  - Hypertension
  - Generalized anxiety
- BP: sitting 150/80 mmHg, standing 126/70 mmHg
- HR 80 bpm; Wt. 55 kg; Ht. 5'1"
- BUN/SCr 17/1.01, potassium 4.0 mEq/L, fasting glucose 109 mg/dL, A1c 7.2%

### How many of LL's medications can increase her falls risk?

- **4**-5
- <u> </u>6-7
- All of them



How will you IDENTIFY & MINIMIZE LL's fall risks?



### American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

2015 Update (prior versions 1991, 1997, 2003, 2012)



#### ... but principles will help reduce falls



### What is New in the 2015 Beers Criteria?

- Medications to avoid or adjust based on kidney function
- List of highly anticholinergic medications to avoid
- History of falls as a risk factor for falls
- Agents to use with caution (vs the agents to avoid)



### **Beers Criteria 2015 Update**

Two new components –

lists of select drugs that should be avoided or have their dose adjusted based on the individual's kidney function

select drug–drug interactions documented to be associated with harms in older adult

- How to use guide
- Alternative therapies



## **Usual Beers Criteria Information**

- Highly anticholinergic agents
- Antiparkinson agents (especially the anticholinergic ones)
- Antispasmodics
- Antithrombotics (dipyridamole and ticlopidine)
- Antiinfective nitrofurantoin with CrCl <30mL/min</li>
- Cardiovascular
- CNS depressants
- Endocrine
- Gastrointestinal
- Pain





### Usual Beers Criteria Information Drug-Disease Interactions

- Cardiovascular
  - Heart failure
  - Syncope
- CNS
  - Chronic seizures or epilepsy
  - Delirium
  - Dementia or cognitive impairment
  - History of falls or fractures
  - Insomnia
  - Parkinson's Disease

- Gastrointestinal
  - History of gastric or duodenal ulcers
- Kidney and urinary tract
  - Chronic kidney disease
  - Urinary incontinence
  - Lower urinary tract symptoms, BPH





## **Beers Criteria Information**

- Medications to use with caution Table 4
  - Vasodilators can exacerbate episodes of syncope
- Non-anti-infective drug-drug interactions to avoid Table 5
  - Antidepressants
  - Antipsychotics
  - Benzodiazepines and hypnotics
  - Opioid receptor agonist analgesics

- with <u>></u> 2 other CNS-active drugs
- Medications to avoid or reduce dose based on kidney function – Table 6
  - (Renal and hepatic function impact dosing, frequency, and selection of agents to reduce fall risk)



## How to Use the American Geriatrics Society 2015 Beers Criteria—A Guide for Patients, Clinicians, Health Systems, and Payers

**Key Principles** 

- <u>Potentially inappropriate</u>, not definitely inappropriate
- Read the rationale and recommendations
- Understand why medications were included
- Offer <u>safer nonpharmacologic and pharmacologic options</u> when appropriate
- Starting point for a <u>comprehensive assessment</u>
- No unnecessary restriction of medication access
- Not equally applicable to all countries



### Alternative Medications for Medications in the Use of High-Risk Medications in the Elderly and Potentially Harmful Drug–Disease Interactions in the Elderly Quality Measures

- Newer generation options with fewer side effects
- Avoid benzodiazepines and "Z drugs"
- Avoid tricyclic antidepressants, paroxetine
- Topical in place of systemic
- Acetaminophen in place of skeletal muscle relaxants, NSAIDs, or opioids whenever possible
- Short-acting over long-acting options (e.g. hypoglycemics, opiates)



# What do you do now to identify and address risks in a patient like LL?

- Systemized assessment tool applied to all patients
- Systemized assessment tool when it seems appropriate
- Clinical judgment when assessing patients
- No process currently in place



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### **Falls Risk Assessment Resources**

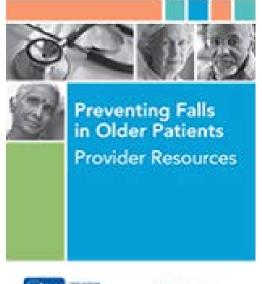
- STOPP has criteria similar to Beers Criteria
- AHRQ has some falls risk screening tools
- Fall Risk Assessment Tool (FRAT)
  - Used in several countries and adapted for some specific institutions
- Key components
  - History of falls
  - Fear of falls
- Most use number of medications or limited risk-inducing medications
- Lack the DEEP DIVE





### Centers for Disease Control Stopping Elderly Accidents, Death, and Injuries CDC STEADI Toolkit

- For providers
  - Algorithm for fall risk assessment and intervention
  - Preventing Falls in Older Patients: Provider Pocket Guide
  - Checklist
  - Assessments
  - Fact sheets
- For patients
  - Stay Independent assessment
  - Check for Safety assessment
  - Educational information





STEATS DEVICE



### American Society of Consultant Pharmacists/National Council on Aging Falls Risk Reduction Toolkit

- Unveiled October 18, 2016
- Companion to the CDC STEADI toolkit
  - More in-depth clinical assessment of medications and medical conditions
- Toolkit components:
  - Falls Risk Checklist
  - Falls Application Cases
  - Communications Documents
  - Build Your Referral Network
  - Bibliography



### **Get to Know your Patient**

- Age
- Transition Status
- Living Arrangements
- Substance Use
- Vital Signs
- Ambulation Status
- Sensory Function
- Lower Extremities
- Simple Gait Assessment
- Medication Self Management
- Falls History

Expresses worry about falling         Feels unstead           Medical Conditions	, full-time
Transition Status       Recent transition         Pending transition       Recent transition         Lives alone       In home care         Lives alone       In home care         Lives alone       In home care         Acsisted livin       Substance Use         Actives alone       Marijuana         Vital Signs       Postural hypotension:       Pulse:         Systolic BP falls ≥ -20 mm Hg       Irregular         Dizzy or lightheaded with standing       Temperature:         Dizzy or lightheaded with standing       Correction provided:         Refaral planned:       Correction provided:         Sensory Function       Hearing defici         Vision:       Hearing defici         Burred vision       Regular use for glasses/contacts         Sporadic use glasses/contacts       Changes in sr         Medication Self Management       Medications disorganized         Medication Self Management       Expresses wory about falling         Persion       Feels unsteau         Changes in at       CoV/Stroke         Dapression       Hemophilia         Impaired renal function       Incontinence         Arthritio, dely dration       Parkinson's di         Malnutrition, dehydration       Parkinson	tion full-time In home care, part-time g facility Skilled care facility Other Illicit substances Pain: Complaint of pain Pain location(s):
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Depression     Hemophilia     Impaired renal function     Lower extremity arthroplasty     Lower extremity     Mahutrition, dehydration     Malutrition, dehydration     Pain     Pain     Pain     Recent medication regimen change     within last wee     Falls risk Medication-Related-Problems detected:     Suboptimal dose*     Loxer to hydrogen	Dementia
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Lower extremity arthroplasty     Lower extremi     Mainutrition, dehydration     Pain     Pain     Verse extremi     Pain     Number of medications (Rx, pm, OTC, vitamin, supplement, he     Recent medications regimen change     within last wee     Falls risk Medication-Related-Problems detected:     Suboptimal dose*     Loxes to high     Interactions between medications,     Lacking medic	Infection (e.g. UTI)
Malnutrition, dehydration       Multiple sclerc         Pain       Parkinson's di         Medication Assessment       Number of medications (Rx, prn, OTC, vitamin, supplement, he         Recent medication regimen change       within last wee         Falls risk Medication-Related-Problems detected:       Dose too high         Interactions between medications,       Lacking medic	
Pain	
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Number of medications (Rx, pm, OTC, vitamin, supplement, he           Recent medication regimen change         within last wee           Falls risk Medication-Related-Problems detected:            Suboptimal dose*         Dose too high           Interactions between medications,         Lacking medic	en den nor en
Recent medication regimen change     I within last wee       Falls risk Medication-Related-Problems detected:     Dose too high       Suboptimal dose*     Dose too high       Interactions between medications,     Lacking medic	rbal) □ ≥ 5 □ ≥ 10
□ Suboptimal dose* □ Dose too high □ Interactions between medications, □ Lacking medic	
□ Interactions between medications, □ Lacking medic	k 🛛 within last month
	Safer evidence-based therapy
	Safer evidence-based therapy ation therapy for all available
□ Allergies and intolerances within □ Unnecessary	Safer evidence-based therapy
current regimen	Safer evidence-based therapy ation therapy for all available quiring indications Difficulty administering any
* suboptimal dose - check doses based on renal and hepatic fun	** Gafer evidence-based therapy ation therapy for all available quiring indications Difficulty administering any medication (sye drops, inhalers, large dosage forms)
** dose too high - causing adverse effects and/or unnecessary risk	Cafer evidence-based therapy     ation therapy for all     available     guiring indications     medication     medication     large dosage forms) tion



## **Medical Conditions**

- Gait and Balance Altering
- Pain Related Gait and Balance Changes
- Central Nervous System
- Organ Function
- Vascular Related Conditions
- Obesity
- Malnutrition
- Urinary Incontinence
- Infections



### **Medication Assessment**

- Medication Regimen Overview
- Lab Values
- Medication Related Problems
- Geriatric Appropriate Medications



# Falls Risk Inducing Drugs (FRIDs)

- CNS Depressants
- Anticholinergics
- Pain Therapy
- Anticonvulsants
- Antihypertensives
- Hypoglycemic Agents
- Over-The-Counter

Falls Risk Checkl	ist	
Check all that apply: Medications		
Anticholinergics (e.g. oxybutinin, trihexiphenidyl, amitryiptyline) Antihypertensives/CV meds (especially o-blockers, nitrates) Dopaminergic agents Opioids	Anticonvulsants Antipsychotics/neuroleptics typical or atypical Hypoglycemia agents Sedative/hypnotics	Antidepressants Benzodiazepines (short or long t 1/2 Muscle relaxants Over-the-counter: diphenhydramine doxylamine
Gait, Strength, & Balance		
Timed Up and Go (TUG) Test ≥12 seconds		Score: seconds
30-Second Chair Stand Test Below Average Score		Score: number
4-Stage Balance Test <10 seconds		Score: seconds
Parallel Stance		Score: seconds
Semi-Tandem Stance		Score: seconds
Tandem Stance		Score: seconds
One-legged Stance		Score: seconds
Observed gait problems or difficulty standing		Yes No







- Key Takeaway #1
  - There are many medications that can increase a patient's fall risk. The more in the regimen, the greater the risk.
- Key Takeaway #2
  - Tools such as the AGS Beers Criteria can help a pharmacist identify those medications posing the greatest risk.
- Key Takeaway #3
  - Utilize a designated process to screen for fall risk, and if risk is elevated, dive deep into medication and medical condition risk factors.





# Vitamin D and Falls: A Complex Relationship



Mollie Ashe Scott, Pharm.D., BCACP, CPP, FASHP Regional Associate Dean and Clinical Associate Professor UNC Eshelman School of Pharmacy Clinical Associate Professor UNC School of Medicine

# What is the 25(OH)D concentration that is considered to decrease the risk of falls?

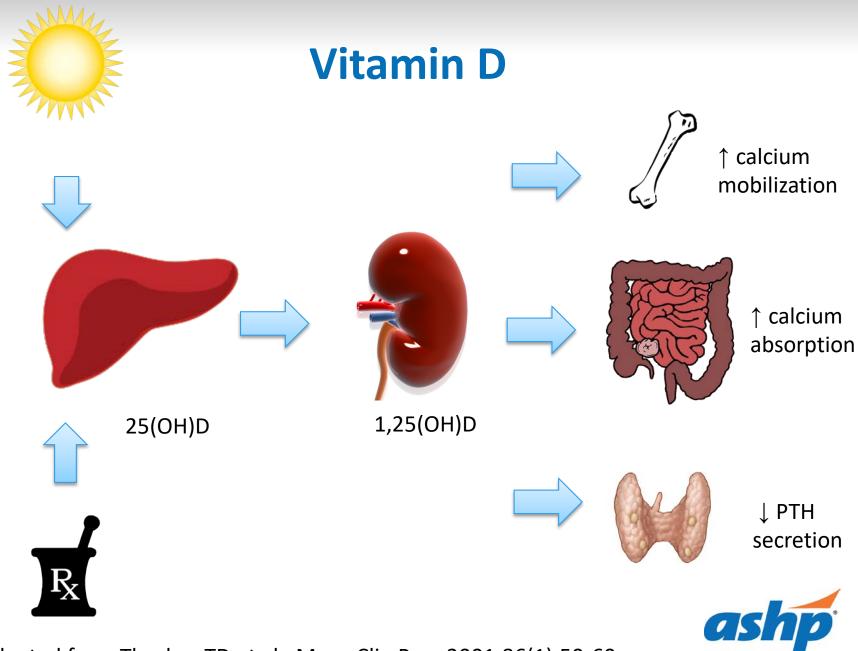
- 🔼 10 ng/mL
- 20 ng/mL
- 🧧 30 ng/mL
- There is not an association between concentration and falls



# Vitamin D

- Vitamin D is important for bone and muscle development, function, and preservation
- Cholecalciferol (D3) is produced in the skin, or obtained from a few foods in the diet
- Ergocalciferol (D2) is found in some plants and is produced commercially
- Factors that influence vitamin D levels include race, vitamin D intake, sun exposure, obesity, age, and activity





Adapted from Thacher TD et al. Mayo Clin Proc 2001;86(1):50-60

MIDYEAR 2016 Clinical Meeting & Exhibition

# **Classification of Vitamin D Status**

25(OH) Vitamin D Concentration	Classification
< 10 ng/mL	Deficient
11-29 ng/mL	Insufficient
≥ 30 ng/mL	Optimal

- The International Osteoporosis Foundation recommends 30 ng/mL as the appropriate target for older adults
- 30 ng/mL is associated with maximal PTH suppression
- More than 75% of older adults fall below 30ng/mL

Rosen, C. N Engl J Med 2011; 364:248-254 Hawdon-Hughes et al. Osteoporos Int 2010;21:1151-1154



### Fall Prevention with Vitamin D: a Meta-Analysis of Randomized Controlled Trials

- Objective: to test the efficacy of supplemental vitamin D with or without calcium in preventing falls in older adults
- Meta-analysis of 8 RCTs (n=2426 patients) of older adults who received vitamin D supplements with specified falls assessment
- Heterogeneity among trials was observed for vitamin D dose and vitamin D concentration
  - 200 600 IU vs 700 1000 IU
  - < 24 ng/mL vs <u>></u> 24 ng/mL



Bischoff-Ferrari, BMJ 2009;339;b3602

### Fall Prevention with Vitamin D: a Meta-Analysis of Randomized Controlled Trials

Decreased fall risk by 19% RR 0.81, 95% CI 0.71-0.92 n = 1921

High Dose Vitamin D

700 - 1000 IU

Bischoff-Ferrari, BMJ 2009;339;b3602

Low Dose Vitamin D 200 IU – 600 IU

No reduction RR 1.0 95% CI 0.89-1.35 n = 505 Fall Prevention with Vitamin D: a Meta-Analysis of Randomized Controlled Trials

- 25(OH) D < 24 ng/mL
- Did not reduce falls
- RR 1.35, 95% CI 0.98-1.84

- 25(OH)D > 24 ng/mL
- Reduced falls by 23%
- RR 0.77, 95% CI 0.65-0.90



Bischoff-Ferrari, BMJ 2009;339;b3602

# **Vital D Study**

- Single center, double blind, RCT of 2317 community-dwelling women age 70 and over in Australia
- Randomized to receive a single oral dose of cholecalciferol 500,000 IU or matched placebo in autumn or winter for 3-5 years
- Falls were defined as "an event reported by the faller or a witness, resulting in a person inadvertently coming to rest on the ground or another lower level, with or without loss of consciousness or injury"



# Vital D Summary of Falls and Fractures

- There were more falls in the vitamin D group compared to placebo (2892 vs 2512 falls)
- 279 (24%) vitamin D users had at least one fall compared to 246 (21.9%) placebo users
- Incidence Rate Ratio for falls: 1.15 (95% CI 1.02 1.30), p value = 0.03
- Vitamin D users had the highest risk of falls in the first 3 months: RR 1.31 (95% CI 1.12-1.54)
- There was no difference in fractures or nonvertebral fractures
- There was an increase in soft tissue injury in vitamin D users



Sanders KM et al. JAMA 2010; 18:1815-1822

### American Geriatrics Society Guidelines on Vitamin D and Falls

Minimum of 1000 IU daily for older adults

Target 25(OH)D level above 30 ng/mL

Vitamin D 4000 IU will ensure 92% of older adults will achieve a 25(OH) D above 30 ng/mL



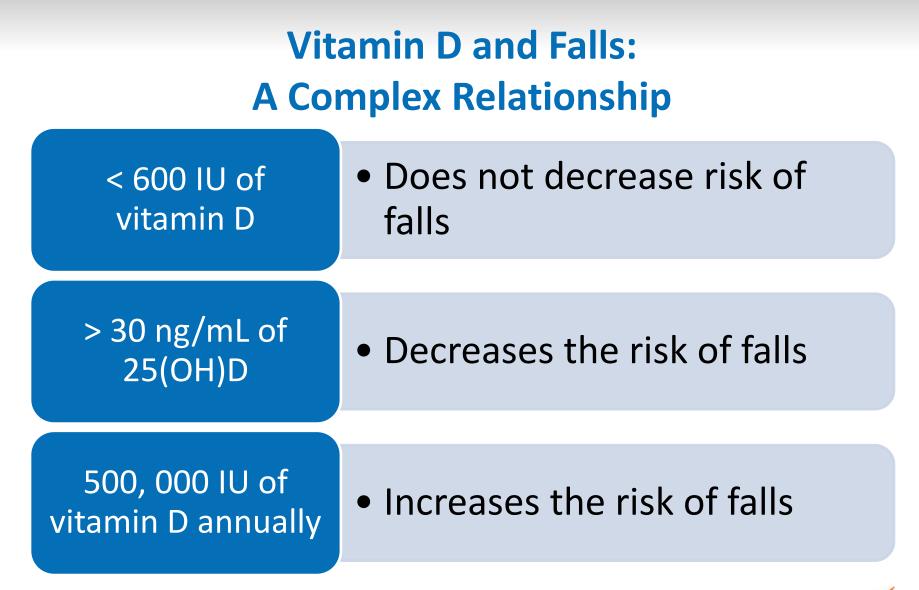
JAGS 2013;62:147-152

# **Dietary Sources of Vitamin D**

Source	Amount of Vitamin D
Salmon	100 – 250 IU
Sardines, canned	300 IU
Tuna	230 IU
Fortified milk, yogurt, and orange juice	100 IU
Fortified cheeses	100 IU
Fortified cereal	100 IU



JAGS 2013;62:147-152







#### **Patient Case**

- Glipizide XL 10 mg po qam
- Glargine (Lantus) insulin 10 units SQ qpm
- Hydrochlorothiazide 25 mg po qam
- Lisinopril 40 mg po qam
- Clonidine 0.2 mg po tid
- Hydrocodone/Acetaminophen
   5/325 1 tab po q4h prn pain
- Diazepam 5 mg po tid
- Vitamin D 400 IU qam
- Vitamin C 1 g qday
- Multivitamin 1 tab po qam



- LL 80 year old woman
  - Diabetes
  - Osteoarthritis
  - Hypertension
  - Generalized anxiety
- BP: sitting 150/80 mmHg, standing 126/70 mmHg
- HR 80 bpm; Wt. 55 kg; Ht. 5'1"
- BUN/SCr 17/1.01, potassium 4.0 mEq/L, fasting glucose 109 mg/dL, A1c 7.2%

# What would an appropriate recommendation for LL's vitamin D dose be?

- Continue vitamin D 400 IU and MVI daily
- Increase vitamin D to 1000 IU daily
- Increase vitamin D to 3000 IU daily
- Increase vitamin D to 500,000 IU annually





- Key Takeaway #1
  - Vitamin D 1000 IU is the minimum dose for older adults
- Key Takeaway #2
  - The American Geriatrics Society recommends a dose of 4000 IU from all sources
- Key Takeaway #3
  - Use of an annual dose of 500,000 IU increases the risk of falls and soft tissue injury





# Screening for Falls: Tools for the Pharmacist



Melanie A. Dodd, Pharm.D., Ph.C., BCACP Department Vice Chair and Associate Professor The University of New Mexico College of Pharmacy

# Which one of the following fall tests helps determine safety in tight spaces?

- TUG
- 30-second sit-to-stand
- 4-stage balance
- Turn around test



# Fall Risk Assessments

#### Tests to perform:

- Clinical balance assessment
- 4-Stage Balance
- Timed Up-and-Go (TUG)
- Get Up-and-Go
- Five Times Sit-to-Stand or 30-second Sit-to-Stand
- Functional Reach Test
- Turn Around Test



# **Clinical Balance Assessment Survey**

How confident are you doing the following activities without falling?

- 1.Cleaning house
- 2.Getting dressed and undressed
- 3. Preparing simple meals
- 4. Taking a bath or shower
- 5. Simple shopping
- 6. Getting in and out of chair
- 7. Going up and down stairs
- 8. Walking around the neighborhood
- 9. Reaching into cabinets and closets
- 10. Hurrying to answer the phone/door
- Rate on 10-point scale: "0"=not at all; "10"=completely
- Tinnetti Falls Efficacy Scale (J Am Ger Soc 1993)



## **4-Stage Balance**

- 1. Stand with feet side by side
- 2. Place the instep of one foot so it is touching the big toe of the other foot
- 3. Place one foot in front of the other
- 4. Stand on one foot
- 10 seconds in each stage

Purpose: Assess static balance

Resource: Centers for Disease Control. Stopping Elderly Accidents, Deaths and Injuries (STEADI).



# Single Leg Stance (SLS)

Normals for SLS (eyes open):

- 60-69 years: 27.0 sec
- 70-79 years: 17.2 sec
- 80-99 years: 8.5 sec

If person unable to balance 5 seconds=high fall risk

Bohannon RW. *Top Geriatric Rehabilitation*, 2006; 22(1): 70-7.

Vellas, et al. One-leg balance is an important predictor of injurious falls in older persons. *JAGS*. 1997;45(6):735-738.



# Timed Up-and-Go (TUG)

- Stand up from a chair with arms, walk 3 meters (to a line), turn around, walk back to chair, and sit down. Walk at a comfortable speed.
- Instruct participant to walk at a comfortable pace
- One practice trial
- Time begins with the verbal instruction "go" and stops when participant returns to seated position
- Allowed to use walking aid
- No physical assistance is given, good idea to conceal stop watch

Purpose: To assess mobility



# **TUG Interpretation**

Time	Interpretation
<10 seconds	"Freely mobile"
10-19 seconds	"Mostly independent"
20-29 seconds	"Impaired mobility"
$\geq$ 30 seconds	"Assisted mobility"



# TUG

- TUG associated with history of falls but predictive ability limited by population
- Cutoff score for high fall risk: >13.5 seconds, sensitivity 87%, specificity 87%
- Indicator of ADL difficulty: > 30 seconds

Morten et al. *Physical Therapy. 2007;*87(1):24-30. Podsiadlo, D., Richardson, S. *JAGS. 1991;* 39(2):142-148. Shumway-Cook, et al. *Physical Therapy*. 2000;80(9):896-903.



# **Get Up-and-Go**

- 1. Sit comfortably in a straightbacked chair **with no arms**
- 2. Rise from the chair
- 3. Walk a short distance (3 meters)
- 4. Turn around
- 5. Walk back to the chair
- 6. Turn around
- 7. Sit down in the chair without using arms for support

#### Scoring:

- 1 = Normal
- 2 = Very slightly abnormal
- 3 = Mildly abnormal
- 4 = Moderately abnormal
- 5 = Severely abnormal

- "Normal" patient gave no evidence of being at risk of falling
- "Severely abnormal" indicates that the patient appeared at risk of falling during the test
- Intermediate grades: presence of any of the following as indicators of the possibility of falling; undue slowness, hesitancy, abnormal movements of the trunk or upper limbs, staggering, stumbling

#### 3+ indicates fall risk

Mathias et al. (1986). *Arch Phys Med Rehabil*. 1986;67:387-389.



## Five Times Sit-to-Stand or 30-Second Sit-to-Stand

- Armless chair with seat height 35.5-46 cm
- Cross arms against chest
- Sitting against back of chair

Timing:

 Begin timing on the word "go" and stop timing when patient sits after the 5th stand

OR

 Count number of times patient comes to full standing position in 30-seconds

**Purpose:** To test leg strength and endurance



## **Sit-to-Stand Average Scores**

30-seconds

Age	Men	Women
60-64	14	12
65-69	12	11
70-74	12	10
75-79	11	10
80-84	10	9
85-89	8	8
90-94	7	4

 Centers for Disease Control. Stopping Elderly Accidents, Deaths and Injuries (STEADI).



# **Functional Reach Test**

- Reach as far as you can forward without taking a step, do not raise/lower arm more than 1 inch from yard stick
- Measure difference
- If only 90 degrees shoulder flexion, test not reliable
- Guard from the front and prepare to catch

Purpose: To reach outside base of support



# **Functional Reach Test**

#### Normal Limits

Age	Inches
20-40	14-17
41-69	13-15
70-87	10-13

- < 6 inches=high risk
- 6-10 inches=moderate risk
- >10= low risk
- <6 inches predicts fall in next 6 months

```
Duncan et al. J Gerontol. 1990;45:M192–M197.
Duncan et al. J Gerontol. 1992;47:M93–M98.
```



# **Turn Around test**

Points	Result
4	Turn 360° safely both directions in ≤8 seconds
3	Turn 360° safely one side at a time in $\leq$ 4 seconds
2	Turn 360° safely, but slowly
1	Unsteady, needs close supervision or verbal cueing
0	Unable, or needs assistance while turning

Record time and score

#### **Purpose:**

- Determine safety in tight spaces
- Tests vestibular influences



# Which one of the following fall tests helps determine safety in tight spaces?

- TUG
- 30-second sit-to-stand
- 4-stage balance
- Turn around test





- Key Takeaway #1
  - Incorporate a standard fall risk assessment into patient visits.
- Key Takeaway #2
  - Establish fall risk baselines for all patients.





# Incorporating Falls Risk Assessment into the Annual Wellness Visit



Mollie Ashe Scott, Pharm.D., BCACP, CPP, FASHP Regional Associate Dean and Clinical Associate Professor UNC Eshelman School of Pharmacy Clinical Associate Professor UNC School of Medicine

# **Annual Wellness Visit**

- Created in 2011 as a component of the Affordable Care Act
- Available for Medicare recipients annually with no copay
- Only 11% of patients received an annual wellness visit in 2013
- Goal is to develop a personalized prevention plan
- Elements include:
  - Medical and family history
  - List of providers and medications
  - Vitals
  - Screening for cognitive impairment
  - Personalized health advice including referral for falls prevention
  - Assessments of health risk factors
  - Screening schedule

https://www.medicare.gov/coverage/preventive-visit-and-yearly-wellness-exams.html https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/ MLNProducts/downloads/AWV\_chart\_ICN905706.pdf

# **Pharmacist-Led Annual Wellness Visit**

- Assessment of patient and provider satisfaction with annual wellness visits was performed in a family medicine residency program
- The pharmacist made 247 medication interventions and 342 nonmedication interventions for 69 patients
- Patients strongly agreed that the visit was important for their health
- Patients strongly agreed that they would like to see the same provider for the next annual wellness visit
- Physicians in the practice strongly disagreed that they would prefer to do the visit themselves
- Physicians strongly agreed that their patients benefitted from a pharmacist-led annual wellness visit



Wilson, JAPhA 2015;55:449-454

### **Example of an Annual Wellness Visit Workflow**

- Pre-visit planning by the pharmacist
- Completion of forms by the patient while waiting
- Falls assessment
- Vitals
- Medication review
- Immunization review
- Screening review
- Clock test for dementia
- Final review of forms with the patient
- Adjust vitamin D dose
- Advice about falls prevention programs
- Patient checks out





#### **Patient Case**

- Glipizide XL 10 mg po qam
- Glargine (Lantus) insulin 10 units SQ qpm
- Hydrochlorothiazide 25 mg po qam
- Lisinopril 40 mg po qam
- Clonidine 0.2 mg po tid
- Hydrocodone/Acetaminophen
   5/325 1 tab po q4h prn pain
- Diazepam 5 mg po tid
- Vitamin D 400 IU qam
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- Multivitamin 1 tab po qam



- LL 80 year old woman
  - Diabetes
  - Osteoarthritis
  - Hypertension
  - Generalized anxiety
- BP: sitting 150/80 mmHg, standing 126/70 mmHg
- HR 80 bpm; Wt. 55 kg; Ht. 5'1"
- BUN/SCr 17/1.01, potassium 4.0 mEq/L, fasting glucose 109 mg/dL, A1c 7.2%

# **Take Home Teaching Points**

- Our patient is taking many medications that increase her risk for falls
- Adjusting her regimen will take teamwork and time
- Her vitamin D dose does not decrease risk of falls and should be increased to maximize efficacy
- There are many assessments that can assess her risk of falls...choose one that works for your own practice





### **Question and Answer**

