June 26, 2019

The Honorable Susan M. Collins
Chairwoman
Senate Special Committee on Aging
United States Senate
Washington, DC 20510-6400

The Honorable Robert P. Casey, Jr.
Ranking Member
Senate Special Committee on Aging
United States Senate
Washington, DC 20510-6400

Re: Annual Report—Prevention and Management of Falls and Fall-Related Injuries

Dear Senator Collins and Senator Casey:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 80,000 physical therapists, occupational therapists and speech language pathologists through our member organizations who provide rehabilitation services throughout the United States. NARA's members provide therapy in all settings across the care continuum including outpatient clinics, skill nursing facilities, assisted living facilities, hospital outpatient facilities, hospital inpatient settings, in patient's homes, and in retirement and assisted living communities. As a member-driven organization, NARA promotes accessible and high quality physical therapy, occupational therapy, and speech-language pathology services through education, support, and advocacy. NARA's membership demographics give it a unique insight into the full breath of the continuum of care for patients and, given the nature of the services its members furnish, NARA has special insight into the needs and risks of the senior population.

NARA appreciates this opportunity to provide input on the Special Committee on Aging's questions related to advancing the goal of reducing the risk of falls and fall-related injuries and NARA heartily applauds the Committee's decision to make that topic the focus of its Annual Report.

Of all the recommendations provided in this document, NARA believes that the primary focus areas that will have the greatest impact in reducing falls would be:

- *<u>Pre-Fall Assessment</u>*: Rather than only assessing the beneficiary's risk after a fall has occurred, NARA recommends including an assessment for every beneficiary during their

annual wellness examination through their primary medical practitioner. The Merit-based Incentive Payment System (MIPS) program provides for a method of assessing patients aged 65 years and older who have a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year) which can be easily utilized for this purpose. NARA believes that beneficiaries would experience greater benefits from a pre-fall assessment to reduce the risk of an initial fall.

- *Early Intervention*: Once a pre-fall assessment has been established for a beneficiary, this information should follow them regardless of the provider or living setting. NARA recommends use of the Otago Exercise Program for Fall Prevention developed in New Zealand and researched by the University of North Carolina Chapel Hill[1]. This evidence-based program is also promoted by the Centers for Disease Control (CDC), the Patient Centered Outcomes Research Project, and the Administration for Community Living in 16 states. Experience demonstrates that the risk of falls will be reduced through early intervention and follow up with a primary care provider and/or case manager. This would allow them to become aware of, and respond to, changes that occur in a patient's living situation and/or health condition. A recent study by the CDC shows that beneficiaries receiving just one fall intervention such as medication management or a home assessment can avert medical costs associated with falls.[2];
- *Intervention Following the Beneficiary*: NARA is of the view that it is vital that all providers be aware of assessments, medical diagnoses, medical history, and/or current medications in order to fully treat a beneficiary and ensure the safest environment. When a beneficiary moves from one living setting to another – oftentimes the fall risk assessment or history of interventions does not follow them, fracturing and compromising care and fall risk management with new practitioners in new living settings.

Reporting and Follow-Up

Individuals may be hesitant to report that they have fallen, even if they present to a provider with unexplained bruising because they fear such consequences as being told they can no longer live independently in their home. They also may not be able to afford the costs (e.g. deductible/co-payments) for recommended follow-up care and intervention. NARA recommends earlier identification of persons who are at a greater risk for falls due to their environment, co-morbidities, or medications. Providers need to be more proactive with addressing the potential risk rather than being reactive. One step in the Medicare program that should be taken, and which NARA endorses, is to modify the current MIPS Measure #154: Falls: Risk Assessment to include a beneficiary with co-morbidities, medications or general weakness that increase the risk of falls, or a history of 2 or more falls in 12 months or fall with injury. The data collected in this measure should be analyzed to identify potential health risks common

[1] https://www.med.unc.edu/aging/cgec/exercise-program/ accessed June 24, 2019
[2] https://www.sciencedirect.com/science/article/pii/S0749379718317598?via%3Dihub accessed on June 24, 2019

with the beneficiaries such as co-morbidities, medications or environment. NARA recommends copay waivers for physical and occupational therapy service post fall to increase access to needed intervention.

Under the MIPS program a physician can report they have referred the beneficiary to have home assessment for falls risk but this is often difficult for the patient to access if they are not homebound due to a gap in regulations and reimbursement. The potential risk for falls may be significantly reduced if there was increased access for a skilled assessor such as a physical or occupational therapist to visit the beneficiary's home in order to make modifications in the home environment prior to discharge from a hospital or post-acute care setting. NARA recommends that a new CPT code or a carved-out benefit for a pre-discharge home assessment be created so the beneficiary can take advantage of this type of falls prevention. NARA also recommends this benefit be available to community dwelling seniors that need in home assessment but do not meet homebound criteria.

NARA believes beneficiaries seen in the emergency department or urgent care who the provider believes may have sustained an injury due to a fall should have a standard protocol for treatment and discharge with a referral to a falls specialist and home assessment by a skilled professional such as a physical or occupational therapist.

Tools and Resources

Patients who have been identified as having a great potential risk of falls should be provided with community-based programs that help prevent falls, should have an environmental home assessment, and providers in all settings have access to their medical treatment history. NARA recommends easing the regulatory burden and creating reimbursement models for providers who provide in home- or home-based services that would assess a patient's home environment and providing teaching and training with the patient and his/her caregivers regarding falls prevention in the home setting.

There are several programs currently being promoted by CDC such as the Stay Independent checklist, The Otago Exercise Program, and Stopping Elderly Accidents, Injuries, and Deaths (STEADI)[3]. The Centers for Medicare and Medicaid (CMS) previously defined environmental regulations regarding barriers that can cause falls and corrections that can be made such as lighting that are now part of survey standards. NARA recommends CMS continue to revisit this type of regulatory criteria in areas such as call light access and reliance on the use of wheelchairs (versus assisted ambulation) which creates institutional dependence and resultant decline in overall physical condition father contributing to fall risks.

[3] https://www.cdc.gov/features/falls-older-adults/index.html accessed on June 24, 2019

Although CMS has concentrated efforts on quality measures there is still a lack of focused resources and competency assessment for decreasing falls while simultaneously reducing antipsychotics. Behavior management is a pressing issue that requires attention now that antipsychotics have been required to be reduced nationwide. There is a need for greater competencies in person-centered approaches to reducing the challenging behaviors that contribute to many falls that are seen in post-acute care settings.

NARA encourages CMS to create or recommend person-centered care training materials for providers. This planning model builds upon the individual's strengths and ability to engage in community activities based on the beneficiary's interests and abilities. While the process includes input from family members, friends, and providers, the focus remains on the individual.[4] CMS could use federal funding such as state-level civil monetary penalties to develop patient centered fall prevention programs. NARA also recommends the creation of a workgroup with therapy professional (APTA, AOTA, ASHA) and trade associations (AANAC, NARA, NASL, ACHA) to develop guidelines for practitioners and caregivers that can be promoted by all.

Medicare

Medicare has already established a required annual wellness visit; however, the falls assessment is only required during the beneficiary's initial visit. NARA recommends Medicare make a falls assessment required at every annual wellness visit. Physicians can utilize the MIPS Measure #154: Falls: Risk Assessment; however, this is typically used post-fall. NARA recommends retiring this Measure in favor of Measure #318 (NQF # 0101): Falls: Screening, Risk-Assessment and Plan of Care to Prevent Future Falls but making this available for all types of collection reporting including Medicare Part B Claims and MIPS CQM.

NARA also recommends a protocol the physician or nurse can use to assess the patient's increase in fall risk based on cognition impairment, visual and auditory deficits, lower body strength, home environment, continence, weight loss, antipsychotic reduction or medication management which could automatically trigger a referral for a home falls and balance assessment for risk at no cost to the patient. Additional programs for CMS to consider:

- Make falls assessment part of prevention and reward the patient for doing it annually;
- Standardize a falls risk assessment and promote one or two evidence-based tests;
- Develop a cognitive assessment that correlates cognitive disability with fall risk potential;
- Develop best practices for post falls treatment and assessment;
- Pilot innovation programs on decrease in falls when a pre-assessment of falls risk is completed;

[4] https://rtc.umn.edu/docs/pcpmanual1.pdf accessed June 24, 2019

- Ease regulatory burden and create reimbursement models for providers who provide in home- or home-based services;
- Change the MIPS Measure #154 to include co-morbidities and medications that have been linked to increased falls;
- Create a partnership between nutritionist/dietitian to strengthen beneficiaries who demonstrate nutritional-related fall risk issues.

There are many opportunities to improve how patients at risk for falls are identified, tracked, and handed off between points of care. It is important for Medicare and providers to coordinate the availability and distribution of risk information to patients, family members and within the community so they will be readily available.

Evidence-Based Practices

The CDC recommends the use of the Otago program and the STEADI program. The STEADI program offers assessments, fact sheets, case studies and additional clinical tools a physician can use to identify a patient's level of risk with correlating interventions. Additional areas to consider related to evidence-based practices are:

- Is there a need for physician education on a fall risk assessment that is evidence-based?
- Best Practices for Post Falls assessment and treatment;
- Promotion of evidence-based resources that can be utilized in home-care and with and maps into the OASIS https://www.homecaremissouri.org/projects/falls/index.php;
- Behavior management resources when reduction in antipsychotics have occurred in skilled nursing settings and challenging behaviors contribute to fall risks becomes a prevalent;
- Partnerships with nutrition/dietitians.

NARA believes the information collected from the MIPS Fall measure could be analyzed to identify interventions and best practices for use in an evidence-based practice of coordinating care for patients who are at risk for falls.

Polypharmacy

NARA supports additional research on the link between polypharmacy and falls-related injuries and/or deaths. A lack of safe medication management or synchronization between different prescribing practitioners can impair a beneficiary's cognition, control, mental health and strength. NARA also recommends:

- Increased awareness of side effects of medications related to falls/ interdisciplinary approach to medication management;

- Continued decrease in Opioid use and recommendation of alternatives;
- Awareness of alcohol and medication interactions.

The CDC's widely promoted STEADI program also includes training for pharmacists that was jointly developed by the CDC and American Pharmacists Association (APhA). A pharmacist's knowledge of how a patient's medications will interact with each other is vital to identifying whether it could create an increased risk of falls.

Transitions of Care

Currently hospitals are not required to provide patient diagnosis, medical history, and other pertinent patient information to post-acute care providers (PAC) which makes it difficult for PAC providers to include that information in the medical record. NARA encourages CMS to finalize the hospital discharge requirements and include in the requirement for them to transfer all patient medical information to subsequent providers as other post-acute providers are required to do. Additional recommendations NARA makes related to transition of care include:

- Consistent assessment across the continuum and practice settings;
- Add Fall Quality measures for Home Health;
- Assessment and Communication of the interaction between cognitive impairment and falls;
- Senior centers grant for development of fall prevention programs;
- Consistent access to a skilled assessor in the home (PT/OT) to recommend home modifications to reduce fall risk.

There is significant opportunity in developing a seamless transition of care related to aging patients and preventing initial and subsequent falls. Providers treating a patient who has previously been identified as at risk, can prepare an appropriate plan of treatment for the patient including education for family members and prevention programs.

Post-Fracture Care

Recently, UCB, Inc. announced collaboration with OpenIDEO, an open innovation platform, to launch Healthy Bones, Healthy Aging Challenge.[5] While the focus of this program is primarily on patients who have been diagnosed with osteoporosis, the resulting innovations they seek can be applied to all older adults. NARA believes there are other methods and opportunities available in order to address post-fracture care, such as:

[5] https://www.ucb-usa.com/stories-media/UCB-U-S-News/detail/article/New-Open-Innovation-Challenge-to-Rethink-Post-Fracture-Care

- Complete root cause analysis of the fall causing the fracture: What medications was the patient on? What was the patient doing?
- Integrated treatment plan that includes pharmacological products, strengthening exercises, and diet for a holistic approach for fracture healing and fall prevention;
- Patient education and engagement through technology, social interaction and more patient-centered activities;
- Medication management and opioid use/reduction;
- Adding quality measures related to falls in home health related to post-fracture risks;
- AM-PAC – Known as a "6 click" system to determine the needed level of care upon discharge based on mobility in post-acute settings to reduce post fracture hospitalization and care costs – recommend this be used before discharge in post-acute settings (assess patient each day until discharge – will determine when they go and where);
- Ease regulatory burden and create reimbursement models for providers who provide in home- or home-based services.

The ability for health care providers to identify a patient that is at an increased risk for falls due to home setting, medical conditions, current medication, etc. is vital to reducing the need for post-fracture care. However, fractures caused by falls are inevitable in older patients and having integrated treatment plans, education for patients and caregivers, medication management, discharge protocols, and a decreased in regulatory burden with incentives for providers who provide home or homed services will help decrease future falls.

Conclusion

NARA thanks you for this opportunity to share some of our insight and recommendations related to best practices in falls prevention and falls-related services across the various healthcare settings. Should you have any questions concerning these comments, please contact George G. Olsen, Esq. of Williams & Jensen, PLLC at ggolsen@wms-jen.com.

Respectfully submitted,

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President
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