June 26, 2019

The Honorable Bob Casey, Chairman
The Honorable Susan Collins, Ranking Member
Senate Special Committee on Aging
G-31 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Casey and Ranking Member Collins:

LeadingAge, ElevatingHOME and the Visiting Nurse Associations of America (VNAA) appreciate the opportunity to recommend policies and resources to help prevent injurious falls among older people.

LeadingAge is a tax-exempt charitable organization focused on education, advocacy and applied research. The mission of LeadingAge is to be the trusted voice for aging. Our 5,800 not-for-profit members include the entire field of aging services - nursing homes, home care providers, affordable housing, retirement communities and assisted living. Quality the public can trust is the fundamental mission of LeadingAge and its members, many of which have served their communities for over 100 years.

ElevatingHOME and its subsidiary VNAA, share the mission of advancing high-quality, patient-centered health care that starts in the home. ElevatingHOME members are mission-driven home health and hospice providers serving rural, urban and underserved communities across the nation. ElevatingHOME members provide cost-effective and compassionate care to the most vulnerable individuals, including older people and persons with disabilities.

According to the Centers for Disease Control and Prevention (CDC) more than 25% of older Americans fall every year, making falls the most frequent cause of injury among people aged 65 and older and the most frequent cause of deaths from injuries in this age group. Resulting costs to Medicare alone total $31 billion annually. LeadingAge, ElevatingHOME and VNAA appreciate the Aging Committee's timely exploration of ideas for reducing preventable falls and improving treatment of those who experience them.

Because our members provide the full spectrum of aging services, they have developed expertise in integrating services and helping older people to live to their highest practicable well-being in a variety of settings. We are pleased to share some of their ideas with the Committee.

Introduction and Summary of Recommendations

Our policy recommendations, which will be discussed in full below, are:

- Consider all settings, not just those funded and regulated by Medicare and Medicaid.
- Consider the purpose of a reporting system.
- Promote the use of evidence-based interventions and tools.
- Explore the potential for a purposeful connection between senior housing providers and falls prevention programs**.**
- Create a home health benefit for Preventive Home Visits (1-3) for Medicare beneficiaries who report a fall.
- Evaluate whether it would be a good idea to add a comprehensive falls risk assessment to the Medicare Annual Wellness Visit.
- Consider expanding the Medicare program to include vision care
- Consider expanding traditional Medicare to include the additional special supplemental benefits (SSBCI) for chronically ill enrollees currently available for Medicare Advantage enrollees.

Consider all settings, not just those funded by Medicare and Medicaid. Falls prevention is not exclusively a health issue and solutions must go beyond only health programs. This Committee is well-positioned to address issues broadly across silos. We urge you to think beyond Medicare and Medicaid funded and regulated settings, as a platform for services in its proposed solutions.

For example, over two million older adults across the country live in publicly subsidized housing communities, often funded by HUD. Many of these residents manage multiple chronic conditions, take multiple medications, and have functional limitations, putting them at higher risk for experiencing a fall. Although there are no national data on falls in affordable senior housing communities (see discussion, below, of challenges associated with reporting and tracking), anecdotally we know that they occur frequently and result in 911 calls that end up as emergency department visits or hospital stays. One examination of emergency medical services data for falls in Salt Lake County identified multiple subsidized housing communities as having high rates of falls. Affordable senior housing communities offer a venue for implementing interventions that could help mitigate falls with an at-risk population and which could support solutions in several of your areas of inquiry below.

Reporting and Follow-Up

Consider the purpose of a reporting system. Reporting falls among older persons is linked, in part, to where they are located at the time of the fall. Reporting is more likely, and often required, in regulated settings. Risk management systems in hospitals are highly attentive to falls, ensuring high accuracy of tracing and consistent language to define and describe the falls. Inpatient rehabilitation facilities and skilled nursing homes caring for Medicare Part A short stay residents publicly report falls through quality reporting programs with specific protocols.

Beyond these regulated settings many questions would have to be answered before undertaking to create and maintain a reporting system. Who would the fall be reported to? Who would be the reporter? Would reporting be mandatory and how would it be enforced? What would be the purpose of the reporting system and who would use it? Would the dollars needed to finance a reporting system be better used in some other falls prevention activity?

In addition, falls that do not result in an injury are not reported or reportable. Those falls may be a warning of a developing illness or loss of function. The Committee should carefully consider whether a tracking system would be both feasible and useful, or whether better awareness by both beneficiaries and medical professionals would be a more effective method of addressing and reducing falls also must be realistic – older adults are no less likely than younger people and perhaps more likely to be wary of reporting falls. They may fear loss of independence and being forced into a healthcare setting. Just because someone has turned 65 we should not assume they are incapable of making their own decisions.

We should think about looking for approaches that are not prescriptive or threatening, that are reasonable and can make a difference for consumers. One example would be a public relations campaign directed at both the Medicare beneficiary and the medical community stressing the importance of beneficiary and physician communication. Another strategy which we discuss is better use of the annual Medicare visit, discussed below.

Tools and Resources

Promote the use of evidence-based interventions and tools. Decreased range of motion and/or mobility may result in unsteady gait or balance, leading to falls. Nursing homes are expected to increase or prevent a decrease in range of motion for residents through a variety of practices and programs, including restorative nursing programs. These practices could usefully be adopted by health and long-term care providers in other settings.

Several LeadingAge members responded to our request for information as to how they help their residents and older people in their communities avoid falls. Examples:

> Andrew Sharp, the Director of Community Life at Clermont Park, a Christian Living Community in Denver, Colorado, developed his organization's *Staying Vertical at Soeren Glen* program based on resources from the CDC and others. The program emphasizes improving physical strength, regular vision and podiatry check-ups, using appropriate assistive devices, and home safety measures.
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> "Watch Every Step" is the mantra of Shelley Matthes BSN, RN-BC, RAC-CT, the Senior Director of Resource Optimization and Operations at Ecumen in Shoreview, Minnesota. She emphasizes the importance of encouraging older people to use assistive devices by making the devices attractive and user-friendly.

The LeadingAge Center for Aging Services Technologies (CAST) has developed a portfolio of hands-on resources that help aging services providers understand, plan for, select, implement and adopt Safety Technologies (https://www.leadingage.org/cast/cast-releases-safety-technology-selection-tool).

The Safety Technologies listed include products that can help detect falls automatically and facilitate the timely dispatch of supportive services, providing analysis of the circumstances leading to the fall to better target the appropriate preventive interventions, through video recording of the fall incident for example, as well as those intended to prevent falls.

CAST also has a portfolio of tools focusing on Functional Assessment and Activity Monitoring Technologies (https://leadingage.org/functional-assessment-and-activity-monitoring-technology-selection-tool) that also include products that can help assess falls risks, predict imminent falls and prevent falls. This sample case study (https://leadingage.org/sites/default/files/The_New_Jewish_Home_Case_Study.pdf) highlights how virtual rehab technology can help individuals improve ambulation, gait and balance and reduce the risk of falling.

Explore the potential for a purposeful connection between senior housing providers and falls prevention programs. Affordable senior housing communities are an efficient platform for addressing risk factors with a vulnerable older adult population. Onsite staffing offers the opportunity to conduct environmental scans of resident apartments to mitigate risks and identify the need for and provide adaptive features such as grab bars. Housing properties can also host, either directly or through collaboration with other community organizations, fitness and evidence-based falls prevention programs. One opportunity would be to explore the potential for a more purposeful connection between housing communities and grantees funded by the Administration for Community Living to deliver evidence-based falls prevention programs.

Create a home health benefit for Preventive Home Visits (1-3) for Medicare beneficiaries who report a fall. A significant barrier in federal policy to implementing home-based programs is the limitation of home health care. The combination of limited resources, limited public literacy and a shortage of persons who can provide support for many older persons limits the possibility of independent adoption of these tools. Creating a benefit for Preventive Home Visits (1-3) for Medicare beneficiaries who report a fall in any setting could fund a nurse or physical therapist to bring these tools into the home, assess the person and environment, and match resources, interventions and education to the individual's risk factors.

Medicare

Evaluate whether it would be a good idea to add a comprehensive falls risk assessment to the Medicare Annual Wellness Visit. Adding protocols to assess fall risk to the annual wellness visit would be another way to improve assessment, prevention and appropriate follow-up.

It may be helpful for the Committee to consider the kind of assessments that are done when people enter a nursing home. This kind of evaluation could be a template for falls assessments in the course of an annual Medicare wellness visit.

An incoming nursing home resident is specifically evaluated for falls, including any history of falls prior to admission and the presence of and total number of falls since admission or prior assessment. This assessment is completed within 14 days of admission and at least every 90 days thereafter (more frequently in cases of a significant change, hospitalization, Part A stay, etc.). For a Medicare A patient, this assessment is completed more frequently.

Other things related to falls risk or prevention that are assessed when a person enters a nursing home include:

- Vision;

- Cognitive patterns including daily decision-making and signs of delirium;
- Behavior including psychosis and wandering;
- Functional status including assistance with activities of daily living, balance, range of motion and the use of mobility devices;
- Functional abilities and goals including self-care and mobility;
- Active diagnoses;
- Medications;
- Special treatments, procedures and programs including therapies and restorative nursing programs.

A similarly thorough assessment during an annual wellness exam could help to identify a Medicare beneficiary's risk of falling and any interventions that might be appropriate. We reiterate our comments above on the need to address the limitations on home health care that make it more difficult to implement interventions.

Consider expanding the Medicare program to include vision care. One policy change in the Medicare program that should be considered is covering vision care. Poor vision puts older people at great risk of falling, and yet vision care and eyeglasses are not covered by Medicare. Many older people have difficulty paying for these services out-of-pocket and so do without them. Legislation to cover vision care under Medicare is introduced in every Congress yet never comes to a vote. Considering the tens of billions of dollars that Medicare spends on care and treatment for beneficiaries who fall, including vision care in Medicare coverage should be evaluated to determine whether it also makes sound economic sense, along with preventing the physical suffering that results from a serious fall.

Consider expanding traditional Medicare to include the additional special supplemental benefits (SSBCI) for chronically ill enrollees currently available for Medicare Advantage enrollees. The Centers for Medicare and Medicaid Services (CMS) has begun implementing some important Medicare Advantage (MA) policy changes that create an opportunity to prevent falls for older persons enrolled in these plans. As of 2019, CMS expanded the types of supplemental benefits that MA plans can offer their enrollees to include home and bath safety devices and/or modifications, and some limited-duration in-home support services. Beginning in 2020, MA plans also will be able to offer some additional special supplemental benefits for chronically ill (SSBCI) enrollees. These SSBCI services may include capital or structural home modifications to accommodate wheelchairs or walkers and home-delivered full and produce that meet the nutritional needs of beneficiaries on special diets. Provision of such benefits may well prove to be cost-effective in heading off falls resulting from physical weakness or a person's inability to use an assistive device in her own home. For this reason and others, these services should be available under traditional Medicare as well as those belonging to MA plans.

Polypharmacy

This is an area where we should be looking at the importance of continuing to improve the work Congress has done to finance and implement the use of electronic health records and investing in a much more robust and interoperable electronic health information exchange – addressing the

reality that most Medicare beneficiaries are not in managed care plans and may obtain prescriptions from multiple providers. They do not necessarily use the same pharmacy and most likely do not have a personal pharmacist to review prescriptions and provide advice.

LeadingAge CAST has developed hands-on resources that help aging services providers understand, plan for, select, implement and adopt Medication Management Technologies (https://leadingage.org/medication-management-selection-tool) that can help address issues related to polypharmacy. Lastly, the Report to Congress: Aging Services Technology Study chapter on Medication Management (https://aspe.hhs.gov/basic-report/report-congress-aging-services-technology-study) also provides information on available technologies related to polypharmacy.

As mentioned above, many affordable senior housing residents are taking multiple medications, creating the potential for unintended complications that can result in falls. Opportunities could be explored for creating and incentivizing collaborations with senior housing communities that could bring medication review, reconciliation and education programs to the housing properties. For example, pharmacy students can do medication brown bags at senior housing properties, enhancing their education experience and bringing a vital resource to the housing property. Pharmacies could also host similar sessions.

HUD is currently testing an enhanced services model in senior housing properties that pairs a wellness nurse with the service coordinator. One key area of this wellness nurse's role is to review resident medications to help identify potential complications and help ensure the resident is taking their medications appropriately. Importantly, wellness nurses can review medications in each resident's apartment to ensure they are seeing all the resident's prescriptions and get a sense of how the resident manages their medications. The wellness nurse can educate the resident on their medications and when challenges are identified, help the resident address them with their physician or pharmacy. The Committee should be aware of the key features of and findings from this current demonstration and, depending on the results, explore ways it can be replicated in other housing communities.

Transitions of Care

Regulations pertaining to nursing homes could be helpful as a guideline for transitions between various settings.

Federal regulations require that when a nursing home resident is transferred or discharged, a discharge planning process must be followed with the resident as an active partner. Upon discharge, a discharge summary must be completed and transferred to the resident and any receiving health or long-term services and supports provider. Specifically related to falls, the discharge summary must provide a summary of the resident's stay including treatments, a reconciled medication list, and a post-discharge plan that will assist the resident to adjust to his or her new living environment, with information on follow up care and services. For persons with a high risk of falling, adding a Medicare benefit to help "falls-proof" a home might be a worthwhile cost to reduce other costs.

Conclusion

LeadingAge, ElevatingHOME and VNAA appreciate the opportunity to present these ideas to the Committee and would be interested in assisting the Committee as it develops its proposals.

Sincerely,

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