

Editorial

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Protecting Veterans from Fall Injury: The Next Step in Patient Safety

For older adults, falls are recognized as a major cause of morbidity and mortality and are associated with substantial health care costs. According to a recent CDC study, U.S. adults aged 65 or older had approximately 10,300 fatal fall injuries and 2.6 million medically treated, non-fatal fall injuries in the year 2000—resulting in direct medical costs of \$0.2 billion and \$19 billion, respectively.¹ Another analysis estimated the average health care costs of a fall injury (including hospital, nursing home, emergency department, and home health care costs but not physician services) to be \$19,400.² Furthermore, the problem is expected to escalate in the coming years. It's been projected that, by 2020, annual direct health care costs of fall injuries for people aged 65 and older will reach \$32.4 billion (in current dollars), and the total (direct and indirect) costs will reach \$43.8 billion (in current dollars).³

As a population, VA patients are older than the general population and, therefore, at greater risk for falls and fall-related injuries. In 1999, approximately 38% of male veterans were aged 65 and older, compared to 13% of men in the general U.S. population.⁴ Although the number of veterans treated through the VHA is expected to decrease in the future, the proportion of patients aged 65 and older is expected to keep rising—to 43% in 2010 and 51% in 2020.⁴ Also, the number of “oldest old” veterans (aged 85 and older), who are at highest risk for injurious falls, is expected to climb to 1.3 million by 2010.⁴ Given these projections, it is likely that fall-related injuries will represent a large volume of service in the VHA for many years to come.

Even now, patient falls are the leading cause of reported adverse events in

the VHA and result in substantial complications. Among the 620 serious falls reported to the VHA Adverse Events Registry in 1999, 60% resulted in hip fractures⁵—a particularly costly injury. One prospective study showed that, when compared to health care costs among patients who had not fallen, those incurred by patients who had a hip fracture were between 78% and 101% higher.⁶

Recognizing the significance of the problem, the VHA has taken a lead in protecting veterans from these adverse events by implementing evidence-based fall prevention programs and building infrastructure within its health

therapy, those who have positive risk factors for osteoporosis or have been diagnosed with the disease, and those with a history of fracture.

Recent studies have investigated the correlation between advanced age and poor outcomes after injury. In an integrated literature review of research published between 1996 and 2005, Jacoby and colleagues confirmed that “the relationship between older age and poorer outcomes persisted when adjusting for injury severity, number of injuries, comorbidities, and complications.”⁸ Richmond and colleagues examined the characteristics and outcomes of serious traumatic

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care facilities to promote patient safety. While these have been important measures, they represent only the first few steps toward reducing morbidity and reigning in health care costs. Now, the VHA must move beyond general screening measures and prevention programs to focus more intently on helping all veterans avoid injurious falls. Although there is a considerable body of literature on fall prevention, little evidence exists for the absolute impact of any given intervention on the reduction of fall-related injury.⁷ Moreover, there is, at present, a major practice gap with regard to appropriate measures for screening patients at increased risk for injurious falls, such as veterans receiving anticoagulation

injury in older adults and found that these injuries affect older adults of all ages and are typically multisystem and life threatening.⁹ Their work further showed that the majority of older adults survive multisystem injury but suffer severe consequences.

These findings highlight the need for future research and quality improvement efforts to examine outcomes beyond mortality and to make the identification and management of comorbid conditions a priority. Richmond and colleagues also suggest that a geriatric consultation service could be an important addition to the interdisciplinary trauma team.⁹ Essentially, what is needed is an initiative to develop evidence-based

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interventions—that would include patient, family member, and provider toolkits—to produce dramatic and sustained reduction of serious harm from patient falls in the hospital and home setting. With its unique ability to integrate practice, research, and education, the VHA is ideally positioned to fill these gaps and to take fall prevention to the logical next step of protecting veterans from injurious falls. ●

Author disclosures

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