June 26, 2019

Senator Susan Collins
Senator Robert Casey
United States Senate
Special Committee on Aging
Washington, DC 20510

Dear Senators Collins and Casey:

On behalf of the North Carolina Falls Prevention Coalition (NC FPC), I am pleased to submit the following recommendations in response to the Senate Special Committee on Aging's request for input related to older adult falls and falls prevention. We were thrilled to see the Senate Special Committee on Aging focus time and attention to and raising the visibility of this critical public health problem. The NC FPC has been in existence since 2008 and currently has 172 active members from more than 80 different organizations and agencies. Additionally, we have 7 local and regional falls coalitions in our state. The NC FPC supported the creation of Healthy Aging NC at the NC Center for Health and Wellness (NCCHW) to be a statewide resource center and hub for evidence-based falls prevention and chronic disease management programs.

The National Council on Aging has provided the committee with national statistics on the burden of falls in older adults. The burden in NC is equally great as we have the 9th highest older adult population in the country. This population is also growing and effective this year NC will have more people over age 60 than under age 18. According to the NC's Injury Epidemiologist at the NC Division of Public Health (DPH), falls are the leading cause of fatal and nonfatal injuries among North Carolinians 65 and older, leading to 1,094 deaths, 18,771 hospitalizations, and 78,799 emergency department visits in 2017. That means that almost three older adults die daily from a fall in NC. Falls are also the most common cause of traumatic brain injury (TBI) among NC citizens 65 years of age and older, with falls accounting for 60% of fatal TBI among older adults. The healthcare costs of falls are also high. The NC Center for Health Statistics identified the total charges (billed) of unintentional falls hospitalizations in NC in 2016 to be $735.9 million, with an average charge of $42,927.

In addition to the direct costs, falls can lead to depression, social isolation, loss of mobility, and loss of functional independence. Chronic conditions, medications, vision and hearing loss along with lack of environmental and home safety all increase fall risk. Given the complexity of this issue, a multi-stakeholder approach is imperative. We support all of the recommendations from the National Council on Aging. The following recommendations stem from input from the robust network of partners in our state who have long been working on reducing falls injuries and deaths in our state.

We would be more than willing to answer any questions you may have as the Committee staff develops the falls prevention report. Thank you for your time and commitment to this issue.

Sincerely,

Ellen Bailey

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REPORTING AND FOLLOW-UP

To what extent are falls unreported among older Americans? What strategies can be employed to encourage patients to promptly notify their health care provider or caregivers of a fall?

We support the NCOA strategy to improve reporting that normalizes language around falls to reduce stigma and fear associated with self-reporting. Evidence-based falls prevention programs (EBFPP) can encourage patients to notify their health care providers or caregivers of a fall. As reported by the NCCHW through the NCOA national database 98% of the over 9,000 participants in EBFPP in NC between 9/1/2014 and 5/31/2019 felt more comfortable talking to their health care provider as a result of participating in the program and 97% were more comfortable talking to their family and friends about falling. These programs widely offered in NC, which include A Matter of Balance and Tai Chi for Arthritis and Fall Prevention can reduce the stigma and fear of talking about falling.

The Medicare Annual Wellness Visit is an excellent opportunity for falls screening and improving follow-up and needs to be prioritized among providers. Additionally, we also advocate for developing other methods for reporting falls and falls risk through professionals who are in the home and know about falls. For example, there are opportunities for EMS/Fire Depts to report falls injuries in the home, but there is no easy referral pathway for these reports to connect with surveillance systems. Facilitating a way to report and sharing these reports can improve our understanding of the exact injury causes and improve prevention efforts and follow-up by the primary care provider.

Like many other states, NC participates in Falls Prevention Awareness Week annually on the first day of fall. With a governor's proclamation and through state, regional, and local coalitions, communities across the state offer health fairs, wellness expos, and falls prevention events that educate the public on the burden of falls and often provide screening events to assess falls risk. The NCCHW staff collect information about state activities from agencies across the state for a NCOA report. The statewide falls prevention staff member who currently serves as the executive director of the NC FPC is currently supported at 80% by an Administration for Community Living (ACL) falls prevention grant through Prevention and Public Health (PPHF) funding and at 20% by a subcontract with the NC Division of Public Health (DPH) through their CORE Injury funding from the Centers for Disease Control (CDC). NC DPH uniquely uses the discretionary Injury funds to support falls prevention efforts. A dedicated FTE working on falls prevention in NC has allowed the state to improve efficiencies through collaboration.

How can follow-up with appropriate healthcare providers be improved after a visit to an emergency department (ED) for a fall?

Transitional care is a priority area of our state coalition's current action planning process and is also a focus of the 2017 ACL PPHF grant received by the NCCHW. Based on our conversations and referral pathway with an Accountable Care Organization (ACO) and Trauma Departments, we recommend the following:

- Increase awareness among clinical providers of the resources in their community, including programs that improve balance and restore strength to prevent future falls and assist in establishing independence at home. This awareness has taken a great deal of outreach and regular communication with ACO staff to remind them of the community resources that exist. Among our level 1 trauma departments, who are required to have staff working on prevention, some of the newer prevention staff hired at health systems like Duke and UNC Healthcare are working to bridge silos amongst the hospitals and the community. However, there are significant challenges to this work given the internal silos that remain with hospitals and health care systems themselves. Staffing resources, competing priorities and a lack of designated process owners to drive the work act as barriers to creating these community hospital links.
- Implement the CDC Injury Center's Stopping Elderly Accidents, Deaths, and Injuries (STEADI) initiative, which includes screening older adults to identify their fall risk, assessing at-risk individuals to

identify their modifiable fall risk factors, and intervening by using effective strategies to reduce fall risk factors. The STEADI algorithm can help providers identify the fall risk, screening and appropriate intervention. In NC, the CDC CORE Injury funding ($25,000 from the discretionary line in this FY), partially funds the NCCHW falls prevention staff member's salary. The staff member's time is used to educate partners on the use of STEADI so that partners can educate their networks on the use of STEADI. Funding to market the information and distribute the resources is also lacking.

- Implement reimbursement (like chronic care case management) to assist clinicians in providing a soft handoff to community-based programs (i.e. –helping to enroll a patient at risk for a fall into a community-based class through NC's Healthy Aging NC directory and following up with motivational interviewing to help them go.) Some clinicians currently indicate to us that they are unable to take the extra step to enroll patients in the community classes, or assist in connecting to the community resource because it is either not a part of their workflow and/or they have limited staff time to dedicate to this follow-up
- Create reimbursement strategies that allow for a variety of professionals to support a patient's needs post-acute care. To maximize cost-effectiveness, focus should be on supporting delivery systems that currently exist and use direct service professionals who are in people's homes, such as physical therapists and certified nursing assistants. Consideration should also be given to community health workers and community paramedicine programs offered through local EMS.
- Increased funding for research to develop a broader continuum of care post-acute fall. There are effective community-based programs offered by peer educators/lay leaders that can improve balance, strength and mobility, but there are fewer evidence-based programs to develop mobility so that older adults can get to community-based programs.
- Improving ED/Hospital Discharge procedures to educate patients and families about falls risk and evidence-based interventions to reduce re-occurrence of falls and reduce falls risk factors, to screen for home safety and/or improve communication with PCPs for follow-up and referral to evidence-based community fall programs. We strongly support the NCOA recommendation of developing a transitional fall-prevention model that builds on the principles of existing care transition interventions to include using the Geriatric ED Guidelines.
- Through our work in developing a referral pathway with health care systems and practices, we have encountered barriers in discharge planning. It is difficult to change the educational materials and/or resources provided to patients in the hospital. Many hospitals have standard templates with discharge instructions and requesting an addition or change to the discharge often takes up to a year. The value of local and regional coalitions is the ability to develop useful resource guides that summarize the community resources and are most familiar with local and regional resources; however, there is a disconnect between the availability of these guides and the use among discharge planners.

TOOLS AND RESOURCES:

What learning tools, resources or techniques can be used to empower patients to change their home environment or modify risk factors to reduce the risk of falls?

- The A Matter of Balance evidence-based program is an 8-session structured group class, often delivered in community settings, that emphasizes practical strategies to reduce fear of falling and increase activity levels. Participants learn to view falls and fear of falling as controllable, set realistic goals to increase activity, change their environment to reduce fall risk factors, including a home safety assessment, and exercise to increase strength and balance. Peer to peer learning and support is also a component of this program. This program is widely offered among aging network providers in NC (through Older Americans Act (OAA) Title IIID funding and with administrative support by the Healthy Aging NC initiative at NCCHW which is funded by 2017 PPHF). There has been a recent engagement of Injury Prevention Coordinators at level 1 Trauma centers and EMS in certain counties to be trained in these programs as a strategy to prevent hospitalizations from falls. Working with the American College of Surgeons, the certifying entity of level 1 Trauma centers, to place a larger emphasis on evidence-based

programs as a requirement for injury prevention professionals' work may lead to a larger adoption of this strategy nationwide.

- Regional falls prevention coalitions in NC develop user-friendly community resource guides that support fall prevention such as free/low-cost home modification organizations, prescription medication review services, PTs and clinicians trained in balance/falls, vision and hearing services, and EBFPPs.
- Improve funding for states and/or local falls coalitions to help the infrastructure of the meetings (co-chairs, food, admin support) so that coalitions can maintain resource directories.
- **Strengthen and fund referral pathways** to community-based services, programs and community **partnerships**, such as fire departments/Emergency Medical Services (EMS). EMS provide transport and have a unique role by providing in-home assistance. Unique partnerships with EMS and Fire Departments offer an opportunity for home assessments, but require additional funding to work.
- A major barrier to these efforts has been lack of adequate funding in general and disparate funding sources across the country, as shown in this resource on Funding for Home Modifications. For example, local Area Agencies on Aging may offer home modifications as part of the services under Title III and the Family Caregiver Support Program of the Older Americans Act. Each state and local jurisdiction may offer a slightly different array of services and qualifying criteria for participants that may vary significantly from one service area to another.

What are the opportunities and limitations surrounding assistive technologies?

The NC Division of Services for the Deaf and Hard of Hearing has helped our coalition to understand that hearing loss greatly increases the risk of falls. A person with mild hearing loss has **triple** the risk of falling and, with each ten decibels of added hearing loss, the risk increases 1.4-fold. A leading researcher at Johns Hopkins has found that as we walk, we pick up environmental cues that help maintain balance. Hearing loss removes those cues: "It also makes your brain work harder just to process sound. This subconscious multitasking may interfere with some of the mental processing needed to walk safely." (Johns Hopkins Medicine, 2019) Over 1.2 million people in North Carolina have at least mild hearing loss. Yet, despite these staggering numbers, both Medicare and NC Medicaid do not cover the cost of hearing aids or the cost of personal amplifiers.

- Provide coverage for hearing aids and/or personal amplifiers by Medicare and Medicaid would expose those with all ranges of hearing loss to meaningful environmental sounds which could then improve a person's ability to better navigate his/her environment. There are 24 states across the US where Medicaid covers either one or two hearing aids; NC does not. Without Medicare and Medicaid covering the costs of these devices, people with hearing loss are placed at greater risk of falling.
- Require all health care practitioners to perform or refer out for a hearing loss screening during each annual physical exam. "Statistics tell us that it takes the average person seven years from the time they think they have a hearing loss until the time they seek treatment." (HLAA 2019.) If practitioners help identify a person's hearing loss, there is a greater chance that more falls will be prevented.
- Support visual alerting devices that alert people with hearing loss to environmental noises around the house will help prevent falls. For example, if a person with hearing loss and thinks but is not sure if someone is ringing their doorbell, they most likely will get up and check the door several times, especially if they are expecting someone. If there is a strobe set up to alert the person to the ringing doorbell, they will know when someone is at the door thus reducing the amount of walking to the door and possibly reducing chance of falling.

Are there any federal policy barriers that make it difficult to offer tools and resources to patients to prevent falls?

The NC FPC agrees with the recommendations put forth by NCOA related to the incentives to address falls in Medicare payments including the Medicare Star Ratings, Merit Based Incentive Payments (MIPS), creation of billing codes for falls prevention, and adding second falls as a Hospital Readmissions Reductions Program measure. In NC, first responders have shared the burden of their offices in repeatedly going to people's homes to

pick people up off the floor. Many of these home visits do not result in a transport to the hospital, but the engagement and opportunities for education and home assessments are valuable services first responders offer in reducing healthcare costs. Similarly, there are many community-based services delivered by aging network professionals that bring volunteers and/or direct care professionals into people's homes. These services sometimes provide older adults with the only interaction/socialization of the day. An example is the home-delivered meals programs. There have been research and/or innovation grants testing the effectiveness of having volunteers and/or in-home aids assess falls risks in the home and engage with people about their risk for falls.

A significant barrier noted by professionals in NC is that research funding does not translate to implementation funding. Many demonstration projects are shown to be beneficial, but the reimbursement pathways to fund community-based organizations to do the work are difficult. Healthcare organizations often bring the community-based services in house because of the inability to pay CBOs. Electronic systems are being developed in every corner of the state to facilitate MIPS and MACRA payments to CBOs, but most CBOs are not equipped with the technological needs that healthcare organizations to prove the value of the service. Electronic systems are costly and customizing them to meet each healthcare organization's needs can add additional significant costs.

There is also a need for Medicare to fund hearing aids and personal amplifiers. There are two population gaps in hearing aid coverage which are 1. The population of every state (including NC) that is not covering hearing aids under Medicaid and 2. the entire population covered by Medicare. It is often assumed that Medicaid is taking care of the covering the gaps where Medicare fails to offer coverage and that is simply not the case in most states.

References from the NC Division of Services for the Deaf and Hard of Hearing:

- Hearing Loss Association of America. (Retrieved June, 2019). Do you think you have Hearing Loss: Symptoms. Retrieved from https://www.hearingloss.org/hearing-help/hearing-loss-basics/symptoms-diagnosing/
- Johns Hopkins Medicine. (Retrieved June, 2019).The Hidden Risks of Hearing Loss. Retrieved from (https://www.hopkinsmedicine.org/health/wellness-and-prevention/the-hidden-risks-of-hearing-loss)
- Lin FR, Ferrucci L, Hearing Loss and Falls Among Older Adults in the United States. 2012 February; 27;172(4):369-371. doi:10.1001/archinternmed.2011.728

EVIDENCE-BASED PRACTICES:

Are there evidence-based practices that reduce the rate of additional bone fractures among those older Americans who have fallen and broken or fractured bones? Are there regional differences in the utilization of these services, evaluations, or screenings?

Evidence-based falls prevention programs (EBFPPs) offer proven ways to decrease falls, fall-related injuries, and fall-related risks among older adults. By helping to prevent falls, EBFPPs can help increase older adults' health status, confidence, independence, and quality of life. NC's aging network has been offering EBFPPs for over 10 years through OAA Title IIID funds. In many cases, these programs are offered through the state's 16 Area Agencies on Aging, though we have seen more interest and involvement among healthcare organizations, YMCAs, faith organizations, etc. to deliver these programs as healthcare has moved from volume to value.

Healthy Aging NC, the state's resource center and hub for EBFPPs located at NCCHW, provides technical assistance, fidelity support and data management for:

- A Matter of Balance an 8-session structured group class that emphasizes practical strategies to reduce fear of falling and increase activity levels. Participants learn to view falls and fear of falling as controllable, set realistic goals to increase activity, change their environment to reduce fall risk factors, and exercise to increase strength and balance.
- Tai Chi for Arthritis and Fall Prevention that helps to improve muscular strength, flexibility, balance, stamina, and more.

HealthyAging NC also provides resources and linkages to the YMCA Moving for Better Balance and Otago Exercise programs.

What are the benefits of Evidence-Based Falls Prevention Programs?
Please refer to this section of the NCOA letter for extensive research and details on the benefits of EBFPP.

NC has received two federal PPHF grants from ACL since 2014 to implement and improve access to EBFPPs in local communities.

Since 2014, 9,187 North Carolinians have participated in A Matter of Balance and Tai Chi for Arthritis and Fall Prevention through April 2019. Among the 63% who have completed these EBFPP:

- 25% indicated that they had improved the self-rating of their health in general
- 88% had not experienced a fall since starting the program
- 97% had not experienced a fall with injury since starting the program
- 90% had reduced their fear of falling
- 98% felt more comfortable increasing activity
- 99% planned to continue exercising
- 46% made changes to the home to reduce the risk of falling
- 20% had their medications reviewed

In 2017, there were 1,094 deaths, 18,771 hospitalizations, and 78,799 emergency department visits related to falls in NC. These are the reported falls. This indicates that we need to increase the reach of these programs at least 10-fold. Bridging the gap between community organizations, health care systems, and federal agencies will increase access to these community programs and increase awareness among clinical providers. As a statewide resource center and hub, Healthy Aging NC has a locator service where anyone can find out where classes are located and how to register. Improving clinical-community communication and incentivizing referrals to these classes is essential. And, ensuring there are funds to support the growth of these programs is also necessary. Title IIID of the OAA allows the funds to be used for a variety of evidence-based health programs. Most local providers chose to use these funds for falls prevention classes, but they must spread the funds to meet the high health and social needs of the population they serve. Thus far, 74 of our 100 counties have offered EBFPP and continued outreach to rural, underserved areas is essential.

Increased and sustained opportunities for states to access the funding for EBFPPs, research funding and/or medical reimbursements can support the testing of innovative models to link clinicians to the programs and support pathways for reimbursement and electronic pathways. Community based organizations are not generally equipped with the same funding and reimbursement to support their IT and billing for services.

POLYPHARMACY
The NC FPC agrees with the NCOA recommendations in this area to improve access to medication reviews and implementation of medication reconciliation, increase utilization of the Medicare Annual Wellness Visit, increase awareness of falls risks related to medication use, and increased funding to research how specific medications affect balance, mobility, and falls. Additionally, NC aging network partners have attempted to offer medication reconciliation through in-home aid services with mixed success. Older adults are often prescribed medications from multiple clinicians. Those who are actually in the home with older adults (caregivers, direct care workers, etc.) often see and know what medications older adults actually take and when. The evidence-based program "Home Meds" has been delivered by two Area Agencies on Aging in NC. This program equips in-home care workers with an electronic system to share a list of prescription and non-prescription medications an older adult might be taking. The electronic system is connected to a pharmacist who reviews the medications and alerts the Area Agency on Aging if there are concerns about interactions. The software is expensive for AAAs to pay for, but has been very helpful in supporting older adults who live in remote areas.

TRANSITIONS OF CARE

How can the transitional period from a hospital or skilled nursing facility to the home be improved in assessing the home for falls risk?

This is one of the most important processes in this request for input and we support the NCOA's recommendation, especially in creating processes and systems to improve communication between healthcare providers, using Health Information Technology to address interoperability between EHR systems, incorporating the CDC's STEADI Initiative, implementing a Falls Plan of Care, and educating caregivers of those patients with special needs. Creating a falls prevention pathway that would operate in all and between all EHR would be more efficient in connecting patients directly to community-based services and providers, thereby improving care during the transitional period.

What more could be done by government agencies to support fall risk assessments and the implementation of protocols that could be used to prevent falls in the home care population?

Post-Fracture Care: What can be done to create a care pathway for patients post-fracture to ensure proper follow up care and prevention of future fractures? Are there best practice models that can provide implementation opportunities? Are there any federal policy barriers to implementing best practices in post-fracture care?

- Reimburse providers to offer follow-up care that includes referrals to EBFPP.
- Utilize at-home support services, such as home health, community health workers, or Community Paramedicine to provide follow-up support that is eligible for reimbursement.