Clinical Practice Guideline: **Fall Prevention Program**

Date of Implementation: **September 15, 2022**

Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) offers a Fall Prevention Program. The objectives of this program are to reduce falls among seniors, improve functional safety at home and in the community, and enhance overall fitness and independence among eligible Medicare members. This CPG describes the expectations of contracted or employed and credentialed ASH physical or occupational therapists who perform fall risk and safety assessments and the follow-up support provided by ASH Coaching services (assessments maybe performed in the member's home or by virtual synchronous video depending on the preference and contract with the health plan client). The Fall Prevention program may be offered to populations younger than 65 years at the discretion of the health plan; the engagement and functions of the program will be the same. The information provided to the member will be applicable to their needs and age.

Indications and Exclusions:

This program is provided as a supplemental Medicare benefit or program available to any eligible member who is not already receiving Physical Therapy (PT) or Occupational Therapy (OT) Medicare home health services based on qualifying criteria.

Fall Prevention & Home Assessment Program Overview

Eligible members are engaged by a Member Concierge who will assist the member in scheduling an available Physical or Occupational Therapist to provide the home assessment. If the member is not eligible for a home assessment, the Member Concierge will help the member navigate their options, including directing them to their health plan for needed services or to appropriate self-care resources and education.

Once scheduled, the member will receive in-home or virtual home fall prevention assessments completed by a credentialed Physical or Occupational Therapist. The assessment includes evaluation of the home environment for safety risks, functional mobility, and activity tolerance evaluation. The Physical or Occupational Therapist will use the Centers for Disease Control and Prevention (CDC) Stopping Elderly Accidents, Deaths, and Injuries (STEADI) Checklist as the basis of the in-home assessment. The practitioner will also evaluate the member in their home and assess for environmental safety concerns, the overt presence of social determinants of health that impact fall risk factors, and the need for equipment to mitigate falls and improve safety. Additionally, the Physical or Occupational Therapist will observe the member and/or ask about specific

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medical issues and comorbidities that could impact balance, mobility, and strength such as activity levels, blood pressure, foot, gait, vision, hearing, and/or medication issues. Any of these concerns will be noted in the *Fall Prevention & Safety Assessment Form,* which will then be submitted to ASH as the claim submission and trigger customer service outreach for coaching support.

An educational *Action Plan* is created by the practitioner and agreed upon by the member. The written Action Plan is provided to the member (or member's caregiver) by the practitioner. The Action Plan outlines recommendations for exercises, any necessary follow-up care or referrals, fall prevention strategies around the home, and resources for addressing risk factors impacted by observed social determinants of health or other areas of the assessment. An ASH Coach provides telephonic follow-up coaching support to address recommendations outlined in the Action Plan.

Covered services (services that are eligible for reimbursement) may be limited by state and/or federal regulations, health plan guidelines, and benefit coverage policies. Refer to the applicable Client Summary for covered services.

For Medicare and Medicaid services, medical record-keeping must follow and be in accordance with Medicare and any additional state Medicaid required documentation guidelines.

Assessment for Fall Risk

Clinicians can reasonably consider a small number of factors to identify older persons at increased risk of falling. Age has a strong correlation to fall risk. Additionally, many clinical factors such as a history of falls and/or gait and balance problems also flag patients for increased risk of falling. Practitioners can efficiently use three key questions to determine if further screening is necessary for at-risk older patients:

1. Has the person fallen in the last year?
2. Are they worried about falling? and
3. Do they feel unsteady?

Positive responses to any of these warrant further evaluation for fall risk.

Persons who have fallen or are otherwise at risk will have their gait and balance evaluated and undergo a multifactorial fall risk assessment with the Physical or Occupational Therapist. The *Fall Prevention & Safety Assessment Form* contains the following elements:

- a focused medical history (e.g., fall history, medical conditions, review of medication classes used),
- self-report questionnaire using the Modified Falls Efficacy Scale (MFES) to assess mobility and balance issues as perceived by the member while performing functional activities,

- objective functional assessments using functional outcome measures, and
- an environmental assessment (e.g., accessibility of the entrance and other areas of the home, presence of stairs, throw rugs, or unlevel surfaces) to identify safety hazards, need for home safety equipment, or modifications that could potentially help mitigate falls.

Tests used by the Physical or Occupational Therapist to assess a patient's gait, lower extremity strength and endurance, and balance for fall risk include, but are not limited to the following:

- *Timed Up & Go (TUG) Test* – evaluates individual's ability to transfer in and out of a chair, measures gait speed, dynamic balance and mobility with score of >12 seconds identifying fall risk;
- *30-Second Chair Stand Test* – assesses functional lower extremity strength; score is compared to population average score based on age and sex;
- *4-Stage Balance Test* – evaluates static balance; an adult who holds a full tandem stance < 10 seconds is at increased risk for falls.

These tests may also provide the practitioner with information about the person's cognition and ability to follow directions. During the home assessment, the practitioner will have the opportunity to observe the member's ability to perform Activities of Daily Living (ADL) and identify areas where a referral for further medical care or home safety products or equipment may be necessary.

Observation for Social Determinants of Health Risk Factors

Practitioners may have an opportunity to identify Social Determinants of Health (SDOH) that are contributing factors for increased fall risk by observing the home and perhaps the community where the member lives, if the visit is in person. Self-report of community can occur whether the assessment occurs in person or virtually. SDOH are defined as "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks" (HealthyPeople 2030). The following SDOH risk factors are included on the risk assessment form.

- **Housing Insecurity:** Not only affordability and environmental concerns such as pests or mold, but challenges such as accessibility (e.g., lack of handrails, stairs, uneven surfaces), structural safety.
- **Food Insecurity:** Defined by Healthy People 2030 as "the disruption of food intake or eating patterns because of lack of money and other resources."
- **Medical Care Insecurity:** Uncertainty and anxiety about getting needed medical care services
- **Transportation Insecurity:** Unable to regularly move from place to place in a safe and timely manner because of a lack of material, economic or social resources.

- **Social Insecurity (Isolation):** Feeling a lack of meaningful social relationships or network

If any risk factors in the above categories are observed, the practitioner will document their findings on the *Fall Prevention & Safety Assessment Form*. This includes housing related limitations to safely ambulate such as limited access to entry or different levels of the home due to stairs or other obstacles. If the member consents to coaching, an ASH Coach will provide guidance on finding available resources. If the practitioner or coach determines that there is a medical concern or that the member is unsafe, appropriate referrals (e.g., to the primary care physician) will be made.

Recommendations and Resources for Fall Prevention

The Fall Prevention Home Assessment program provides recommendations for action in the following areas:

1. Exercise (i.e., Otago Exercise Program) and physical activity (e.g., walking);
2. Safely aging in place (e.g., home safety items such as grab bars, raised toilet seat, etc.); and
3. Pursuing medical services or care (e.g., physical therapy evaluation and rehabilitation, primary care provider, vision screening, etc.).

The recommendations provided by the practitioner and supported through coaching are evidence based and consistent with the CDC STEADI program and American Geriatric Society/British Geriatric Society Prevention of Falls in Older Persons Guidelines. Any therapeutic recommendations outside the structured protocol of the STEADI program should be made by a medical physician or applicable treating provider.

Exercise is the intervention most strongly associated with not only fall prevention, but also reduction of fall-related fractures. Exercise programs with the strongest evidence of preventing falls in older people living in the community involve balance and functional exercises. Older adults should be encouraged to engage in regular exercise. Exercise should include muscle-strengthening activities twice per week, as well as aerobic physical activity that is either of moderate intensity for a minimum of 2 ½ total hours (150 minutes) per week or of vigorous intensity for at least 1 ¼ total hours (75 minutes) per week. For older adults identified as at risk for falling (e.g., due to a recent fall or ambulatory difficulties), the DHHS also recommends balance training at least three days per week.

The member will be provided with recommendations and resources for specific exercises to improve strength and balance, and overall fitness. The Physical or Occupational Therapist will explain and demonstrate how to safely perform the appropriate exercises and get the members acknowledgement that the recommendations are understood. ASH Coaches will support the member in using the resources and following the practitioner's recommendations.

Environmental hazards are associated with an increased risk for falls. The practitioner will provide recommendations for minimizing home hazards. These recommendations include removing obstacles from walkways, fixing poor lighting, or adding handrails or grab bars. An ASH Coach will support the member in identifying resources to follow the recommendations, including home safety and support products such as assistive devices for ambulation or adaptive equipment to support safe performance of Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs).

Referrals for Emergency or Other Medical Services

A member's condition and/or symptoms during a visit may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner, in accordance with the practitioner's scope of practice, training, and experience, to refer the member for appropriate co-management (e.g., to their primary care physician or to the Health Plan case management staff as determined by the client) or if immediate emergency care is warranted, to contact emergency care services as appropriate.

Practitioners are required to have a written plan of action regarding urgent and emergent situations including calling emergency services (e.g., 911, etc.). This emergency response plan must be followed by the practitioner when the care provided indicates that a referral to an acute care facility or emergency room for medical or mental health intervention is necessary for the safety of the member. The emergency plan should include a formal, written protocol appropriate to the services being rendered via home-based or virtual encounters and the practitioner's scope and training. Examples of indications for emergency action include, but are not limited to

- vital signs critically abnormal;
- patient falls at home and incurs an injury; and
- significant change in mental health status.

See the *Managing Medical Emergencies (CPG 159 – S) clinical practice guideline* for more information on common signs and symptoms of medical emergencies.

Coaching Support

Members have access to live fall prevention coaching with ASH Coaches. Coaching tools and techniques such as learning to identify and adopt new habits ("habit science"), cognitive behavioral education and motivational interviewing are used to influence learning and the adoption of the Physical or Occupational Therapist's recommendations for health improvement and to encourage the implementation and adherence to the risk-reduction guidance. The coaches will provide fall risk reduction information based on the Physical or Occupational Therapist's recommendations both telephonically and through e-communication. Information provided will include Health Plan support programs and resources as applicable. A resource library is available to members to improve safety and fitness as well as other general healthy aging information. Coaches will escalate, to the QA

process, any cases where there is a concern for the participant's appropriateness for the program or for other medical or behavioral concerns outside the scope of the program. Clinical staff including Medical Physicians, Nurses, and Pharmacists, are available to the coaching team to provide QA assistance as necessary in support of participants.

Licensure Guidelines for Appropriate Use

Practitioners providing home-based or virtual rehabilitation services shall be appropriately qualified professionals per best-practice standards. Physical or Occupational therapists shall have appropriate licensure as defined by federal, state, and local guidelines. Practice shall comply with any jurisdiction-specific requirements for home health or telehealth where applicable. Practitioners providing the structured Fall Prevention Assessment and educational Action Plan are not practicing Physical Therapy and will recommend patients seek medical or physical therapy evaluation and treatment if an indication for clinical services appear to be indicated during the Assessment.

Practitioner Scope and Training

Practitioners should practice only in the areas in which they are competent based on their education, training, and experience in delivering home-based rehabilitative services within their scope of practice. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases, it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or, if immediate emergency care is warranted, contact 911 as appropriate. For more information, see *Managing Medical Emergencies (CPG 159 – S) clinical practice guidelines*.

Health Care Ethics and Integrity

Practitioners are obligated to abide by the code of ethics and standards of conduct of their profession. The following basic principles make up the code of ethical conduct for the practice of home-based services.

Practitioners will:

- obtain informed consent from the member as required by law
- protect the public and the profession by reporting any conduct that they consider unethical, illegal, or incompetent
- respect the rights, responsibilities, welfare, and dignity of all members
- provide care based on medically necessary needs of the member

- be committed to providing competent care consistent with both the requirements and limitations of their profession
- refer patients to other facility locations or providers if home-based services may not be appropriate or adequate for the patient's health care needs
- comply with the laws and regulations governing the practice of their healthcare profession and home-based services
- avoid any activities with patients that are not within accepted medical practices

Practitioners will not:

- engage in practices that may pose a conflict of interest
- assume dual relationships outside of patient-practitioner relationship
- engage in conduct that constitutes harassment, verbal or physical abuse, or unlawful discrimination in any actions or practice
- practice while impaired such that the practitioner cannot practice with reasonable skill
- misrepresent in any manner, either directly or indirectly, their skills, training, professional credentials, title, identity, or services
- accept gifts, tips, or other valuables from patients or give gifts to patients

Confidentiality

All federal and state laws regarding the confidentiality of health care information and a member's rights to his or her medical information apply to home-based services in the same manner as clinic-based services. This could include maintaining confidentiality from family members or others in the home during delivery of rehabilitation services unless the patient gives appropriate consent.

Non-Discrimination

ASH does not discriminate against a member, provider, or practitioner for any reason and does not support any discrimination against members for any reason, including but not limited to age, sex, gender, gender identification (e.g., transgender), gender dysphoria, marital status, religion, ethnic background, national origin, ancestry, race, color, sexual orientation, patient benefit type (e.g., Medicaid), mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, source of payment, geographic location within the service area or based on political affiliation. ASH renders credentialing, clinical performance, and medical necessity decisions in the same manner, in accordance with the same standards, and within the same time availability to all members, providers, practitioners, and applicants.

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