AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Reducing the Risk of Falling (FRM)

Quick Reference Guide

2026

Table of Contents

MEASURE SNAPSHOT **3**
How The Years Line Up **4**
In One Sentence **4**
CMS Cut Points **4**
2026 Industry Performance (2025 → 2026 Trend) **5**
WHAT THE MEASURE IS ASKING **5**
In Plain Language **5**
Why it Exists **5**
What A Care Team Actually Controls **6**
MEASURE SPECIFICATION **8**
HEDIS-HOS Survey-Based Measure **8**
Commonly Misunderstood **8**
HOW PERFORMANCE IS MEASURED **9**
Medicare Health Outcomes Survey (HOS) **9**
Internal Performance is Not the Official Star Result **10**
Adjustment and Comparability **10**
HIGH-YIELD INTERVENTIONS **10**
Risk Stratification — Who to Reach First **11**
COMMON PITFALLS AND PRACTICAL FIXES **13**
HOS Survey Integrity — What CMS Prohibits **13**
BARRIERS AND EVIDENCE-BASED SOLUTIONS **14**
Patient-side **14**
System and Workflow **14**
Disparity Gaps Requiring Targeted Action **15**
CLINICAL CONTEXTS AND APPLICATIONS **16**
Clinical Contexts **16**
Patient Journey **18**
Companion Guides – Making Connections **19**
DOCUMENTATION THAT SUPPORTS CARE **19**
Documentation that Reflects the Care **19**
Clinical Documentation Optimization – SOAP Example **20**
Documentation Examples **21**
One Status, Clearly Stated **21**
KEY TAKEAWAYS **22**
Changes to Monitor **23**
REFERENCES **24**

MEASURE SNAPSHOT

CMS Part C Star Measure: C15 – Reducing the Risk of Falling

CMS Definition: Percentage of Medicare patients aged **≥65 years** who had a fall or problems with balance or walking in the past 12 months, were seen by a practitioner during that period, and received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.[1]

For a patient with a fall or balance/walking concern, provide a **specific fall-prevention intervention the patient understands and can later recognize as care their practitioner provided or recommended**.[1]

FIELD	ENTRY
CMS measure name	Reducing the Risk of Falling, FRM
Domain	Managing Chronic (Long Term) Conditions
CMS weighting category	Process Measure
Weight	**1 — standard-weighted**
Primary data source	HEDIS-HOS survey — patient-reported
Unit of measurement	CMS contract-level measure — individual clinicians and practices do not receive a C15 Star Rating
Trend direction	Higher is better
Case-mix adjusted	**No**[1]
Measurement period	HOS data collection, 07/17/2024 – 11/01/2024, two years before reporting year[1]
Recall window	The past 12 months, at the moment the patient answers — falls, balance problems, practitioner visits and recommendations are all self-reported over that period[1]
Star measure credit	**C15 credit is based on the eligible patient's HOS response.** Claims, CPT II codes, referrals, and EHR documentation may support care and tracking but **do not independently create numerator credit**[1]
Supporting/Internal Tracking Codes — Do Not Close C15	**CPT II 1100F/1101F** — falls screening, by fall history found **CPT II 0518F** — falls plan of care documented **CPT II codes** support documentation, internal registries, and quality tracking when applicable; they **do not independently close C15**. Verify current coding requirements separately before use[1,3]

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; FRM = Fall Risk Management (HEDIS label); HOS = Health Outcomes Survey

How The Years Line Up

Care/12-Month Recall
Falls/balance problems, practitioner contact, and fall-prevention intervention **during the 12 months before the patient's HOS response**

↓

Survey
2026 Star Rating HEDIS-HOS collection **ended November 1, 2024**

↓

Published Rating
Reported in the **2026 Star Ratings**

↓

Quality Bonus Payment Year
Contributes to the overall Star Rating used for **2027 Medicare Advantage quality bonus payment determinations**

In One Sentence

For patients aged **≥65 who had a fall or problem with balance/walking in the past 12 months** and saw a practitioner during that period, C15 measures the percentage who report that their current practitioner **recommended how to prevent falls or treat problems with balance or walking**.

CMS Cut Points

These are the CMS base-group cut-point ranges used for the 2026 Star Ratings. Final measure-level Star assignment also incorporates CMS statistical significance testing; the cut points should not be interpreted as guaranteed prospective or current thresholds for C15.

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA/MA-PD	<51%	≥51% to <57%	≥57% to <62%	**≥62% to <71%**	**≥71%**

ABBREVIATIONS: MA = Medicare Advantage; MA-PD = Medicare Advantage Prescription Drug; PDP = Prescription Drug Plan

2026 Industry Performance (2025 → 2026 Trend)

- **National Numeric Average:** C15 performance increased slightly from **57% in the 2025 Star Ratings to 58% in the 2026 Star Ratings**
- **Average Measure Rating:** The average C15 measure rating increased from **2.6 Stars to 2.7 Stars**
- **Lower 2026 Base-Group Cut Points:** For the 2025 Star Ratings, the 4-Star range was **≥63% to <73%** and 5-Star performance was **≥73%**. For the 2026 Star Ratings, the corresponding cut-points decreased to **≥62% to <71%** and **≥71%**, respectively. These cut points are rating-year specific and represent data collected during the measurement period; they may be used as directional benchmarks

WHAT THE MEASURE IS ASKING

AAVBC PERSPECTIVE — FALL RISK A CLINICAL SIGNAL, NOT JUST SURVEY ITEM

C15 should not be approached as a survey exercise. In older adults, especially those with **multimorbidity, frailty, medication burden, prior falls, or new balance/walking concerns**, PCPs should remain alert to changes that increase fall risk. Falls and balance problems can lead to **injury, functional decline, emergency care, hospitalization, and loss of independence**, making early recognition clinically important beyond the Star measure. The goal is to **recognize the concern, connect it to a specific and feasible intervention, and reinforce follow-through** so the patient understands the care provided and can act on it.

In Plain Language

C15 asks whether an older patient with a **fall or balance/walking problem** remembers their current practitioner **providing or recommending care to help prevent falls or treat balance/walking problems**. Official measure credit comes from the patient's **HEDIS-HOS response**; claims, CPT II codes, referrals, and EHR documentation may support care and follow-up but **do not independently create C15 numerator credit**. For care teams, the priority is to turn a **positive fall/balance concern into a specific, feasible intervention the patient understands and can complete.**

Why it Exists

In older adults, a fall can **worsen pre-existing pain, mobility limitations, frailty, and chronic disease**, while fear of falling may lead to reduced activity, deconditioning, and further loss of independence. The effects can also extend to **caregivers and families**, who may need to provide

additional supervision, transportation, or assistance with daily activities. **Exercise and individualized multifactorial interventions can reduce fall risk** through practical, modifiable strategies.[3,5,6]

QUALITY OUTCOME — WHY FALL PREVENTION MATTERS

Age-related loss of **muscle strength, balance, and physical reserve** can make falls more likely and recovery more difficult. Fall prevention should begin **before major mobility decline occurs**, with practical strategies that preserve function and independence.

Exercise: Emphasize regular **strength/resistance training, balance work, and mobility/aerobic activity**—for example, chair rises or resistance exercises, Tai Chi or structured balance training, and walking as appropriate to the patient's ability.

Nutrition: Support muscle and bone health with **adequate protein and overall nutrition**, and address calcium/vitamin D intake when clinically appropriate.

What A Care Team Actually Controls

Star Ratings are calculated at the CMS contract level, not for individual clinicians or practices. Care teams nevertheless influence the clinical care, access, understanding, and follow-through that contribute to C15 performance.

DIRECTLY WITHIN THE PRACTICE	INFLUENCED, SHARED WITH OTHERS	OUTSIDE THE PRACTICE
• **Use Annual Wellness Visits and other appropriate older-adult encounters to assess fall/balance risk** and identify patients who need a specific intervention • **Screen broadly** for slips, trips, unsteadiness, and balance/walking problems—not only "falls" • **Assess modifiable fall risks** including gait/balance, orthostasis, medications, vision/hearing, cognition, and home hazards as appropriate • **Provide a clear, individualized intervention** based on the risk identified • **Place and facilitate referrals/orders** rather than stopping at a recommendation • **Use teach-back** so the patient or care partner understands the plan and why it was recommended • **Document and follow up** on the specific problem, intervention, next step, owner, and outcome	• **PT/OT access and completion** for gait, balance, strength, assistive-device, and home-safety needs. • **Fall-detection/personal emergency response devices** for higher-risk patients who live alone or may be unable to summon help after a fall • **Durable medical equipment access**; walkers, canes, shower chairs, or other safety equipment • **Medication optimization with pharmacy** when sedating, CNS-active, anticholinergic, or orthostatic-risk medications may contribute • **Vision/hearing evaluation and follow-through** when sensory impairment may increase risk • **Care-partner involvement** when cognition, memory, or function may affect implementation • **Home-safety and community resources** including OT, transportation, and feasible home modifications	• HOS scoring methodology • CMS cut points • Contract-level calculations and adjustments

ABBREVIATIONS: HOS = Health Outcomes Survey; PT = physical therapy

MEASURE SPECIFICATION

HEDIS-HOS Survey-Based Measure

Official C15 scoring is based on eligible patients' HEDIS-HOS responses - not the practice's EHR registry, fall-risk screening list, claims, or coding.

ELEMENT	SPECIFICATION
Denominator	Medicare patients aged ≥65 who report a **fall or balance/walking problem during the prior 12 months** and report seeing a practitioner during that period[1]
Numerator	Patients who report that they **received a recommendation from their current practitioner for how to prevent falls or treat problems with balance or walking**[1]
The survey questions	HOS establishes whether the patient: **1)** Had a fall and/or balance/walking problem, **2)** Saw a practitioner during the applicable period, and **3)** Reports that the practitioner **did anything to help prevent falls or treat problems with balance or walking**[1]
Exclusions	No practitioner visit during the applicable period; evidence of hospice[1]
Clinical exclusions	**No additional clinical exclusions:** frailty, dementia, prior falls, and assistive-device use do **not** automatically exclude a patient[1]
Case-mix adjustment	**Not case-mix adjusted**[1]

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; HOS = Health Outcomes Survey

⚠ RED FLAG — "PATIENT DENIES FALLS" IS NOT AN EXIT

"No falls" does not end the screen. Ask about **slips, trips, unsteadiness, walking problems, and loss of balance**. Older adults may deny a "fall" while still reporting a balance or walking problem relevant to C15.[1,3]

Commonly Misunderstood

- **A charted fall-risk screen is assumed to create C15 credit → it does not.** Documentation, CPT II codes, and EHR fields may support clinical care and internal tracking, but C15 performance is determined by the eligible patient's **HEDIS-HOS response**

- **A practice fall-risk registry is assumed to be the official denominator → it is not.** Practice registries are internal tools for identifying care opportunities; the official C15 denominator is derived from **HEDIS-HOS survey responses, and is not typically shared with plans**
- **Frailty, dementia, or prior falls are assumed to automatically exclude a patient → they do not. It is not case-mix adjusted.** These conditions are not **automatic clinical exclusions;** eligibility is determined by the official C15 measure specification[3]

HOW PERFORMANCE IS MEASURED

Medicare Health Outcomes Survey (HOS)

The **Medicare Health Outcomes Survey (HOS)** is a CMS-sponsored survey administered to a **random sample of Medicare Advantage patients**, with NCQA supporting survey implementation and HEDIS measurement. The questionnaire contains **56 questions comprising 71 individual items** covering physical and mental health, daily functioning, chronic conditions, and selected HEDIS measures, and takes approximately **15 minutes by mail or 20 minutes by phone**.

For fall risk, **four HOS questions (Q39–Q42) address falls and balance/walking concerns:**

- **Q39 — Discussion with a provider:** Assesses whether the member **talked with a healthcare provider about falls or problems with balance or walking** during the prior 12 months
- **Q40 — Fall history:** Assesses whether the patient **experienced a fall during the prior 12 months**
- **Q41 — Balance or walking problems:** Assesses whether the patient **experienced difficulty with balance or walking during the prior 12 months**
- **Q42 — Fall-prevention intervention:** Assesses whether the patient's provider **recommended or provided an intervention to reduce fall risk or address balance/walking problems**. Examples explored by the survey include **assistive devices, exercise or physical therapy, and vision or hearing evaluation**, as well as other fall-prevention actions

Official Star-Scoring Pathway

Official C15 credit comes from the eligible patient's HOS response. Claims, CPT II codes, referrals, EHR fields, and internal dashboards can support care and tracking but **do not independently create numerator credit**.[1,7]

Internal Performance is Not the Official Star Result

CALL IT THIS	WHICH MEANS
Official result	CMS-calculated HOS-based measure result
Internal performance proxy	Practice tracking of **positive concern → specific action → completion**
Documentation completeness	Whether the problem, intervention, owner, and follow-up are captured.
Patient understanding	Whether the patient/care partner can explain the plan and why it matters

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services

Adjustment and Comparability

C15 is not case-mix adjusted.[4] As a result, differences in measured performance across contracts may reflect not only care delivery, but also differences in **health status, age, chronic-disease burden, access, rurality, language, transportation, and other social or clinical factors** that can influence fall risk, intervention uptake, and HOS responses. Care teams should **stratify internal data to identify inequities and tailor outreach, access support, and fall-prevention interventions to patient needs.**

HIGH-YIELD INTERVENTIONS

Performance is usually lost at three points: **risk is missed, a positive finding does not lead to a specific intervention, or follow-through is incomplete**.[3]

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
At the Annual Wellness Visit, ask about slips, trips, unsteadiness, and balance/walking problems—not only falls	**Routine, AWV older-adult encounters — PCP**	Patients may describe a fall as a **slip, trip, stumble, or loss of balance**. Broad language reduces missed risk and identifies patients who may need intervention[3,8]
Before the encounter closes, convert every meaningful positive finding into a specific intervention	**Routine, AWV PCP**	Screening alone does not address fall risk. **A positive finding should lead to a specific, individualized action** based on the patient's modifiable risks and priorities[5,6]

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Explain what you found and why the intervention addresses fall risk	**Routine, AWV PCP**	Patients are more likely to understand and remember a plan when the clinician **connects the intervention to the problem identified today**[3]
Do not stop at the referral. Facilitate the next step and track it to an outcome	**Checkout, follow-up — Referral coordinator/care team**	**A referral/order is not completion.** A clinically appropriate intervention has little value if the patient cannot access or start it[9]
Review prescription and OTC medications for modifiable fall-risk contributors, particularly with polypharmacy, dizziness, orthostasis, sedation, or CNS-active/ anticholinergic medication	**At assessment/ early follow-up — PCP with/without pharmacist**	Sedating, CNS-active, anticholinergic, and BP-lowering medications may contribute to **sedation, orthostasis, impaired cognition, or instability**. Individualize medication changes rather than using a one-size-fits-all prescription[10,11]
Close with teach-back: "Can you tell me the plan in your own words?" When possible, involve a care partner and provide printed instructions	**AWV, Routine— PCP/clinical staff**	Teach-back confirms that the **patient or care partner understands the intervention, why it was recommended, and what happens next**[3]
Reinforce the plan at the next touchpoint. Re-state the specific intervention and confirm whether it started or was completed	**Next contact — care manager/ PCP/clinical staff**	Reinforcement supports **implementation, continuity, and later recall**—especially when cognition, memory, or multiple care priorities may dilute the original conversation[3]

ABBREVIATIONS: CNS = central nervous system; MA = medical assistant; OTC = over-the-counter; PCP = primary care provider; PT = physical therapy

Risk Stratification — Who to Reach First

Prioritize follow-up by immediate safety risk, clinical vulnerability, recurrent falls, unresolved interventions, and support needs. All patients with identified fall risk should receive follow-up, with earlier outreach for higher-risk patients.[3]

PRIORITY GROUP	CRITERIA	RECOMMENDED RESPONSE
Higher clinical priority — prompt outreach	Recent fall with **injury, ED visit, or hospitalization**; **recurrent/frequent falls despite prior intervention**; new severe dizziness/syncope or neurologic change; unsafe gait or inability to ambulate safely; **advanced age with frailty/functional decline**; osteoporosis or prior hip fracture; persistent gait/mobility limitations after hip replacement; or inadequate caregiver/home support when safety is a concern	**Address immediate safety first.** Assess injury and acute contributors; review medications, orthostasis, gait/mobility, and home safety as indicated. Confirm needed support and facilitate appropriate PT/OT, assistive-device, or other intervention. **Follow up according to clinical risk; escalate promptly for acute safety concerns**[8]
Routine/AWV	**Patients ≥65 who do not meet higher-priority criteria**, and patients **<65 with a fall, balance/walking concern, or other clinically meaningful fall-risk factor**	Identify the concern and modifiable risks. When positive, **complete a focused assessment, provide a specific intervention, and establish follow-up**[3,11]
Routine preventive follow-up	Patients **<65 without a fall or balance/walking concern** and without another identified high-risk feature	Continue routine preventive care; reassess with a **new fall/balance concern, medication change, mobility decline, or other meaningful change in fall risk**[3]
Unresolved intervention follow-up	A fall-prevention intervention was **recommended or started, but completion, adherence, or outcome is unknown**	**Confirm whether the intervention occurred and whether it helped.** Address unresolved barriers and establish the next follow-up step[3]

ABBREVIATIONS: PCP = primary care provider; PT = physical therapy

QUALITY OUTCOME: HOME HAZARDS MODIFICATION CAN REDUCE FALLS

Targeted home-hazard modification produced an approximately 7% reduction in falls across pooled studies. Focus on feasible, individualized changes such as lighting, loose rugs, stair navigation, bathroom safety, footwear, and grab bars.[12]

COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
The click without the conversation	The fall-risk assessment is completed, but the patient hears **no clear explanation or action** they are likely to remember	Pair every positive screen with a brief, explicit statement: **name the problem, name the action, and explain why it matters**[3]
A plan in the narrative, no order in the system	"Will refer to PT" is documented, but **no active referral/order is placed or tracked**	**Place and facilitate the referral before checkout** when possible, then track it to scheduling/first attendance
Advice the patient cannot act on	The recommendation is clinically appropriate but **not feasible because of cost, transportation, housing, distance, or access**	Follow-up, attain a clear picture of the specific barriers. Resolve the barrier or choose a feasible alternative[3,6]
The fourth-quarter charting push	HOS reflects care delivered over the prior period. **Late documentation cannot replace care that did not occur**	Build screening, intervention, and follow-up into **year-round routine care**[1,3]

ABBREVIATIONS: EHR = electronic health record; OTC = over-the-counter; PT = physical therapy

HOS Survey Integrity — What CMS Prohibits

Do not coach patients on how to answer HOS. Never suggest a preferred response, rehearse survey answers, or alter clinical care solely to influence the survey.

Do: provide appropriate care, explain what was done, use teach-back, and reinforce the care plan at later encounters.

BARRIERS AND EVIDENCE-BASED SOLUTIONS

Patient-side

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Fear of losing independence	Patients may hide instability because they fear losing **driving, independence, or the ability to remain at home**[3]	Frame fall prevention around **preserving independence and mobility**. Offer choices whenever possible[3]
"That wasn't a fall, I tripped"	Patients minimize or relabel events as a "trip," "stumble," or "clumsy moment"[3]	Normalize and clarify: **"Even if you didn't end up on the ground, that tells me something about your balance"**[3]

ABBREVIATIONS: OTC = over-the-counter

System and Workflow

Suggested clinical workflow: MA/clinical staff administer a STEADI-based fall/balance screen during rooming → a positive response routes to the PCP for focused assessment → the PCP selects and documents a specific intervention → the care team facilitates the intervention and confirms follow-through.

BARRIER	HOW IT SHOWS UP	WHAT HELPS
The 15-minute episodic visit	Fall prevention competes with multiple chronic and acute issues during a short visit[3]	Use pre-visit planning and team-based workflows to identify fall/balance concerns before the PCP enters the encounter. **Use the AWV and other appropriate encounters for focused assessment and intervention**; coordinate with pharmacy and PT/OT as needed [3,8]
Referral loops with no return signal	PT, vision, DME, or home-safety referrals leave the practice with **no confirmation that the patient scheduled or completed the intervention**	**Closed-loop referral system: Track referrals to an outcome—not just order placement.** Assign a referral coordinator to establish an alternative plan when the original recommendation is not feasible or not effective[3]

BARRIER	HOW IT SHOWS UP	WHAT HELPS
No reinforcement pathway	An intervention occurred previously but is **never reinforced at later touchpoints**, weakening implementation and recall	Reinforce the plan during **existing clinical touchpoints**—rooming, medication follow-up, care-manager calls, AWVs, or routine visits. Reinforce what actually happened[3]

ABBREVIATIONS: EHR = electronic health record; PT = physical therapy

Disparity Gaps Requiring Targeted Action

Some patients face barriers that make an otherwise appropriate fall-prevention plan **difficult to start or complete**. Identify these barriers early and adapt the intervention so it is **feasible, understandable, and accessible.**[1]

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Dual-eligible and low-income patients	Home- safety recommendations may be unrealistic for renters or patients who cannot afford modifications, equipment, or related services[3]	**Ask about feasibility before finalizing the plan.** Use plan/community benefits, OT/home-safety services, DME resources, landlord-supported modifications, or lower-cost alternatives[3]
Rural and socially isolated patients	PT, vision, or specialty care may require **travel or transportation the patient cannot arrange**, so the referral never becomes an intervention	Use the **closest feasible option**, transportation benefits, community exercise programs, telehealth components when clinically appropriate, or home-based services. **Follow up rather than assuming the referral occurred**[3,6]
Limited English proficiency and diverse cultural groups	Language discordance or beliefs that instability is simply part of aging may reduce **disclosure, understanding, and uptake of recommendations**[3,13]	Use **qualified interpreters or bilingual team members**, culturally relevant language, teach-back, and independence-focused framing. Provide translated, concise materials when available; avoid relying only on English portal messages or handouts[3]

ABBREVIATIONS: DME = durable medical equipment; OT = occupational therapy; PT = physical therapy

CLINICAL PEARL: MATCH THE DEVICE TO THE FALL RISK

There is no single “best” fall-prevention device. Choose DME based on the patient’s specific risk and home environment. Common options include **properly fitted canes or walkers** for gait instability, **grab bars and shower chairs** for bathroom safety, and **wearable fall-detection/personal emergency response devices** for higher-risk patients who live alone or may be unable to summon help after a fall.

CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	WHY IT MATTERS FOR FALL RISK	CLINICAL ACTION
Polypharmacy and high-risk medications	Sedating, CNS-active, anticholinergic, and BP-lowering medications can contribute to **dizziness, orthostasis, cognitive effects, and instability**[10,11]	**Review medications for fall-risk contributors** and individualize dose reduction, substitution, tapering, or monitoring when appropriate. Use current **AGS Beers Criteria and medication-safety guidance**; document the medication identified, clinical rationale, action taken, and follow-up **Ask about alcohol and other sedating substances** when assessing fall risk, particularly when used with sleep aids, CNS-active medications, or other agents that may worsen dizziness, sedation, or impaired balance

CONDITION OR SITUATION	WHY IT MATTERS FOR FALL RISK	CLINICAL ACTION
Orthostatic hypotension and dizziness	Postural BP changes can contribute to **dizziness, instability, and falls**[8]	Check orthostatics when indicated; review **medications, hydration, cardiovascular factors, and symptoms**, and address modifiable causes **Educate the patient about orthostatic hypotension**, including rising slowly, recognizing dizziness or lightheadedness, and using appropriate fall-prevention strategies **Reassess symptoms and fall risk at follow-up**, and escalate promptly if syncope, worsening instability, or other safety concerns develop[8]
Gait impairment, weakness and frailty	Reduced strength, low BMI, and impaired gait identify patients who may benefit from structured exercise or PT[5,9]	Facilitate PT/exercise rather than handing the patient a referral. When formal PT is unnecessary or inaccessible, consider an appropriate evidence-based community option **such as Tai Chi or another structured balance/strength program** **Assess footwear when gait instability or balance concerns are present; encourage well-fitting, supportive footwear** with appropriate traction and address footwear that contributes to instability program[6,9]
Vision and hearing impairment	Sensory impairment may contribute to unsafe navigation and instability[1,8]	Refer when clinically appropriate and **track the referral to completion**. If sensory impairment contributes to unsafe navigation, incorporate the finding into the patient's broader fall-prevention plan[8]
Cognitive impairment	Cognitive impairment can increase fall risk while also reducing **implementation and recall of the prevention plan**[3]	**Simplify to one clear action**, use teach-back, provide a concise written plan, and—with permission—involve a care partner. **Assign a follow-up owner and reinforce the same recommendation at later touchpoints** when memory or cognition may affect implementation[3]

CONDITION OR SITUATION	WHY IT MATTERS FOR FALL RISK	CLINICAL ACTION
Home-safety and assistive-device needs	Environmental hazards, unsafe transfers, gait instability, or inability to summon help after a fall can increase injury risk and make an otherwise appropriate prevention plan incomplete	Match the intervention to the specific risk: **properly fitted cane or walker, grab bars, shower chair, OT/home-safety evaluation.** For higher-risk patients who live alone**, use a fall-detection/personal emergency response device when appropriate** **Ask about difficulty with transfers** including bed, toilet, shower, chair, and getting into or out of a vehicle when mobility or balance is impaired
Neurological conditions	Parkinsonism, prior stroke, peripheral neuropathy, vestibular disorders, and other neurologic conditions may impair **gait, balance, coordination, sensation, or reaction time**, increasing fall risk	Assess for **new or worsening gait change, weakness, sensory loss, tremor, coordination problems, or recurrent falls**. Refer for neurologic, PT, vestibular, or other specialty evaluation when clinically indicated, and **track follow-through**

ABBREVIATIONS: CNS = central nervous system; OTC = over-the-counter; PT = physical therapy

Patient Journey

BEAT	CONTENT
Presents as	Older adult with **persistent gait difficulty after prior hip replacement** lives alone and reports increasing difficulty with transfers and navigating the bathroom, without a recent acute fall
PCP action	Focused assessment identifies mobility and home-safety concerns. PCP recommends **assistive-device evaluation and OT/home-safety assessment**, reviews transfer safety, and discusses fall-detection/personal emergency response support because the patient lives alone
Close the loop	Care team confirms OT/assistive-device access and that recommended home-safety changes are feasible and initiated
Follow-up	Reassess mobility, transfer safety, device use, new falls or near-falls, and any unresolved home-support needs

ABBREVIATIONS: PCP = primary care provider; OT = occupational therapy
Note: Case is illustrative and is not a reported individual case

Companion Guides – Making Connections

GUIDE	WHEN TO REACH FOR IT
Monitoring Physical Activity QRG (C06)	Use when **strength, balance, mobility, or exercise** are part of the fall-prevention plan
Care for Older Adults — Medication Review QRG (C08)	Use when **polypharmacy, sedating/CNS-active medications, anticholinergic burden, or medication-related dizziness and orthostasis** may contribute to fall risk
Osteoporosis Management QRG (C10)	Use when fall risk coexists with **osteoporosis, fragility-fracture risk, prior fracture, or other factors that increase the consequences of a fall**
Controlling Blood Pressure QRG (C14)	Use when **antihypertensive treatment, orthostatic symptoms, dizziness, or treatment intensity** may affect fall risk and require coordinated management

ABBREVIATIONS: QRG = Quick Reference Guide

DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- **Documentation does not independently create C15 credit.** It supports clinical care, continuity, follow-up, and reinforcement
- For a positive fall/balance concern, document the **specific problem, specific intervention, next step, and follow-up owner**[3,11]
- When medication-related risk is addressed, document **what changed, why it changed, and how follow-up will occur**[3,15]

What Belongs in the Record

ELEMENT	WHAT TO RECORD
The finding	**What happened:** fall, slip, trip, unsteadiness, balance/walking problem, fear of falling; injury/frequency when relevant
The assessment	Gait/balance findings; functional testing when indicated; orthostatics; vision/hearing; footwear; environmental hazards; relevant conditions[8]

ELEMENT	WHAT TO RECORD
The medication review	Prescription and OTC medications reviewed for **sedation, orthostasis, anticholinergic effects, cognitive effects, or other fall-related risk**; document what changed and why[10,11]
The specific intervention	**PT/exercise, medication optimization, assistive-device evaluation, vision/hearing evaluation, home safety, orthostasis management, or another individualized action**[5,6]
Understanding and feasibility	Teach-back/care-partner confirmation; identify **cost, transportation, distance, housing, cognition, or other barriers**
Ownership and outcome	**Named care–team owner, follow-up deadline, and outcome:** started, completed, declined after discussion, or replaced with a feasible alternative

ABBREVIATIONS: OTC = over-the-counter; PT = physical therapy

Clinical Documentation Optimization – SOAP Example

*SOAP documentation should show the **fall/balance concern, relevant assessment findings, clinical interpretation, specific intervention, and follow-up plan**.*

S — Subjective

Patient reports **two recent episodes of unsteadiness when rising at night** and increasing fear of falling. Denies recent injury or syncope. Reports intermittent dizziness with position change and uses an OTC sleep aid most nights. No recent PT, balance training, or assistive device evaluation. Patient states the episodes have made them more cautious when walking at night.

O — Objective

Medication list reconciled, including prescription and OTC agents; **sedating, anticholinergic, and orthostatic-risk medications reviewed**. Orthostatic vital signs obtained because of positional dizziness. Gait instability noted during ambulation; functional gait/balance assessment performed when clinically appropriate. Vision/hearing status, footwear, assistive-device use, and home-safety concerns reviewed. No acute neurologic change identified during the encounter.

A — Assessment

Fall risk with multiple modifiable contributors: gait instability, positional/orthostatic symptoms, and sedating medication exposure. Fear of falling may also be contributing to reduced confidence and activity. No immediate injury or acute neurologic red flag identified; patient remains appropriate for outpatient fall-prevention intervention with close follow-up.

P — Plan

PT referral placed for gait, balance, and strength training. Medication regimen reviewed; modifiable sedating or orthostatic risk medication exposure addressed and rationale discussed with the patient. Patient is educated on orthostatic precautions, including **rising slowly, recognizing dizziness/lightheadedness, maintaining safe mobility, and reporting worsening symptoms**. Home-safety and footwear recommendations reviewed based on identified risks; assistive-device evaluation to be considered if instability persists.

The patient completed the teach-back **and can explain the fall-prevention plan and why each intervention was recommended**. Referral/care team assigned to facilitate PT scheduling and confirm initiation within 14 days. Follow-up planned to reassess **dizziness, medication tolerance, gait/balance symptoms, new falls or near-falls, and intervention completion**. Escalate sooner for syncope, injury, new neurologic symptoms, or inability to ambulate safely.[8,11]

Documentation Examples

Complete — Vision-Related Fall Risk

"Patient reports increasing difficulty seeing in low light and two recent near-falls while navigating stairs at home. Vision assessment is overdue. **Fall risk reviewed; vision referral placed and facilitated, and home-lighting/stair-safety recommendations discussed.** Patient completed teach-back and understands the reason for the intervention. Care-team owner assigned to confirm vision follow-up and reassess near-falls and home-safety concerns."

Complete — Intervention Declined/Alternative Plan

"Fall/balance concern identified and PT discussed. Patient declines formal PT because of transportation limitations after risks, benefits, and alternatives are reviewed. Barrier documented. **Home-based balance/strength program and home-safety plan selected as feasible alternatives.** Patient completed teach-back; named care-team owner assigned to reassess implementation and determine whether additional intervention is needed."

Not Enough - Incomplete

"Fall risk assessed." → **No specific problem or intervention.**

"Discussed fall precautions." → **No specific action.**

"Will refer to PT." → **No active referral placed; no clinical context or goals documented**

"Patient is steady." → **No assessment method or prevention plan.**

One Status, Clearly Stated

Use one clear status so follow-up matches the patient's current stage.

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
No concern identified	Broad screen negative; reassess when clinically indicated or at routine follow-up
Action needed	Positive concern identified; **specific intervention not yet initiated**
Intervention initiated	Referral/order/medication change/device/home-safety action started
Intervention completed	Outcome confirmed and reinforced
Barrier/unresolved	Original plan not feasible, declined, or incomplete; **assign owner and establish the next plan**

KEY TAKEAWAYS

1 The Annual Wellness Visit is a key opportunity to assess fall and balance risk

Use the AWV to **identify concerns, complete a focused assessment when indicated, and connect a positive finding to a specific, feasible fall-prevention intervention**.

2 C15 is a patient-reported measure, not a documentation measure

The official result is derived from eligible patients' **HEDIS-HOS** responses. Claims, coding, CPT II codes, referrals, and EHR documentation support care and follow-up, but **they do not independently create C15 numerator credit.**

3 The clinical objective is effective fall prevention—not the survey response

Care teams should identify fall/balance concerns, assess modifiable risks, and provide a **specific, individualized intervention** the patient can understand and realistically use.

4 A common missed opportunity is identifying risk without converting it into action

Screening alone does not reduce fall risk. A positive fall/balance finding should lead to a **specific, feasible intervention**—such as PT/exercise, medication optimization, an assistive device, home-safety action, or another intervention matched to the patient's identified risk.

5 Asking only "Have you fallen?" can miss clinically important risk

Patients may describe events as **slips, trips, stumbles, unsteadiness, near-falls, or balance/walking problems** rather than "falls." Use broader screening language during Annual Wellness Visits and other appropriate older-adult encounters.

6 Structured documentation has value for closing the loop, even though it does not score C15

Document the **specific problem, intervention, next step, follow-up owner, and outcome.** Clear documentation helps the care team distinguish an intervention that was recommended from one that was actually started, completed, declined, or replaced with a feasible alternative.

7 Clinical vulnerability and feasibility should guide intervention and follow-up

Prioritize patients with recurrent falls, injury, unsafe gait, dizziness/syncope, polypharmacy, cognitive impairment, or unresolved fall risk. Consider **transportation, cost, housing, language, cognition, and access** when choosing an intervention; a plan the patient cannot implement is not an effective plan.

8 A referral is not complete until follow-through is confirmed

Facilitate access to **PT, DME, vision/hearing care, home-safety services, or other recommended interventions**, confirm what actually happened, and address unresolved barriers when the original plan cannot be completed.

9 Fall prevention is an ongoing primary care activity and should not be limited to the Annual Wellness Visit

Reassess fall/balance risk when **symptoms, medications, mobility, or function change,** and reinforce the prevention plan during routine clinical touchpoints.

Changes to Monitor

KIND OF CHANGE	GOOD PRACTICE
Measure status and specifications	Confirm that **C15 Reducing the Risk of Falling remains an active Part C Star measure**, and recheck its official name, weighting category, weight, eligible population, exclusions, data source, and scoring pathway. Do not assume measure status or specifications remain unchanged from one rating cycle to the next
Rating-year methodology	**Revalidate the applicable CMS cut points and rating-year methodology, Categorical Adjustment Index treatment, Part C Improvement Measure inclusion, and any disaster-adjustment provisions** when CMS publishes each new Star Ratings cycle**.** Prior-year thresholds should not be carried forward automatically[2]

KIND OF CHANGE	GOOD PRACTICE
Survey wording and measurement dates	Recheck the current **NCQA HOS denominator, numerator, look-back period, and survey wording** before each annual update[1,16]
Clinical guidance	Refresh fall-prevention recommendations using current **CDC STEADI, USPSTF, AGS Beers Criteria, exercise/fall-prevention, medication-safety, and relevant specialty guidance**. Update clinical recommendations without confusing changes in clinical guidance with changes to the **C15 scoring methodology**[5,11,13,14]
Coding, documentation, and data exchange	Confirm current **CPT II fall-risk codes, documentation conventions, EHR/registry workflows, and referral or external-care data exchange** before each measurement cycle. These tools support clinical care, internal tracking, and follow-up but **do not independently create C15 numerator credit**
Internal tools and templates	Annually review **screening language, EHR prompts, referral tracking, teach-back, and follow-up workflows**. Retire outdated cut points, survey dates, and instructions

ABBREVIATIONS: AGS = American Geriatrics Society; CDC = Centers for Disease Control and Prevention; HOS = Health Outcomes Survey; NCQA = National Committee for Quality Assurance; USPSTF = US Preventive Services Task Force

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