Supplemental Digital Content 1. Table of Evidence

| Authors | Year | No. of Participants | Method (Study Design, Sample, and Data Collection) | Outcome |
| --- | --- | --- | --- | --- |
| Smith, Stevens, Ehrenreich, Wilson, Schuster, O'Brien Cherry, Ory | 2015 | 38 medical providers (34% nurses, 26% MDs, 18% NPs, 8% PAs, 8% MAs, and 3% specialty care) | Questionnaires and clinical engagement and education sessions | 89.3% of PCPs reported ever discussing fall prevention. Providers ranked falls as the lowest priority of 5 conditions after DM, CAD < mental health, and musculoskeletal. <20% referred older patients to community-based fall prevention programs. <16% conducted functional assessments annually. Eighty-one percent discussed details of prescribed medicines, 47% conducted a cognitive screening, 37% asked most or all of older patients if they fell within the last 12 months, and <16% conducted balance test annually |
| Rubenstein, Solomon, Roth, Young, Shekelle, Chang, MacLean, Kamberg, Saliba, Wenger | 2004 | 372 vulnerable older adults in two managed care plans | Systematic study. Quality indicators to assess for falls and instability to older adults. Structured literature reviews and process of care quality indicators | Lack of documentation and incomplete physical examination led to underdetection of falls and gait disorders |
| Howland, Hackman, Taylor, O'Hara, Liu, Brusch | 2018 | 136 surveys distributed, 97 of 136 targeted providers responded | Questions reflecting 4 dimensions relative to older adult fall risk assessment and intervention: provider beliefs, knowledge, attitude, and clinical practice. Ninety-three percent MDs, other 7 were PAs, NPs, or did not specify | 87% agreed that they could do things to prevent patients from falling, 96% agreed that all patients aged >65 years should be assessed for fall risk, 85% agreed that a fall risk assessment will cover factors that could be modified, 94% agreed that EBP interventions could reduce falls, 52% agreed that they had expertise to conduct fall risk assessment, 68% agreed that it is the standard to assess fall risk of older adults, and 14% were aware of STEADI |
| Baker, King, Fortinsky, Graff, Gottschalk, Acampora, Preston, Brown, Tinetti | 2005 | 7 hospitals, 26 homecare agencies, 138 primary care providers, and 119 outpatient rehabilitation facilities | Dissemination project in North Central Connecticut | Reported barriers related to fall risk management included inadequate provider referrals, lack of awareness, lack of expertise, Medicare coverage, and lack of federal mandate for physicians |
| Laing, Silver, York, Phelan | 2011 | 83 professionals and 101 elders in Washington | Structured telephone surveys to employees of senior serving organizations | 38% employees felt “very knowledgeable” about fall prevention, majority did not offer fall prevention practices, and 1/3 elders perceived falling to be the least important health concern and had minimal knowledge of fall prevention practices |
| Child, Goodwin, Garside, Jones-Hughes, Stein | 2012 | 19 used in review | Review of literature between 1980 and 2012 for qualitative research studies that examined barriers and facilitators to effective fall preventions interventions | Data synthesis displayed practical considerations, adapting for the community and psychosocial factors |
| Goodwin, Jones-Hughes, Thompson-Coon, Boddy, Stein | 2011 | Articles published between 1980 and 2010.15 studies identified. | Systematic review | Barriers included lack of skills and knowledge, time, complex and social issues, financial issues, lack of coordination, or organizational issues |
| Fortinsky, Iannuzzi-Sucich, Baker, Gottschalk, King, Brown, Tinetti | 2004 | Emergency department physicians, hospital-based discharge planners, home health nurses, and primary care physicians. Total of 33 participants | Cross-sectional study using a structured interview | The most commonly reported barrier was patient compliance. Other barriers included lack of Medicare reimbursement and inadequate availability of health care providers |
| Jones, Ghosh, Horn, Smith, Vogt | 2011 | 100 primary care physicians | Random sampling of 100 PCPs from a statewide health care provider database | 8% PCPs based their fall prevention practices on clinical guidelines. Barriers were time, education, and priority |
| Lee, Day, Hill, Clemson, McDermott, Haines | 2013 | 245 older community dwellers in Australia | Prospective cohort study and cross-sectional survey 1 year later | 38% reported falling in a 12-month period, and 54.7% of fallers consulted their general practitioner. Of the 245 participants, 22.4% had a discussion with general practitioners, and of those, 58.2% reported being given a recommendation |
| Stevens, Phelan | 2013 | 6 geriatricians, 6 primary care providers, 2 NPs, and 4 RNs | Literature review and in-depth interviews | Community MDs did not adequately identify falls and gait disorders or evaluate patients who reported falling, 37% of older adults in primary care were asked about falls, and 8% of 68 primary care practitioners used clinical guidelines ton fall prevention. Reported lack of information about methods for assessing risk and strategies |
| Dickinson, Horton, Machen, Bunn, Cove, Jain, Maddex | 2011 | 187 older adults in the United Kingdom. Age ranges 60–95 years, mean age 75 years | Qualitative study with older adults who declined to participate in fall prevention interventions using 17 focus groups, semistructured interviews | Patient reluctance to report falls and their observation of provider response hindered fall prevention strategies. Health care professionals frequently failed to refer patients to fall prevention interventions following fall report. |
| Milisen, Geeraerts, Dejaeger | 2008 | 99 primary care workers and 1,142 community-dwelling older adults | Descriptive study performed by 10 local health networks throughout Flanders | 87.5% of health care providers agreed that fall prevention was important, but different disciplines failed to agree on how to integrate in daily practice. Barriers included time constraints (57.3%), poor motivation by patients (53.3%), inadequate cooperation among health care providers (37.3%), and inadequate financing mechanisms for fall prevention |
| Burns, Haddad, Parker | 2018 | 1210 US primary care practitioners | Doc Styles Survey—web-based survey of health care providers | 89.3% self-reported discussion of any fall prevention approaches. Provider and practice suggested different approaches and barriers |
| Chou, Tinetti, King, Irwin, Fortinsky | 2006 | 125 primary care physicians | Qualitative study using a semistructured interview | Patient factors, logistical factors, and physician factors influenced fall risk evaluation and management |
| Loganathan, Ng, Tan, Low | 2015 | 20 health care professionals | Qualitative methodology involving 10 in-depth interviews and 2 focus group discussions | Lack of fall prevention guidelines, insufficient training, and patient engagement created barriers to proper fall management |
| Kielich, Mackenzie, Lovarini, Clemson | 2017 | 37 general practitioners | Cross-sectional study design—hardcopy surveys and online survey link | Key barriers were workload, lack of training, and demands of routine clinical practice |
| Moreno-Peral, Conejo-Ceron, Fernandez, Berenguera, Martinez-Andres, Pons-Vigues, Motrico, Rodriguez-Martin, Bellon, Rubio-Valera | 2015 | 29 articles | Meta-ethnographic synthesis following manual and electronic searches retrieving 29 articles | Barriers included intrapersonal factors, interpersonal, institutional, and environmental |

*Note: EBP = Evidence Based Practice; MD = Medical Doctor; PA = Physician Assistant; PCP = Primary Care Providers; STEADI = Stopping Elderly Accidents, Deaths, and Injuries.*