Rates of older adults dying as a result of falls have been growing at 3% per year, with the greatest increases among those 85 years and older. One explanation for these trends is that older adults account for a greater percentage of the overall population every year and also have greater risks of complications, delirium, loss of function, and mortality than younger patients who experience similar fall injuries. In response to these concerns, trauma centers around the country have introduced special assessments of older adults admitted to trauma surgery units. Additionally, the American College of Surgeons (ACS) has written 2 dedicated guidelines, 1 for the care of trauma and 1 for the general surgical care of older adults.

A common principle now used by centers specializing in geriatric trauma is an assessment of an older adult’s physiological reserve. No fancy tests or equipment are needed. Unlike when treating patients undergoing elective surgery, when clinicians treat patients with trauma, they do not have the luxury of obtaining preoperative stress test data that indicates patients’ physiological resilience to injury or surgical repair. Therefore, clinicians rely on simpler data: merely asking patients (or their families) what they could do prior to hospitalization (ie, prehospital functional status). Simpler can be better: while we know that a time-consuming comprehensive battery of functional status questions can do the job, both sets of ACS guidelines promote the use of a set of just 5 questions about activities of daily living for older patients with trauma and undergoing surgery.

The article by Hatcher et al adds to the literature on trauma surgery by introducing a new clinical outcome to the many already associated with prehospital functional status: readmission for a fall injury. The authors found that frailty was associated with readmission for a fall injury within the first year and the number of falls over the first year.5 We reported on the overall scope of the problem of hospital readmissions after fall-related injuries earlier this year.6 In a large national database of acute hospital admissions (not only trauma admissions), falls were among the leading diagnoses for 30-day posthospital readmission, particularly among older patients with a history of cognitive impairment or acute mental status change and among those for whom the index admission involved treatment for a fall injury. This is similar to the outcome reported by Hatcher et al, although our study had a shorter follow-up period. We now know that, for patients admitted for a fall-related injury, the leading cause—of all diagnoses—for any type of 30-day readmission is a second, distinct fall.6 This suggested a simple test for predicting future falls: identifying patients who had been admitted for a fall. As in most large databases, however, critical information about prehospitalization functional status was not available.

Thus, Hatcher et al have done the important legwork possible in clinical observational studies, undertaking the careful process of reviewing the patient’s medical record for evidence of prehospitalization functional impairment, defined in their study as the need for a mobility assistive device or help performing daily self-care. Because physical therapists are required to assess prehospitalization function and mobility impairment, their documentation is a valuable source of critical preinjury information. Using this information, Hatcher et al reported that prehospitalization functional impairment was an independent risk factor for 1-year readmission for a fall, even after controlling for whether the index admission was for a ground-level fall. Therefore, while admission for a fall and prehospitalization functional impairment might have been expected to identify similar types of patient risk, with patient resilience in the postdischarge period indicated by assessing fall...
history, the results of Hatcher et al\textsuperscript{5} suggest that there is further value in taking the time to ask questions about function too.

The results of the study by Hatcher et al\textsuperscript{5} mean that we should gather information on prehospital function and fall history during the process of admitting older patients to the trauma service for fall injury. If done efficiently, this could even be accomplished prior to obtaining a formal physical therapy consultation (and could help prioritize physical therapy services as well). Hence, the time to start preventing readmissions is at admission. Preventing falls in the community has always relied on multidisciplinary and often low-tech efforts; the research by Hatcher et al\textsuperscript{5} underscores the importance of the entire medical team for gathering simple-to-acquire information on prehospital physical, cognitive, and social factors that will ease the way for patients to return safely to their homes.\textsuperscript{7}

But this might not be enough. In the very important article by Newgard et al\textsuperscript{8}, their findings suggest that fall injury, seen from the viewpoint of trauma surgery, is only the tip of the iceberg. Newgard et al\textsuperscript{8} found that trauma registries capture the most severe cases admitted to trauma and neurosurgery services, but lurking unseen are a vast number of patients admitted to orthopedics and general medicine with injuries ranging from an isolated hip fracture to a nonoperatively managed long bone fracture—or those merely unable to walk following a painful fall. Even a fall resulting in shoulder pain can be devastating for older adults who use walkers, putting their ability to maintain independence at home at risk.

So what can be done going forward? We see this new focus on fall readmissions as an opportunity to embed multidisciplinary fall prevention into care at the acute injury admission.

First, efforts to improve the care of fall injuries should be harmonized across surgical and medical disciplines. With the shared objective of preventing fall-related readmissions, clinicians can leverage the sheer volume of patients seen across disciplines to better meet the needs of patients with fall-related injuries once the injury is stabilized by the surgical specialty. Injury recovery continues after the stabilization of bones, nerves, and skin. Therefore, functional recovery will include the physical process of reconditioning after prolonged bedrest, gait and balance rehabilitation, and plans for temporary or permanent use of assistive mobility devices.

For this reason, efforts should extend to care provided outside the hospital. For some patients, there may be a need for postacute nursing home care. However, because most patients want to remain in the home, improved coordination of care to help hospital-to-home transitions is needed. Such efforts should include referrals for intensive outpatient rehabilitation for injury, including social programs to provide transportation and family leave policies for families to help transport their loved ones, perform home exercises, and practice self-care. Posthospital outpatient follow-up can increase medication reconciliation and review for medications that induce fall risk.

Second, we must recognize that, for an older patient, a readmission is not the only or even the main outcome to be avoided. A fall-related traumatic injury can result in a cascade of negative effects, including fear of falling and anxiety that can create self-imposed limits on activity and ultimately result in social isolation. We need improved and extended programs after the intensive physical rehabilitation process to help older adults safely reenter their communities, neighborhoods, or even rooms in their homes to allow them to optimize their overall self-care and maintain their independence. In an ideal health care system, measuring mobility, activities of daily living, and well-being along with readmissions would be an opportunity to encourage needed advancements in supporting postfall recovery for the many older adults who will be encountering injury because of falling.

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ARTICLE INFORMATION

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