Barriers and enablers for screening and assessing fall risk in older adults: an overview

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Introduction/Purpose of Document

Although the terms are sometimes used interchangeably in the literature, fall risk screening and fall risk assessment are two distinct but inter-related diagnostic processes utilized in the field of fall prevention.[1] Fall risk screening is the process of administering measures and tools (e.g., the Timed Up and Go Test) in order to identify individuals at risk of falling, and to determine the need for further evaluation, while fall risk assessment is a more time consuming and comprehensive process aimed at identifying fall-related risk factors (e.g., medication use) that can be addressed through preventive interventions.[2] Timely access to fall risk screening and assessment are key components of effective fall prevention among older adults.[3,4]

Despite their importance in guiding the development of effective fall prevention interventions, the implementation of fall risk screening and assessment are inhibited by a range of barriers and challenges. Through a synthesis of the published literature as well as surveys and interviews conducted with Canadian fall prevention practitioners/clinicians, the following report provides an overview of the key barriers to fall risk screening and assessment as well as the key enabling factors or facilitators promoting the implementation of screening/assessment. This report has been prepared as a background document to inform a series of upcoming consultation sessions planned by the Ontario Fall Prevention Collaborative. These sessions will engage fall prevention practitioners/clinicians working in primary care settings, community settings and Ontario Health Teams in validating the key barriers to effective fall risk screening and assessment in Ontario and identifying potential strategies for overcoming these barriers.

Fall Risk Screening/Assessment Barriers and Enablers: An Overview

Insights from the Published Literature

Research focused specifically on the identification of barriers and enablers/facilitators to fall risk screening and assessment for older adults is relatively limited and comprised mainly of qualitative studies or cross-sectional surveys. Most of these studies have been conducted in primary care settings.[5]

A cross-sectional survey of general practitioners (GPs) in two areas of South-east France was conducted to determine the factors affecting annual fall risk screening among patients aged 75 or older.[6] Questionnaires were sent to 1,836 physicians and completed by 493 (26.8% response rate). Barriers to annual fall risk screening included patient selecting not to be screened (56.3%), forgetting to screen (36.6%), unsuitable working conditions for screening (18.5%), lack of time (13.3%), lack of knowledge (13.3%), and inadequate financial remuneration (11.1%). Factors that facilitated fall risk screening included perceived usefulness of annual screening for falls, satisfaction with available interventions/treatment for falls and fall risk, and increased consultation time. One

paradoxical finding of the study is that while almost two thirds of respondents (65.3%) felt that annual screening for fall risk was useful, only 28.8% screened their patients for falls on an annual basis.[6]

An earlier (2006) study on barriers and facilitators to integrating fall risk evaluation in primary care practice conducted qualitative, semi structured interviews with 18 primary care providers who were part of a health care collaborative assisting community dwelling older adults in Hartford, Connecticut.[7] Barriers and facilitators to fall risk screening identified by respondents were grouped into three thematic categories. Physician factors included lack of awareness of the importance of fall risk screening compared to other diagnostic procedures (e.g., cancer screening), competing priorities (e.g., hypertension management), the appropriateness of referrals for dealing with fall risk, and level of physician training, which was both a barrier and a facilitator. Logistical factors included the availability of transportation for older adults, time requirements for immobile patients, physician reimbursement, scheduling, and family involvement in cases where a family member needed to be present for accurate reporting. Physician perceptions of patient factors included concerns about patients self reporting falls (due to denial, memory loss, etc.), patient attitudes towards medication (both a barrier and facilitator), and positive feedback from patients referred to fall prevention interventions, such as physical therapy.[7]

Comparatively little research has focused on the barriers and enablers to fall risk screening and assessment in hospital settings. One of the few studies addressing this issue surveyed 103 patients (70 years of age +) attending the emergency department and outpatient clinic at a hospital in the Netherlands as well as 36 health care professionals serving older adults at the facility.[5] Patients identified many factors as facilitators for in-hospital fall risk screening and no factors as barriers. Facilitators identified by patients included the flexibility of screening programs, minimal time investment, supportive staff and motivation to reduce fall risk. Health care professionals regarded characteristics of the screening program, such as specificity and flexibility, as key facilitators. However, health care professionals were less positive about fall risk screening programs than their patients and identified multiple barriers, including time, lack of knowledge, lack of training, inadequate facilities, reimbursement, and the benefits of providing fall prevention advice to patients lacking the resources or capacity to act upon it.[5]

Lack of time to conduct fall risk screening and assessment is a recurring barrier irrespective of health care setting. For example, a survey of 102 emergency providers at a US hospital found that while a majority of respondents (82/102) recognized the importance of fall prevention, most (90%) were not willing to spend more than five minutes on fall risk screening or assessment.[8] A survey of 29 health care professionals serving older adults at acute care clinics in the midwestern United States found that 71 percent of respondents stated there was “almost never” or only “sometimes” sufficient time to screen for falls during patient visits.[9]

Another recurring finding of studies focused on fall risk screening and assessment are the organizational and system level factors extending beyond patient/provider characteristics. These include limited coordination and communication between key service providers, insufficient human and financial resources for fall prevention work, including screening/assessment, restrictive organizational mandates, and 'siloing' within health care systems that impedes the cross-disciplinary information sharing and collaboration needed to consistently assess fall risk and implement effective counter-measures.[5, 6, 10, 11] These findings suggest that any efforts to increase the prevalence of fall risk screening and assessment will not yield beneficial results until a more aligned, integrated system supporting implementation is established.

Canadian Perspectives on Fall Risk Screening and Assessment Barriers and Enablers

A small body of unpublished research provides insights into the fall risk screening and assessment barriers and enablers experienced by Canadian practitioners. This includes an online survey and a subsequent series of key informant interviews conducted by the Ontario Fall Prevention Collaborative as well as data collected by the Centre for Effective Practice, an Ontario-based organization supporting knowledge translation for primary care in Canada.

Ontario Fall Prevention Collaborative

In November 2020, the Ontario Fall Prevention Collaborative launched an online survey on the utilization of fall risk screening and assessment tools and resources by Ontario practitioners. The survey was completed by 40 individuals, over 41 percent of whom worked in primary care (20.83%) or emergency care (20.83%). Smaller numbers of respondents worked in public health, home and community care and paramedic urgent care.[12]

The survey included a question asking respondents to identify barriers to the use of fall risk screening and assessment tools. Consistent with the extant literature, time-related factors were cited as major barriers by over 20 percent of respondents. Specifically, 13.24% of respondents agreed that fall risk screening and assessment "takes too long to complete", while 8.82% agreed that screening and assessment "takes up too much staff time." Other barriers noted by respondents included lack of organizational support (14.71%), lack of training (14.71%), lack of electronic records and tracking processes (13.24%), lack of knowledge and skills within the organization (11.76%), and the inability to conduct fall risk screening and assessment using virtual modalities (7.35%).

More in-depth, qualitative information on barriers to fall risk screening and assessment was collected through a series of key informant interviews commissioned by the Collaborative in the spring of 2022 as part of a larger study on the development and utilization of clinical practice guidelines (CPGs) for fall risk screening and assessment in Ontario.[13]

Ten semi-structured interviews were conducted with individuals directly involved with the development or utilization of fall risk assessment CPGs and related resources in British Columbia, Ontario, New Brunswick and Saskatchewan.

Respondents' perceptions of the barriers to the effective utilization of fall risk screening and assessment CPGs mirrored most of the findings of the research literature. A lack of time for comprehensive fall risk screening and assessment was the most frequently noted impediment:

> "I think the one that comes to mind as the biggest challenge or barrier is the amount of time that they [CPGs] take. So I think a lot of falls risk tools and guidelines offer a very comprehensive process that is not feasible for how our primary care system is set up. And so as a result it is not possible for a lot of providers to fit them in."

> "So the fact that staff are strapped for time. Like on admission, there are so many other competing things that they need to assess for, especially if somebody is acutely ill. It shouldn't happen, but it [fall risk assessment] sort of falls to the lower end of priorities."

Other barriers noted by respondents that matched the findings of previous research include lack of staff training, logistical issues, including limited availability of skilled assessors on a 24/7 basis in health care facilities, physician reimbursement issues and a lack of awareness about the preventable nature of falls. As one respondent noted, this belief often extends to clinicians serving older adults.

> "Many people don't know that falls are preventable, and that includes people with clinical backgrounds. There's still a prevailing belief that falls result from accidents and accidents happen ... when we first started presenting to the guideline advisory committee, the members of it, all of whom have medical degrees, were shocked to hear about the burden of falls, that falls were preventable, and that there were guidelines that already existed."

One identified challenge that was not as prevalent in the literature concerns the mindset of older adults undergoing fall risk assessment. Several respondents noted that the recipients of fall risk assessment, many of whom may be acutely ill, may not realize the full benefits of assessment-related advice to avert future falls due to 'information overload.'

> "The other issue we found was that the patients themselves were often very overwhelmed when they first came in. And so sometimes what would happen is that a lot of these CPGs were kind of throwing things at patients right away...and unfortunately what happens is that the patients are so overwhelmed they're not able to take in what's been given to them."

> "As a physician you're telling them to do twelve things, and you're asking for an issue. Things are going to be dropped. Things might fall through the cracks."

Respondents offered a range of ideas for surmounting the barriers to effective fall risk screening and assessment. One of the key emergent themes concerned the 'normalization' of fall risk assessment as a regular preventive health measure. Specifically, communication campaigns are needed to encourage older adults to proactively schedule fall risk screening and assessment with their health care providers on a regular basis.

> "I think the other piece is also just normalizing fall risk assessment and prevention ... this isn't like diabetes or chronic pain or something that a patient proactively books an appointment with their primary care provider to talk about ... it's something that should be brought up at age 65 and every year after that."

> "And I also think raising awareness with the public, understanding that falls and injuries from falls are not normal. You might not prevent all the falls, but if you can prevent fall-related injuries you're making progress."

One respondent who identified the COVID-19 pandemic as a major impediment to fall risk assessment ("We were told … that because of the pandemic physicians are exhausted. They don't want anything new to change their practice.") went on to describe how the pandemic could potentially be leveraged within the current health policy climate to build increased commitment to fall risk assessment:

> "Older adults are staying home to avoid COVID-19 and don't have the same engagement in their communities – not going to exercise classes. We know it's quite likely that falls and the risk of falls is increasing, and that people's strength is deconditioning ... but what would help people to deal with that? All of the same things that would help lower the risk of falls! ... So I feel like we need to align more with those instances and recognize that the policy window is sort of where you make it."

Respondents also emphasized the need to raise awareness of the benefits of fall risk screening and assessment to front-line providers, who may not be cognisant of the need for a comprehensive approach to screening for fall risk.

> "Most of the people who are working front line don't actually know, for example, what the RNAO guidelines are ...They just have a sheet and a chart. They don't know the background or anything about that ... We really have to come together as a team and get clients and residents involved and communicate what the risk factors are."

> "And I think the Ontario Health Teams need to understand it as well. If they don't support it, if the Ministry doesn't support it, it's not going to happen ... I think OHTs need to push up to the Ministry to enable doctor's practices to undertake this [fall risk screening and assessment]."

Changes in health human resources policies that increase access to fall risk screening and assessment were also noted as potential solutions. For example, one respondent described how extending GEM nurse availability enabled more older adults to be assessed for fall risk.

> "From a health human resources standpoint, often people who fall don't necessarily come during regular working hours. So often the people who are using these CPGs are there Monday to Friday from 8 to 4, that kind of thing, right? So people who are coming in the evenings or on weekends, and so we need to find a way to be able to ensure that these CPGs are being utilized ... one place actually switched one of their GEM nurse times ... so that the GEM nurse was there to be able to support people who were coming later into the evening ... So we need to find ways to be able to support at all times"

One obvious solution to addressing the time barrier to fall risk screening and assessment is to develop shorter, more circumscribed clinical practice guidelines and screening tools. There were mixed views about the appropriateness of this option. While one respondent supported the notion of "choosing things that are more practical and providing ways of breaking fall risk assessment into smaller, more manageable pieces," a clinician cautioned against "allowing physicians to influence the development of algorithms. They will make it so simple that it might lose its value ... you don't want to limit effectiveness in the hopes of getting more buy-in"

Centre for Effective Practice

In 2021 the Centre for Effective Practice (CEP) created a list of barriers and enablers for fall risk screening and assessment as part of its academic detailing training for fall prevention and management.[14] Academic detailing provides evidence-based information about best practices to primary care practitioners in Ontario, including family physicians and primary care nurse practitioners.[15] The list was derived from a review of the literature as well as input from CEP's primary care and clinical leads.[16]

The barriers to fall risk screening and assessment identified by the CEP reflect many of the barriers identified by the Ontario Fall Prevention Collaborative and the extant research literature on the topic. They include limited time, lack of knowledge on how to conduct a fall risk assessment, the complexity of coordinating follow-up (i.e., multiple interventions), balancing fall prevention with other patient priorities, patient complexity, patient motivation (e.g., beliefs about falls, stigma associated with falling), lack of knowledge about community-based services for referrals, and the inability

to conduct home visits and arrange in-person assessments for housebound elderly patients. Enablers included a combination of practice-based advice, such as dealing with time limitations by dividing fall risk assessment into multiple appointments and delegating assessment tasks to other team members, and specific resources developed by CEP and other organizations with a fall prevention mandate (e.g., the CEP falls tool and checklist, a Falls Electronic Medical Record (EMR) tool, the Centers for Disease Control (CDC) patient handout on fall risk), and virtual care.

Further information about barriers to fall risk screening and assessment is available in the Academic Detailing statistics maintained by the CEP. Between October 2021 and September 2022, 74 primary care practitioners who engaged in an academic detailing discussion on fall prevention and management from the CEP noted their perceived barriers to fall risk screening/assessment.[17]

Lack of time for screening/assessment was the most predominant barrier, cited by 37 percent of respondents. Other barriers included patient reluctance to implement recommended interventions (e.g., giving up medications, using assistive devices), inability of patients to implement interventions (e.g., installing grab bars) due to cost, patient reluctance to discuss falls, and long wait times for fall clinics and other community services. Additional responses included lack of perceived yield and value of screening in addition to uncertainty about which screening and assessment tools to use. Several providers noted they felt they had nothing more to offer patients who fell frequently.

GeriMedRisk, a non-profit virtual clinical service connecting Ontario physicians, nurse practitioners and allied health professionals with a team of specialists in geriatric medicine, psychiatry and pharmacy, was noted as a facilitator for fall risk screening and assessment by several respondents.[18] GeriMedRisk was mentioned as a helpful resource that enabled primary care practitioners to provide appropriate follow up on key issues arising from fall risk screening and assessment, such as medication use and health conditions contributing to increased fall risk among older adults.

Summary and Next Steps

Table 1 integrates the findings of this report (i.e., the review of the literature and the work of the Ontario Fall Prevention Collaborative and the Centre for Effective Practice) into a comprehensive summary of identified barriers and facilitators/enablers for fall risk screening and assessment. To better enable the development of feasible strategies promoting the uptake of fall risk screening and assessment, the barriers and facilitators/enablers have been divided into four categories: patient factors, provider factors, socio-environmental factors, and organizational-system factors.

The contents of this table and the accompanying report will be validated with participants at the upcoming stakeholder consultation sessions in the winter of 2023. The table and report will also serve as a basis for facilitating stakeholder discussions about

additional barriers to fall risk screening/assessment as well as strategies for reducing barriers and increasing facilitators. A final report summarizing the results of the stakeholder consultations, including recommendations for action, will be available in the spring of 2023.

Table 1. Fall Risk Screening and Assessment Barriers and Enablers

Level	Barriers	Enablers/Facilitators
Patient Factors	Low motivation to undergo screening/ assessment due to concerns about stigma associated with falls/ aging. Lack of awareness about preventable nature of falls (falls are a normal part of aging) Reluctance to implement recommendations arising from screening/ assessment (e.g., giving up medications, use of assistive devices) Information overload' (patient overwhelmed with feedback and recommendations at time of screening/assessment) Cognitive factors	Communication campaigns focused on benefits of screening and assessment and aimed at 'normalizing screening/assessment as a regular preventive measure, engage family members Screening/assessment offered at flexible times Screening assessment not overly time consuming Patient satisfaction with recommended interventions Divide screening/assessment into multiple visits Have family member/advocate present at screening/assessment to assist patient with understanding diagnosis/advice

Level	Barriers	Enablers/Facilitators
Provider Factors	Lack of time for screening/assessment (most common barrier) Balancing screening/assessment with competing health priorities of patients Lack of knowledge/training re. screening/assessment Lack of awareness about preventable nature of falls (falls are a normal part of aging) Lack of knowledge about health and community services for patient referrals post screening/assessment Challenges with screening/assessment and appropriate follow up for patients with complex, multi-factorial health issues Lack of a structured approach to screening/assessment	Divide screening/assessment into multiple appointments Delegate assessment tasks to other team members Create shorter screening tools and clinical practice guidelines (mixed reaction from respondents) Increase access to screening/assessment training opportunities and sources of best practice info (e.g., CEP academic detailing) Communication campaigns focused on benefits of screening and assessment and aimed at 'normalizing screening/assessment as a regular preventive measure Promote existing 'clearinghouse' resources for service referrals (e.g., the healthline.ca) Promote resources/supports for primary care providers (e.g., GeriMedRisk) Utilize EMR searches and reminders to screen all patients 65+ (or alternate category), utilize EMR assessment tools where available (i.e. CEP/eCE Falls Tool for Telus PS)

Level	Barriers	Enablers/Facilitators
Socio-Environmental Factors	Availability of transportation for screening/assessment sessions Cost of implementing screening/assessment recommendations (e.g., installing grab bars, purchasing assistive devices) for low-income older adults Language/cultural barriers Lack of home visits and in-person screening/assessment due to pandemic and flu season Primary care provider 'burnout' as a result of the pandemic	Mobile falls clinics, reach out to family members for transport, paratransit services, Home/Community Services in-home assessments, utilize virtual care for some screening measures (e.g, "do you hold onto furniture or counters to get around the house?") Raise awareness of income support and subsidy programs (e.g., Ontario Seniors' Home Safety Tax Credit, Ontario Assistive Devices Program, March of Dimes, Quipit, local services) Have family member/advocate present at screening/assessment to assist patient with understanding diagnosis/advice Look at ways of leveraging pandemic in ways to promote screening/assessment (e.g., emphasize fall risk factors, such as deconditioning) that have resulted from the pandemic
Organizational and System-Level Factors	Screening/assessment only available during limited times Long wait list times for falls clinics and other services Insufficient financial resources for screening/assessment Inadequate financial remuneration for screening/assessment by MDs Lack of organizational support for screening/assessment (not viewed as a priority) Lack of electronic patient records for information sharing/coordination between health service providers 'Siloing' within health care system that limits cross-disciplinary collaboration needed for effective screening/assessment and patient follow-up	Implement health human resource re deployment policies that increase access to screening/assessment (e.g., GEM nurses working shifts on evenings, weekends) Utilize GeriMedRisk and other services as an interim measure while awaiting other services Review MD billing codes available for screening and assessment Communication campaigns focused on benefits of screening and assessment and aimed at 'normalizing screening/assessment as a regular preventive measure

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