

**Improve Public Policy Response and Medicare Coverage
for Fall Prevention and Intervention**
July 2010

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**IMPROVE PUBLIC POLICY RESPONSE
FOR FALL PREVENTION AND INTERVENTION**

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Marriott Courtyard Embassy Row
1600 Rhode Island Avenue, NW
Washington, DC 20036
June 8, 2010

MEETING SUMMARY

On June 8, 2010, the Centers for Disease Control and Prevention (CDC) and the American Occupational Therapy Association (AOTA) convened a meeting of key representatives from Federal agencies, national organizations, and other relevant stakeholders to begin a dialog about current policies that hinder access or promote access to appropriate prevention and treatment services and to identify potential policy changes needed to begin addressing the issue of falls prevention from a policy perspective.

WELCOME AND CHARGE TO PARTICIPANTS

Grant Baldwin, PhD, MPH, Director, Division of Unintentional Injury Prevention (DUIP), National Center for Injury Prevention and Control (NCIPC), CDC

Jessica Shisler Lee, Acting Deputy Associate Director for Policy, Office of Policy, Planning, and Evaluation, NICPC, CDC

Dr. Baldwin welcomed participants thanked Jessica Shisler Lee and AOTA for their work in organizing this meeting and conducting the preparatory work for the day's discussions. Preventing falls in the older adult population is one of the Division's top priorities. This meeting provides the opportunity to examine policies related to fall prevention and identify those with potential for dramatically improving fall rates in both the short and long term. The CDC's new director, Dr. Thomas R. Frieden, strongly supports efforts to identify public policies with potential to improve public health and safety.

Many factors that are essential for development of sound, effective policy should provide the framework for today's discussions:

- Effectiveness: does the recommended policy work in the real world?
- Cost: is the policy realistic in terms of cost compared with benefit?
- Feasibility: is implementation in practice a likely possibility?
- Acceptability: is the policy consistent with community values and political considerations?

- Sustainability: are resources likely to be available for maintenance over time?

Dr. Baldwin concluded with a quotation from Johns Hopkins University's Thomas R. Oliver:

“Science can identify solutions to our most pressing public health problems, but only politics can turn most of those solutions into reality. “

Ms. Lee introduced herself and reviewed the purpose of today's meeting, which is the culmination of a partnership between AOTA and CDC. The goals for the meeting were to examine fall prevention policy, mobilize the assembled community or experts and organizations interested in the topic, prioritize issues, and identify a unified direction for moving forward. Preparatory work for this meeting included a literature review, a scan of existing policies (with emphasis on Medicare policy), and interviews with key informants representing Federal agencies and a number of national provider and nonprofit organizations. The information from this research was assembled to help CDC, AOTA, and meeting participants begin a dialog about fall prevention policies that hinder access to appropriate assessment, treatment, and follow-up in older populations.

INTRODUCTIONS

Elaine Bratic Arkin, Facilitator

After introductions, Ms. Arkin reviewed the day's agenda and the contents of the meeting package to set the stage for an informal, creative discussion about fall prevention policy.

OVERVIEW OF THE PROBLEM

Rita K. Noonan, PhD

Acting Team Leader, DUIP, NCIPC, CDC

Older adults want to live independently and grow old living in their own homes. A fall is often seen as “the beginning of the end”—the first step towards a move to a nursing home. Dr. Noonan reported on the significant statistics concerning falls:

- 30-35 % of older adults fall each year.
- Falls account for 64% or 2.1 million non-fatal injuries in Emergency Departments: that's one every 15 seconds.
- 45%, or almost 17,000 unintentional injury deaths among those ages 65 and older are caused by falls.
- Falls are the leading cause of unintentional injury deaths among people age 65 and older. Every 35 minutes, an older adult dies from a fall injury, which is equivalent to about six plane crashes per month.
- In 2000, it was estimated that the cost of falls among older adults was about \$19 billion. By 2008, this estimate had grown to approximately \$26.3 billion.

Although it is very difficult to change both public and provider behavior, CDC recognizes that some policies have been effective in generating long-term change. CDC's approach is to examine and focus on those factors with the greatest potential for effecting change:

- Modifiable risk factors: those behaviors we can actually do something about;
- Biological factors: factors that can be improved, such as muscle weakness, gait and balance problems, poor vision;

- Behavioral factors: behavior that puts some people at risk; for example, some people are at risk because they take four or more medications daily, or because they take psychoactive medications, are inactive, or engage in risky behaviors such as climbing a ladder.
- Environmental factors: these include risk in an individual's surrounding environment, such as clutter and tripping hazards, lack of stair railings or grab bars, and poor lighting.

Success in achieving behavior change usually is greater when risk reduction is done in combination with the following reduction actions:

- Exercise to develop balance and lower body strength. Exercise has many positive health benefits, but a key component regarding fall prevention and exercise is that adherence to an exercise program or motivation may decline over time thereby decreasing the effectiveness.
- Individualized physical therapy or group class, as appropriate for each individual.
- Occupational therapy provided along with home modifications (e.g., railings, grab bars, lighting, etc.), which in combination appear to lower risk of falling.
- Review and management of medication by appropriate providers.
- Improving vision to the fullest extent possible and accommodating to vision limits with assistance of a trained professional.

CDC believes that to effectively prevent falls, three key sectors must be engaged and work together: public health; the Aging services network; and health care delivery systems. Public health uses the following approach to advance what is known about falls: identifying or developing interventions, translating and refining the approach for widespread use. In the public health model this information is disseminated through national partnerships and funding opportunities. In order to effectively prevent falls, the three key sectors-- public health, healthcare delivery systems and aging services -- must be engaged and work together.

With its strong knowledge base about what works in fall prevention, CDC has assembled a compendium of information describing 14 effective interventions from around the world. The compendium, "*Preventing Falls: What Works*" is available on the CDC Website at http://www.cdc.gov/ncipc/preventingfalls/CDCCompendium_030508.pdf. Through Core II funding, CDC has supported bringing two proven interventions into community settings, Tai Chi and Stepping On. Interaction with the aging network has been critical to this effort. The Administration on Aging (AoA), the National Council on Aging (NCOA), and CDC's Division of Injury Response have been key partners in this process. Through these collaborations, CDC has been able to provide information, resources, and evidence-based programs to state health departments and aging networks in California, New York, Wisconsin, and Oregon.

CDC works closely with the health care delivery sector on prevention efforts. In a 2008 New England Journal of Medicine article, Mary Tinetti, MD, Director of the Yale Center for Clinical Investigation's Program on Aging, described how an effort in Connecticut to disseminate evidence about fall prevention, coupled with interventions to change clinical practice, led to significant population-level declines in both serious fall-related injuries and fall-related use of medical services. This Connecticut model and other research indicate that the most effective single approach for fall prevention is an individualized assessment by a physician or health care provider to identify and address an individual's specific risk factors.

The American Geriatrics Society (AGS) has issued evidence-based guidelines for practitioners, but more needs to be done to promote their use. DUIP is now developing a distillation for screening and treatment in a physician pocket guide to help health care providers follow the AGS guidelines more easily. The Division also is looking at a variety of formats and training modules to stimulate greater assessment, treatment, and referral for fall prevention.

Public health relies on unified efforts of key partnerships, each performing different roles. Some key partners include: the NCOA's Falls Free Initiative™ with 31 state coalitions active in fall prevention; the National Business Group on Health, which is offering injury prevention and cost information to their members (which include most Fortune 100 and 500 companies); CMS, which provides data and reimbursement strategies; and the Fall Prevention Center of Excellence, which offers a patient self-assessment tool.

CDC's goal is to connect all three sectors—public health, health care delivery, and the aging network, to create seamless coordination for clinical assessments, treatment, and referral to community-based programs that are supported through Aging Network services and/or public health agencies. Dr. Noonan also recognized Elizabeth Zurick, the CDC project officer, who was not able to attend the meeting.

OVERVIEW OF AOTA OUTREACH AND ANALYSIS OF POLICIES

Carol Siebert, MS, OTR/L, FAOTA

Interview Results. At CDC's direction, AOTA set out to identify existing policies related to falls and the major policies that affect the prevention of falls or lowering falls risk. During March and April 2010, AOTA conducted interviews with individual experts and organizational representatives with an interest in fall prevention among the elderly. Through these interviews, AOTA sought to elicit input on barriers to the provision of services and to identify specific problems and general issues related to fall prevention.

From the numerous issues identified during these interviews, a number of recommended themes emerged:

1. Use health care reform's focus on prevention as an opportunity to make fall prevention a national priority.
2. Create a dedicated funding stream for fall prevention and ensure CDC funding for evidence-based programs.
3. Create consistent policy language across all funding streams.
4. Consider fall prevention a chronic rather than acute condition to be treated over a lifetime.
5. Create a multi-disciplinary approach to fall prevention with seamless coordination of all health and services providers—clinical and nonclinical—who care for at-risk elderly
6. Link providers across the spectrum with aging services and evidence-based community programs.
7. Reimburse for prevention, maintenance of function, and all medically necessary equipment and home modification related to falls.
8. Optimize role of vision care in falls prevention.
9. Energize communities to take the lead in providing a safe environment.
10. Demonstrate the cost benefit of fall prevention, including the value of shortening acute episodes and preventing nursing home admissions.

11. Create national outreach and education to achieve common understanding and goals for departments of public health, families, residents, providers, and CMS of how dramatically falls affect people.

Policy Analysis. AOTA has conducted an analysis of related policies. To facilitate the analysis, AOTA used the newly released American Geriatric Society/British Geriatric Society guidelines “Prevention of Falls in Older Persons (2010) to study impact on practitioners and patients.

Interventions rated as A or B were used to establish a threshold for effectiveness.

The overarching finding was that public policy and Medicare have a significant influence on provider behavior. Roles of Medicare that affect falls prevention can be divided into three areas:

- Medicare as an educator for both providers and beneficiaries
- Medicare as a regulator of policy.
- Medicare as a payer.

There are a number of strengths in current Medicare policy as it affects fall prevention:

- The “Welcome to Medicare” examination (Initial Preventive Physical Exam/IPPE) currently provides the only instance where Medicare will pay for preventive physical examination and falls risk assessment.
- Falls risk assessment and intervention is promoted in the recent revision of the Minimum Data Set (MDS) Version 3.0. Although not directly related to reimbursement, MDS is mandated for use in skilled nursing facilities (SNF).
- Falls risk assessment and intervention are components of the Outcomes and Assessment Information Set (OASIS) Version C for home health.
- Home Health Compare includes a falls-related patient outcome item; this system can be used by the general public to evaluate how providers compare with one another.
- The Physician Quality Reporting Initiative (PQRI) includes two items on falls risk assessment and intervention and provides reimbursement incentives for physicians who conduct them.
- Palmetto GBA, a Medicare Administrative Contractor, has promoted falls prevention by recognizing the falls risk ICD-9CM code (V15.88) implemented in 2005 in local coverage and has offered guidance to providers to promote falls prevention efforts within the current limitations of Medicare coverage policies.

Despite these strengths, fall prevention efforts are impeded by lack of awareness by both providers and beneficiaries. Moreover, some policies unintentionally impede or complicate fall prevention efforts. Beneficiaries receive little or no information about fall prevention in communications from Medicare. Many providers are unaware of the importance of fall risk assessment and prevention, as well as of Medicare options. Although the ICD-9-CM code for falls risk was implemented in 2005, it is not widely known or used by providers. Other issues that are problematic include the following:

- In home health care, there are limits on monitoring sustainability of falls risk management strategies following discharge.
- Vitamin D is a proven fall prevention intervention that is relatively inexpensive and easy to administer. Although Vitamin D is available over the counter, some patients cannot afford to buy it, and physicians are limited in prescribing it by Medicare Part D. Consideration of Part D policies in this regard could promote higher utilization of Vitamin D when appropriate for both SNF- and community-dwelling adults.

- The term “medical necessity” is based on diagnosis and treatment of an illness, injury, or malformation of a body part. This definition creates an inherent tension between providing assessment or intervention to prevent falls and “medical necessity.”
- Discrepancies and inconsistencies exist in local coverage determination (LCD) policies that affect falls intervention, as well as in recognition and use of the ICD-9-CM code for falls history/falls risk. These policies differ from one state to another.
- Coordination and follow-up with at-risk patients or those who have already fallen present another area of concern. Providers infrequently coordinate or follow up after issuing a prescription or referral to another health care provider; emergency room referrals are made to individuals’ primary providers, but personnel in emergency rooms have limited time for follow-up. Many older individuals do not have a primary care doctor, but have a series of specialists for particular conditions and diseases. In many cases, no one provider coordinates all the medical care received or follows up on referrals to other providers. Coordination and follow-up is especially lacking for the patient who visits the emergency department after a fall, but is not admitted.
- Policy classifying and reimbursing for Durable Medical Equipment (DME) under Medicare presents additional challenges. Classifying DME such as grab bars and bath benches as “presumptively nonmedical” may not be cost beneficial when considered from a falls prevention perspective. Moreover, although Medicare covers some mobility devices, it restricts coverage for training the patient how to properly use and care for the equipment and how often that equipment may be changed, regardless of the patient’s changing status.

In summation, AOTA’s analysis highlighted three main categories of policy issues that are useful as a focal point for the day’s discussion:

1. Medicare coverage, consistency, and education;
2. Coverage for durable medical equipment and safety equipment for the home environment; and
3. Linkages and coordination between health systems/providers and community organizations/entities.

Discussion. Following Ms. Siebert’s presentation, the facilitator invited participants’ questions, clarifications, and comments. Discussion covered the following topics:

- **Provider Education.** There is a major need for provider education and awareness about the correct use of codes. For example, many providers lack knowledge about how and when to use the V code. Because use of the V code does not indicate medical necessity under current Medicare rules, there is confusion about whether or not falls-related services are Medicare-reimbursable.
- **Role of hospitals in fall prevention.** Hospitals are making a major effort to reduce fall risk for patients within their facilities. Some hospitals also may include fall prevention information in their discharge packages, but it is unclear if this information is read or acted upon by patients and their families and caregivers. Once the patient has left the hospital, the hospital’s stake in the patient’s safety is limited at the present time. (Some policy directions on Serious Reportable Events including falls and on addressing re-hospitalization rates may

increase attention by hospitals.) Hospitals do, however, have an interest in lowering readmission rates and may refer discharged patients at risk to home health agencies for follow-up. Safety issues in the transition process from hospital to home or other facility are becoming a major concern. Increasingly, there are emerging efforts to attempt care coordination; hospitals, home health providers, and primary care physicians all will have a big role in these efforts. Pilot and demonstration programs may provide needed information.

- **Physician Quality and Reporting Initiative (PQRI):** PQRI is a CMS initiative that incentivizes qualified medical professionals to voluntarily report on various quality indicators. Fall prevention is a multi-modal issue, whereas quality indicators are disease-focused. Policy makers may not fully understand that under PQRI, physicians are reimbursed for aggressively managing a specific condition or disease such as high blood pressure, and bringing it to a specified level. However, aggressive treatment to reach that level may involve one or a combination of medications that also may increase the risk for falls. Use of the V code for this issue potentially could be helpful.
- **Use of home health care.** Currently home health care is provided under Medicare Part A for homebound patients or for patients living in a community facility. Many nonprofit care organizations vary in size and in the services they can provide to patients. The amount of coverage allowed for physical and occupational therapy under Part B is limited by caps. While physical and occupational therapy can be undertaken under Part B, there is no reimbursement built into structure for travel time or other agency expenses; in addition, it is impractical to send patients to facilities to learn, for example, how to get into and out of their own bathtubs.
- **Training reimbursement.** Policies are needed to cover reimbursement for fulfilling training requirements. The American Association of Homes and Services for the Aging is developing and testing a geriatric training program for home health aides, with a focus on falls prevention. There should be a greater focus on falls prevention training for home health, allied, and other professional providers who work with geriatric and dementia patients. New programs are being developed for training in Skilled Nursing Facilities (SNF) as well.
- **Falls and fall prevention as a chronic condition.** Medicare coverage tends to be more for acute rather than chronic conditions. Falls risk is a chronic consideration for every adult age 65 and older. Falls prevention should be seen on a continuum in a process of health care across the years of an older person's life. It would be beneficial to foster change in the CMS policy of the Centers for Medicare and Medicaid Services (CMS) and in the culture of fragmented dealing with chronic health conditions as people develop conditions related to aging. CMS regulations need to allow for innovation and change in policy that looks at how regulations intersect and/or work together (or against one another). The whole concept of "medical necessity" should be reevaluated as well.
- **Vitamin D.** Use of a prescription for Vitamin D is problematic, even when prescribed in large units. Congress has excluded vitamins from Medicare part D, even with a prescription. However, Medicare Part A has no formal language related to vitamin payment, which allows nursing homes to provide Vitamin D under Medicare Part A. Long-term care residents

ineligible for Part A face that problem, because when their coverage reverts to Part D, Vitamin D is no longer covered. However, in some states, Medicaid will pay for Vitamin D.

Multidisciplinary approach to geriatric patient care. Fall prevention is a multidisciplinary issue, and requires a new focus on the multidisciplinary approach to patient care. As a rule, this approach is used in nursing homes, but not in hospitals or other provider settings. Some multidisciplinary provider groups are now beginning to emerge all over the country. The Patient Protection and Affordable Care Act (P.L. 111- 148) promotes the establishment of care coordination pilots, chronic care management and accountable care organizations; these efforts must be infused with attention to falls prevention. It is important and timely therefore to get information on safety and fall prevention into the medical school curriculum so that new physicians are comfortable with the concept. (The Association of American Medical Colleges has developed competencies for medical students in geriatrics which contains information on falls.) In addition, CDC currently is working on developing an outreach and education initiative that begins with medical school and provider education. CDC and other interested organizations, including those at this meeting, should take the lead in developing an education module to help medical students understand fall prevention and the value and necessity of the multidisciplinary approach. For example, slides depicting human interest stories could make a big impression on medical students that they will remember and apply for their entire careers. The American College of Physicians, represented by Dr. Jerry Earll, may be able to assist in this endeavor.

- **Education and training for older adults, their families, and caregivers.** One of the greatest challenges is to help older adults, families, and caregivers recognize that falls are preventable. Even among older adults who have fallen, falls often are regarded as a problem for someone else, not them. In addition, many family members lack knowledge about safety issues and fall risk. It is important to educate them and encourage them to talk to their parents about it. Family members should be trained to become knowledgeable about safety issues in the nursing home, to know what to look for and how to report issues of concern. Health care reform may offer a new opportunity to provide support for family caregivers, including long-distance caregivers. Many new technologies are becoming available to help long-distance caregivers.

Two major issues in home care involve caregiver support and cognitive impairment with patients who have fallen. Policy changes will be required to address availability of resources to care for these patients, including caregiver training. At Holy Redeemer Home Care, occupational therapists are trained using evidenced-based approaches (Gitlin, Winter, Corcoran, Dennis, Schinfeld, & Hauck, 2003) to work with people with dementia, and the training has had positive effect. This training, along with provision of resources and information, has allowed some patients to stay in their homes with fewer complications.

Caregiver training must be an ongoing process rather than a one-time effort if it is to effect behavior change. Only a handful of provider structures, like PACE, are incentivized to do this. In addition, PACE also is capitated, so it doesn't face many of the issues being addressed at this meeting but within that capitated program has found options that are cost-effective. PACE is innovative and covers everything related to fall prevention—making it a model for other coordination or accountable care approaches. In response to this comment,

Maureen Amos from the National PACE Association noted that falls prevention is a huge issue for the organization. Rates of falls in PACE programs are slightly below that of other providers. PACE is now working to create a best practices guide for intake. PACE is incentivized to keep its patients as healthy as possible because it cannot bill beyond the capitated federal/state levels.

Going forward, it will be essential to put programs with demonstrated effectiveness into practice. Health care reform provides an opportunity to think more broadly about Medicare in the health care system, and to incorporate external factors, coordination, wellness visits, and all other critical elements. Success for new Medicare coordinated care programs will depend on developing projects that look in new directions and fully consider the cost issues of problems such as falls.

Dr. Harry Feliciano, director of medical affairs at Palmetto GBA, provided a unique perspective as a Medicare contractor. Palmetto sees itself as a public entity that does not provide care, but processes claims. But this, in Dr. Feliciano's description, presents opportunities to act in support of public health. Palmetto works to develop policy and offer education in a coordinated fashion that is vertically integrated. Palmetto relies on input from experts, physical therapists, occupational therapists, respiratory care providers, and others so that policy makes sense across the spectrum of providers.

Palmetto uses the International Classification of Function (ICF) for describing function and linking to impairments for developing a care plan. The organization also has developed Brief ICF Core Sets. A brief core set is "list of ICF categories with as few categories to be practical, but as many as necessary to describe in clinical studies and possibly clinical encounters the typical spectrum of problems in functioning of patients with a specific condition." Because the population of individuals who fall is heterogeneous, Palmetto wanted to identify all elements that should be incorporated into evaluation. The Brief Core Set for Falls Evaluation and Care Planning is not a mandating instrument, but helps educate providers about the domains to consider in talking with at-risk populations, and to understand which ICF categories are important as a brief core set, along with specific interventions and outcomes. Palmetto plans to launch this concept not only for falls, but also for other areas such as hospice, interaction with providers and inpatient rehabilitation facilities, and to help educate hospital systems about improving language that ensures effective communication with third-party payers. Dr. Feliciano provided a handout to participants which included the Brief Core Set for Falls.

- **Advocacy.** Effective advocacy must be a significant part of this effort. The American Public Health Association has been working on policy issues for many years and understands that to become strong advocates for falls prevention, it will be necessary to present it not only as an issue of concern, but also to put it into context. What is the burden of falls in the older population relative to the burden of other diseases associated with aging? How can we marry policy, education and advocacy to the fullest possible potential? To that end, a multidisciplinary approach also is advisable. Involve the Aging Network from the start; for example, the AOA, the NCOA, and the National Association for Area Agencies on Aging can intercede as partners at the federal and local levels.

In final comments of this discussion period, Judith Tobin, representing CMS, assured the audience that CMS is acutely aware of these problems and is interested in the advice of the group gathered for this meeting. As both a physical therapist and a representative of CMS, Ms. Tobin fully anticipates that CMS will continue listening to advice from stakeholders and will continue improving the approach to what is measured, how measurements are performed, what constitutes data sources, and finally, how to align incentives for better outcomes without putting additional burdens on providers.

LUNCH PRESENTATIONS

THE WELLNESS VISIT AND FALL PREVENTION

Howard Bedlin, Vice President, Policy and Advocacy, National Council on Aging

Increasingly, seniors and others find themselves unfamiliar with the new health care reform act, the Patient Protection and Care Act (PPACA). This act contains important provisions for providers, seniors at risk for falling, and those with chronic conditions. Section 4103 relates to the Annual Wellness Visit, reflects language changes for which NCOA has advocated. In the past, prevention services have been under-utilized in the Medicare program. The new Annual Wellness Visit presents an opportunity to educate seniors about services they can use. Although some ambiguities remain as to the effective date of the provisions pending development of guidelines and a comprehensive health risk assessment model, it appears that they will be available for seniors by September 2011.

There are two key elements to the major provisions:

1. Comprehensive health risk assessment; and
2. Personalized prevention plan services.

The risk assessment component will be available to any Medicare beneficiary, regardless of the residential setting. It will address chronic diseases, modifiable risk factors, and emergency or urgent health care needs. The assessment may be conducted in person by providers, or by phone, via the Internet, or at a community facility. Advocates are urging that the Secretary of the Department of Health and Human Services coordinate the assessment process with community organizations. The risk assessment also should become integrated and coordinated with existing and emerging health information technologies, and there may be some experimentation with personal technology related to self-management skills.

Another major provision calls for coverage for personalized prevention services; this includes establishment and updating for family histories, lists of suppliers and providers, routine measurements for each patients, review of medications, and detection of cognitive impairment. It also will include a 5-to 10-year screening schedule based on recommendations of the US Preventive Health Services Task Force (USPSTF), a list of risk factors and conditions for which interventions are recommended, and treatment options and their associated risk. New services also will allow for personalized health advice and referrals as appropriate to programs and interventions that reduce health risks and promote self management, including weight loss, smoking cessation, nutrition education, and fall prevention.

Assessments generally can be conducted by health professionals, but that category includes

physicians, medical professionals under supervision of a physician, health educators, registered dietitians or nutrition professionals, or a team of professionals. The law allows for Secretarial discretion on others who can participate.

In coming days, it will be critical to effectively disseminate the word that falls prevention is explicitly mentioned in the legislation and should be emphasized in educational and regulatory materials. This and other prevention services will have no co-payments or deductibles. This message needs to be front and center, because many people are unaware of the provisions of this law.

Discussion. In response to questions from participants, the following points were made:

- Dr. Mary Barton of the USPSTF estimated that about 30-40 per cent of clinical preventive services approved by the USPSTF fall into Medicare Part A or B.
- This legislation does not contemplate any new Medicare-covered preventive services. But other parts of the legislation may provide new opportunities, for example, to educate physicians about better use of services that already exist under Medicare and to provide information for making more and better referrals to other providers such as occupational therapists, optometrists, and ophthalmologists.
- This legislation affects a host of people—physicians, community providers, caregivers and patients. It represents a new emphasis on integration of needed services, with medical, nonmedical, and community resources.

FALL PREVENTION GUIDELINES

Mary Barton, MD, MPP, US Preventive Services Task Force

The USPSTF currently is reviewing primary care interventions to prevent falls. While the new guidelines are not yet available, Dr. Barton laid out the history of the Task Force and its decision-making process.

The USPSTF was created 25 years ago to provide an unbiased look at evidence for services in primary care, such as screening tests, medication to prevent disease, and counseling for health behavior change. The Task Force is made up of 16 non-Federal experts in prevention and primary care who are named by the director of the Agency for Healthcare Research and Quality (AHRQ). Members represent disciplines of internal medicine, geriatrics, family medicine, pediatrics, ob-gyn, behavioral medicine and nursing.

There is a tension today between specialty provider groups defined by a body part and the less clearly defined undifferentiated mass of primary care. For example, the American Cancer Society has focused thinking on the numerator of people who have cancer, while the USPSTF looks at the denominator—the full number of people screened to find that numerator of cancer patients.

The process for examining evidence practice is as follows: The AHRQ, USPSTF and Evidence Based Practice Center (EPC) contribute to determining the topic scope and decisions on approach for systematic review of the literature, and key questions in an analytic framework. The EPC presents a review of data, and the Task Force then uses a standard method to assess confidence in evidence before arriving at a decision.

Increasingly, there is published information providing evidence of interventions' effectiveness. The EPC focus is to uncover all relevant published literature in order to find all data that sheds light on the question of which interventions work, as well as any associated harms. The Task Force first develops an analytic framework for a topic that provides a graphic depiction of the process and makes a number of essential considerations explicit:

1. The target population, intervention, comparison and most important outcomes.
2. Intermediate outcomes that may mediate the effects on or serve as surrogates for the more distal outcome.
3. Discrete questions that can be answered through a review of the evidence.
4. Downstream consequences of the initial intervention and possible subsequent interventions – the adverse as well as beneficial effects, and all of these together determine the overall balance of benefits and harms.
5. Ability to distinguish studies that provide a direct link between an intervention and an outcome (top arrow) from less direct linkages between screening and reduced morbidity.

From this analytic framework the task force develops key questions, which include the following:

1. Who is the population at risk?
2. Are there trials that show screening intervention leads to reduced morbidity and mortality?
3. If not there, can we put together a chain of evidence for working in primary care?
4. What is the evidence of the quality of the screening test?
5. Does it detect cases at earlier stage?
6. Is there efficacious treatment that makes a difference for patients screening and found early?
7. What are intermediate outcomes and what are final outcomes?
8. What are adverse outcomes of screening?
9. What are adverse outcomes of treatment? (count all people helped as well as harmed)

After answering key questions, the Task Force weighs net benefit (benefit minus harms), assigns a level of certainty to estimate, and makes recommendation grades according to the following scale.

USPSTF RECOMMENDATIONS GRADES				
CERTAINTY	MAGNITUDE OF NET BENEFIT			
	LARGE	MODERATE	SMALL	ZERO/NEG
High	A	B	C	D
Moderate	B	B	C	D
Low	I: INSUFFICIENT EVIDENCE			

Positive recommendations receive grades A and B. Grade A denotes a high certainty of large net benefit, for example, cancer screening for colorectal cancer. Grade B are recommendations with moderate certainty about net benefit. Grade C suggests only a small net benefit where, although some people may benefit, the recommendation is not feasible or appropriate for wide application to the entire population. Grade D is a recommendation against the intervention because it may cause harm rather than help, or where the screening may identify something for which there is little evidence-based care that can address the problem.

A geriatrics work group currently is translating this method from the cancer model to geriatric care in a way that allows for values like independence and ability to remain in the home, rather

than days or years of life gained) as in the cancer model. For recommendations relating to falls, the EPC looked in particular to determine any adverse effects to risk assessment or interventions and whether they affect quality of life or mortality. The Task Force has looked at the evidence and is getting ready to release recommendations. When the draft recommendations have been completed, they will be placed on the AHRQ website and the public will be given an opportunity to comment on them.

New efforts currently are under way to increase transparency of the Task Force and increase opportunities for people to learn about Task Force activities, such as inviting groups representing patients to be official partners of the Task Force. As a result, AARP has joined as an official partner to be the voice of consumers.

Discussion. In response to questions about medical necessity and coverage under the new PPACA, Dr. Barton commented that these questions cannot be answered until Medicare posts information about the regulations.

AFTERNOON DISCUSSION

The facilitator outlined the process for afternoon deliberations, which were conducted and reported by attendees at each separate table. She specifically asked participants to think about opportunities for increasing fall prevention efforts through policy change and collaborations, identification of “low hanging fruit” opportunities that could happen relatively quickly and easily, gaps that are important to address, and potential next steps. Individual tables were responsible for deliberating and reporting back to the group their two or three priority issues. Topics to be addressed included the issues identified in the policy analysis report:

1. Medicare opportunities, coverage, policy consistency, and provider education.
2. Availability of durable medical equipment to enable modification of the home environment.
3. Link and coordination between health systems/health providers with community organizations/entities.

Reports from the Tables

• Topic 1: Medicare Coverage and Consistency

1. Under health care reform, include falls prevention in demonstration projects taking place in medical home establishment and care coordination, utilizing an interdisciplinary, multi-modal model that includes pharmacists.
2. Use part of Section 4202’s provision providing \$50 million for evaluation (possibly under CMS Research and Development) to evaluate falls programs.
3. Undertake intensive provider education. CMS has a dissemination tool, the Medicare Learning Network, which could be used as an avenue for disseminating information about use of the V code and falls as part of the diagnostic tools of practitioners and the quality reporting program.
4. Use the policy analysis report prepared for this meeting to develop one comprehensive position paper that reflects key issues and solutions offered at this meeting and serves as a framework for moving forward. This paper would form the main element of a comprehensive briefing package that would offer consistent messaging and requests to

address falls. The document would be used to present solutions to CMS and for briefing local and Congressional officials.

5. Conduct education and outreach on falls risk assessment for providers and for patients as part of the “Welcome to Medicare” Physical.
6. Ensure that health care reform links assessment, treatment, follow-up, and community based programs.
7. Referrals should be made to Medicare-covered services, including occupational therapy or physical therapy, if the beneficiary meets coverage criteria. Referrals in other cases should be to community organizations that have certified/accredited falls prevention programs. Referral to any services for fall prevention or intervention should be added to MDS and OASIS data sets.
8. Build the evidence base on implementation practices from the real world. Present numbers, studies, programs, solutions, and strategies.
9. Provide a link to evidence-based community programs, reinforced through demonstration grant dollars.
10. Clear up inconsistencies in CMS LCD definitions and establish standards to address falls prevention related issues.
11. Because CMS is interested in following patients only until discharge, use OASIS for follow-up to ensure a link between referrals and community services and programs.
12. Create a concrete structure such as a Task Force that includes CMS for communicating among Federal agencies with a consistent platform for bringing organizations together, rather than relying on one-one-one personal relationships.
13. Identify the missing parts of this puzzle: many interventions are processes that providers can conduct (e.g., tests), whereas concerns about fall prevention may require behavioral changes.
14. Build more elements of AHRQ’s developing geriatric framework into CMS reimbursement, such as outcomes of independence, quality of life, maintenance of function or living situation, and control of chronic disease.

Topic 2: Availability of Durable Medical Equipment

1. Conduct an outcome study with demonstration projects already under way.
2. “Money follows the person” projects under Medicaid and other programs have been in play several years. Learn from those providing DME and follow through with additional initiatives.
3. Go Green, Go Safe: support Falls Prevention Day in September; ask people to donate DME they no longer need; ask the public for help with refurbishing; create an “Angie’s List” for reputable DME installers.
4. Develop a compelling case for reimbursement of currently non-covered items like bath chairs by creating a demonstration project for a targeted population at high risk for falls; identify a foundation for potential reimbursement.
5. Where the cost of DME is covered, ensure reimbursement for training in its use is available and made use of by beneficiaries.
6. Link private industry that might provide DME with the community in order to find way for patients in need to reuse DME that other people no longer need. Enlist assistance of industries and foundations to provide equipment to community.

7. Find ways to broaden understanding and use of effective DME, especially bathroom equipment.
8. Link assessment for DME equipment needs in the home with the annual wellness evaluation; send occupational or physical therapists into the home to do the assessment.
9. Depending on size and cost, provide additional reimbursement in home care setting for small DME items like nightlights (perhaps have them considered as supplies.)
10. Negotiate for set rates for DME with manufacturers.
11. Provide some education and guidance for family members on the purchase of DME so that they understand what is and isn't actually needed, and how to go about obtaining, getting training, and using/installing it.
12. In terms of coverage, it will be important to link availability of DME to cost reductions or savings. Identify the top one, two or three DME items (based on evidence) that would have the greatest impact, and use that as a starting point for coverage.
13. Provide reimbursements based on documented changes in functional need rather than on an arbitrary timeline.
14. Increase funding for cost/benefit analysis studies to illustrate the therapeutic benefits of the equipment (demonstration project) that could set the stage for potential reimbursement.
15. Increase consumer awareness and education about DME so that consumers have a better understanding and can make educated decisions.
16. Utilize a community model to redistribute DME in a safe manner.
17. Broaden definition of "presumptively nonmedical" items that could be covered DME.

Topic 3: Link and coordination between health systems/health providers and community organizations/entities

1. There are 14 evidence-based community fall prevention programs in the Aging Services Network. Bring together a national task force with national agencies, including the AoA, CDC, AHRQ, and NIA to look at programs in the community: what are the linkages, how do these programs work, how can connections to the health system be improved. Then use this information as the basis for demonstration programs that CDC could evaluate.
2. Home health benefit—at discharge from home health, have an OASIS requirement asking if referrals were made to local community evidence-based programs, information and supports.
3. Conduct a demonstration program with a home health agency to follow up with patients at risk; look at social work visits within the home health arena, because the social worker has the best information and greatest ability to link to the community for patients.
4. Additional roles for CDC:
 - Take the lead in communicating with providers about fall resources.
 - Identify local models where fall prevention is working to see if they can be replicated elsewhere.
 - Study and develop a practice manual that includes information about the need for continuous improvement mechanisms.
 - Work more closely with the AoA to combine the scientific face of CDC with the AOA network.
 - Seat a task force of appropriate Federal Agencies and professional associations to identify evidence-based programs and services within community-based

organizations and to identify linkages between health care and the Aging Services Network.

- Develop a falls prevention program model in which older adults could enroll, supported by local Area Agencies on Aging. There could be more intensive programming for higher-risk individuals, paid for by patients or other types of funding.
 - In demonstration models, use a bundled payment system. Have a requirement that these projects demonstrate that the patient has been connected with appropriate local agencies and resources.
5. CMS could require that referrals are made to appropriate community organizations if referral to Medicare-covered services such as occupational therapy or physical therapy is not warranted (i.e., the individual does not meet coverage criteria).
 6. Encourage outreach with senior's services and local agencies to educate health care providers about available services in their area.
 7. Electronic health records should play a role in emerging practice. Ensure that falls and fall risk is represented in electronic health records (EHR); create an automated feature for EHR so that when an older adult has a V code associated with their record, a notice could go out to all of the patient's providers. Represent falls risk and assessment in automated health records; automation facilitates ability to communicate with patients and/or family and provider when the patient is discharged.
 8. Communicate fall risk when coordinating services during care transitions between hospital, SNF, community and home care; improve communication during discharge from acute care as individuals reenter the community, including changes in medication.
 9. Make community efforts more self-sustaining by linking with state Medicaid office in some way for referrals or funding.
 10. Improve communication between programs and CMS. (In an AoA grant for chronic disease self-management, grantees were required to communicate with state agencies). Use Medicare as a partner to be the hub for funding and referrals.
 11. Create/facilitate municipal policy related to community accessibility and safety.

Additional Comments from the floor. Following reports from each table, the group was invited to raise any remaining issues. Comments provided both during this time and in writing at the close of the meeting included the following:

1. What is a fall? It is critical to define falls so that we can all speak from the same page.
2. Widely disseminate the results of this meeting along with the policy report.
3. Submit a proposal to the American Society on Aging to talk about findings of the policy analysis.
4. CMS will be writing regulations on how to do preventive visits, so it is important to get these policy issues to CMS and all interested parties.
5. Create a case for falls; explore how falls risk ranks against other public health priorities like heart disease and diabetes, not only in terms of mortality, but also in terms of morbidity and quality of life.
6. Hold a Congressional hearing on falls prevention, including identifying policy gaps; have a large forum and make a compelling presentation about this issue. Amidst the many problems this country faces, many people are unaware of this issue.

7. Join forces with the National Safe and Healthy Housing Coalition, which is working to integrate coding, health, and housing issues, such as lead in the home, indoor air quality; this group also is focused on older adults and falls. Prevention should be incorporated into related activities. (It was noted that the American Public Health Association will publish a book this year on safe and healthy housing with National Safe and Healthy Housing Coalition, the Home Safety Council, and CDC.)
8. Recognize and build on the benefits and opportunity that exists because Medicare is a public program open to change and evolution.
9. Consider revising outcomes to include maintenance of function for independence, ability to remain in the home.
10. Incorporate ICF into existing tools.
11. Medicare acute care, emergency care, home health and other services should not end at discharge. Encourage Medicare and emergency rooms to look beyond the discharge to refer to community services and address causes of the fall.
12. Provide access to a resource directory with information on community-based resources as part of Medicare personal prevention plan.
13. In developing provider education, incorporate other reimbursement risk factors and services, such as low vision and vision screening; educate providers about reimbursement linked to the AGS guidelines.
14. Encourage outreach by Area Agencies on Aging to educate health care providers about their services, as they provide effective links to communities and consumers.
15. Fund prevention demonstrations that include fall prevention as an explicit outcome, linking health care practice to evidence-based programs and services; use CMS evaluation funds to measure outcomes.
16. Work with the Medicaid State Directors to try to get data from states about outcomes when DME is available under Medicaid.
17. The E codes for falls encountered in emergency care room is so inconsistently recorded that it is difficult to obtain data about its use (except in Florida, where the Florida Hospital Association has organized training specific to this topic). Increase utilization for better tracking and information.
18. Use emergency service for increasing teachable moment and data collection about falls. Partner with emergency rooms, Emergency Medical Service (EMS), and Fire Departments. In Los Angeles City and County, the AoA is working with the Fire Department to take advantage of that teachable moment after someone has fallen, when that person understands the seriousness of the event and wants to make a change to avoid additional injury in another fall.
19. Fall issues easily lend themselves to easy introduction at the community, even high school, level. Public representatives should look for opportunities to introduce the topic to the community. Include information about fear of falling issues, what happens when people fear falling and how that fear leads to and exacerbates other health problems.
20. Explore the issue of outdoor falls; baby boomers see themselves as active, independent, and very different from their parents; very active adults have different kinds of fall risk than sedentary older adults.

SUMMATION

Christina Metzler, Chief Public Affairs Officer, the American Occupational Therapy Association

Ms. Metzler reviewed the original meeting purpose and summarized the day's proceedings. Falls are everyone's concern and problems related to falls will grow even larger as the population ages. The focus today has been on Medicare and public policy issues. Our discussions showed clearly that many elements must be considered together in addressing public policy. Managing all of those elements can be difficult, but we began that dialogue today, by identifying a host of important issues:

- The concept of medical necessity. We were reminded of how great a program Medicare is and that we have the ability to approach Congress to ask for changes we need to see.
- The V code—how to use it and how it links to medical necessity. Is there a need for additional research? Should history of falls be considered a chronic disease? Should we promote the V code use, other data in OASIS and SNFs to gather better data? If so, what are the best questions to ask?
- Expanding coverage for DME. Perhaps there is a way to begin this process, incrementally, such as limiting initial efforts to one population with hopes of later expansion if proven effective.
- Coordination within health care systems and between health care and other systems.
- Accountable care. We need to advocate for criteria that make sense, not only in terms of saving money, but also saving lives.
- Outcomes. We need to look at outcomes beyond morbidity and mortality. What do we want to achieve? Are there other factors, like using the terms of the ICF that would focus attention on these types of outcomes? How do we improve quality of life and facilitate the ability to keep independent and in their own homes?
- The Patient Protection and Affordable Care Act provides new opportunities. Demonstration dollars could be used to look at falls and fall prevention and how the topic fits into larger pieces of Medicare, home care, and the ability to sustain people after they have received interventions and training so that they can remain independent. The new prevention and wellness visit in Medicare offers great possibility if done in a targeted, effective, and useful manner that provides linkages and coordination between the provider and community resources. We have a responsibility to ensure that falls prevention is included as one indicator in any demonstration project.

This meeting has been a first step in clarifying and putting forward needed Medicare and other policy recommendations. AOTA will provide you with a summary of this meeting and the full policy analysis as we consider the best way to take forward the issues discussed today to providers, policy makers in Congress, and CMS. As noted in the meeting today, there is a great need to educate a whole range of different providers, patients, families, and caregivers on the full impact of falls in this country.

At Ms. Metzler's request, attendees offered additional recommendations about other groups that should be involved in this effort, including:

- National Safe and Healthy Housing Coalition;
- Fire departments and first responders;
- The Environmental Protection Agency, which has a related program dealing with issues like sidewalk safety, etc;

- The National Safety Council and its Safe Communities Program;
- Park districts and other entities that conduct physical activities programs;
- CMS grantees, which are looking at new ways to collect information on therapy needs, post-acute care choices, what happens, why, outcomes, etc., which could be useful for promoting some of these policy issues;
- Care Transition Initiative;
- Safe States Alliance, which has a policy priority related to older adult falls;
- National Caregivers Association;
- Health plans—all the different health plans, models, Medicare Advantage. They are in position to try some of these approaches because they have some flexibility. If a Congressional hearing were held, Congress could ask someone from managed care and Medicare Advantage, and Lifelines to come talk about what they're doing;
- Housing programs and services that cover home modifications, such as Community Development Block Grants, which could help fund programs such as Rebuilding Together, Some Secure, and the Handy Workers Program;
- Architects, home builders, coders, and the renovation industry--to deal with structural characteristics of the home;
- Hospitals as linkages for care;
- Many state and local societies;
- Nurse practitioners, who may be spending more time on prevention with clients than physicians;
- The 31 states coalitions that already are working with state and local representatives and other local groups on policy issues. If all organizations represented at this meeting joined with the 31 states, it would strengthen coalition; and
- The American Medical Association (possibly at its half-year meeting).

Ms. Metzler expressed thanks to CDC for fostering this important conversation and committing to moving today's discussion to action.

CLOSING

Jessica Shisler Lee thanked attendees on behalf of CDC and expressed her hope of strengthening the relationships between CDC and the diverse group of organizations represented here today.

The meeting was adjourned at 4:30 PM.