Testimony of

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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

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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.