OBJECTIVES

• Identify the prevalence and characteristics of chronic pain complaints

• Describe the risks and benefits of opioids for chronic vs. acute pain treatment

• Assess the potential for opioid prescriber guidelines to help or hinder pain management

What is Pain?

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”

- International Association for the Study of Pain (IASP)
Neurobiology of Pain

• Complex- Involves peripheral, dorsal horn, ascending track and descending inhibition mechanisms

• Pain results from activation of peripheral receptors (nociceptors) by a stimulus

• Chronic pain- Caused by changes in peripheral nerves, spinal cord structures and supraspinal structures

Acute vs. Chronic Pain

• Acute: Typically lasts 3-6 months
  • Is the result of actual tissue damage secondary to injury, surgery or the exacerbation of chronic disease

• Chronic: Persists on a daily basis for a month beyond what would be considered necessary to heal the underlying injury
  • Seems to serve no purpose and is much more complex and difficult to manage than acute pain
  • Divided into cancer/terminal and non-cancer/non-terminal categories

The Many Causes of Pain

• Injury (trauma, surgery)
• Disease (pancreatitis, PUD)
• Neuropathy (diabetic, alcoholic, impingement)
• Joint degeneration
• Side effect of drugs
• Infection (pyelonephritis, abscess)
• Unknown???
Common Chronic Pain Syndromes

- Low Back Pain
- Peripheral Neuropathic Pain
- Postherpetic Neuralgia
- Arthritis (often post-traumatic)
- Chronic Daily Headache and Migraine
- Complex Regional Pain Syndrome
- Pelvic Pain

- Fibromyalgia
- Orofacial Pain
- Trigeminal Neuralgia
- Temporomandibular Disorder
- Somatic Symptom Disorder
- Phantom Limb Pain
- Central Post-stroke Pain
- Spinal Cord Injury

The Prevalence of Pain in the United States

- Pain is the number one reason that patients present to their physician
- 100 million adults in the United States are affected by a chronic pain condition
  - Chronic back pain is the most common condition, followed by severe headaches, arthralgia, and neck pain
- The total healthcare costs secondary to pain ranged from $560 billion to $635 billion in 2010 (eclipsing the cost of heart disease, diabetes or cancer)
  - Patients with chronic pain utilize about twice as many health care resources as the general population

Pain is a Global Phenomenon

- Globally, it is estimated that 1 in 5 adults suffer from pain and that another 1 in 10 adults are diagnosed with chronic pain each year
- Primary care settings in Asia, Africa, Europe, and the Americas had patients reporting persistent pain prevalence of 10 to 25%
  - True for both the developed and the developing world
  - Developing countries bear higher burdens of persistent pain and lesser likelihood of effective treatment
  - Chronic pain is typically accompanied by substantial comorbidities
- Pain should be a global public health priority
  - Understanding pain as a disease (rather than a symptom) may reduce the global burden of this health problem and its comorbid conditions
Prevalence of Pain in Persons with Substance Use Disorders

- Substance use disorder and pain are interrelated, with each condition influencing the treatment of the other
- Chronic pain complicates the efforts of many individuals with substance use disorders to enter and sustain recovery
- 24% of patients admitted for treatment of addiction experienced severe chronic pain
- 37% of patients in methadone maintenance treatment programs (MMTPs) reported severe chronic pain
- ~80% of patients in both groups reported pain of some type and duration
- These patients are at increased risk of receiving inadequate pain management

Pain Assessment

- Pain complaints should always be taken seriously
- No diagnostic test to measure existence or severity of pain
- Thorough history
  - Quality and location of pain
  - Associated signs and symptoms
  - Exacerbating and alleviating factors
  - Temporal aspects
  - Interference with daily functioning
  - Response to prior treatments

- Psychological history
  - Prior psychiatric diagnoses
  - Work history
  - Legal history
  - Substance abuse history
  - Prior or current suicidality

- Focused physical exam (neurological and musculoskeletal)
  - Sensory changes
  - Motor changes
  - Passive and active range of motion
  - Postural and gait abnormalities
  - Imaging as indicated
Addiction Assessment

• Urine toxicology screen

• Relevant substance use history
  • Frequency, duration, amount used
  • Route of administration
  • Previous attempts at reduction or cessation
  • History of withdrawal, tolerance, blackouts, seizures
  • Previous treatments
  • Assess readiness to stop or cut down

Addiction Assessment

• Other History
  • Failure to fulfill major obligations
  • Recurrent use in hazardous situations
  • Recurrent legal problems
  • Continued use despite negative consequences

• Mental Status Exam
  • Sensorium, intoxication, mood, psychosis, suicidality

• Physical Exam
  • Liver, heart, lungs, CNS/PNS
  • Track marks
  • Lymphadenopathy

The History of Pain Management
John Bonica

- Opened America’s first pain clinic at UW School of Medicine in 1960
- Utilized many specialties within medicine to treat pain
- Used bio-psycho-social, comprehensive approach with minimal role of opioids
- Patient must participate and cannot be “fixed” like automobiles
- Many clinics followed this approach, but were dissolved by the 1990’s as insurance companies balked at payment

The History of Pain Management

- Throughout most of the 20th century doctors who prescribed opioids were treated as virtual outlaws
- In the 1970’s attitudes began to change
- 1980: Dr. Jan Stjernsward from Sweden was made chief of the cancer program for the World Health Organization (WHO)
  - Created WHO “Pain” Ladder, which included opioids for intractable pain
  - WHO also claimed that freedom from pain is a universal right

The WHO Pain Ladder
Kathleen Foley

- 1980s - Dr. Kathleen Foley (Memorial Sloan Kettering Cancer Center) became the voice for dying cancer patients.
- Pioneered the field of palliative care medicine and promoted the use of opioids in cancer patients.
- She also advocated for the use of opioids in the treatment of non-cancer pain.

Russell Portenoy

- Neurologist who did a fellowship under Foley.
- He was thrilled to be able to relieve the crippling pain he saw in patients.
- "I believe in drugs. I think pharmaceuticals are a great gift to humanity.
- Pushed for the use of opioids in non-cancer pain.

How Opioids Became So Prevalent

- Release of long-acting opioids.
- Marketing of OxyContin.
- More insurance companies reimbursing for pills, but not therapy.
- "Pill Mills".
- Climate: WHO ladder, universal right to pain treatment,
  "vital sign: providers really want a solution.
- Prescription opioids link to heroin.
Opioid Prescriptions have Skyrocketed in Past Twenty Years

Public Health Goals

• Heighten awareness about pain and its health consequences
• Emphasize the prevention of pain
• Improve pain assessment and management in the delivery of healthcare and financing programs of the federal government
• Use public health communication strategies to inform patients on how to manage their own pain and limit opioid use
• Address disparities in the experience of pain among subgroups of Americans

Current Regulatory Issues

• Joint Commission
  • “Recognize the right of patients, residents or clients to appropriate assessment and management of pain”
  • “Screen patients, residents or clients for pain during their initial assessment and, when clinically required, during ongoing, periodic reassessments”
• State Laws
  • [Link to database]
  • Maryland has a Board of Physicians educational guideline, requires 1 hour CME on pain for physician licensing
• Centers for Medicare and Medicaid Services (CMS) require pain assessment, treatment and ongoing review of patient response
### What are “effective” pain treatments?

#### Traditional Medical Model
- Medication
- Surgery
- Nerve Blocks
- Physical Therapy
- Cognitive Behavioral Therapy
- Comprehensive Program

*Usually covered by insurance. Taught in traditional medical schools. Overseen by FDA.*

#### “Less” traditional
- Massage
- Acupuncture
- Exercise / stretching
- Prayer
- Chiropractic medicine
- Herbal remedies / homeopathy
- Self-help
- Biofeedback
- Pilates

*Less often covered by insurance. Not taught in traditional medical schools. Not as available.*

### FDA Approved Indications for the treatment of Pain with Opioids

- Pain (Moderate to Severe)
- Postoperative pain, short-term management during hospitalization
- Pain, chronic, intractable (morphine)
- Pain, when opioid analgesics are appropriate
  - Pain, chronic, in patients requiring daily around-the-clock analgesic (hydrocodone)
  - Pain, chronic (Severe), in patients requiring a long-term daily around-the-clock opioid analgesic (oxycodone, fentanyl)
- Pain (Moderate to Severe), Not responsive to non-narcotic analgesics
- Breakthrough cancer pain, in opioid-tolerant patients

### The health care provider must...

*Often make clinical recommendations based upon insufficient evidence*
**Risks of Opioid Treatment**

- Constipation (most common problem)
- Nausea / vomiting
- Overdose, decreased respiratory drive
- Euphoria
- Hypotension and bradycardia
- Sedation
- Confusion
- Physical dependence
- Opioid use disorder
- Sleep disruption
- Urinary retention
- Sexual side effects
- Immunosuppression
- Fractures (especially in women)
- MDD
- Opioid induced hyperalgesia

**Risks of Untreated or Undertreated Pain**

- Relapse / new SUD
- Mental health symptoms (ie, depression, anxiety)
- Suicide
- Exacerbation of cognitive impairment (esp. in elderly)
- Functional loss and increased dependency
- Loss of productivity
- Impaired mobility (increased risk of falls/fractures)
- Impaired immune function and healing
- Increased health care utilization and costs
- Sleep disturbances
- Withdrawal and decreased socialization
- Legal Problems

**Risk of New Substance Use Disorder with Chronic Opioid Pain Treatment?**

- The exact rate of OUD in chronic pain patients is not known, but is thought to increase as the daily opioid dose increases and may be as high as 26% among patients prescribed opioids
- Persons at higher risk include those with
  - History of substance use disorder
  - Comorbid mental illness
Why use Opioids at All?

• Very few alternatives available (especially in rural or low SES)

• Lack of access to specialty pain treatment

• Providers desire to relieve suffering

• Legal ramifications of under-treatment of pain

Opioid Prescribing Guidelines

• What is a guideline?
  • “systematically developed statements aimed at helping people make clinical, policy-related and system-related decisions”
    http://www.agreetrust.org/

• Who usually writes guidelines?
  • Professional societies (local, national, international)
  • Policy makers
  • Insurance payers

• Audience for guidelines differ
  • Primary care providers, pain specialists, providers in certain regions or certain specialties, hospital administrators

Examples of Guidelines – APS and other professional societies

  • Developed by pain researchers and clinicians
  • Audience: any provider treating patients with chronic non-cancer pain
  • “Although evidence is limited, the expert panel concluded that chronic opioid therapy can be an effective therapy for carefully selected and monitored patients with chronic non-cancer pain.”

• https://www.asipp.org/Guidelines.htm
  • Meant for interventional pain specialists
  • “Since evidence supporting the efficacy for use of opioids as treatment of chronic non-cancer pain is limited and based on short-term studies, long-term opioid therapy for chronic non-cancer pain should be reserved for select patients with moderate to severe pain that significantly affects function to the extent that improvement in function is indicated if documentation supports that opioids result in improvement in function.”
Pain Association Guidelines- 2009
(APS and AAPM)

• Full History and Physical
  • Substance abuse, misuse and addiction
  • Benefit to harm evaluation
• Obtain Informed Consent
• Consider trial of chronic opioid therapy (COT) to
determine appropriateness

Pain Association Guidelines- 2009
(APS and AAPM)

• Monitoring
  • Pain intensity
  • Level of functioning
  • Progress towards therapeutic goals
  • Presence of adverse events
  • Adherence to prescribed treatment
• Random urine drug screens for all patients
• In high-risk patients (h/o abuse, psychiatric issues, aberrant behaviors)
  • More frequent and stringent monitoring
  • Consultation with psychiatrist and/or addiction specialist

Pain Association Guidelines- 2009
(APS and AAPM)

• Reassess and consider discontinuing COT when rapid
dose escalation or high dose needed
• Anticipate, identify, and treat common opioid associated
adverse effects
• Routinely integrate psychotherapeutic interventions
• Clinicians should be aware of federal and state laws
### CDC Guideline for Prescribing Opioids for Chronic Pain (2016)

1. Determining When to Initiate or Continue Opioids for Chronic Pain
2. Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation
3. Assessing Risk and Addressing Harms of Opioid Use

### Determining When to Initiate or Continue Opioids for Chronic Pain

1. Try non-pharmacologic and non-opioid pharmacologic treatments before opioids
2. Document intended and actual clinical improvements
3. Counsel patients on risks and benefits

### Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. Try IR (vs ER) opioids first
5. Start with lowest effective dose
6. Prescribe in low quantities for acute pain
7. Re-evaluate benefits and harms often
Assessing Risk and Addressing Harms of Opioid Use

8. Assess risk factors and mitigate risks
9. Check PDMP before prescribing and periodically thereafter
10. Conduct UDT before prescribing and periodically thereafter
11. Avoid concurrent benzodiazepine use
12. Refer patients with opioid use disorder to addiction treatment

Why is there controversy around guidelines?

- Turning chronic pain patients into adversaries of patients and families suffering with substance use disorders
- With multiple guidelines available, are providers at increased risk of legal action?
- What will insurance payers do?
- Who funded guideline development?

Are guidelines useful in helping manage chronic pain?

- Unfortunately, guideline production is flourishing but uptake in community is floundering
- Need to consider implementation during guideline development
- No evidence that guidelines improve pain treatment OR affect substance use disorder outcomes
What are the unintended consequences of past guidelines?

- Vast increase in opioid prescription/use
- Patients with more pain, worse function, and decreased quality of life
- Current opioid epidemic

Research Gaps

- What is the effect of length of time in MAT on risk of relapse with acute pain treatment?
- Does 12-step meeting attendance provide protection against relapse with opioid analgesic therapy?
- What analgesic combinations can reduce opioid requirements in pain treatment?
- What is the prevalence of chronic pain patients successfully maintained on opioids?
- What risk stratification tools can predict which chronic pain patients develop opioid use disorder?
- What clinically should be done with the tens of millions of patients that may be tapered off of opioids and still report chronic pain?
- What is the acceptability and efficacy for non-opioid pain treatment strategies in persons with history of substance use disorders?

Conclusions

- Chronic pain is a significant burden to individuals and to society.
- The increased reliance on opioids for chronic non-cancer pain treatment has been associated with a dramatic rise in persons with opioid use disorder and opioid overdose deaths.
- Guidelines designed to inform clinical practice differ in recommendations for opioid use in chronic non-cancer pain treatment.
- Consensus is needed that balances access to adequate pain management with devastating harms of addiction.
A Collaborative Approach to Fall Prevention
Using the ASCP-NCOA Toolkit

Agenda

- Overview of the CDC STEADI and ASCP/NCOA Toolkits
- Case Study Presentation and Discussion – Pharmacologic and Medical Issues
- Building Your Referral Network
- Interprofessional Fall and Fall Risk Management: Introduction to the Role of Physical and Occupational Therapy
- Case Work and Discussion
- Wrap-Up

Faculty

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  Founder & President, Meds MASH, LLC
- Michelle Fritsch, PharmD, BCACP
  Executive Director, North Carolina Association of Pharmacists
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  Senior Payment Specialist, American Physical Therapy Association
- Alice Bell PT, DPT, GCS
  Clinical Assistant Professor, Academic Fieldwork Coordinator, Towson University
- Jacqueline Wilson, MS, OTR/L
  Academic Fieldwork Coordinator, Towson University
Overview of the CDC STEADI and ASCP/NCOA Pharmacist Toolkits

Penny Shelton, PharmD, BCGP, FASCP
Executive Director, North Carolina Association of Pharmacists

Michelle Fritsch, PharmD, BCGP, BCACP
Founder & President, Meds MASH, LLC

Faculty Disclosure

Penny Shelton and Michelle Fritsch do not have any relevant financial relationships with commercial interests pertaining to the content presented in this program.

Learning Objectives

• Identify and utilize components of the CDC STEADI toolkit.
• Describe the purpose of the ASCP-NCOA Falls Risk Reduction Toolkit for pharmacists and other clinical practitioners.
• Identify and utilize each component of the ASCP-NCOA Falls Toolkit in a simulated case.
• Define how the ASCP-NCOA Falls Toolkit may be used in your practice as a falls risk reduction resource.
Cases

CDC STEADI
- Toolkit for professionals
- Toolkit for patients

STEADI Professional Components
STEADI Patient Components

ASCP/NCOA Toolkit Components

• Falls Risk Checklist
• Falls Application Cases
• Communications Documents
• Build Your Referral Network
• Bibliography

Support provided by Sanofi

Falls Risk Checklist

Four key areas of the checklist
• Get to know your patient
• Medical Conditions
• Medication Assessment
• Fall Risk Inducing Drugs (FRIDs)
Get To Know Your Patient

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

- Age over 80
- Falls
- Recent transition
- Lives alone
- In home care, full time
- Assistant living facility
- Skilled care facility
- Alcohol intake less than 1 oz/day
- Marijuana
- Other illicit substances
- Opioids
- Tapered
- Transition: In Hospice
- In Home Care
- Transition: In Hospice
- Complete of pain
- Pain score 0/10
- Can ambulate
- Crutches
- Walker
- Standard walker
- Assistive
- Sensory Function
- Visual
- No vision
- No vision in last year
- Pasta vision
- Activities
- No use of glasses/contact lenses
- Regular use of glasses/contact lenses
- Visual deficit
- Amblyopia
- Albinism
- Visual field deficit
- Tactile
- Can feel
- Changes in taste
- Changes in smell
- Taste deficit
- Almondism
- Albinism
Medical Conditions

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

Medical Conditions
- Afib
- Anxiety (alternative)
- Depression
- Impaired renal function
- Lower extremity arthropathy
- Malnutrition, dehydration
- Pain
- Arthritis (osteo, rheumatoid)
- CKD/ESRD
- Hemophilia
- Incontinence
- Lower extremity fracture/pain
- Multiple sclerosis
- Parkinson’s disease
- Cardiovascular disease
- Diabetes
- Impaired hepatic function
- Intubation (e.g. UTP)
- L.E. neuropathy - noninfectious
- M.D.
- Obstructive

Treat Me
**Medication Assessment**

- Number of medications (Rx, prn, OTC, vitamins, supplements, herbal)
- Recent medication regimen change
- Falls out Medication-Related Problems detected
- Lab values
  - "Critical" labs
  - Electrolytes, glucose, SCr, BUN, hepatic enzymes
- Calculate estimated creatinine clearance (Cockcroft Gault)
- Possibly medication concentrations

---

**Medication Overview & Lab Assessment**

**Medication Overview**
- Number of medications (polypharmacy = falls risk)
- Number of doses per day & complex regimens associated w/ falls risk
- Recent medication changes

**Lab Values**
- "Critical" labs
- Electrolytes, glucose, SCr, BUN, hepatic enzymes
- Calculate estimated creatinine clearance (Cockcroft Gault)
- Possibly medication concentrations

---

**Medication Assessment**

<table>
<thead>
<tr>
<th>Medication Related Problems</th>
<th>Geriatric Appropriate Medication</th>
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<tbody>
<tr>
<td>Each medication is necessary</td>
<td>Beer’s List</td>
</tr>
<tr>
<td>Safest evidence-based therapy</td>
<td>STOPP</td>
</tr>
<tr>
<td>Dose too low to be effective</td>
<td>START</td>
</tr>
<tr>
<td>Dose too high causing adverse effects or unnecessary risk interactions between medications, food, medical conditions</td>
<td>MAI</td>
</tr>
<tr>
<td>Ability to effectively administer each medication</td>
<td></td>
</tr>
<tr>
<td>Allergies and intolerances</td>
<td></td>
</tr>
<tr>
<td>Indication without an associated therapy</td>
<td></td>
</tr>
</tbody>
</table>
Falls Risk Inducing Drugs (FRIDs)

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

Gait, Strength, & Balance

<table>
<thead>
<tr>
<th>Test</th>
<th>Time Limit</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timed Up and Go (TUG) Test</td>
<td>12 seconds</td>
<td>______ seconds</td>
</tr>
<tr>
<td>30-Second Chair Stand Test</td>
<td>Below Average Score</td>
<td>______ number</td>
</tr>
<tr>
<td>4-stage Balance Test</td>
<td>&gt;10 seconds</td>
<td>______ seconds</td>
</tr>
<tr>
<td>Permanent Stance</td>
<td></td>
<td>______ seconds</td>
</tr>
<tr>
<td>Tandem Stance</td>
<td></td>
<td>______ seconds</td>
</tr>
<tr>
<td>One-legged Stance</td>
<td></td>
<td>______ seconds</td>
</tr>
<tr>
<td>Observed gait problems or difficulty standing</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

(See STAND for instructions for the above functional assessments)
Experts in geriatric medication management.
Improving the lives of seniors.

Considerations

- Number per class/risk type
  - < 2 CNS depressing medications
- Limit anticholinergic burden
- Medical conditions, medications, other factors
- Patient specific
- (Pharmacists are uniquely suited for this in-depth analysis)
- Consider all risks and benefits

Alternatives

- 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)
- Lowest possible dose to achieve therapeutic goal
- Use nonpharmacologic approaches whenever possible

Building Your Referral Network: A Collaborative Approach to Falls Prevention

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Executive Director, North Carolina Association of Pharmacists

Who’s Involved in Falls Prevention?

- Physicians, nurses
- Physical therapists
- Occupational therapists
- SNFs and ALFs
- Senior housing
- Home health
- Emergency Medical Services/1st responders
- Hospitals and Trauma Centers
- Public health/injury prevention
- Schools of pharmacy, nursing, OT, PT
- The Aging Network

The Aging Network

- Department of Health and Human Services
- Administration for Community Living/Administration on Aging
- Tribal Organizations
- State Units on Aging
- Area Agencies on Aging
- Local Government
- Consumers
- State Agencies
- Governors and State Legislatures
- Service Centers
- Transportation
- Nutrition Services
- Community-Based Services
- In-Home Services
- Assisted Living Services
- Institutional Services
- Legal Assistance
- Financial Assistance
- Social Services
### Falls Prevention Programs

- Otago Exercise Program
- A Matter of Balance
- Stepping On
  - Includes a pharmacist presentation
- Tai Chi
- Stay Active and Independent for Life (SAIL)

### Payment for Falls Prevention?

- Primary Care Practices
- Accountable Care Organizations
- Medicare Advantage Plans
- Patient Centered Medical Homes
- Hospitals
- Others

### CPT Codes

<table>
<thead>
<tr>
<th>Description</th>
<th>Coding</th>
<th>Considerations</th>
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<tbody>
<tr>
<td>Welcome to Medicare Examination</td>
<td>G0402</td>
<td>Billable within first 12 months of enrollment only</td>
</tr>
<tr>
<td>Annual Wellness Visit</td>
<td>G0438</td>
<td>Initial AWV</td>
</tr>
<tr>
<td></td>
<td>G0439</td>
<td>Subsequent follow-up to an AWV</td>
</tr>
<tr>
<td>Evaluation and Management</td>
<td>99201-99205</td>
<td>New patient</td>
</tr>
<tr>
<td></td>
<td>99211-99215</td>
<td>Established Patient</td>
</tr>
</tbody>
</table>

A falls risk assessment is a required element of the Welcome to Medicare examination (Initial Patient Preventative Physical Exam).
Quality Measures

Table:

<table>
<thead>
<tr>
<th>MIPS/PQRS Measures/CPT Codes</th>
<th>MIPS/PQRS Measure 104, 119, 126</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls screening, assessment, and plan of care</td>
<td>1101F</td>
</tr>
<tr>
<td>2+ falls in past year</td>
<td>1102F</td>
</tr>
<tr>
<td>1+ falls in past year with injury</td>
<td>1100F</td>
</tr>
<tr>
<td>2 or more falls in year</td>
<td>1100F</td>
</tr>
<tr>
<td>Fall risk assessment completed within 12 months in persons with fall history</td>
<td>2268F</td>
</tr>
<tr>
<td>Fall risk intervention within 12 months in persons with fall history</td>
<td>0516F</td>
</tr>
</tbody>
</table>

MIPS/PQRS Measure 154, 155, 318

- Falls in past year
- 1+ fall in past year with injury
- 2 or more falls in past year
- Fall risk assessment completed within 12 months in persons with fall history
- Fall risk intervention within 12 months in persons with fall history

ACO Measures
- Screening for fall risk at least once within 12 months

HEDIS Measures for Medicare Advantage
- Reducing the Risk of Falling
  - Measure C18

Interprofessional Fall and Fall Risk Management

Introduction to the Role of Physical and Occupational Therapy

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Jacqueline Wilson, MS, OTR/L
Clinical Assistant Professor, Academic Fieldwork Coordinator, Towson University

- Causes of falls
- When/why to refer for therapy
- Indications for Therapy Referral
- Review of APTA Clinical Summary on Fall Risk in Community-Dwelling Elders
- Occupational Therapy Evaluation
- Occupational Therapy Interventions
- Timed Up and Go Test
- Review of Prevention of Falls in Community-Dwelling Older Adults: U.S. Preventive Services Task Force Recommendation Statement
- Evidence based Interventions
  - Dose specific exercise prescription

Evidence based interventions

- Dose specific exercise prescription
Causes of Falls

• Not part of aging process
• Occur due to:
  – Physical dysfunction
  – Cognitive deficits
  – Medications
  – Environmental hazards

Indications for Therapy Referral/Consultation

• Changes in or difficulty in mobility
  – Unsteady gait
  – Reduced spatial awareness
• Use of new or different mobility device
• Report of fall
• Difficulty rising from a chair
  – Muscle weakness
• Report of change in environment

Indications for Therapy Referral/Consultation

• Observed change in self care management
  – Grooming
  – Dressing
  – Medication management
• Noticeable cognitive/motor challenges
  – Handling money
  – Payment for medications
  – Organizing thoughts in conversation
  – Problem solving and direction following
When to refer for therapy?
Why refer for therapy?

- *Time, Time, Time*
- When consulting with a client, if you feel there is not enough time to explain, train, and maintain the regimen needed for safety and well-being, then consider making a referral for occupational therapy or physical therapy.
- Therapists have the time during their therapy sessions to address the specific needs and goals of a client.

APTA Clinical summary

- Examination recommendations
- Risk factors
- Tests and measures
- Interventions

Occupational Therapy Evaluation

- Occupational Profile
- Assessments
- Identification of strengths, needs,
- Collaborative development of goals
- Consultation with the client and caregiver
Occupational Therapy Interventions

- Medication management
  - Secure a prescription
  - Fill a prescription
  - Understanding the prescription
  - Taking medications
  - Medication apps

- Falls management
  - Assessment of home environment
  - Sensorimotor education and activities

Timed Up and Go Test

https://www.youtube.com/watch?v=BA7Y_oLElGY

Prevention of Falls in Community-Dwelling Older Adults: US Preventive Services Task Force Recommendation Statement

- Summary of Recommendations and Evidence
Evidence-Based Interventions

- Dose Specific Exercise Prescription

Interprofessional Fall and Fall Risk Management

Case Work and Discussion