

Assessing the Frequency of Fall Risk Screening in Older Adults on Chronic Opioid Therapy in Primary Care



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I. Introduction

Opioids are commonly used to manage chronic pain in older adults. In one year, one-third of adults 65-years or older had used prescription opioids for pain.¹ In 2018, Utah providers wrote 57.1 opioid prescriptions for every 100 persons.²

Seniors using opioids are at greater risk for falls and increased mortality from falls due to opioid use.^{3,4} These consequences can be reduced if patients are effectively screened and

interventions implemented.⁵

The Agency for Healthcare Research and Quality (AHRQ) has begun a learning collaborative to improve the management of opioid use and misuse among older adults in primary care.



Research question: In patients 50 years or older who are taking opioids for a minimum of 3 months and seen at the Sugarhouse Health Center Internal Medicine, Geriatric Medicine, and Family Medicine outpatient clinics, what percentage of these patients were screened for fall risk between the dates of April 1, 2021 to March 29, 2022?

II. Methods

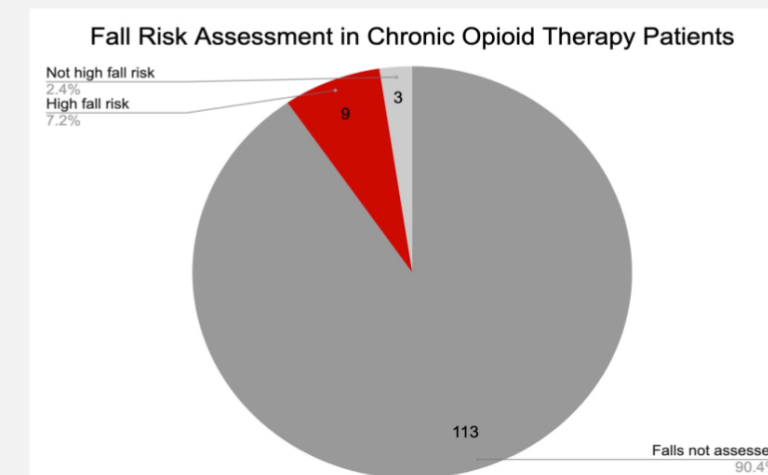
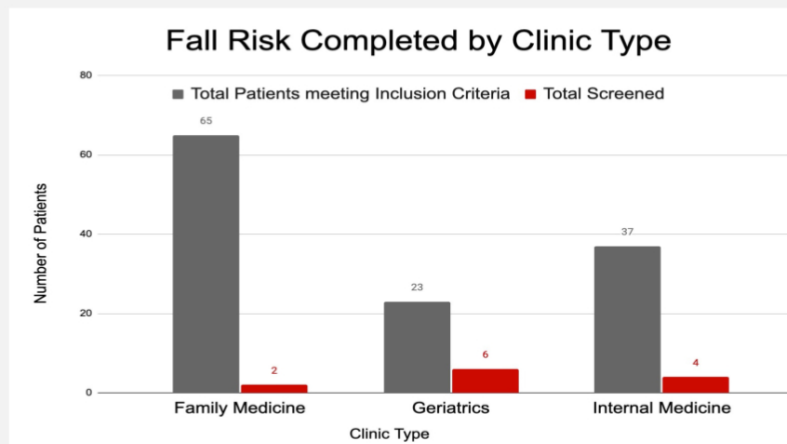
This study was a retrospective chart review. Patient inclusion criteria included: patients 50 years old and older, who were prescribed an opioid medication for a minimum of three months within the study time frame, seen in a primary care setting at Sugarhouse Clinic. Exclusion criteria included if opioids were prescribed for palliative care, since the intervention would be different for these patients. We collected data based on our

inclusion criteria from a database created by a University of Utah data analyst. The quantitative data analysis included descriptive statistics of patients who have completed fall screens and who had high fall risks. Patients were categorized by age (64 years and younger, and 65 years and older), gender and if the patient had a concurrent benzodiazepine prescription.

III. Results

From April 1, 2021 through March 29, 2022, there were 125 patients who met inclusion criteria. 65 (52%) patients within the sample were female, and 60 (48%) were male. 45 patients were aged 64 years or younger, and 80 patients were aged 65 years or older. Mean age was 69.02. The majority of fall risk assessments were completed in the Sugarhouse Geriatrics clinic.

Within our patient population, 12 (9.6%) out of the 125 were assessed for fall risk. Out of the 12 patients who were assessed for fall risk, 9 screened high for fall risk. 38 (30.4%) of 125 patients in the sample had a concurrent benzodiazepine prescription. Of these patients, 5 were screened for fall risk, and 4 were found to be at high risk for falls.



IV. Conclusions

The data revealed that only 9% of older adults on chronic opioid therapy were screened for fall risk at in primary care at a single University based community clinic. The low screening seems multifactorial and could be attributed to the lack of criteria or clear instructions on when to screen for fall risk, insufficient staff available to conduct the screening, and limited time allotted for each appointment.

Results also showed a profound difference in the frequency of fall risk assessment throughout different clinical settings. The most significant number of patients screened at the geriatric clinic may point toward the fact that board-certified geriatric clinicians are trained in fall risk assessment and that each of these clinics has different times allotted to each visit, geriatrics being the longest, followed by internal medicine then family medicine. It

was noticed that the fall risk further increased in patients who were concurrently using benzodiazepines and opioid medications. This research will provide a foundation for Sugarhouse clinic to apply interventions to reach its clinic goal of screening 25% of patients within this population for fall risk.

Further research should include evaluating if there is a need to complete fall risk assessments in patients 50 years and younger. Additionally, the patient dashboard should consider adding which fall risk tool was given to patients and how many of these patients fell.

This will ensure a uniform interpretation of the fall risk and will help measure the accuracy of fall risk screening tool.

V. References

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