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FALLS PREVENTION: NATIONAL, STATE, LOCAL SOLUTIONS TO BETTER SUPPORT SENIORS

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C O N T E N T S

FALLS PREVENTION: NATIONAL, STATE, AND LOCAL SOLUTIONS TO BETTER SUPPORT SENIORS

WEDNESDAY, OCTOBER 16, 2019

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:28 a.m., in Room 562, Dirksen Senate Office Building, Hon. Susan Collins, Chairman of the Committee, presiding.

Present: Senators Collins, Hawley, Braun, Rick Scott, Casey, Blumenthal, Jones, Sinema, and Rosen.

OPENING STATEMENT OF SENATOR SUSAN M. COLLINS, CHAIRMAN

The CHAIRMAN. The Committee will come to order.

Good morning. Each year, the Senate Aging Committee releases a bipartisan annual report on an issue affecting older Americans.

Today's hearing on the prevention of falls is the subject of our report this year and represents the culmination of much work on this important issue.

Nearly 200 organizations representing patients, clinicians, community service providers, and others have contributed valuable insights and recommendations on ways to reduce falls and related injuries. We will hear more about that this morning.

Falls are the leading cause of fatal and non-fatal injuries for older Americans, often leading to a downward spiral with serious consequences. In addition to the physical and emotional trauma of falls, the financial toll is staggering. In the United States, the total cost of fall-related injuries is approximately $50 billion annually, and that is expected to double to $100 billion by the year 2030. Seventy-five percent of these costs are borne by the Medicare and Medicaid programs.

While we tend to attribute falls to external factors like uneven sidewalks or icy stairs, clinicians also attribute them to such factors as medications, medical reasons, or muscle strength.

One key cause is osteoporosis, which can be especially dangerous for people who are completely unaware that they suffer from low bone density.

While Medicare covers bone density testing, reimbursement rates have been slashed by 70 percent since 2006, resulting in 2.3 million fewer women being tested. As a result, it is estimated that more

than 40,000 additional hip fractures occur each year, which results in nearly 10,000 additional deaths.

I have introduced the Increasing Access to Osteoporosis Testing for Medicare Beneficiaries Act with Senator Ben Cardin to reverse these harmful reimbursement cuts.

I would like to recognize Ann Elderkin, who is with us today, and has assisted us greatly with this legislation. She is the executive director of the American Society for Bone and Mineral Research and a resident of Cape Elizabeth, Maine.

Another major risk factor for falls among seniors is medications. Ninety percent of older Americans take at least one prescription medicine, and 36 percent take five or more. Taking multiple prescription drugs can cause interaction problems that increase the risk of falls, like vision disturbances, confusion, and sleepiness.

Certain frequently prescribed drugs themselves can also trigger side effects that increase the risk of falls. These medications often are not tested adequately in older adults.

At my request, the Fiscal Year 2020 FDA funding bill directs the agency to assess the impacts of drug interactions and ensure that older adults are adequately represented in clinical trials.

To address this risk factor, we must also encourage medication reconciliation in the Medicare Annual Wellness Visits.

In addition to medical factors, the Committee heard from stakeholders about the importance of education and community interventions. For example, MaineHealth, my State's largest health care organization, developed a peer-led program called "A Matter of Balance" in 2003. It aims to increase activity levels, improve balance, and reduce the fear of falling for older adults.

Let me provide an example. Ginny is 90 years old and lives alone in coastal Maine. Last winter, she slipped and fell down her front steps. She signed up for "A Matter of Balance" but was really unsure how it would help. Her improvements exceeded her expectations, including more than just physical progress.

Over the course of the class, her confidence increased. Ginny shared that her fear of falling often kept her alone, essentially imprisoned in her own home. With the support from the group, she is now getting out and socializing, including a recent trip to an island off the Maine coast.

Since 2006, more than 6,200 Mainers have participated in the program, which is now in 46 States across the Country.

Home health, especially occupational therapy, is another falls prevention tool. I have introduced the Home Health Payment Innovation Act with Senator Debbie Stabenow that would give Medicare Advantage and Accountable Care Organizations flexibility to waive the antiquated "homebound" definition so that more people can receive these services.

Senators Scott, Sinema, Burr, and Rosen have already cosponsored this bill. Medicare Advantage is starting to expand this benefit, which is a welcome first step.

Home modification is another strategy to prevent falls. Senator King and I have introduced the Senior and Disability Home Modification Assistance Act to coordinate programs that provide home modification resources and to help people age in their own homes. As the Chair of the Transportations and Housing Appropriations

Subcommittee, I recently created and set aside some grant funding for this very purpose.

Last month, the Senate unanimously approved a resolution spearheaded by our Committee, marking the first day of fall, September 23d, as National Falls Prevention Awareness Day. We are a little bit late, but I hope that this hearing will also help to promote awareness. Now is the time and now is our opportunity to take action to prevent falls.

Our report includes recommendations to key Federal agencies to take steps to reduce falls, and we will be following up with those agencies, so for everybody's benefit, here is a copy of our annual report on falls preventions. The Committee has given it its stamp of approval. It is bipartisan, and I am very pleased that we will be able to share this with everyone who has an interest.

I now am pleased to turn to our Ranking Member, Senator Casey.

OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., RANKING MEMBER

Senator CASEY. Thank you, Chairman Collins, for holding this hearing and for the work done by you and by both staffs on this report.

I am pleased that the Committee took up the issue of falls prevention this year. In order to inform our hearing today and release the Committee's annual report entitled "Falls Prevention: National, State and Local Solutions to Better Support Seniors," the Committee solicited input from stakeholders, experts, academics, and Federal agencies.

We received nearly 200 comments from stakeholders about falls prevention and responses from nearly every relevant Federal agency.

There is good reason for that response. As the report finds, falls are a serious issue that affect a growing number of Americans each year.

I will just give you two numbers—30 and 50. The first is 30,000. In 2016, almost 30,000 older adults died from falls. In 2015, falls cost the United States health care system 50 billion—with a "b"—$50 billion, as Senator Collins indicated, so, in 2016 and 2015, those two numbers, 30,000 deaths, $50 billion in terms of cost.

Those numbers are staggering, and they may not even tell the whole story because many older adults do not tell anyone when they fall. We must remove the stigma associated with falling so that our loved ones can get the help they need to age in place, where they want to be, in their homes and communities.

As our report illustrates, there are steps that can be taken to make this a reality. I will start with one, physical mobility. That is a key. Staying active, walking, stretching, strength-training, all of that is proven to reduce risks, the risk of falling among older adults.

Second, continuing to invest in the development, dissemination, and evaluation of proven interventions is critical. It is why Chairman Collins and I are working to get more resources for evidence-based programming for seniors through our efforts to reauthorize the Older Americans Act.

Number three, home modifications can also help. Yet to a senior on a fixed income, even installing a grab bar in the shower may be out of reach due to cost.

The research community also has a role to play by ensuring that older adults are part of clinical trials so that we know the prescription drugs they may need do not come with a dose of falling.

Providers must be trained to screen patients for their falls risk and refer those in need of intervention to the appropriate service provider.

A conversation that allows a provider to assess a patient should be part of every, every wellness visit.

I am hopeful that our work over the past year, along with this hearing today and the release of this report, will do the following: 1) launch that type of dialog between patients and providers; 2) propel the research community to do more; 3) to get more dollars invested into supporting home modifications; and 4) encourage more older adults to be active.

I am particularly interested in sharing this report with the relevant agencies and learning how the recommendations will be implemented. Not just put in a report. Implemented.

I want to thank each of our witnesses for being here, and want to reiterate my thanks to Chairman Collins for holding this important hearing and for her leadership in releasing this report.

Just to note for today in terms of my presence, I have to leave briefly to introduce a judicial nominee in the Judiciary Committee. They do not tell us when they are having these hearings, and they just happen to schedule it at the same time. I will be in and out but not too long.

Thank you, Chairman Collins.

The CHAIRMAN. Thank you very much, Senator Casey.

I also want to acknowledge the presence of Senator Blumenthal, Senator Rosen, and Senator Jones. Thank you so much for your interest and for being here today.

We will now turn to our panel of witnesses. First, I am delighted to introduce Peggy Haynes, who is the senior director of MaineHealth Partnership for Healthy Aging, where she leads MaineHealth's efforts to deliver quality aging and senior care of Maine seniors. Ms. Haynes' primary focus has been on MaineHealth, a highly successful A Matter of Balance program, which I described in my opening statement. She has led the successful translation and national dissemination of A Matter of Balance to a lay leader model. Under her leadership, the organization has received national recognition for accomplishments in health promotion and collaboration.

I will now turn to our Ranking Member to introduce our second witness.

Senator CASEY. Thank you, Chairman Collins.

I am pleased to introduce Virginia Demby of Chester, Pennsylvania. Virginia brings decades of experience as a nurse, to her testimony today, having talked to the patients she treated about the importance of staying active later in life. Now Virginia is putting into practice what she told patients all those years as a nurse.

In addition to taking a falls prevention class offered through her local senior's center, Virginia is a regular at kickboxing and yoga.

Virginia, some days around her, I would like to know how to kickbox.

Senator CASEY. Sometimes you can also find her dancing and even weightlifting. We will hear more about that later, I hope.

As Virginia will explain, she has not stopped encouraging others to get moving either.

Virginia is joined today by Ellen Williams, Health and Wellness program manager at the County of Delaware Services for the Aging.

Ellen, thank you for being here as well.

Virginia works with Ellen to encourage other seniors in Delaware County, Pennsylvania, to take these classes and to stay active.

Thank you, Virginia, for being here and to let us in on your secrets to staying healthy, and thank you for your advocacy in your community.

The CHAIRMAN. Thank you.

I want to acknowledge that Senator Rick Scott of Florida, who has been a very loyal member of this Committee, has also joined us.

Next, we will hear from Kathleen Cameron, a veteran health care professional in the field of aging. She has more than 25 years of experience as a pharmacist, researcher, and program director focusing on falls prevention, geriatric pharmacotherapy, mental health, long-term services and supports, and caregiving. Since 2014, Ms. Cameron has been the senior director of the National Council on Aging's National Falls Prevention Resource Center, and last but certainly not least, we will hear from Liz Thompson, the chief executive officer of the National Osteoporosis Foundation, and again, I want to thank the foundation for working with me in my office on the legislation that we have introduced to reverse the harmful cuts in osteoporosis and bone density screening.

Ms. Thompson has 30 years of experience. In 2018, she launched the National Bone Health Policy Institute, which seeks to spread greater awareness about the importance of bone health.

I want to thank all of our witnesses for being with us today, and, Ms. Haynes, we will start with you. Thank you for being here, all the way from the great State of Maine.

STATEMENT OF PEGGY HAYNES, SENIOR DIRECTOR, HEALTHY AGING, MAINEHEALTH, PORTLAND, MAINE

Ms. HAYNES. Thank you, Chairman Collins, Ranking Member Casey, and Committee members. I am Peggy Haynes. I am the senior director of Healthy Aging at MaineHealth. We are Maine's largest integrated health care delivery system.

Our vision is to make our communities the healthiest in America, which led us to focus on fall prevention. Health care has a critical role to play in fall prevention, from screening for falls, assessing fall risk factors, reviewing medications, and referring to both medical and community-based interventions.

Falls are multi-factorial, and a range of interventions are needed. We recognize this by becoming founding members of the Evidence Based Leadership Collaborative, promoting the increased delivery of multiple evidence-based programs.

Today I am here to share our work with A Matter of Balance. In Maine, we took an evidence-based, clinically led program that

was challenging to replicate and used Maine's experience, innovation, and common sense to create a program that is now reached across the country. A Matter of Balance reduces the fear of falling and increases activity levels in older adults. It is a small group program, where participants learn to view falls and fear of falling as controllable, set realistic goals to increase their activity, reduce their fall risk factors, and use exercises to gain strength and balance. Eight 2-hour classes include group discussion, problem-solving, and exercise training.

A Matter of Balance was developed with funding from the National Institute on Aging through a randomized control trial at Boston University in the mid-'90's. We brought A Matter of Balance to Maine, using our clinical staff to offer the program in the community. While it was very well received, the expensive of using clinical staff limited our dissemination.

In 2003, the Administration on Aging used Older Americans Act funding for translational research to get the scientifically proven programs off the shelf and into the community. MaineHealth and our partners were awarded a grant to develop lay leader model for A Matter of Balance.

We made adaptations, keeping the class structure and curriculum true to the original research. Now classes are taught by lay coaches. Curriculum materials include master trainer manuals and coach manuals, participant workbooks, and exercises that were adapted to focus on strength and balance, and we added visiting health care professionals.

We developed a training structure. We teach master trainers who then teach and support coaches with an established curriculum.

We provide support by updating materials and resources by quarterly conference calls through technical assistance and outcomes measurement.

The results tested in Maine reflected the same statistically significant increases for up to 12 months in falls efficacy, falls management, and falls control, and for up to 6 months, improvement in physical activity and reduced isolation. Ninety-seven percent of participants are more comfortable talking about fear of falling and increasing activity levels, and 99 percent plan to continue to exercise.

A Matter of Balance participation was associated with total medical cost savings of $938 a year in the 2013 CMS report to Congress.

We work in partnership with our agencies on aging to provide State-wide access to classes. As Senator Collins mentioned, over 6,200 Mainers have benefited from the program.

Nationally, 1,700 master trainers are spread across 46 States, and since 2006, over 96,000 older adults have attended classes.

I would like to also share a participant story. Sandy, following back surgery, was using a cane. One winter morning, taking her dog outside, she fell on the ice breaking her femur. After 3 months of physical therapy, she was still using a walker and was stuck at home. Sandy's daughter saw an ad for A Matter of Balance and encouraged her to attend.

Skeptical, Sandy started the program. Within 4 weeks, she was no longer using her walker and had graduated to relying on a cane.

Sandy said, "The program teachers you to think and stay in tune with your body." Sandy then took Tai Chi, again, skeptically. She was not an earth muffin. Two months into taking Tai Chi, Sandy no longer needed her cane. She has gone on to be a coach for A Matter of Balance in Tai Chi, and she is now teaching other older adults to know they can get up and to reclaim their lives. In her words, "Now I am free. I am here again, and I am back to being me."

Thank you for the opportunity to speak with you and for your leadership to reauthorize the Older Americans Act and your support for National Falls Prevention Awareness Day, and thank you for recommending the increased funding for fall prevention so more older adults can live independently.

The CHAIRMAN. Thank you very much for your testimony.

Ms. Demby?

STATEMENT OF VIRGINIA DEMBY, ADVOCATE FOR COMMUNITY AND OLDER ADULTS, CHESTER, PENNSYLVANIA

Ms. DEMBY. I am Virginia Demby. I was born in Chester, Pennsylvania. I also live in Chester, Pennsylvania. When I was younger, I would often work two and three jobs in order to meet my needs and the needs of my family members.

Life has not been easy for me. I was also born with some birth defects. I had many things happen to me, and doctors did not know what was wrong with me. Many of the doctors were telling me, "It is all in your mind," and I would fall a lot. Many times, I found that when I would get out of bed, when I tried to stand up, it was not going to happen and I would find myself on the floor.

Before I got a wheelchair, I many times crawled across the floor to get to the bathroom because I did not want to make a mess. Even today, I still remain very independent, in spite of all the things that have happened to me.

Nobody taught me what to do. I figured it out for myself because the time came that I also developed fibromyalgia, after having had a knee replacement. Due to some of the birth problems, defects that I had, I would constantly develop tissue growths and would always have to go back to the hospital to have those tissue growths removed, which also prevented me from walking, prevented me from standing up. I could not participate in many things.

Doctors did not know what to do for me. I developed fibromyalgia before doctors even knew what it was. Most of them had never heard of it. I had arthritis, osteoporosis, rare genetic inherited blood factor, problems with the heart. I realized if something did not happen for me, I was not going to live. I could not possibly make it.

Then there was also a matter of economics. When I reached the point where I could no longer keep my home, after having spent years of doing things to help other people even at that point, I no longer had enough money to even take care of myself. I have been very grateful to have assistance, where a portion of my rent is paid every month, and to have the SNAP program so that I can eat. Even with that, it is not enough money, getting Social Security and SSI, to really take good care of myself.

I had to learn how to be a very thrifty shopper. I had to learn how to go to stores and find foods and things at a price I could pay for so that I could do healthy eating, so that I could look after my body, look after my mind, so many older adults have not had that experience. Nobody has taught them. They have not had the educational training, and they end up isolated, alone, not knowing what to do, not enough funds to support themselves.

Many of them, like me, also end up in apartment buildings, nursing homes, and still not getting what they need.

Healthy Steps. If you learn about it, if you participate in it, there is the opportunity to learn how to be active, how to regain what you have lost, what it is like to be rejuvenated, how to find a way to prepare your meals and shop so that you can have what is going to be healthy for you because, like I said, you cannot afford to do it on Social Security. SNAP helps a little bit, but it is not enough. Then you get criticized because that is what you get.

Older adults lose their confidence, and no wonder. They become fearful, and no wonder. I am finding older adults are the ones who need the most help. Many of them are very set in their ways, very stuck in their thinking, afraid to share with other persons, and do not know who to turn to or where they can get help. Most older adults, as they have come along, their families along with them have all expired, and there they are left alone, no place to go, do not know what they are going to do and they just sit. They do not know that sitting is just going to make them even less active as time goes on. I go out and encourage them. I find them. I go to the apartment buildings. I go to the Department of Housing in the city where I live, and I encourage them to set up sessions. Have persons like COSA with Ellen coming in. Get in touch with the older people. Have them come, take the classes, participate, and where they do not have family and friends, buddy up and help each other. Get back to walking. Walk together.

Me, as the Senator said, I do line dancing, Zumba, kickboxing, weightlifting, boxing, extreme exercise. I used to run. I do not do the running anymore because I am very visually impaired. Now I walk, but I do distance walking. I tell older adults, "If you can walk a little bit, keep adding on to the distance that you can walk. Get those muscles working again. Health can be repaired, but you have to participate in it. Open up. Talk to your doctors. Ask questions, and if you do not understand what they are saying to you, ask them to break it down for you so that you can understand. Find someone to go to the doctors with you that may have more understanding of the body and the mind than you have, who may have a little more knowledge of medical terminology, and ask them to speak for you. Ask them to step in and help you understand what the doctors are talking about. Make sure you are getting the right kind of doctors. Make sure you are getting competent, caring doctors. Check out those doctors. Find out where did they go to school. Where did they do their internship? In the cases that they work on, how long have they been doing that kind of work? Do not be afraid to ask for a specialist. Search out the different organizations that can provide you with some help."

I am looking to live a long life. My grandmother was 105 and was very functional. My grandfather was 98 and very functional.

I just recently had a sister pass who was 94. Her only problem was arthritis, so because I have that long-life background, I expect it, and I am looking forward to it. I am determined to continue being functional. I am determined to continue doing things that will help older adults, and all that I do, I get no moneys for it. I do it for free, all because I care.

The CHAIRMAN. Thank you very much for your very compelling testimony.

Ms. Cameron?

STATEMENT OF KATHLEEN A. CAMERON, SENIOR DIRECTOR, CENTER FOR HEALTHY AGING, NATIONAL COUNCIL ON AGING, ARLINGTON, VIRGINIA

Ms. CAMERON. Good morning. Chairwoman Collins, Ranking Member Casey, and members of the Committee, I appreciate the opportunity to speak with you on behalf of the National Council on Aging about the critical issue of older adult falls and the promise of falls prevention.

I have dedicated a large part of my professional career to this issue. It is also very personal for me because my mother passed away due to consequences from a hip fracture she sustained after a fall.

Almost every person knows an older adult who has fallen and whose quality of life, dignity, and independence were dramatically changed, as was the case for my mother. It is a health issue that crosses all genders, ethnicities, and income levels.

NCOA's mission is to improve the lives of millions of older adults, especially those who are struggling. Falls prevention is a critical pillar of our work.

NCOA directors the National Falls Prevention Resource Center that is funded by the Administration for Community Living, and we lead the National Falls Free Initiative, which includes coalitions in 43 States.

Every year, on the first day of fall, we sponsor Falls Prevention Awareness Day to ring attention to the issue and proven solutions. Thank you, Senators Collins and Casey, for leading the effort to pass the annual Senate resolution to designate the day this year and for enlisting the vast majority of Committee members as co-sponsors. Thank you.

We know the predictors for falls. We have tools to identify those most at risk, and we have proven strategies to reduce risks and falls. Yet falls rates continue to escalate. Every hour, four older adults die from fall-related complications. This number is expected to reach seven by 2030 if we do not take significant steps now—by 203, fall-related costs are projected to double to $101 billion, and right now, as you mentioned, Senator Collins, Medicare and Medicaid pay the majority of these costs.

Many factors contribute to falls, which is why NCOA advocates for multi-stakeholder solutions. First, we need a coordinated Federal effort. Today, there is no one comprehensive strategy under the purview of any one single agency. A coordinated effort could be modeled after the National Alzheimer's Project Act and include a National Awareness and Action Campaign. It could also include a cross-agency collaboration to develop the infrastructure to make it

easier for older adults to access and afford falls reduction strategies.

Second, we need early identification of falls risk factors and early intervention. Falls should be recognized as a medical condition to increase accurate reporting, compliance with medical recommendations, and payment for prevention and treatment.

Falls risk screening and assessment tools must be used consistently. The CDC study is a gold standard, saving an estimated $3.5 billion over 5 years. We recommend incentivizing health care providers to use it.

We also must promote electronic health records to coordinate communication and data exchange among those involved in falls prevention, also critical is widespread implementation of evidence-based community programs such as A Matter of Balance, Fit and Strong, Tai Chi, Healthy Steps that Ms. Demby mentioned.

Older Americans Act health promotion funds have supported these programs, and the Prevention and Public Health Fund has made crucial new investments.

Since 2014, the $5 million allocated annually from the Prevention and Public Health Fund has allowed us to reach 100,000 older adults in 30 States through community-based organizations' efforts. Although impressive, much more is needed, especially in rural and underserved areas of the Country.

We also need to focus on two of the most modifiable risk factors—medications and home safety. NCOA recommends all older adults receive at least an annual review of medications, especially during transitions of care, to identify fall-related side efforts. CMS should mandate that Part D plans expand medication therapy management services to include reviews for falls risk.

We must incentivize people to modify their homes for aging in place. NCOA also urges wider implementation of evidence-based programs such as CAPABLE.

We appreciate the efforts of Senators Collins and Casey to mobilize bipartisan support for OAA reauthorization to coordinate home modification and promote innovation.

Finally, we must improve Medicare to prevent falls. We urge CMS to provide Medicare reimbursement for falls risk screening, referral management, and evidence-based community programs. Expand payment for the Welcome to Medicare and Annual Wellness Visit to physical and occupational therapists. Develop Medicare falls prevention billing codes, and use the CMMI to examine innovative payment models.

We must face older adult falls head on. We understand the problem, and we know the solutions. Now we must create a coordinated strategy and devote resources to save lives.

Thank you for this opportunity, and I welcome questions from Committee members.

The CHAIRMAN. Thank you very much for your statement.

Ms. Thompson?

STATEMENT OF LIZ THOMPSON, CHIEF EXECUTIVE OFFICER, NATIONAL OSTEOPOROSIS FOUNDATION, ARLINGTON, VIRGINIA

Ms. THOMPSON. Good morning, Chairman Collins and Ranking Member Casey. Thank you so much for calling this hearing today

on a vitally important issue. I want to especially thank you, Madam Chairman, for your longstanding work on bone health issues. It is truly appreciated.

The National Osteoporosis Foundation strongly agrees with the Committee that a thoughtful analysis in search for policy solutions to the problem of falls among older Americans must include an examination of bone health, osteoporosis, and bone fractures.

In a minute, we will turn to some very big numbers, but before we do that, I want to make sure we are keeping patients and their families front and center.

In December 2018, my friend and colleague, Claire, lost her mother, Rosaline Burke, to complications related to a fall. In June of this year, my father, Alvin, died of complications related to a fall. These millions of people that we are talking about are not abstract to Claire and me. We know their stories. They are our stories. As we discuss the issues today, remember Rosaline and Alvin and the millions of people they represent.

Now, I promised you numbers, and here we go. I have a few slides that I will briefly review a few findings from a report that we commissioned recently from Milliman, the actuarial firm.

Slide 1, please. Approximately 2.3 million fractures, bone breaks, were suffered by 2 million Americans on Medicare. That is right, more than one fracture per person. Those numbers are not acceptable.

Slide 2, please. Secondary fractures are extremely costly. This is the second fracture people incur. The additional cost in Medicare for the 307,000 people who suffered a bone break in the 2 to 3 years after their first fraction was $6.3 billion.

Slide 3, please. While we know from previous studies that about 50 percent of secondary fractures can be prevented by appropriate treatment, we also know from other studies that 80 percent of those who have suffered a fracture do not receive the treatments that we know work. That is not acceptable.

Slide 4, please. The total annual cost to Medicare and their families, including caregiver costs, is expected to balloon from $57 billion in 2018 to $95 billion in 2040 if we do nothing.

Slide 5, please. Our new report from Milliman gives us hope. Our report finds that preventing even a modest 20 percent in the rate of secondary bone breaks could lead to a savings of $1.2 billion in Medicare fee-for-service.

What do we need to do to stem this crisis? The National Osteoporosis Foundation has put forward an aggressive call to action to stem this crisis. First, we recommend that Congress should direct CMMI to conduct a Medicare demonstration or create a bundled payment model that incentivizes better coordination and management of care, such as the provision of fracture liaison services, to beneficiaries who have suffered one or more bone fractures and may be at risk of additional fractures.

Today Medicare does not pay for the innovative care coordinated model known as FLS, or fraction liaison service, but we know from work by Kaiser and Geisinger, this model could have incredible impact on our seniors and our pay system. Number one, Congress should pass Chairman Collins' bipartisan Increasing Access to Osteoporosis Testing for Medicare Beneficiaries Act of 2019. This

legislation would set more adequate payment rates for screening and should increase access to this critical preventive service. Based on a 35 percent prevention rate, we estimate 26,000 hip fractures could have been avoided if Medicare beneficiaries continued to receive DXA scans. Number three, appropriate quality measures for both optimal screening and treatment of osteoporosis and bone fractures should be established, adopted, and incentivized by Medicare and other payers, Number four, Congress should direct and fund HHS to implement a national education and action initiative aimed at reducing falls and bone fractures among older adults. One such model for this is already in place. The initiative is the Million Hearts 2022, an initiative co-led by the CDC and CMS, which aims to prevent 1 million heart attacks and strokes within 5 years.

These steps along with others called for in the committee's excellent report being released today provide a roadmap for improving and saving lives and lowering health care costs.

Thank you so much for the opportunities to share our views on this very important topic. We look forward to working closely with the Committee as its work progresses.

I look forward to any questions you may have.

The CHAIRMAN. Thank you very much, Ms. Thompson, and my sincere condolences on the loss of your father. As I have learned more about this issue, falls are the single greatest factor in the downward spiral that can lead to the passing of a loved one, and I am sorry that you had to experience that personally as well.

I am struck, as I hear your testimony, that this is an issue where we know what to do in many cases. It is not something like Alzheimer's disease, where we still have not figure out. We know what to do, and yet we are slashing reimbursements. We are not focused on it. The public is not aware of how significant falls are, and that makes it all the more frustrating. I am sure it does to each of you.

The costs are also so significant. Ms. Thompson, I want to start with you. I am just stunned by the fact that CMS slashed the reimbursement rates for the bone density scan by some 70 percent, and we have seen the results in the last 13 years. Indeed, one of your charts, if I read it correctly, showed that even after a fracture, only 9 percent are being scanned. How important is it that we increase the reimbursement level?

I had two medical experts in Maine, Cliff Rosen, who is the director of the Center for Clinical and Translational Research at the Maine Medical Center, and Ann Elderkin, whom I previously mentioned, who was the executive director of the American Society for Bone and Mineral Research, write that the DXA scans have declined dramatically, and as a result, we are seeing way more fractures.

How important is it for us to fix this reimbursement problem?

Ms. THOMPSON. First, I want to say thank you for recognizing the fantastic work of Anne Elderkin and the ASBMR. They are a terrific partner with us as well.

Next, I want to say on behalf of all of us who are working in this, we do not believe there is any reasonable justification for the cuts that have been made to reimbursement. They were misguided, and they reduced access to screening. We believe this was penny wise and pound foolish.

For those of you who do not know, I just want to make sure we understand how we got to this point. Congress first cutoff the DXA payments in 2007 along with Medicare payments for other imaging services as part of the Deficit Reduction Act in 2005, and then further cuts, phased in over time, were done to physicians in the course of interpreting those DXA results.

It came up a little bit under the Affordable Care Act of restoring it to 70 percent of the 2006 level, but that increase only lasted for 2 years. In the end, a provision to increase Medicare payments for DXA was not included.

We strongly support your legislation, Increasing Access to Osteoporosis Testing for Medicare Beneficiaries, to get back to the levels where patients will have access and physicians will have the ability to do this critically important test.

Thank you so much for your leadership in this, Senator Collins.

The CHAIRMAN. Thank you for giving us the history as well. That is very helpful.

Ms. Haynes, you have done such an extraordinary job with A Matter of Balance program, which is such a commonsense, inexpensive way to reduce the risk of falls and the fear of falling that can cause seniors to become homebound.

I am curious, however, how you reach individuals who are living in the more rural areas of the State of Maine. Are the local community health centers and rural hospitals and physical therapists participating in offering the program, or is it mainly available in Southern Maine?

Ms. HAYNES. Actually, it is available State-wide, and Aroostook Area Agency on Aging has been doing a wonderful job. We just had two folks come down to our master training last week because they have demand that they cannot meet for classes.

I asked them what their secrets were. Town halls, churches, where do people go, the rural health centers, where there are meeting rooms, people team up. You said to buddy up, so they give each other rides. People who can still drive pick up those that cannot. In small communities, that is easier in some ways because you know each other, and you have known each other for years. It really is a matter of reaching out and finding those locations where people already go.

Likewise, we just trained more folks from Franklin County because they have a waiting list, and they are going to very small communities. In both of those situations, they have serious winter issues to deal with too.

Senior housing is another place, if there is senior housing. You mentioned early on, we need to touch all of those places. It is an issue for housing. It is an issue for health care. It is an issue for our community-based organizations. We need to work together, whether you are urban or rural, for those touch points.

The CHAIRMAN. Thank you very much.

Senator Casey?

Senator CASEY. Thank you, Chairman Collins. Thank you for indulging in my schedule with the Judiciary hearing, and I am back.

I wanted to start with Ms. Demby. Virginia, it is obvious that you are an advocate in more ways than one, and that you are certainly a force to be reckoned with. This question could only go to

someone with your background and your credentials as an advocate.

You said that you are working with Ellen, who is with you today, to connect other seniors with falls prevention classes and getting scores of your friends and neighbors moving, literally, but you are just one person, and we know that today's report, among its other recommendations, suggest that the Federal Government engage in a national effort, really a national campaign to promote falls prevention strategies.

Here is the question: Do you think this type of investment, a falls prevention campaign, would be helpful in getting more people across our Commonwealth and our Country moving literally?

Ms. DEMBY. Yes. I live in an apartment building that is designated for seniors and persons with disabilities. I am now also seeing younger persons being admitted into those facilities to be residents there, and even with seeing that, I see the seniors still separated. I see seniors, the older adults, being mistreated by managers and property owners, intimidated, afraid to speak up. I go and speak for them, or I encourage them to speak for themselves, or I tell them, they must change their way.

Many of them do not even leave the building unless somebody comes and takes them, and usually, it is for a medical ride. Where I live, if it is not a medical ride that you are getting, if someone you know does not take you, if a family member does not take you, you do not get to go. They go nowhere.

I approached the housing authority in the city where I live, Chester, Pennsylvania, and they have promised me, because of what they know of me, that if a center is closed, all I have to do is get a schedule from COSA, from Ellen, COSA's instructors, get it set up and bring them in to teach those seniors, but then there is a problem with that too sometime because sometime that older adult has no way to get there, and it is not considered a medical ride, so they get left out.

I further went to the extent of going to find a way to get it to them, going to find a way to get them to it. It is a must. Until the death of that older adult, they must find a way. They must have a way to participate. There must be support for them. There must be somebody who speaks up for them, especially when they do not speak for themselves. I am that community advocate and that advocate for older adults. I do not know anyone else in the area where I live or anywhere in Pennsylvania that somebody has taken that on and is doing it.

Senator CASEY. A national campaign is pretty important?

Ms. DEMBY. Yes, very.

Senator CASEY. Thank you.

I just have a little bit of time left. I wanted to turn to Kathy Cameron and ask a question just emanating from your testimony.

You stated that the Falls Prevention Resource Center at NCOA is responsible for supporting "implementation, dissemination, and sustainability of evidence-based falls prevention programs." We know that there is evidence, strong evidence that that works.

Can you explain some of the challenges that you see and what is needed to grow the number of an availability of evidence-based programs for seniors?

Ms. CAMERON. Yes. Thank you, Senator Casey.

We work with community-based organizations and State agencies across more than 30 States to implement these evidence-based programs, and they are using Prevention and Public Health Funds in order to do that. Most of these grantees have 3-year grants, and a big part of what we work on is to develop sustainability strategies with them. Part of that includes outreach to health care providers, informing partnerships with health care entities, whether it be a Medicare Advantage Plan or local health system or hospital system. A lot of time, these entities do not know anything about these programs, so that is definitely a challenge.

We work with them to articulate the value that these programs bring to older adults, most importantly, in terms of improving their independence, reducing the fear of falling that can often lead to social isolation and depression, but, also, many of these programs have shown a return on investment that can be of benefit to some of these health care payers.

Those are some of the challenges, but many of them are also strapped for money to pay for these programs, so that is why we really believe greater investments in evidence-based programs are needed, really as a Medicare preventive service is what is required, like other preventive services in Medicare. Evidence-based programs need to have payment in order for them to be more widespread across the U.S.

Senator CASEY. Thank you.

The CHAIRMAN. Senator Braun, welcome.

Senator BRAUN. Thank you, Madam Chair.

As usual here, I think of any of the committees that I serve on and four others, you have some of the best topics that are pertinent to, I think, what affects us all in the real world.

Prevention, an ounce of prevention worth a pound of cure, I took that on as a mantle for fixing health care in my own company as a CEO 11 years ago.

When I talked about things like wellness and prevention, the insurance industry was more interested in remediation and claims processing, so we are on to something here.

I guess my curiosity would be, since the portal for most, before they get to Medicare, is through private insurance, I know when we look at all the information we have got currently to try to prevent, we see clusters of diabetes. Of course, we have cancer. We have heart disease. Falls and the prevention of them would not be high on the radar screen.

I guess I got a couple questions, and I will start with Ms. Cameron. When it comes to tools in the private sector, what is our responsibility of kind of putting this out there as something you need to be aware of before you get on Medicare?

Other than a BMD, which I know the particularity of what that test says, is there anything through general biometric screenings that would give us, as employers, the information to say, "Hey, you may have an issue down the road, even though you are not falling currently"?

Ms. CAMERON. Great. Wonderful question. Thank you.

Yes, prevention is truly important, and I believe starting early and educating people in their forties and fifties about falls preven-

tion and what they can do, particularly around improving balance and strength and continuing exercise programs, physical activity throughout their elder years, just like Ms. Demby has been doing throughout her life.

Some of the things that employers could look for are chronic illnesses. We know that heart disease, diabetes, arthritis are risk factors for falls, so ensuring that those conditions are well managed from the very beginning is really important.

Often the medications that are used to treat some of those conditions can also lead to increased risk for falls, and we are seeing much higher rates of medications being prescribed really across all age groups, but particularly among older adults. Educating people early on too about medication side effects like drowsiness, dizziness, visual impairment that can sometimes happen with certain medications is really important from that perspective.

Senator BRAUN. A standard blood panel test, which is probably the baseline of any biometric screening, we started that when I put in a new dynamic based upon—also employees, patients be engaged in their own well-being. I found that so much of our society is "fix it," regardless of the cost, and we changed that and it is unbelievable what can happen. My employees have not had a premium increase in 11 years. People did not believe me when I ran on that, so it can work.

When things are simple, they work better. What is the first baseline, other than just observation that if you have heart disease or arthritis, common sense would tell you, you are going to be prone to falling? Is there any simple tool, and does a standard blood test reveal anything? - because that is simple, and you get the results.

Ms. CAMERON. Well, we have a tool called STEADI, the Stopping Elderly Accidents, Deaths, and Injuries, and that is an assessment for falls risk that looks at a number of different risk factors, so it is a very comprehensive approach. It is based on some guidelines that were developed by the American Geriatric Society, so that is a great place to start.

There are also functional assessments that can be done to measure a person's strength and balance, for example, that could be started early on, so those are simple things that could be put in place.

Senator BRAUN. Thank you.

Ms. Haynes, a question for you. Are you aware of any of the major insurers that are going to be the interactors with us as business owners that have fall prevention as part of what they talk about?

We do a lot of things with our underwriters looking at what we can do to prevent things, and I do not recall that I have heard much input. Are insurance companies actually talking about it?

Ms. HAYNES. Thank you for the question.

I am not aware of any that in the commercial younger population talk about fall prevention.

I think to your point about wellness programs and keeping people active and encouraging that kind of—whether it is a walking meeting or whatever, those are activities that we all need to do while we are still in that population.

For Medicare, it is a different story, where we do include in, for example, the annual wellness visit, the question about "Have you fallen?" The bee in my bonnet, I guess, and my teams is you would not say, "You have high blood pressure. See you." You would say, "Come back, and let us do an assessment and find out what it is," and then you would make a referral, whether it is PT or an OT, to Senator Collins' point about the home health, homebound benefit being restrictive. We would take those kinds of actions and then refer out, whether it is a community program or a medical intervention.

Senator BRAUN. Thank you.

Ms. HAYNES. CMS has a big role to play.

Senator BRAUN. I would do this as a public challenge to insurance companies, which many Senators are wrestling with them and the health care industry in total, that there ought to be more awareness of this kind of thing. Just because you do not handle many claims associated with it because that domain is going to be in Medicare, that does not mean you should not be talking about it.

Thank you.

The CHAIRMAN. Thank you.

Senator Jones, I think you came in before Senator Rosen, but I am not sure. You were here? I am sorry. Senator Rosen.

Senator JONES. She fell recently.

The CHAIRMAN. I know.

Senator ROSEN. I did fall and fracture my wrist. I was at a parade and high-fived someone, and I went in a little too far. I could have used some of the—I wore the wrong shoes. I should have had flats on, a whole nother story, but, anyway, I thank you for bringing this really thoughtful hearing here for all of your work in advocacy because, as a daughter and daughter-in-law, I took care of my parents and in-laws as they aged, and so went through OT, PT. My mother-in-law fell in the garage and had to have a knee replacement. I really understand how important it is, what I learned as a caregiver taking them to OT and PT, about how you get in and out of cars and grab for things, so it is not just the patient. It is also sometimes the family members that can benefit from some of this training.

I wanted to say that in July, I launched a bipartisan Senate Comprehensive Care Caucus, which serves to raise awareness and work toward improvements in areas of palliative care, care coordination, and issues impacting caregivers, because for some seniors, as you said, lack of care coordination is a barrier for people as they need to receive services, such as your evidence-based falls prevention programs.

Ms. Cameron and Ms. Haynes, as advocates for older adults, I want to ask you a couple of questions. Can you speak about some of the care coordination services you would like to see provided in our communities, and what can Congress do to help coordinate amongst these evidence-based programs discussed today? Housing, health care providers, and even using telehealth apps, people are on their iPad. People are doing a lot more things, perhaps, so we break down those barriers so that everybody gets the care they need.

Ms. Demby, sure, you can answer.

Ms. DEMBY. Some of this could probably be incorporated into the physical education program in schools. Money is being taken away from some of the physical education programs. Some of the children are not really getting what they need.

If fall prevention is included in the school curriculum, by the time you get to be an older adult, you know something about it. You know how to fall. You have learned something about fear. What do I do when I know I am going to fall? At that very instant it happens, I need to know to relax.

Senator ROSEN. Of course, those teenagers are fearless.

Ms. DEMBY. Let the fall take place. Relax.

Senator ROSEN. Yes.

Ms. DEMBY. When you relax, there is less injury——

Senator ROSEN. Yes, ma'am.

Ms. DEMBY [continuing]. and sometimes no injury at all. I had to learn that, and I had no one to teach me.

Senator ROSEN. Well, so, Ms. Haynes or Ms. Cameron, can you speak to how we can integrate this, even using apps or telemedicine or television, even, Skype? I do not know. Use technology to maybe help people, even in their homes?

Ms. CAMERON. Yes. Well, I think there are a number of opportunities to better coordinate around falls prevention, the first being utilizing the annual wellness visit. First of all, we need to increase the uptake of the annual wellness visit among Medicare beneficiaries, but we really feel that that visit has been a missed opportunity to fully assess for falls risk and intervention and referral to a number of different programs that are available in the community that we have been talking about today, so using that visit to really coordinate care is vitally important.

The CDC has done research on the impact of primary care coordination in doctors' offices using the STEADI toolkit that I mentioned earlier, and they have been able to show a reduction in falls, reduction in health care utilization as a result of developing a falls plan of care that could be put in place for those who are at high risk for falls, and then we are also waiting for the results of a study funded by PCORI, or the Patient-Centered Outcomes Research Institute. A number of universities are involved in that initiative, using a falls care manager to coordinate the care around for those who are at high risk for falls. I am hopeful that that is going to have some positive results on outcomes for older adults as well as reduction in health care utilization.

Senator ROSEN. Fantastic. Thank you. I think I am just about out of time, if you go quick, yes.

Ms. HAYNES. I will go quickly.

We have been doing a lot of work as a health system coordinating between our care managers and our community-based organizations with direct referrals for the evidence-based programs.

The other piece is just the opportunity that might be presented by CMMI for an innovative grant to bring together t hose organizations that you suggested. A model might be the community-based care transition program, which was quite successful.

Senator ROSEN. Thank you so much.

The CHAIRMAN. Thank you, Senator.

Senator Hawley?

Senator HAWLEY. Thank you.

Thank you all for being here today and for your testimonies, and a special thanks to Chairwoman Collins for holding this hearing and for your leadership on the Committee's annual report on falls prevention.

I was proud to joint Chairwoman Collins, Ranking Member Casey, and many of my colleagues on the Committee in cosponsoring the Senate's resolution on National Falls Prevention Awareness Day, and I hope that that resolution and your testimony here today will help elevate this issue and educate more people about it, so thank you so much for being here.

I also want to mention that I am personally very proud that my home State of Missouri was featured in this year's report. The Show Me Falls Free Missouri Coalition is an organization that includes over 50 partners from both the public and private sectors. To help reduce the risk of falls and falls-related injuries, the coalition offers education and outreach, both online and in person, to help connect Missourians to resources and evidence-based programs, and this program is just one of many, where we are seeing effective coordination between States and partners in the community to help prevent falls.

I am hopeful that the report will help encourage more of these kinds of partnerships by highlighting some of the good work that is currently being done.

One area I would like to explore today is the link between falls and traumatic brain injury. According to the Center for Disease Control, falls are the leading cause of traumatic brain injury for individuals who are 65 and older. Specifically, four in five TBI-related emergency department visits in adults age 65 and older were caused by falls, and I understand that those rates are significantly higher for individuals who are 75 and older.

Ms. Cameron, maybe let me ask you. To your knowledge, what is currently being done to ensure that older adults who have sustained a fall are being screened for brain injury and referred to appropriate resources, and what more do we need to do?

Ms. CAMERON. That is a great question. I think oftentimes, we are missing opportunities to do that screening for those who have had a brain injury as a result of a fall, but we need to educate more of those who have had a brain injury about interventions available in the community.

One thing that we do not have a lot of are interventions specifically designed to prevent TBI, and we need to look at that more closely and see what is really effective in preventing traumatic brain injury, what types of physical activity, those sorts of things, and how we can prevent the sequelae from those who do suffer a traumatic brain injury, but, again, it is all about awareness and education to ensure that those with a TBI as a result of a fall get into programs, so they can prevent future falls from happening.

Senator HAWLEY. Thank you very much. That is very helpful.

Switching gears slightly, my home State of Missouri has a large rural population, and the Chairwoman asked a question in this vein that I thought was important. I can say from growing up in rural Missouri, I know that access to care in rural areas can be a

big challenge, and it is one that is becoming particularly acute in my home State and I suspect in many other places.

Ms. Cameron, let me ask you again. In your view, are current falls prevention programs adequately accessible in rural areas, and what do we need to do to improve access for our seniors, many seniors who live in rural places like where I am from?

Ms. CAMERON. I think there is always more we can do to increase access, and that is one of the areas that we are focused on in terms of the technical assistance that we provide to State grantees that have received Prevention and Public Health Fund grants.

To me, it is all about partnerships, as Peggy Haynes was talking about, ensuring that rural organizations are partnering with others so that older adults in rural communities can access those programs, partnering up. Perhaps it is on training coaches and leaders for these programs is one avenue, maybe looking at alternative models in which programs can be developed, using telehealth approaches.

We are just starting to look at ways in which programs like A Matter of Balance, I think, CDSME, the Chronic Disease Self-Management Education, can be provided in person and then having folks remotely join these programs. I think there is a number of models that we need to explore more in depth to ensure that those in rural communities can engage in programs.

Senator HAWLEY. Would you like to add something to this, Ms. Haynes?

Ms. HAYNES. I would. Thank you for asking.

One partner we have not talked about that we have partnered with in Maine—and I am a native Michigander, and the Upper Peninsula in Michigan is using A Matter for Balance and that is our cooperative extension programs. We have those all over the country. They are great partners. They are already getting out into the community, so just to think more broadly about who we can tap into.

Senator HAWLEY. That is super. Thank you.

Well, my time has expired, but thank you all so much again for being here today. Thank you for the important work that you do. Thank you, Madam Chair.

The CHAIRMAN. Thank you.

Senator Jones?

Senator JONES. Thank you, Chairman Collins.

The CHAIRMAN. The very patient Senator Jones.

Senator JONES. Thank you, and thanks for all of our witnesses for being here today.

I am patient in part because, as we speak, my mom is also recovering from one of her latest falls. I worry that my mother has skewed the average in Alabama somewhat, and it has been a real challenge for her. She is in assisted living now, and as hard as she tries to stay conscious about it, it is a continuing problem.

Fortunately, we have been very lucky. She has not broken any bones. She is on blood thinners and has not hit her head, which is a fear.

Many of the falls do not result in very serious injuries, but they are falls nonetheless. What I have seen, I think, with my mom, sometimes falls beget falls. I am not sure that folks are adequately

getting followup. When they go and they are treated for a fall, they are seen in the emergency room or a nurse in an assisted living comes, and the patient is saying, like my mom, "Oh, I am fine. I am fine. I am fine. Do not worry about it. Do not call an ambulance. I am not going in, anyway." It is a problem because everybody just goes about their business.

My question is a little bit compound. Number one, how important is it—and I guess this is mainly to Ms. Cameron and Ms. Thompson. How important is it for any fall of an elderly person to receive some form of whether it is physical therapy, occupational therapy to have some followup to see how they are doing? How important is that? Number two—and I have experienced this with my mom, who says, "I do not want that." After a fall, you get kind of sore, and it hurts to go through physical therapy sometimes, so they are just like, "I do not want that." Education the patient as much is kind of a compound problem, and I would like for you all to address that because I believe—and I have tried to preach to her that I thought some form of physical therapy was incredibly important, regardless of what happened during the fall itself. I will let either of you address it.

Ms. CAMERON. Sure. We see a lot of stigma associated with falls, and many older adults feel that if we address falls that their independence may be reduced in some manner, but we want to educate them that falls prevention is all about ensuring long-term independence, helping to reduce the fear of falling that they may experience that could lead to such things as social isolation and depression.

One thing that we feel at a minimum physicians should ask an appointment, "Have you had a fall?"

Senator JONES. Right.

Ms. CAMERON. "Do you have a fear of falling, or do you worry about falling?" If they say yes to any of those questions, action should be taken to educate them about the importance of falls prevention, and it is not something to reduce their independence but really to empower them that they can have control over their falls risk.

Senator JONES. One thing I just want to throw out, my mom uses a walker, but when she first started using that walker, nobody really told her how to use the walker.

Ms. CAMERON. Yes.

Senator JONES. They just said, "Here, you need to go get this walker," and I am telling her all the time. She is pushing that walker and leaning forward, and I said, "Please walk up into this walker." I think part of that education process goes back to the early times.

Ms. CAMERON. It is referral to occupational and physical therapist to ensure that those assistive devices are being used properly because we do not want them to cause other falls.

Senator JONES. Is it important for after any fall to get somebody to come talk to them, look at it, try to help them work through the soreness, work through the physical therapy a little bit? Is that important?

Ms. THOMPSON. It is critically important. It is not just the physical therapy, but again, I would underscore only 9 percent of people

who have had a fracture are screened and what we know is not just that falls beget falls, but fractures beget fractures. That is really what we are trying to prevent.

As I said earlier, 80 percent of patients who have had a fall or a break are not getting the treatment that they need. We need to kind of back that up in the system so that we make sure that not only are they protected by wonderful devices that we have, but they have the medication, and they have the other support that they need.

Senator JONES. Okay. Thank you. I am going to give you mom's cell number, and you can call her and reiterate that.

Ms. THOMPSON. I would be delighted.

Senator JONES. Real quick, Ms. Cameron, you mentioned the problems associated with medication with elderly patients. How can pharmacists play a role in this? I think pharmacists, to some extent, are underutilized in so much of our health care issues today. Can pharmacists play a role in helping this, fall preventions with elderly patients?

Ms. CAMERON. Absolutely. Thank you for that question. I am a pharmacist myself, so, yes, pharmacists are playing, are starting to play a greater role in falls prevention activities. I think certainly the annual wellness visit is a key area again where pharmacists can do medication reviews, medication reconciliation.

Right now, in the annual wellness visit, all that is required related to medications is an inventory, actually creating a list of all the medications that an older adult is on, but we need to go much more in depth about those medications and look for a duplicative therapy, maybe inappropriate doses. Maybe the older the adult does not understand how to take those medications, and there are a number of side effects. Many medications, particularly psychoactive medications that we are seeing huge increases of being prescribed to older adults, those can cause those side effects that lead to falls.

Pharmacists are in the best position. They have the training to identify where there are problems, and they can work collaboratively with physicians to ensure that the medication therapy is appropriate, effective, safe, and used correctly by older adults.

Senator JONES. Great. Thank you. Thank you all for being here today. Appreciate it.

The CHAIRMAN. Thank you.

Senator Sinema?

Senator SINEMA. Thank you, Chairman Collins and Ranking Member for holding today's hearing.

Nearly one in three Arizonans over the age of 65 report falling each year, and in 2016, falls amongst older Arizonans were responsible for more than 42,000 emergency room visits, 14,000 long-term hospitalizations, and nearly a thousand deaths, so hospital bills related to unintentional falls in Arizona annually total almost $1 billion. For many older Arizonans, falls can result in injuries that cause pain or limit mobility for the rest of their lives, but falling does not need to become a part of growing older.

As today's witnesses have made clear, there are a range of early interventions and technologies that can reduce the risk of falling and mitigate the consequences. With that information, I would like

to ask our panel a couple of questions. My first question is for Ms. Cameron and Ms. Haynes.

Earlier this year, Banner University Medical Center in Phoenix became the first hospital in Arizona to open an accredited geriatric emergency department. In the specialized department, older patients are cared for by nurses and doctors who are specially trained to detect and prevent falls. A dedicated pharmacist monitors all medications taken by a patient to prevent adverse drug reactions which may cause dizziness. Patients are given non-slip socks, and their belongings, food and water, are kept close to their bed so they do not need to get up.

Practical and commonsense approaches like this are extremely affordable and can prevent thousands of injuries a year, yet relatively few health care facilities have chosen to make investments in these initiatives. What more should health care facilities, whether hospitals, doctors' offices, or long-term care facilities do to mitigate the risk of falls, and what more can be done to better incentivize health care providers to prevent falls?

Ms. HAYNES. Thank you for the question.

One really wonderful opportunity that Maine Health is involved with is the John A. Hartford Foundation and IHI initiative around age-friendly health systems, which focuses on the four M's: what matters to the patient; mentation which would be depression, delirium, and dementia; mobility; and medications. That would be, I think, my soapbox.

I have worked with older adults in various settings for 40 years. It is medication, not just review, reconciliation, and really de-prescribing and some focus on that.

There are 120 health systems now focusing on that initiative, and I think it is a wonderful opportunity for us to build on exactly what you are suggesting.

Ms. CAMERON. Yes. One recommendation that we have in our written statement relates to the Hospital Readmissions Reduction Program, where we really believe that second falls should be added as a falls Hospital Readmission Reduction Program measure to incentivize hospitals to engage in falls prevention efforts, either by offering programs themselves or partnering with community-based organizations deliver programs to their patients who are being discharged for falls. It really incentivizes them to do some discharge planning around those patients who are being discharged who are at high risk for falls and really engaging health care providers in those efforts but also referring to evidence-based community programs.

Senator SINEMA. Thank you.

My next question is for any of our panelists, especially those who have experienced working with rural communities.

This year's Aging Committee report highlights an innovative solution to the challenges posted by unintentional falls from Northern Arizona. The Northern Arizona Agency on Aging has an extremely successful program called Carenect that connects low-cost wearable devices for seniors. These devices can connect seniors to multilingual care coordination centers, which can call emergency services if they fall.

Carenect also addresses the serious problem of social isolation. The coordination center and their trained staff are available day or night to talk to and connect seniors with local programs in their area where they can socialize.

While many Americans can purchase services like this commercially, for seniors in rural Northern Arizona, these devices were either unaffordable or unavailable due to limited broadband and cell phone coverage in many rural areas.

The Carenect system was designed to reach seniors in rural communities, including our Tribal areas. Northern Arizona seniors benefit from the innovative leadership of the Area Agency on Aging, but many other older Americans living in rural communities are not so lucky.

What are the unique challenges and risks faced by seniors living in rural areas with respect to falls prevention, and what efforts could this Committee support to reduce the risk of falls for all seniors, no matter where they live?

Ms. HAYNES. I would suggest that is a fantastic model that we should learn a lot more about.

I think one of the things we see in our rural areas—and it may be because Maine has some of the oldest housing stock in the country—is around home modification. People want to remain in their own homes for the most part, and they may not be safe or adapted for whether it is a grab bar or—my younger sister had her knees replaced, and the walker did not fit through the bathroom door, so that would be an OT going in before some of those things happen.

I think that model and some of what we discussed earlier about innovative grant funding to be able to replicate that as well as taking a look at the home modification piece in rural areas.

Ms. CAMERON. Yes. Certainly, transportation is a huge issue for older adults living in rural areas who are no longer able to drive themselves and may not have family members who can get them, whether it is so doctors' appointments or to some of the programs that we have been talking about, so looking at innovative approaches in rural areas to provide access to transportation is sorely needed.

Senator SINEMA. Thank you.

Thank you, Chairman.

The CHAIRMAN. Thank you very much.

Unfortunately, we have votes beginning at 11 o'clock. Although there are numerous additional questions that we would love to ask each of you, I think we will wait and submit those to the record for you and give other members that opportunity as well. The record will stay open until Friday, October 18th, for additional records.

In my closing comments, I want to put back up the map that shows the rate of falls in every State, and the reason that I do is actually the rate is remarkably similar from State to State.

Alaska is an outlier being higher than average. Hawaii is an outlier being lower than average, but in general, what we found when we crunch the data is that about a third, nearly a third of older adults will suffer a fall.

It is hard for me to think of another health care problem that affects nearly a third of older Americans where we do not have a

strategy and we are not pursuing policies that would make a difference. Not only does this cause tremendous harm to the senior and often sets off a downward spiral, but it is extraordinarily expensive as we have learned today and yet many of the remedies are not expensive.

Our report focuses on recommendations in four key areas, all of which we have touched on today. One is raising awareness. One is improving screening and referrals for those at risk of falling. A third is targeting risk factors, including increasing the availability of home safety evaluations and modifications. Fourth, which we have touched on only lightly, is reducing polypharmacy; in other words, the interaction of prescription drugs with one another and also with food and drink, which a lot of times are factors as well. We have a series of recommendations under each of those four key areas.

I am going to ask unanimous consent—and I do not think that my colleague will object—that the huge number of responses that we had from nearly 200 stakeholders be entered into the record so that we have a complete hearing record.

The CHAIRMAN. I want to thank all of our witnesses for sharing their personal experiences, their families' experiences, and their expertise today.

I will share mine as well. A couple of years ago, I slipped on my front steps and badly broke my ankle at Christmastime and had to crawl back into the house and had broken both bones and have ended up with a plate and eight screws in just one ankle. That taught me what a fall was like, and I was forever grateful not only to the surgeon who repaired me, but to the occupational therapist and the physical therapist who helped me regain function.

I am on the young side of the older population, but this was a real lesson to me and I will tell you that to this day, I have a fear of falling. I hold onto railings now, which is probably not a bad idea. I no longer wear high high-heels. I have changed a lot of lifestyle factors.

The point was made that we need to teach people at an earlier age about what you can do to reduce the possibility of a fall, but it was the occupational therapist—and surgeon, of course, but the occupational therapist and the physical therapist who really got me back on my feet and walking again.

Doug Jones was talking about the walker, which I had at the beginning, and I did not want to use it because I felt only very elderly people used walkers, "I will not use the walker," which was not smart, of course, so someone—I think it was Ms. Cameron—mentioned the stigma that is associated with falls, and that is what I felt when I fell too.

I think it is so important that we talk about these personal experiences, that we encourage people to come together. I would love to have taken A Matter of Balance, if only I had had the time to do so, because I think it would have helped me in so many ways, but you have helped us identify very specific steps that we can take to change the trajectory of falls among seniors and improve the health and well-being of our older Americans.

We have to remember that our older population is growing very rapidly in this Country, and Maine is the first State next year to

reach the milestone—and it is not a good one—where we will have more people over age 65 than we do people under age 18, but our Nation as a whole is going to reach that demographic milestone, and that is why getting ahead on this issue is so important.

With the release—and it is online already and soon will be available in printed form. It is being printed, even as we speak. With the release of our 2019 Committee report on "Falls Prevention: Nation, State, and Local Solutions to Better Support Seniors," I hope that we can reach more people, and that is the purpose of this hearing as well.

I do want to thank all of the individuals, organizations, and universities who contributed to our public comments, as well as Federal agencies and private organizations who engaged with us throughout the process.

I also want to acknowledge the Committee staff on both sides of the aisle who worked closely together to prepare our report.

I want to thank a fellow, a Health and Aging Policy fellow, who we have had for this year, Thuc Nhi Nguyen, who worked very hard on this report. She holds a PhD in Social Work from Boston College and brought her expertise in aging to this report, and I know that we also benefited from the Minority staff having an Health and Aging Policy fellow this year. I noticed that she went to the University School of Medicine in St. Louis, which just might be how Missouri sneaked into the report and it did not just focus on Maine and Pennsylvania.

In all seriousness, this is a huge problem, and unlike so many others, it is one where we know what to do. Whether it is Ms. Demby getting her friends together to go exercise or Ms. Haynes' extraordinary work on A Matter of Balance or Ms. Cameron's work on so many issues, including the polypharmacy issue where she brings a special expertise being a pharmacist, or Ms. Thompson's work on osteoporosis, I am just determined to fix that reimbursement.

Ms. THOMPSON. Thank you very much.

The CHAIRMAN. That just makes no sense at all and the work, of course, of the Ranking Member.

I want to thank everyone for your contributions and now turn to the Ranking Member for his closing statements.

Senator CASEY. Thank you, Chairman Collins, and thanks for bringing your passion and your personal perspective to this critically important issue.

We know from today's testimony and from the report that we have got to redouble our efforts at the national level to invest in falls prevention efforts. We cannot do it without partners at the State and local level as well as those in the community.

As I said in my opening, I look forward to engaging in active dialog with departments and agencies across the Federal Government to implement these important recommendations from this report, which we have to make sure we implement the recommendations, not just have them in writing.

I also want to thank our witnesses here today for sharing valuable insights into the need for this work, and we are grateful for the time and expertise and your passion as well for these issues.

I also want to reiterate our thanks to the staff. I will mention five staff members on the Committee who helped to draft the report over the last year in support of this hearing: Samantha Koehler, Beth Prusaczyk, Sarah Khasawinah, Amy Pellegrino, and as the Chairman mentioned, Thuch-Nhi Nguyen and any other staff member who worked to make this possible.

Chairman Collins, thanks very much, and I think we are just about ready to vote.

The CHAIRMAN. We are.

Thank you, Senator.

This hearing is now adjourned.

[Whereupon, at 11:08 a.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

MaineHealth

Written Testimony

Testimony of Peggy Haynes, MPA
Senior Director, Healthy Aging
MaineHealth
Portland, Maine

Senate Special Committee on Aging
October 16, 2019
Dirksen Senate Office Building, Room 562
Hearing: Falls Prevention: National, State, and Local Solutions to Better Support Seniors

Thank you Chairman Collins, Ranking Member Casey, and Committee Members:

I would like to extend my sincere gratitude for this wonderful opportunity to talk with you today about fall prevention and A Matter of Balance, a program that has reached thousands of older adults through a journey that began twenty years ago.

MaineHealth is Maine's largest integrated healthcare delivery system, covering eleven of the sixteen counties in Maine and one county in New Hampshire. MaineHealth's vision is "working together to make our communities the healthiest in America." This vision led us to focus on fall prevention, which is the leading cause of unintentional injury, Emergency Department (ED) utilization and death among older adults. (https://www.cdc.gov/homeandrecreationalsafety/falls/fallcost/falls-by-state.html) The health care community has a critical role to play in fall prevention – beginning with screening for falls, assessing fall risk factors, reviewing medications and referring to both medical and community-based fall prevention interventions. Our health system is focused on preventing falls in every care setting.

We know that falls are multi-factorial, and a range of interventions must be available to older adults to address their risks. The need for a range of community-based options led MaineHealth to be a founding member of the Evidence Based Leadership Collaborative, promoting the increased delivery of multiple evidence-based programs that improve the health and wellbeing of diverse populations. I am here today to share our work with the evidence-based program called A Matter of Balance (MOB).

Summary

A Matter of Balance was designed to reduce the fear of falling and increase the activity levels of older adults who have concerns about falls. It is an evidence-based small group, cognitive restructuring program where participants learn to view falls and fear of falling as controllable, to set realistic goals for increasing activity, to change their environment to reduce fall risk factors, and to promote exercise to increase strength and balance. Eight two-hour classes include group discussion, problem-solving, skill building, assertiveness training, a visiting health care professional, sharing of practical solutions, two videos, and exercise training for strength and balance.

A Matter of Balance is designed to benefit community-dwelling older adults who are concerned about falls, have sustained a fall in the past, restrict activities because of concerns about falling, are interested in improving flexibility, balance and strength, and are age 60 or older, ambulatory and able to problem-solve.

A Matter of Balance was developed through a randomized controlled trial at the Roybal Center for Enhancement of Late-Life Function at Boston University, funded by the National Institute on Aging. (Tennsdedt, el al., 1998).

Statistically significant outcomes were found up to twelve months after taking the class in Falls Efficacy, Falls Management, and Falls Control, and up to six months upon class completion for exercise and concern about falling interfering with social activities. (Ibid)

Further analysis published in the 2013 CMS report to Congress: A Retrospective Analysis of over 6,000 claims of A Matter of Balance participants from across the country found A Matter of Balance participation was associated with total medical cost savings, and cost savings in the unplanned inpatient, skilled nursing facility (SNF), and home health (HH) settings. A Matter of Balance participation was associated with a $938 decrease in total medical costs per year. This finding was driven by a $517 reduction in unplanned hospitalization costs, a $234 reduction in skilled nursing facility costs, and an $81 reduction in home health costs. (Report to Congress, 2013)

Story of Development

In 1999, MaineHealth worked with Boston University to bring the award winning falls program to Maine, using our health system clinical staff to offer the program in the community. A Matter of Balance is team taught and was originally led by clinicians – nurses, physical therapists and occupational therapists. While very well received by the community, the expense of the time for teams of clinical staff, to offer the program limited its dissemination.

In 2003, the U.S. Administration on Aging, using Older Americans Act funding, launched a three year public/private partnership to increase older adults' access to programs that have proven to be effective in reducing their risk of disease, disability and injury. The funding was targeted towards getting the scientifically proven programs off the shelf and into the community. Because MaineHealth had experience offering the evidence-based Chronic Disease Self-Management Program, a proposal was developed to translate A Matter of Balance into a lay leader model. The grant goals were: to test whether a volunteer lay leader model is successful when compared with original research (replicated original research tools and methodology), maintain fidelity to the original Matter of Balance curriculum, and share our approach with others in Maine and around the country. (AoA Grant #90AM2780)

A Matter of Balance: Lay Leader Model

In order to make A Matter of Balance work for lay leaders, the grant team made adaptations to the model, while keeping the class structure and curriculum true to the original research. Adaptations include: classes are taught by lay leaders, called coaches, instead of healthcare professionals; in addition to a Master Trainer manual, participant workbooks and a coach manual; strength and balance exercises were modified to make them safe for people with osteoporosis and joint replacements;; and, finally, the healthcare connection was maintained by adding a guest health care professional to the curriculum for one class to address adaptive equipment, how to get up from a fall, and answer clinical questions.

Maintaining fidelity is critical to the implementation of any evidence-based program. A training structure was developed that includes a two-day Master Trainer session led by two Lead Trainers employed by MaineHealth and deployed around the country. An eight hour coach training was developed based on original Matter of Balance leader manual. The Master Trainers are responsible for

observing coaches during training and while leading A Matter of Balance/Lay Leader class in the community. Wherever possible, organizations use a mentor model in which anew volunteer is paired with an experienced coach. Finally, MaineHealth provides support for Master Trainer sites through networking and sharing of resources, quarterly conference calls, availability through e-mails and phone calls, and assistance with measuring outcomes and participant satisfaction.

Over the course of the three year translation, a repeated measures single group design was employed. Participants from Maine experienced significant increases in Falls Efficacy, Falls Management, and Falls Control at six weeks, six months, and twelve months, thus achieving comparable outcomes with those of participants in the Randomized Controlled Trial. (Healy, et al., 2008) Furthermore, participant satisfaction shows that 97 % are more comfortable talking about fear of falling and feel comfortable increasing activity, and
99 % plan to continue exercising.

A Matter of Balance reaches across the state of Maine. MaineHealth works in partnership with our five area agencies on aging to provide access to classes from the rural communities in Aroostook and Franklin Counties to our more "urban" communities like Lewiston and Portland. Since 2006, over 6,215 Mainers have benefited from the program that are tracked in the database. Nationally, there are 1700 active Master Trainers at 770 licensed organizations in 46 states, Puerto Rico and the Virgin Islands. Since 2006, A Matter of Balance has reached over 96,000 older adults across the country.

This dissemination has been fueled by the use of Older Americans Act funds under Title III D and Fall Prevention funding through the U.S. Administration for Community Living, advocacy from the National Council on Aging Falls Resource Center, and growing collaboration with organizations such as universities, trauma centers and Emergency Medical Technicians/community paramedicine programs.

In order to address diverse populations, access to A Matter of Balance is made available with translations in Spanish, two Chinese dialects, Russian, Albanian, Korean, Portuguese, with a Japanese translation in pilot. A low vision translation is also available. Temple University is currently working on a translation/toolkit for people with developmental disabilities.

Organizations offering A Matter of Balance have access to on-going demographic, class and outcome data collection through partnerships with Sound Generations in Seattle and the National Council on Aging Fall Prevention Resource Center for Administration for Community Living grantees.

Finally, I'd like to share the story of a woman in our health system that took A Matter of Balance. Sandy had problems when her back went out. Following surgery, she left the hospital using a cane. One winter morning, she took her dog outside, wearing her slippers, and fell on the ice breaking her femur. Even after three months of physical therapy, she was still using a walker and "stuck at home". Sandy's daughter saw an ad in the paper for A Matter of Balance and encouraged her mother to attend. Although skeptical, Sandy started the program. Within four weeks, she was no longer using her walker and had graduated to relying on a cane. By the end of the class, she was able to go on vacation to the Jersey shore. "The program teaches you to think and keep in tune with your body". Next Sandy took Tai Chi – again, a bit skeptically, she "is not an earth muffin". Two and a half months into taking Tai Chi, Sandy no longer needed her cane. She has gone on to be certified as a coach for A Matter of Balance and certified to teach Tai Chi. She wants to teach other older adults to know they can get up and move and reclaim their lives. In Sandy's words: "now I am free, I am here again, and I am back to being me."

Thanks to the support provided by the Older Americans Act, older adults across the country have access to evidence-based programs that enhance their well-being and allow them to take control of their lives. I want to thank you for the opportunity to speak with you, and to express my gratitude to Senator Collins and the Committee for your leadership in the effort to reauthorize the Older Americans Act and requesting increased funding so more older adults across the country can lead healthier, independent lives.

Citations

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Report to Congress November 2013: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act.

Tennsdedt, S., Howland, J., Lachman, M., Peterson, E., Kasten, L. & Jette, A. (1998). A randomized, controlled trail of a group intervention to reduce fear of falling and associated activity restriction in older adults. Journal of Gerontology, Psychological Sciences, 54B (6), P384-P392.

Supporting Tables

A Matter of Balance SalesForce database

Overview for this report period							
	# Orgs	# Classes*	# Sites	# Leaders	# Attended	Avg Class Size**	# (%) Completed
1/1/2006 - 10/3/2019	230	6,334	3,233	4,543	67,590	11.1	54,272 (80%)

National Council on Aging – Administration for Community Living grantees

Overview for this report period							
	# Orgs	# Classes*	# Sites	# Leaders	# Attended	Avg Class Size	# (%) Completed
9/1/2014 - 10/4/2019	378	4,528	2,891	3,220	53,980	12	42,542 (79%)

Virginia Demby
Testimony before the
United States Senate Special Committee on Aging
October 16, 2019

Chairman Collins, Ranking Member Casey, and Members of the Committee, thank you for inviting me to testify today. It is an honor to be here.

My name is Virginia Demby. I am 84 years old and a resident of Chester, Pennsylvania. I am a retired nurse and sometimes worked two or three jobs at a time to stay active and make ends meet. I also helped my sister raise her children and helped provide for my family. I'm now retired and live in a senior apartment complex. I use my Social Security and SNAP benefits to make ends meet.

I have always been an active person and I played sports all throughout school as a child. I loved to play basketball, soccer, volleyball, and run track. I carried this love with me throughout my life.

When I worked in healthcare I saw what happened to people as they got older. I saw that it became hard to stay active and keep your mind sharp. When you get up in age, the body changes. And, your thinking may change. But I also learned that a lot of those things don't have to happen. You can avoid them if you keep your mind and body active, that is why I stay active in my community.

I do have some health problems that challenge me. I've had a knee replacement, I have fibromyalgia, glaucoma and low vision. Because of my fibromyalgia I spent eight years in a wheelchair, but I didn't let it slow me down. I told the doctors I was going to walk again, and I made it happen.

Through COSA, Delaware County Pennsylvania's Area Agency on Aging, I learned about a class being offered at my local Center for the Blind and Visually Impaired to prevent falls, called Healthy Steps for Older Adults. Because I have always been so active and know the importance of physical activity, I decided to attend the class. I had also fallen in the past and wanted to make sure I prevented this from happening again.

At the class, I learned about my individual risk of falls after the instructor conducted a series of assessments. I liked this because I knew the information was about me personally and not just general information about the risk for all older adults. After learning about my risk level, we spent time learning about ways we could reduce our risk and prevent falls. This part of the course was such a blessing because it gave me the tools and information I needed to take charge of my own physical health. We talked about how to strengthen my heart, my lungs, my joints, and my bones. I learned how to improve my mood and energy. We also learned about things you can do around the house to make it safer and how important it is to eat healthy food. I knew a lot of this information because I was a nurse, but it was good reinforcement.

After taking the class, I wondered what other classes were out there and I started taking all sorts of other classes such as Tai Chi, kickboxing, yoga, Zumba, line-dancing, weight-lifting, and more. These exercise classes are taught in many different places and I take the bus to get to them. I am thankful for public transit because without that I could not get to these classes.

It is not just through the classes where I stay active. I met other people in the classes and we would do the exercises together. We bonded. Then after the classes ended we would meet and go on walks together. We socialize now. And I encourage them to do more and stay active.

I think it is so important that older adults stay active, stay engaged, and stay physically and mentally healthy. My older sister was 94 and she passed away just a few months ago. We were close and looked out for each other. She had arthritis and had problems walking. I encourage everyone to be involved and be more active both physically and mentally.

And now I'm working with Ellen at COSA to help her spread the word about the fall prevention classes. I help make connections for her in the community so she can teach the classes at different places and for different groups. I live in low-income senior housing and so many people where I live don't get out. They are sedentary. I want to help Ellen get these classes offered in these senior apartments. I promised her I would help her get it done. And I will. I know not everyone can do all of the things I do, but even mild exercises, easy things, can make a difference.

Classes like Healthy Steps for Older Adults are so important for seniors. It gives them the opportunity to keep their bodies and minds healthy. It helps them take care of themselves so they don't fall. It also helps them stay social and get out. I hope more of these classes are made available and more older adults can access them.

Related to that, I know the committee released a comprehensive report on falls prevention. I applaud the committee for releasing it and I fully support the report's recommendations. I can only do so much in the community to encourage people to stay fit and active. This is the reason that I support a national education campaign so more adults can access these classes. Funding to implement existing programs and ensuring continued development of evidence based programs is crucial.

Through conversations that I have had, I understand that Chairman Collins and Ranking Member Casey are helping to lead the charge to reauthorize the programs funded through the Older Americans Act. This is so important. I'd like to thank Senator Casey, in particular, for his work to ensure that the reauthorization bill includes policies to ensure more evidence-based programs for older adults are developed, tested, and disseminated. Evidence based programs work. I am proof.

Thank you for the invitation to testify before the Committee today and for your support of the Older American's Act which provides funding for programs like these for older adults. I look forward to answering your questions. Thank you.

Testimony of

Kathleen A. Cameron

Senior Director

Center for Healthy Aging

Submitted to the

Special Committee on Aging

U.S. Senate

on

Falls Prevention:

National, State, and Local Solutions to Better Support Seniors

October 16, 2019

National Council on Aging

251 18th Street, Suite 500

Arlington, VA 22202

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INTRODUCTION

Chairwoman Collins, Ranking Member Casey, and members of the Committee, I appreciate the opportunity to speak with you today on behalf of the National Council on Aging (NCOA) about the critical issue of older adult falls and the promise of falls prevention.

At NCOA, our vision is a just and caring society in which each of us, as we age, lives with dignity, purpose, and security. Our mission is to improve the lives of million of older adults, especially those who are struggling. Since 1950, we have partnered with thousands of organizations across the country to develop innovative programs that empower older adults to remain healthy, economically secure, and independent in their communities.

NCOA's Center for Healthy Aging supports evidence-based health promotion and disease prevention programs in the community and online. A major focus of our work is falls prevention. We direct the National Falls Prevention Resource Center, funded by the Administration for Community Living/Administration on Aging, through support from the Prevention and Public Health Fund. The Resource Center is responsible for:

- Increasing public awareness and educating consumers and professionals about the risks of falls and how to prevent falls
- Supporting and stimulating the implementation, dissemination, and sustainability of evidence-based falls prevention programs and strategies to reduce the incidence of falls among older adults and adults with disabilities
- Serving as the national clearinghouse of tools, best practices, and other information on falls and falls prevention.

NCOA also leads the National Falls Free® Initiative and supports state falls prevention coalitions that are now active in 43 states. Every year, on the first day of fall, NCOA sponsors National Falls Prevention Awareness Day to bring attention to the issue and proven solutions. In 2018, national awareness and media efforts for the event collectively reached 154.7 million individuals through national, state and local press releases, social media, and more. At the state and community level, the state falls prevention coalition members reached an additional 2.5 million individuals through fall risk screenings, participation in community-based falls prevention programs, and public awareness events. We would like to thank Senators Collins and Casey for once again leading the effort to pass the annual Senate resolution to designate September 23, 2019 as National Falls Prevention Awareness Day, and for enlisting the vast majority of the Committee as cosponsors this year.

In 2015, we issued an updated version of our Falls Free® National Falls Prevention Action Plan[1] in collaboration with a variety of stakeholders that included federal agencies and national organizations. We also lead the National Home Safety and Home Modification Workgroup, in partnership with the University of Southern California Leonard Davis School of Gerontology, which recently received a grant from the Administration on Aging to identify and improve access and dissemination of home modification programs for older adults and persons with disabilities.

Older adult falls are a common, serious, growing public health problem. Today falls are the number-one cause of injury, and death from injury, among older adults. The statistics are alarming:

- Every 11 seconds, an older adult is injured by a fall.
- Every 19 minutes, an older adult dies from a fall.
- By 2030, 7 older adults will die from falls every hour if current rates are not addressed.
- Each year, approximately 25% to 30% of adults aged 65 and older fall, and 20% of these falls result in serious injuries, impaired mobility, loss of independence, depression, and social isolation.
- More than 95% of hip fractures are caused by falls.
- Falls are the most common cause of traumatic brain injuries (TBIs), resulting in nearly 80% of TBI-related emergency department visits, hospitalizations, and deaths in adults aged 65 and older.
- In 2015, more than 3 million older adults received treatment in emergency departments for falls and fall-related injuries, with unintentional falls accounting for approximately 30,000 older adult deaths in the United State that same year.
- The Centers for Disease Control and Prevention (CDC) recently estimated that fall-related deaths among U.S. adults aged 75 years and older almost tripled from 8,613 in 2000 to 25,189 in 2016.

While the number of falls is growing, so is the older population in the U.S. as the baby boomer generation ages. According to the Census Bureau, the current population of adults aged 65 and older is over 51 million, representing 15.6% of the total population. Considering that 30% of this age group falls, approximately 15.3 million older adults will fall this year alone. This estimate does not include people who fall more than once, whose risk of falling again doubles after the initial fall. Problems with mobility, balance, and loss of muscle strength as people age contribute to the likelihood of falling. In addition,

[1] https://www.ncoa.org/resources/2015-falls-free-national-falls-prevention-action-plan/

people are living longer with chronic conditions such as cardiovascular disease, diabetes mellitus, arthritis, and chronic pain. These illnesses, as well as many of the medications used to treat them, all increase fall risk.

Only one-third of those who fall seek medical care. The annual direct medical cost for fall injuries is $50 billion, up from $38 billion in 2013. Falls account for 6% of Medicare expenses ($29 billion) and 8% of Medicaid expenses ($8.7 billion). With the aging of the baby boomer population, the cost of treating the consequences of falls is projected to increase to over $101 billion by 2030.

Falls are costly, both personally and financially, but they are also preventable. The CDC estimates that between 9,562 and 45,164 medically treated falls could be prevented annually. The associated annual Medicare savings would range from $94 million to $442 million.

Extensive research has been conducted on the scope and magnitude of the problem, factors that increase fall risk, and interventions to reduce falls and injury. Effective clinical interventions, evidence-based community programs, and clinical-community partnerships have been identified and must be scaled and fully supported to realize a significant reduction in falls and related injuries among older adults. Due to the multi-factorial nature of older adult falls, NCOA advocates for a multi-stakeholder approach to this issue. We articulated a number of recommendations[2] in response to the Committee's May 15, 2019 request for information. This testimony highlights a subset of these recommendations, which we hope have the potential to receive immediate attention.

STRATEGY: ESTABLISH A COORDINATED CROSS-AGENCY FEDERAL EFFORT TO ADDRESS FALLS

THE NEED

The statistics regarding the prevalence and incidence of falls and their consequences are well documented, the key risk factors for falls have been identified, and the clinical and community strategies that address and reduce falls risk have been developed and proven to be effective. However, there is no local, state, and federal coordination around a comprehensive strategy to address falls in older adults.

Although a number of federal agencies (e.g., ACL, CDC, HUD, CMS) engage in falls prevention efforts, these efforts have not yet resulted in meaningful change in reducing falls as the leading cause of injury-related morbidity and mortality in older adults. This lack of change is most likely due to the

[2] https://www.ncoa.org/resources/senate-aging-committee-letter/

multifactorial nature of falls and falls prevention, as well as the fact that a coordinated and comprehensive falls prevention strategy does not fall under the purview of any one single agency or organization. Thus, fully addressing the health consequences of falls and implementing best practices to reduce falls rates and risk require that diverse sectors work together to address this complex issue. Only then will comprehensive efforts, including research, innovation, and funding, around falls prevention be fully realized.

Given the current constraints on the federal budget, particularly on discretionary investments in public health and community services, NCOA recognizes the challenges of increasing much-needed annual appropriations. However, it is important to note that in response to the $50 billion cost of older adult falls on the healthcare system nationwide, the federal government spends only $7.1 million annually on initiatives that have proven returns on investment. Most of this funding—$5 million—was only made available in recent years due to the creation of the Prevention and Public Health Fund, which has been subjected to cuts and has remained largely stagnant since its inception. We are pleased that the House FY20 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill provides a 50% increase (from $2.05 million to $3.05 million) for older adult falls funding at the CDC.

Despite limited funding directly focused on falls prevention, a federally coordinated falls prevention national strategy will increase opportunities to leverage resources across disparate agencies and will contribute to the sharing of valuable information and systematic solutions that align with agency charge and bottom-line objectives to reduce falls and falls risk in older adults.

THE SOLUTION

NCOA supports the following solutions as part of a comprehensive strategy to address falls in older adults.

1) **Establish a cross-agency federal effort on falls prevention.** This effort could be modeled after the National Alzheimer's Project Act (NAPA) to build upon and leverage Health and Human Services (HHS) programs and other federal efforts to help change the trajectory of falls and fall-related injuries among older adults. The NAPA law calls for a National Plan for Alzheimer's disease and related disorders with input from a public-private Advisory Council on Alzheimer's Research, Care, and Services. A similar federal effort for falls prevention would include a National Plan for Falls Prevention with input from an Advisory Council. This plan would include the development of recommendations to HHS for priority actions to expand and coordinate programs in order to reduce falls risk and improve the health outcomes of people at risk for falls

while reducing the financial burden of fall-related injuries and conditions on individuals, families, and society. We believe this approach would provide a guide for the most effective and achievable means for improving health and well-being of older adults that would result in a call to action across federal, state, and local agencies. It would encompass both promoting healthy lifestyle behaviors that reduce falls risk and creating environments that make it easier to access, afford, and engage in strategies that reduce falls risk. We are pleased that the bipartisan bill to reauthorize the Older Americans Act (OAA), H.R. 4334, the Dignity in Aging Act of 2019, approved by the House Committee on Education and Labor, includes language to provide for a federally coordinated falls prevention strategy led by AoA.

2) **Launch a targeted national awareness and action campaign on falls prevention.** As part of the cross-agency effort, the campaign would focus on changing knowledge, attitudes, and behaviors about falls risks, falls, and fall-related injuries and increasing knowledge about available falls prevention interventions and programs for both the general public and professionals. The campaign would encompass the tenets of the CDC's social-ecological model, which considers the interplay of falls risks and prevention strategies at all levels of society, including the individual, relationship, community, and societal factors. Federally coordinated action plans have been implemented for several important health and societal issues and have resulted in significant action and change.

STRATEGY: PROMOTE EARLY IDENTIFICATION OF FALLS RISK FACTORS AND EARLY INVENTION

THE NEED

Falls and falls risk should be recognized as a "medical condition" by health care, public health, and the public to increase accurate reporting of falls, compliance with medical recommendations, and reimbursement for prevention and treatment for falls-related conditions and consequences. To date, self-reporting is the sole method of data collection on the prevalence of falls. Not only are falls poorly understood in definition ("an event which results in a person coming to rest inadvertently on the ground or floor or other lower-level"), but the stigma and embarrassment around falling add to a lack of reporting on falls. This lack of reporting results in a missed opportunity to gain insight into the cause of a fall, which can provide important information to prevent a second fall and mitigate conditions that caused the fall in the first place.

Research has documented the risk factors for falls, as well as the impact of these risk factors on health status and quality of life. Increasing age is one of the key risk factors for falls, followed by a

previous history of falls and female gender. Other risk factors include reduced balance and strength, medication effect, the presence of chronic conditions, vision and hearing impairments, and a fear of falling. The basis of epidemiology and the science of public health is that knowing the risk factors for a fall allows for the development of strategies to reduce falls risk. Due to an abundance of research on falls risk, the factors associated with falls are widely known and evidence-based solutions and strategies to reduce falls have been developed and implemented in select areas of the country.

Despite this knowledge and resources, insufficient strides have been made in reducing falls in older adults. In fact, a 2019 CDC study demonstrates that the rate of falls and deaths from falls is increasing. From a broad perspective, this reflects a lack of action at an individual level to engage in activities that reduce falls risk, as well as a lack of action at the community level, especially in the medical community, to identify falls risk factors in patients and refer them to appropriate treatment. Research has indicated that while over 90% of older adults visit a health care provider annually, less than 33% are screened for falls risk factors. This can be attributed to a lack of reimbursement for assessment and screening, a lack of knowledge of evidence-based falls prevention programs available in the community or appropriate referral sources (such as physical and occupational therapists), and competing priorities that discourage falls risk screening and referral.

When opportunities for early identification and treatment of risk factors are missed, falls occur. Falls are the leading cause of injury-related hospitalization among older adults and a leading diagnosis for hospital readmissions. In fact, more than one-third of older adults hospitalized for a fall died within 1 year, and more than half of older adults injured in a fall die within 7 years of the initial fall. Research has shown that patients and their caregivers are often unaware of evidence-based best practices when they leave the hospital. Only 12% of patients who follow up with their primary care physician after a fall have the health record of the fall event and treatment received while in the emergency care setting available. This lack of communication compounds the underlying issue of identifying the etiology of the fall and referral to appropriate treatment.

THE SOLUTION

NCOA supports the following solutions to address the need for better identification of falls risk factors and participation in falls prevention and falls treatment programs.

1) **Launch a targeted, national awareness and action campaign on falls prevention.** As described previously, a cross-agency federal campaign would address the need for education about falls, falls risk factors, and available falls prevention interventions and programs. Many national

resources have been created by NCOA, CDC, and others for both consumers and professionals about falls risk and effective strategies to prevent falls. The awareness campaign would result in more accurate reporting of falls, as well as enhanced referrals to falls prevention treatment, and actions or strategies to reduce the identified risk factors.

2) **Promote the consistent use of existing screening tools for falls risk.** There are opportunities to screen for falls risk factors at the Welcome to Medicare Visit and at the Annual Wellness Visit (AWV). To promote falls screening, the CDC National Center for Injury Prevention developed the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) initiative, which includes a falls risk screening algorithm tool based on the American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons and Recommendations. This tool is the gold standard for falls risk assessment and has demonstrated that every 5,000 health care providers who adopt STEADI produce a savings of $3.5 billion in direct medical costs over a 5-year period. NCOA recommends that the STEADI tool become the universal tool used for falls risk screening in older adults and that reimbursement for its use in clinical practice be incentivized.

   Tools are also available for care transition, such as discharge from an emergency room or hospital setting, yet they have not been used consistently. The Continuity Assessment Records and Evaluation (CARE) item set, developed by the Centers for Medicare & Medicaid Services (CMS), is an example of such a tool. CARE is intended to provide up-to-date and accurate information at the time of hospital discharge, during the post-acute care admission, and during discharge after post-acute care. The Society for Post-Acute and Long-Term Care Medicine (AMDA) has also developed a Universal Transfer Form to facilitate the transmission of necessary patient information from one care setting to another. NCOA recommends the adoption of standardized discharge tools with the hope that the promise of meaningful use of interoperable electronic health records will reduce treatment errors stemming from inaccurate or incomplete information, reduce readmissions and adverse events, and halt costly duplicative health services.

3) **Promote evidence-based falls prevention programs.** These programs are based on rigorous research and have demonstrated reliable changes in decreasing falls, falls-related injuries, and falls-related risks among older adults. Evidence-based falls prevention programs also address the full range of falls risk—from exercise programs such as Tai Chi, EnhanceFitness, and Staying Active and Independent for Life for lower-risk older adults to programs, such as Otago, which

increases strength and balance in high-risk frail older adults. Other programs, such as A Matter of Balance and Stepping On, address a range of falls risk factors, including fear of falling and communication skills.

Currently, the Administration for Community Living is providing $5 million in funding per year through the Prevention and Public Health Fund to implement and improve access to evidence-based falls prevention programs in local communities. Since 2014, these programs have reached nearly 100,000 older adult participants in 30 states. Although impressive, evidence-based falls prevention programs are not as widely available as required to meet the needs of older adults in the community. In particular, rural and underserved areas of the country lack access to these programs. Not only should evidence-based falls prevention programs be available in every community, but referrals to these programs should be associated with the use of the STEADI tool and integrated into the healthcare referral system to adequately address multiple falls risk factors.

The sense of urgency to address falls in older adults vis-à-vis evidence-based falls prevention programs and clinical strategies at the local level is insufficient without a significant national investment to scale solutions nationwide and reduce falls and falls risk in older adults. NCOA was one of 23 organizations that wrote to appropriators to call for at least doubling investments at CDC and AoA for FY20. We commend Senator Collins' and Casey's leadership on the Senate deliberations on OAA reauthorization, which to date has resulted in draft legislation that strengthens the innovation, demonstration, and evaluation authorities at AoA and calls for technical assistance for evidence-based programs adaptations to serve diverse populations in various communities.

4) **Focus on two of the most modifiable risk factors to reduce falls risk—medications and home hazards.** While many risk factors are associated with falls, medication use and the home environment are two that present clear solutions.
    a. **Medication Management**: Numerous factors are associated with an increased risk of falling and fall-related injuries, but none is as potentially preventable or reversible as medication use. The risk of falling has been shown to increase with the number of prescription and over-the-counter medications taken. Older adults taking more than three or more medications are at increased risk for falls and recurrent falls. In addition, numerous epidemiological studies have identified specific therapeutic categories of medications that increase the risk that an older person will fall. These therapeutic

categories are problematic because they often cause side effects and adverse effects that predispose older people to falls. The most common include orthostatic hypotension causing dizziness, lightheadedness, and balance impairment; sedation, decreased alertness, confusion, and delirium; blurred or impaired vision; compromised neuromuscular function; and anxiety.

Fortunately, these effects are reversible with a clinical review of cause and subsequent modification of the medication regimen, such as lowering the medication dose, discontinuation, or switching to a safer alternative medication. As a companion to the CDC's STEADI Resources, the American Society of Consultant Pharmacists and NCOA developed a toolkit for clinicians to mitigate the risk associated with medications. In addition, the CDC developed STEADI-R_x to help community pharmacists engage patients and providers to improve falls-related health issues. While medication reviews are effective, they are an underutilized intervention to prevent older adults falls. A 2018 CDC study concluded that medication reviews and modifications to address medications potentially linked to falls could avert $418 million of annual direct medical costs attributed to falls and prevent an estimated 113,960 falls.

NCOA recommends that: 1) A qualified health care provider review an older adult's medications at least annually, 2) CMS mandate that Medicare Part D Prescription Drug Plans expand Medication Therapy Management Services to incorporate medication reviews for falls risk reduction to all older adults, and 3) The cross-agency federal awareness campaign described earlier be designed to increase awareness of falls risks associated with medication use (prescription and nonprescription/over-the-counter medications).

b. **Home Modifications:** Many older adults want to remain in their homes as they age, yet homes that were once supportive often present problems over time that can lead to falls. More than 40% of older adults experience some type of disability that limits their performing of at least one activity of daily living (ADL) such as bathing, dressing, or walking. These difficulties are associated with poor quality of life, depression, and increased risk of falls. Because disability is one of the strongest predictors of nursing home admission and long-term care services, home modifications are the most effective intervention to increase the capacity of an individual to age in place and decrease the demands on the health care system. In particular, low-income older adults are impacted

by this risk factor since they have higher rates of disability and are more likely to live in deteriorated housing. In all cases, inadequate and disparate funding sources and cost of repairs and modifications have been identified as major barriers to home safety modifications. NCOA has long advocated for greater Medicare and Medicaid coverage for home assessment and modification services, including approaches such as Money Follows the Person that provide consumers with more discretion in the use of Medicaid expenditures for purposes such as home modification, the inclusion of home modification as a benefit under managed care and other new models of service delivery, and greater insurance reimbursement of home modifications (e.g., long term care insurance).

NCOA supports The Senior and Disability Home Modification Assistance Initiative Act of 2019 (S. 702, H.R. 1583) that will require the Assistant Secretary for Aging to coordinate federal efforts related to home modifications. It is especially important to provide positive examples of attractive, affordable, and culturally appropriate home modifications for a variety of different home settings. We believe this effort would be an important start in addressing this key risk factor for older adult falls, and we applaud the Education and Labor Committee for also including coordination of federal home modification programs and benefits in H.R. 4334, and Senators Collins and Casey for advocating for similar language in the Senate draft bill.

NCOA promotes wider dissemination and implementation of the evidence-based falls prevention program Community Aging in Place, Advancing Better Living for Elders (CAPABLE) as an effective home modification intervention. This program involves a teamwork approach and integrates an assessment-driven, individually tailored package of interventions delivered by an occupational therapist, a registered nurse, and a handyman. Older adults in this program work with their CAPABLE team to identify environmental modifications to the home, develop action plans to engage in strength and balance exercises to increase physical function, and engage in strategies to reduce falls risk, such as medication reviews and correct assistive device use. This program has been found to reduce Medicaid costs by $867 per month per person and significantly reduce hospitalization expenditures. NCOA applauds the Senate and House Appropriations Committees for proposing another $10 million in FY20 to the

Department of Housing and Urban Development for Aging in Place Home Modifications grants that include the provision of CAPABLE.

STRATEGY: IMPROVE MEDICARE POLICIES TO PREVENT FALLS

THE NEED

The annual direct medical cost for fall injuries is $50 billion, up from $38 billion in 2013. Falls account for about 6% of Medicare ($29 billion) and 8% of Medicaid expenses ($8.7 billion). With the aging of the baby boomer population, the cost of treating falls is projected to increase to over $101 billion by 2030. Falls are common and costly, both personally and financially, but most importantly they are also preventable. The CDC estimates that between 9,562 and 45,164 medically treated falls could be prevented annually. The associated annual Medicare savings range from $94 million to $442 million.

While CMS now provides payments for health care providers to conduct falls prevention activities through payment and delivery reforms (e.g., Welcome to Medicare Visit, Medicare AWVs, etc.), research finds that only about half of primary care practices are currently offering AWV and less than 20% of eligible Medicare beneficiaries are receiving them. Non-white patients with higher medical risk and dual-eligibles are the least likely to receive an AWV. Because traditional Medicare does not cover most long-term services and supports (LTSS), individuals and their families bear most of the costs for this assistance.

Medicare may only cover certain assistive devices, such as canes and wheelchairs, while omitting coverage for others, such as grab bars for the shower or other changes to the home that would improve function, reduce the risk of falls, and help older adults age in place. Moreover, Medicaid covers only a portion of LTSS costs once dual-eligibles meet “nursing home level of care” criteria. The Bipartisan Budget Act of 2018 gives Medicare Advantage plans greater flexibility to tailor benefits to the needs of their beneficiaries. However, few have expanded coverage for falls risk assessments and evidence-based falls prevention programs. It is uncertain the extent to which falls prevention will be included in Medicare Advantage Plan offerings as supplemental benefits for the chronically ill in 2020.

THE SOLUTION

NCOA recommends the following solutions to reduce the economic costs associated with falls and falls-related injuries.

1) **Provide Medicare reimbursement for falls risk screening and referral management.** Medicare providers need a pathway for reimbursement to complete falls risk screening, assessment, and intervention to address risk factors, including referral management to a falls prevention program. CMS currently provides separate reimbursement for screening for depression for the at-risk population. A similar mechanism should be enforced to ensure that health care providers who complete falls risk screenings and falls prevention referrals are compensated for the additional workload this requirement requires. A comprehensive falls risk assessment should be compulsory as part of the AWV in order to establish an individually tailored and effective Falls Plan of Care (FPOC). Evidence has shown that individuals with a FPOC have fewer falls than those who do not, and they are effective at addressing modifiable risk factors for falls. Lastly, the reimbursement for falls risk screening and falls prevention referral management should be treated as an add-on service to an established Medicare evaluation and management service such as transitional care management. CMS could establish this benefit as a Healthcare Common Procedure Coding System (HCPCS) service with an administrative rule change.
2) **Expand payment of providers for the Welcome to Medicare and AWV to include both physical therapists and occupational therapists.** These professionals have the extensive training and expertise to administer evidence-based screening tools and to make the appropriate referrals, including one to a primary care physician, to increase reporting and identify those at risk for falls for preventive care. As of now, Medicare will only cover rehabilitative services provided by physical therapists and occupational therapists.
3) **Develop Medicare falls prevention billing codes.** Health care providers are more likely to conduct falls screenings, assessments, and interventions when they are reimbursed for those services. Currently, they are not. Medicare providers should be reimbursed for clinical interventions to effectively manage risk factors identified during these visits. If falls risk is identified, the burden is put on the patient to schedule a follow-up visit to discuss how to reduce or manage their falls risk. Currently, there are no direct provider reimbursement options for the clinical management of falls and no Current Procedure Terminology (CPT) code specific to falls risk assessment, management, and care planning. The creation of a CPT code to describe this service would facilitate appropriate reporting of this service and ensure that all elements of the service are performed and reimbursed. More falls could be prevented if Medicare reimbursed providers for both preventive screening and effective treatment.

4) **Add second falls as a Hospital Readmissions Reduction Program measure.** The Hospital Readmissions Reduction Program, mandated by the Affordable Care Act, requires CMS to reduce Medicare payments to inpatient prospective payment system hospitals with excess readmissions. This program went into effect on October 1, 2012. This is a penalty program that reduces the base diagnosis-related group (DRG) payments for discharges as a result of performance on specific readmission measures. Such measures currently include unplanned 30-day readmissions for acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, elective total hip arthroplasty, coronary artery bypass graft surgery, and total knee arthroplasty. NCOA recommends that a measure be added for readmissions due to a second fall and could include fractures, brain injuries, and other related injuries.
5) **Utilize CMMI to foster innovative falls prevention pilot programs and demonstrations.** The Center for Medicare & Medicaid Innovation (CMMI) could run pilots to examine the effects of innovative payment models and care coordination strategies to encourage falls prevention in primary care practices. New payment and care delivery models could emphasize prevention, care coordination, and quality of care in ways that embrace falls prevention. They also could encourage providers to deliver care in ways that reduce costs, which should incentivize providers to focus on strategies, such as falls screening and referral to evidence-based programs, that yield health care savings. CMMI also should fund demonstration projects around strategies to activate communities and bring key stakeholders together to reduce preventable falls. In addition, we recommend further examination of the significant potential for reductions in hospital readmissions through greater use of evidence-based falls prevention programs.

CONCLUSION

Thank you for the opportunity to share our expertise and recommendations, including establishing a coordinated cross-agency federal effort to address falls, promoting early identification of falls risk factors and early intervention, and improving Medicare policies to prevent falls. NCOA welcomes questions from Committee members.

Statement of

Elizabeth Thompson, CEO

National Osteoporosis Foundation

Before the

U.S. Senate Special Committee on Aging

Hearing On

"Falls Prevention: National, State, and Local Solutions to Better Support Seniors"

October 16, 2019

Good Morning Chairman Collins and Ranking Member Casey. Thank you so much for calling this hearing today and for the opportunity to present to the Committee on a vitally important topic that literally impacts every American in one way or another. And thank you Madame Chairman for your longstanding and outstanding leadership on bone health issues. It is truly appreciated!

The National Osteoporosis Foundation (NOF) is the leading health organization dedicated to preventing osteoporosis and broken bones, promoting strong bones for life and reducing human suffering through programs of public and clinician awareness, education, advocacy, and research. Established in 1984, NOF is the nation's only health organization solely dedicated to osteoporosis and bone health. We are delighted that the Committee has chosen to focus its report this year on the important issue of falls and fall-related injury.

NOF strongly agrees with the Committee that a thoughtful analysis of and search for policy solutions to the problem of falls among older Americans has to include an examination of bone health, osteoporosis and bone fractures. **Bone loss and osteoporosis are fundamental underlying contributors to the worst consequences of falls among older Americans – broken and fractured bones, which can lead to disability, loss of independence and even death.** In addition, there are instances where an osteoporotic fracture precedes or causes the fall.

In the U.S. more than 55 million people either already have osteoporosis or are at high risk of the disease due to low bone density. ***Osteoporosis-related bone fractures – often the result of falls -- are responsible for more hospitalizations than heart attacks, strokes and breast cancer combined*.** And as the nation ages, the number of osteoporotic fractures suffered annually will grow 68% by 2040, exacting an even greater economic and human toll on Medicare beneficiaries, their caregivers and taxpayers.

It gets blurry at times talking about numbers. But we have to keep individual patients and their stories front and center. Take the story of NOF patient advocate Claudia Kaufman of Washington, D.C. Claudia is 65. She has osteoporosis and has suffered multiple bone fractures. She fell on a curb and shattered her shoulder May 2010. She has broken 3 toes getting in and out of the bathtub. In November 2015 she slipped on wet boards and fractured her wrist when catching herself in the fall. She recently learned that after her first fracture -- in 2008 -- she had a screening that showed she had osteopenia -- a precursor to osteoporosis. But her doctor never followed up to give her the results. She says that if she had been told, she could have started treatment earlier and possibly avoided the repeat fractures. Because she had such a bad fracture, she will need a shoulder replacement. She has been a lifelong swimmer, and just a few weeks ago, she was given the news that she likely can't swim again.

So as we discuss the issues today, we have to keep in mind Claudia and the millions of other Americans she represents.

The good news is that we have the tools to stem this crisis. Medicare pays for state of the art bone density testing to identify those who are at risk of bone fractures, allowing for early and effective preventive steps and interventions. Medicare also pays for FDA approved drug treatments for osteoporosis that can help reduce spine and hip fractures by up to 70 percent and cut secondary (repeat) fractures by about half. And leading health systems like Geisinger and Kaiser Permanente have successfully employed new models of coordinated care for those with bone fractures to significantly improve rates of screening and treatment, reduce rates of fractures *and lower costs*.

We are pleased today to be able to brief the Committee on the results of a major new report commissioned by NOF examining the economic and clinical impact of bone fractures suffered by Americans in the Medicare program. The analysis also provides insights on potential savings to Medicare that could be realized if the rate of secondary (repeat) fractures were reduced through model prevention practices. The report, prepared by the independent actuarial firm Milliman, is based on their review of an extensive database of Medicare fee for service claims paid in 2015. The full report can be found here.

The report finds that bone fractures related to osteoporosis ("osteoporotic fractures") take a dramatic economic and human toll on our nation, but that reducing a small fraction of secondary fractures could yield large savings to Medicare:

- Approximately 2.3 million fractures were suffered by 2 million Americans on Medicare in 2015.

- The additional costs to Medicare just for the 307,000 who suffer a second fracture in the 2-3 years after an initial fractures was over $6.3billion.

- Only 9 percent of women who suffered a fracture were screened for osteoporosis, while most were not receiving approved treatments or model care coordination practices.

- Over 40% of Medicare beneficiaries with a new osteoporotic fracture were hospitalized within a week after their fracture and nearly 20% died within 12 months following a new osteoporotic fracture.
- It concludes that reducing just 20 percent of these "secondary" fractures by employing best practices could reduce Medicare spending by over $1.2 billion over up to 2 to 3 years.

Osteoporotic Fractures are Widespread and Costly

- Up to 2.3 million osteoporotic bone fractures were suffered by Medicare beneficiaries in 2015. *That is more than the number of heart attacks, strokes or new cancer cases.* Approximately 1.4 million beneficiaries (or about 4% or in 1 of every 25) in the traditional Medicare fee-for-service (FFS) program suffered over 1.6 million fractures. And an estimated 600 thousand beneficiaries in Medicare Advantage plan suffered up to 700,000 fractures.
- The incremental annual medical costs in the year following a new osteoporotic fracture was over $21,800, which included only direct costs identifiable through an administrative medical claims database.
- An estimated 307,000 Medicare FFS beneficiaries of those who had a new osteoporotic fracture, suffered one or more additional subsequent fractures within two three years. The estimated incremental medical cost to Medicare of a subsequent fracture over the 180-day period following a new osteoporotic fracture was over $20,700 which would account for **over $6.3billion** in allowed cost to Medicare.
- Total costs to Medicare and patients are actually substantially higher because the Milliman analysis **does not** include costs incurred by:
    - the roughly 30 percent of Medicare beneficiaries who get their care through Medicare Advantage Plans;
    - prescription drug costs paid through Medicare Part D, or
    - long-term care costs not covered by Medicare (mostly covered by Medicaid).
- In keeping with this, the report cites a peer-reviewed study from earlier this year which estimates the total annual expense of providing care for osteoporotic fractures among Medicare beneficiaries, including direct medical costs as well as indirect societal costs related to productivity losses and informal caregiving to be **$57 billion in 2018 growing to over $95 billion in 2040.**[i]

Osteoporotic Fractures Exact a Major Human Toll

Among the report's detailed findings on the health and human toll of osteoporosis on older Americans:

- Over 40% of Medicare beneficiaries with a new osteoporotic fracture were hospitalized within a week after their fracture. Of those with a hip fracture, over 90% were hospitalized within a week.
- 19 percent of Medicare beneficiaries with a new osteoporotic fracture developed at least one pressure ulcer within three years of their initial fracture.
- 7 percent of Medicare beneficiaries with a new osteoporotic fracture became eligible for Medicaid within 3 years of their bone fracture.
- Nearly one in five Medicare beneficiaries died within 12 months following a new osteoporotic fracture. This accounted for approximately 260,000 deaths among Medicare beneficiaries who suffered an osteoporotic fracture in 2015. Of these, about 164,000 were female and 96,000 were male. 30 percent of those with hip fractures die within 12 months of their fracture.

Tools to Prevent Fractures Go Unused

The study also documents the failings of our health care system to utilize available tools that are proven to reduce the number of fractures, particularly repeat fractures.

- Although dual-energy X-ray absorptiometry (DXA) is highly effective at identifying at-risk individuals and is recommended for all women age 65 years and older, the report found that only 9% of female Medicare FFS beneficiaries received a BMD test within six months following a new osteoporotic fracture.
- While Milliman's analysis did not include a review of Medicare Part D claims, the report cites a 2019 peer-reviewed finding that "while Medicare covers effective screening and treatments, the percentage of patients aged 50 and older, with either commercial or Medicare supplemental health insurance, who received a registered therapy for osteoporosis within twelve months of a hip fracture has **declined in the U.S. from 40% in 2002 to 21% in 2011."**[i]
- The report finds that innovative care coordination models such as fracture liaison services (FLS) utilized by leading systems like Geisinger and Kaiser and in many other countries to reduce the rate of secondary osteoporotic fractures are not widely utilized in the United States.
- The report does cite a promising trend in improving rates of screening and treatment of those in Medicare Advantage (MA) plans. Average MA rates of testing and/or treatment for women within six months post-fracture, which include both BMD testing and

pharmaceutical therapies, are approximately 45% for 2017. Medicare Advantage plans receive bonus payments if they meet quality measures for higher rates of treatment or screening after bone fractures.

Preventing Secondary Fractures Would Bring Big Savings

- The report finds that preventing even a modest percentage of subsequent fractures after a new osteoporotic fracture may lead to Medicare cost savings. It estimates that reductions of 5% to 20% in the rate of subsequent fractures could lead to savings of $310 million to over $1.2 billion for the Medicare FFS program during a follow-up period of up to 2 to 3 years after a new osteoporotic fracture.

A Call to Action: Policy Changes Needed To Move Us Forward

The National Osteoporosis Foundation is putting forward a call to action to the nation to make the needed policy changes to address the crisis in osteoporosis. NOF calls for the following changes based on the report's findings:

- ***Medicare and other payers should incentivize and promote the provision of evidence-based care management and coordination such as fracture liaison services for those who have suffered a bone fracture and are at risk for another.***

Medicare does not pay for an innovative care coordination strategy known as Fracture Liaison Service (FLS) that has been demonstrated to improve utilization of effective screening and therapies and therefore improve outcomes and reduce costs. This care coordination program could also be used for chronic care management of osteoporosis and reimbursed as such. The Fracture Liaison Service (FLS) secondary fracture prevention program model of care has been in operation for more than 15 years in leading health systems in the U.S. and in countries around the world. FLS ensures that patients suffering fractures caused by osteoporosis undergo a fracture risk assessment to prevent further fractures by treatment of osteoporosis and falls prevention strategies, delivering highly effective care while significantly reducing the costs associated with secondary fractures. FLS operates under the supervision of osteoporosis specialists and collaborates with the patient's primary care physician. Usually led by nurse practitioners or other allied health professionals, it ensures older adult fracture patients receive appropriate diagnosis and treatment of their likely osteoporosis. The program creates a population registry of fracture patients and establishes a process and timeline for patient assessment and follow-up care. In addition to managing osteoporosis, where appropriate, FLS programs will refer patients to falls prevention services.

Numerous studies have demonstrated the effectiveness of FLS. For example, Kaiser Permanente has found that its FLS program has reduced the hip fracture rate expected by over 40% (since 1998). If implemented nationally, Kaiser estimates a similar effort could reduce the number of hip fractures by over 100,000 and save over $5 billion/year. Geisinger Health System reports that it achieved $7.8 million in cost savings from 1996-2000 from its implementation of FLS.

A recent meta-analysis of 159 publications evaluating the impact of fracture liaison services found that compared with patients receiving usual care (or those in the control arm), patients receiving care from an FLS program had higher rates of bone density testing (48.0% vs 23.5%). treatment initiation (38.0% vs 17.2%) and greater adherence to treatment (57.0% vs 34.1%). https://www.ncbi.nlm.nih.gov/pubmed/29555309)

CMMI has rightly focused on identifying and testing practices and payment models that hold promise of improved health care outcomes and bring better value to beneficiaries, their caregivers and taxpayers. Unfortunately, the Primary Care Plus model does not incentivize bone health or second fracture prevention. CMS could, for example, provide that the costs of fracture care in at-risk models not be attributed to the provider or accountable entity if they meet certain benchmarks on bone health, e.g., 95% of patients at risk for low bone density have had a DXA, 95% of patients with a fracture after age 50 are evaluated and appropriately treated.

Given the prevalence and cost to Medicare of bone fractures and substantial evidence that innovative practices can improve outcomes and reduce costs, **Congress should direct CMMI to conduct a Medicare demonstration or create a bundled payment model that incentivizes better coordination and management of care, such as through the provision of fracture liaison services, to beneficiaries who have suffered one or more bone fractures and may be at risk for additional fractures.**

- ***Cuts to Medicare payment rates for osteoporosis screening should be restored so as to better encourage appropriate utilization of this proven way to reduce fracture rates.***

Medicare pays for state of the art bone density testing (dual-energy X-ray absorptiometry (DXA)) which is highly effective in identifying those who are at risk of bone fractures allowing for early and effective preventive steps and interventions. This bone density testing is more powerful in predicting fractures than cholesterol is in predicting myocardial infarction or blood pressure in predicting stroke. However, federal policy changes have led to a major reduction in the use of this important preventive service. Medicare payment rates for bone-density tests have been cut by 70 percent resulting in 2.3 million fewer women being tested. And in the last 5 years the osteoporosis diagnosis of older women has declined by 18 percent. This is unacceptable.

NOF strongly supports enactment of Chairman Collins' bipartisan S.239, "Increasing Access to Osteoporosis Testing for Medicare Beneficiaries Act of 2019". This legislation would set more adequate payment rates for screening and should increase access to this critical preventive service. Based on a 35% fracture prevention rate, we estimate over 26,000 hip fractures could have been avoided if Medicare beneficiaries continued to receive DXA scans. Conservative estimates indicate over 5,200 deaths could have been avoided in the Medicare 65+ population if DXA testing rates had continued to increase as expected.

- ***Appropriate quality measures for both optimal screening and treatment of osteoporosis and bone fractures should be established, adopted and incentivized by Medicare and other payers.***

NCQA measures for follow up care for those who suffer fractures should be strengthened and incentive by Medicare. Current Medicare Advantage Star rating measure related to post-fracture care should be improved by creating separate measures for high-rates of post-fracture screening and *and* appropriate drug therapy treatment and adherence. The current measure is of more limited impact in incentivizing best practices because it measures the percentage of women age 65-85 who had *either* a bone mineral density test *or* a prescription for a drug to treat osteoporosis within 6 months of their bone fracture. There should be separate measures for appropriate screening and appropriate treatment. Similar measures should be established and incentivized for traditional Medicare. The President's October 3 Executive Order calls on HHS to consider quality measures similar to Medicare Advantage Star Ratings for traditional Medicare. This may provide an important opportunity.

- **A national education and action campaign should be launched to raise awareness about and promote action to reduce the rate of falls and bone fractures**.

Studies have shown that just over 20% of older Americans who break their hip are started on FDA approved therapies to strengthen their bones. This compares to 96 percent who are started on beta blockers post hospitalization for a heart attack. The NOF Milliman report finds that 18.6 percent of Medicare beneficiaries who fractured their hip in 2015 had a subsequent bone fracture over the next year. By comparison, those who are hospitalized for an acute myocardial infarction are at a 9.2 percent risk for another AMI related hospitalization in the next year. An innovative national campaign, Million Hearts, has had a very positive impact on improving care and outcomes aimed at reducing heart disease. **NOF calls on Congress to direct and fund the Department of Health and Human Services to implement a similar national education and action initiative aimed at reducing falls and bone fractures among older Americans. Such an initiative could set national goals for primary and secondary prevention of osteoporosis and reductions in the rate of falls and primary and secondary bone fractures.**

Million Hearts® 2022 is a national initiative co-led by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) to prevent 1 million heart attacks and strokes within 5 years. It focuses on a small set of priorities selected for their ability to reduce heart disease, stroke, and related conditions. CDC's Division for Heart Disease and Stroke Prevention provides leadership and support for the Million Hearts® initiative. More information about past and current activities of the Million Hearts campaign can be found at: https://millionhearts.hhs.gov/files/MH_At_A_Glance_2022-508.pdf

These steps along with others called for in the Committee's excellent report being released today, provide a roadmap for improving and savings lives and lowering health care costs.

Thank you so much for the opportunity to share our views on this very important topic. We look forward to continuing to work closely with the Committee as its work progresses.

I look forward to any questions you may have.

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[i] Lewiecki EM, Ortendahl JD, Vanderpuye-Orgle J, et al. Healthcare Policy Changes in Osteoporosis Can Improve Outcomes and Reduce Costs in the United States. *JBMR Plus*. May 2019. doi:10.1002/jbm4.10192

Statements for the Record

National Safety Council Statement
For the Senate Special Committee on Aging
Hearing on
"Falls Prevention: National, State, and Local Solutions to Better Support Seniors."
October 16, 2019

The National Safety Council (NSC) is a nonprofit organization with a century-long mission of eliminating preventable deaths at work, in homes and on the road through leadership, research, education and advocacy. Our more than 15,000 member companies represent employees at more than 50,000 U.S. worksites.

According to National Safety Council *Injury Facts®* falls are currently the third leading cause of preventable death. In 2017, 31,190 older adults aged 65 and older died from preventable falls, and more than 3 million were treated in emergency departments.[i] Over the past 10 years, the number of older adult fall deaths has increased 58%, while emergency department visits have increased 40%.Today, an older adult dies from a fall every 19 minutes. According to the Centers for Disease Control and Prevention (CDC), more than one in four older adults report a fall each year.[ii]

Fall injuries are among the 20 most expensive medical conditions, and government-funded programs, such as Medicare and Medicaid, finance about 75% of these costs. As the American population continues to age, and with 10,000 people in the United States turning 65 every day, we could expect to see 49 million falls, 12 million fall injuries and almost 100,000 fall-related deaths per year by 2030.[iii]

According to CDC, the financial cost to the nation is $31 billion annually in Medicare spending alone to treat these injuries. However, while falls represent the leading cause of preventable death among adults 65 years of age and older, they are not an inevitable part of aging in America and are on the whole, preventable.

In order to address fall prevention for older Americans, the National Safety Council has previously urged Congress to support $4 million to the CDC National Center for Injury Prevention and Control programming and research to prevent older adult falls and $10 million to the Administration for Community Living (ACL) engagement of the aging services network to implement and sustain evidence-based falls prevention programs, in conjunction with leading advocacy and support organizations nationwide. A copy of this letter is attached.

Older adult falls may be best addressed by providing evidence-based falls prevention programs in communities, and through identification of specific risk factors that older adults may face. More than 90% of older adults see a medical provider at least once a year, and many of these individuals see their pharmacists even more frequently. Clinicians and pharmacists can both serve as critical resources to help inform and empower older adults to address one or more specific fall risk factors.

The National Safety Council supports the CDC STEADI (Stopping Elderly Accidents Deaths and Injuries) program[iv] to help all healthcare providers make fall prevention a routine part of clinical care. STEADI includes a coordinated care plan that offers healthcare providers a 12-step framework to manage older patients' fall risk.[v]

Given that certain medications can increase fall risk, CDC also created STEADI Rx to engage with community pharmacists and coordinate on falls prevention efforts. STEADI-Rx offers tools for pharmacists on how to screen, assess, and coordinate care to reduce older adult fall risk.[vi]

There are other steps to take to reduce chances of a fall. A review of 54 randomized clinical trials[vii] found that the combination of exercise and vision assessment and treatment likely has the strongest association with decreasing fall injuries among older adults. A 2015 CDC study assessing the cost-benefit analysis of three older adult fall-prevention programs identified a positive return on investment for all three programs. The three programs demonstrated that the cost of decreased direct medical costs was greater than the costs associated with implementing the program. Two programs focused either on Tai Chi or improving balance and administered to persons age 80 and older resulted in a greater than 100% return on investment.[viii] A similar 2015 study found that adults who consistently participate in exercise programs can reduce their risk of experiencing a medically treated fall by 20% to 30%.[ix]

Preventing and reducing falls lowers healthcare spending, improves health and fosters independence. Congress should lead by providing necessary funding to the CDC and ACL and publicizing already available resources such as STEADI.

While we all are aging every day, falls do not have to be a part of that process. Understanding fall risks is the first step to keeping our loved ones and ourselves safe. Thank you for the opportunity to share this testimony, and for supporting a national conversation that will help older Americans lead their fullest lives.

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[i] https://injuryfacts.nsc.org/home-and-community/safety-topics/older-adult-falls/
[ii] https://www.cdc.gov/mmwr/volumes/65/wr/mm6537a2.htm
[iii] https://www.cdc.gov/mmwr/volumes/67/wr/mm6718a1.htm?s_cid=mm6718a1_w
[iv] https://www.cdc.gov/steadi/index.html
[v] https://www.cdc.gov/steadi/pdf/Steadi-Coordinated-Care-Final-4_24_19.pdf
[vi] https://www.cdc.gov/steadi/steadi-rx.html
[vii] https://www.ncbi.nlm.nih.gov/pubmed/29114830
[viii] https://www.ncbi.nlm.nih.gov/pubmed/25662884
[ix] https://www.cdc.gov/pcd/issues/2015/14_0574.htm

March 22, 2019

The Honorable Rosa DeLauro
United States House of Representatives
Committee on Appropriations
Labor, Health and Human Services,
Education and Related Agencies
Washington, DC 20515

The Honorable Tom Cole
United States House of Representatives
Committee on Appropriations
Labor, Health and Human Services,
Education and Related Agencies
Washington, DC 20515

The Honorable Roy Blunt
United States Senate
Committee on Appropriations
Labor, Health and Human Services,
Education and Related Agencies
Washington, DC 20510

The Honorable Patty Murray
United States Senate
Committee on Appropriations
Labor, Health and Human Services,
Education and Related Agencies
Washington, DC 20510

Dear Chairman DeLauro, Ranking Member Cole, Chairman Blunt and Ranking Member Murray:

The undersigned organizations are committed to protecting our older Americans and urge you to fund the Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control programming and research to prevent older adult falls at a minimum of $4 million, and the Administration for Community Living (ACL) engagement of the aging services network to implement and sustain evidence-based falls prevention programs at a minimum of $10 million, for FY 2020.

Falls are not an inevitable part of aging in America yet they represent the leading cause of preventable death among adults 65 years of age and older. It is an escalating health risk for this population, but with sound research and science, more can be done to prevent fall-related injuries. In 2014, there were 29 million falls among adults over the age of 65, which is one fall every second of every day, and of those who fell, 37.5% reported requiring medical treatment or restricted activity for at least 1 day. An older adult dies from a fall every 19 minutes. In 2015, total medical costs to treat older adult falls exceeded $50 billion. As the baby boomer generation continues to age, these injuries, deaths and associated costs are likely to increase substantially unless more is done.

The CDC houses the experience required to institute public health strategies to create a safety system for older adults. With the implementation of its Stopping Elderly Accidents, Deaths and Injuries (STEADI) toolkit, the CDC provides easy and effective resources for professionals who work with older adults daily, including physicians and pharmacists. They are also evaluating fall prevention strategies to help communities identify the best, evidence based efforts to prevent falls and keep older adults safe and independent.

The Administration for Community Living (ACL) is leveraging the CDC investment in provider training and program translation to improve access to evidence-based programs in local communities to prevent falls among older adults. These much-needed funds will expand access for seniors to attend programs that will identify and ameliorate risks and reduce health care costs associated with

emergency room, physician, hospital and rehab visits. Older adult falls costs Medicare $31 billion annually.

Attached is a state-by-state chart of the human costs associated with this preventable injury in one year alone. As you can see, in the U.S. it ranges from a high rate in Arkansas of 34% of adults 65 years old and older to a low in Hawaii of 20%. According to CDC, the financial cost to the nation is great as well with Medicare spending $31 billion annually to treat these injuries.

This funding request is such a small investment when compared with the return it could provide to maintain the safety, health and productivity of our older Americans. I hope you will join with us in support for this funding.

Sincerely,

American Physical Therapy Association
Association of State and Territorial Health Officials
Brain Injury Association of America
Easterseals
Fall Prevention Center of Excellence, Leonard Davis School of Gerontology
Lorain County Public Health
Meals on Wheels America
MobileHelp
National Alliance for Caregiving
National Asian Pacific Center on Aging (NAPCA)
National Association of Area Agencies on Aging
National Association of Nutrition and Aging Services Programs (NANASP)
National Association of RSVP Directors
National Association of State Head Injury Administrators
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Floor Safety Institute
National Safety Council
Prevention Institute
Safe States Alliance
Trust for America's Health
Wisconsin Institute for Healthy Aging
WISER

October 15, 2019

Chairman Susan Collins
Senate Special Committee on Aging
U.S. Senate
Washington, D.C. 20510

Ranking Member Robert P. Casey, Jr.
Senate Special Committee on Aging
U.S. Senate
Washington, D.C. 20510

Dear Chairman Collins and Ranking Member Casey:

Trust for America's Health (TFAH) is pleased to submit this letter for the record for the Senate Special Committee on Aging's upcoming hearing "Falls Prevention: National, State, and Local Solutions to Better Support Seniors." TFAH recognizes that given the growth of the older adult population, the health issues prevalent in this population and the gaps in services and supports for older adults, public health can and should play a greater role in improving the health and wellbeing of older Americans. Since 2017, TFAH has been working to transform our public health system to become "age-friendly".[1]

Federal, state and local health departments have traditionally played key roles in preventing falls among older adults, including researching and disseminating data on falls and on evidence-based prevention practices[2], convening multiple sectors to address fall prevention and implementing evidence-based practices in clinical and community settings.[3] The Centers for Disease Control and Prevention (CDC) is working to make fall prevention a routine part of clinical care through its Stopping Elderly Accidents Deaths & Injuries initiative (STEADI). STEADI provides free continuing education for primary care providers to ensure that they address the fall risk of their older patients, identify modifiable risk factors, and connect patients to evidence-based programs that reduce fall risk.[4]

CDC also supports state and local health departments and other community organizations in implementing evidence-based fall prevention programs. For example, CDC supported the YMCA of the USA (Y-USA) to implement Tai Chi: Moving for Better Balance, which Y-USA adapted to fit the YMCA training system.[5,6] Y-Moving for Better Balance (MFBB) is being implemented in local Y's across the country and is being spread nationally through a train-the-

[1] https://www.tfah.org/wp-content/uploads/2018/09/Age_Friendly_Public_Health_Convening_Report_FINAL__1___1_.pdf
[2] https://www.cdc.gov/homeandrecreationalsafety/pdf/falls/CDC_Falls_Compendium-2015-a.pdf#nameddest=intro
[3] https://www.cdc.gov/homeandrecreationalsafety/falls/community_preventfalls.html
[4] https://www.cdc.gov/features/older-adult-falls/index.html
[5] https://www.cdc.gov/homeandrecreationalsafety/pdf/falls/FallPreventionGuide-2015-a.pdf
[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4410333/

trainer process for YMCA instructors. A cost-benefit analysis of return on investment (ROI) showed that this program had a net benefit per participant of $529.86 and an ROI of 509%.[7]

Public health plays an important role in convening multiple sectors to address fall prevention as well as implementing evidence-based solutions. The Hawaii Fall Prevention Consortium, for example, was formed in 2003 with support and leadership from the Hawaii State Department of Health Injury Prevention and Control Section (DOH/IPCS).[8] Two statewide conferences were conducted as well as a statewide needs assessment that DOH/ICPS utilized to develop fall prevention recommendations in the Hawaii Fall Prevention State Plan 2013-2018 and which the State Executive Office on Aging used to inform their State and Area Plans on Aging.[9] This work in Hawaii is an excellent example of collaboration between the public health and aging sectors. In 2011, the Executive Office on Aging and DOH/IPCS jointly established the Hawaii State Fall Prevention Task Force which developed a comprehensive statewide approach to fall prevention. Examples of new programs implemented in Hawaii include: an annual public awareness campaign; Tai Chi programs on all islands; training primary care providers to use fall prevention screening tools and referrals to resources[10]; and a home safety assessment program conducted by the Hawaii Fire Department. Many local public health departments across the country are helping to implement and spread awareness of fall prevention programs such as A Matter of Balance[11], and are providing education for older adults in their communities on the benefits of physical activity to prevent falls.

Despite the strong role of public health in addressing fall risks and the partnerships in some areas between the public health and aging sectors, these efforts are hampered due to lack of adequate funding. The Prevention and Public Health Fund currently supports fall prevention at the Administration for Community Living ($5M) and at the CDC ($2.05 million).

Preventing falls will require additional funding and infrastructure at the CDC, which currently has minimal funding to support to the role of health departments in healthy aging generally and fall prevention specifically. Public health investments such as these are critical to improve the lives of older Americans and contribute to long-term cost savings.

Thank you again for the opportunity to comment on efforts surrounding fall prevention, and we look forward to working with you toward a healthier nation. If you have any questions, please contact Kevin McIntyre, TFAH's Associate Government Relations Manager at kmcintye@tfah.org.

Sincerely,

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[7] Carande-Kulis, V., et al., A cost–benefit analysis of three older adult fall prevention interventions, Journal of Safety Research (2015), http://dx.doi.org/10.1016/j.jsr.2014.12.007
[8] http://health.hawaii.gov/injuryprevention/home/preventing-falls/information/
[9] http://health.hawaii.gov/injuryprevention/files/2013/09/HIPP-2012-2017-Falls-Prevention-671KB.pdf
[10] https://health.hawaii.gov/injuryprevention/files/2016/11/SER_Older_Adult_Falls_Hawaii-2011-2015.pdf
[11] https://mainehealth.org/healthy-communities/healthy-aging/matter-of-balance

John Auerbach, MBA
President & CEO

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

OCT 15 2019

The Honorable Susan Collins
Chairman
Special Committee on Aging
United States Senate
Washington, DC 20510

Dear Chairman Collins:

Thank you for your letter on the importance of falls prevention for Medicare and Medicaid beneficiaries. We appreciated the opportunity for Dr. Shari Ling, the Deputy CMS Chief Medical Officer, and other CMS staff to discuss this issue with your staff in July, and are happy to continue the dialogue by providing more information about CMS work as it relates to the prevention of falls.

The Welcome to Medicare visit, also called the Initial Preventive Physical Examination, and the Annual Wellness Visit both include a number of services that clinicians performing these exams are required to furnish to Medicare patients. In the Welcome to Medicare visit, a clinician must review a beneficiary's functional ability and level of safety, which can be done through appropriate screening questions or a screening questionnaire and must include a review of fall risk. There are similar requirements in the Annual Wellness Visit, where clinicians must perform or update a health risk assessment, which addresses activities of daily living, including physical ambulation (including balance and risk of falls) and must furnish personalized health advice. In all these visits, the clinician is required to provide appropriate health education and referrals to health education and preventive counseling services or programs. Additional information about these visits is outlined in Medicare regulations at 42 CFR 410.15 and 42 CFR 410.16.

With respect to fall-related measures, several are included in the Merit-Based Incentive Payment System (MIPS) for clinicians, in quality reporting programs in four post-acute care settings, which include Skilled Nursing Facilities, Long-Term Care Hospitals, Inpatient Rehabilitation Facilities, Home Health Agencies, and in the inpatient hospital setting. In addition, clinicians participating in accountable care organization (ACO) initiatives such as the Medicare Shared Savings Program or the Next Generation ACO payment model report a falls-related measure through their ACO.

In 2019, under MIPS, there are a number of ways that clinicians can choose to report quality measures. For groups of 25 or more clinicians, there is a set of 10 measures called the CMS Web Interface, which is one of the submission methods for quality data that can be reported by the whole group. ACOs are also required to report measures through the CMS Web Interface. Among these 10 measures, there is a falls measure, *Falls: Screening for Future Fall Risk*[1] in the 2019 CMS Web Interface. In 2017, we estimate that this falls measure was reported by approximately 480,000 clinicians, including those clinicians in ACOs.

Clinicians can also report under MIPS using other submission methods, one of which is to choose six measures from a list of over 200 measures. Among these measures, there are three that are related to falls in the 2019 performance period:

- *Falls: Plan of Care*[2] – Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.

- *Falls: Risk Assessment*[3] – Percentage of patients aged 65 and older with a history of falls that had a risk assessment for falls completed within 12 months.

- *Falls: Screening for Future Fall Risk*[4] – Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

In addition to reporting quality measures, clinicians attest to between two and four Improvement Activities under MIPS, and in the 2019 performance period, one of the Improvement Activities on the list that they can select from is the following:

- Implementation of fall screening and assessment programs – Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).

For the post-acute settings, we calculate a measure, the *Falls with Major Injury* measure, from information submitted on patient assessment instruments. This measure is reported on CMS's "Compare" websites for nursing homes, inpatient rehabilitation facilities, and long-term care

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[1] https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Web-Interface-Measures/2019_Measure_CARE2_CMSWebInterface_UPDATED.pdf

[2] https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019_Measure_155_MIPSCQM.pdf

[3] https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019_Measure_154_MIPSCQM.pdf

[4] https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS139v7.html

hospitals.[5] Home health agencies began to submit data on this measure on January 1, 2019, and the measure will be publicly reported on Home Health Compare. Home Health Agencies already report data for another falls measure, *Multifactor fall risk assessment conducted for all patients who can ambulate* that is currently publicly reported on Home Health Compare.[6]

In the hospital setting, we have one composite measure, the *Patient Safety and Adverse Events* composite measure, which provides a performance score based on how often patients have certain complications related to inpatient hospital care. There are ten complications that are part of this measure, one of which is *Broken hip from a fall after surgery (in-hospital fall with hip fracture)*.[7] This composite measure is reported on Hospital Compare and is also in the Hospital-Acquired Conditions Reduction program and the Hospital Value-Based Purchasing program.

Additionally, a policy was established in 2008 under which Medicare does not make additional payments for inpatient hospital care for selected hospital-acquired conditions if the condition was not present on admission, and if the condition could reasonably have been prevented through the application of evidence-based guidelines. CMS has selected certain conditions for this payment policy, and one category of conditions is falls and trauma. If a selected condition results in assignment of a case to a secondary diagnosis that would lead to a higher payment, hospitals will not receive the higher payment amount but will be paid as though the secondary diagnosis was not present. There is a similar provision in the Medicaid program implemented in 2011, under which States may not pay for services related to certain provider-preventable conditions in hospitals. This includes most hospital-acquired conditions selected under the Medicare provision described above, as well as provider-preventable conditions identified in a State Medicaid plan.

Finally, you asked about existing Medicaid waivers as well as the work of the Center for Medicare and Medicaid Innovation (Innovation Center) with respect to fall prevention activities. No Medicaid waivers are aimed specifically at fall prevention. While there is no Innovation Center model targeting fall prevention, all CMS Innovation Center models are intended to reduce program expenditures while preserving or enhancing the quality of care. We anticipate that clinicians participating in the models are likely to adopt strategies to reduce beneficiary falls such as screening for fall risk, in order to improve beneficiary outcomes and reduce hospitalizations. As noted above, the Next Generation ACO model tested by the Innovation Center requires ACOs to report measures using the CMS Web Interface, and one of the measures is *Falls: Screening for Future Fall Risk.*

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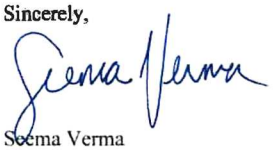
[5] https://www.medicare.gov/nursinghomecompare/search.html, https://www.medicare.gov/inpatientrehabilitationfacilitycompare, https://www.medicare.gov/longtermcarehospitalcompare

[6] https://www.medicare.gov/homehealthcompare/search.html

[7] https://www.medicare.gov/hospitalcompare/Data/Serious-Complications.html

CMS recognizes the importance of preventing falls in our quality reporting programs, and our value-based payment programs as described above and we appreciate your leadership on this important matter. Please do not hesitate to contact the Office of Legislation at (202) 690-8220 if you have additional questions. I will also share this response with the co-signer of your letter.

Sincerely,



Seema Verma

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