FALL PREVENTION POLICY
Compilation of Common Themes
Identified through Interviews
With Individuals and Representatives of Organizations

At the request of the Centers for Disease Control and Prevention (CDC), during March and April 2010, the American Occupational Therapy Association conducted interviews with individuals and organizational representatives who have a strong interest in the issue of fall prevention among the elderly. Interviews were conducted with seven individual experts and with representatives of a wide range of organizations (listed below), representing Federal government agencies, providers, and other nonprofit organizations concerned with fall prevention in the elderly. An overview of those interviews begins on Page 2.

ORGANIZATIONS PARTICIPATING IN INTERVIEW SESSIONS
1. Administration on Aging
2. Agency for Healthcare Research and Quality
3. American Academy of Family Practitioners
4. American Association of Homes and Services for the Aging
5. American Bar Association, Medicare Advocacy Project
6. American College of Physicians
7. American College of Surgeons Committee on Trauma
8. American Medical Association
9. American Optometric Association
10. American Physical Therapy
11. American Public Health Association
12. American Society of Consultant Pharmacists
13. Home Safety Council
14. Missouri Alliance for Home Care
15. National Academy of Home Care Physicians
16. National Association of Area Agencies on Aging
17. National Association of Community Health Centers
18. National Association of Directors of Nursing Administration in Long Term Care
19. National Association for Home Care and Hospice
20. National Association of Professional Geriatric Care Managers
21. National Association of State Medicaid Directors
22. National Council on Aging
23. National Safety Council
24. Programs of All-Inclusive Care for the Elderly (PACE®)
25. Rebuilding Together
26. Staying Healthy through Education and Prevention (STEP)
27. Visiting Nurse Service of New York
28. Visiting Nurse Associations of America
OVERARCHING ISSUES

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.
TARGETED AUDIENCES FOR RECOMMENDED ACTIONS

CONGRESS
1. Educate Congress that the issue of older adult falls is a health crisis.
2. Create public awareness by making the first day of Fall “Annual Fall Awareness Day.”

FEDERAL OR STATE AGENCIES
1. Designate fall prevention as a top DHHS priority.
2. Provide strong funding for fall prevention activities in communities and throughout health services systems.
3. Create additional partnerships among government agencies to support national initiatives (similar to approach used with influenza immunization initiatives).
4. Support use of taxonomy of ICF rather than ICD to promote better surveillance regarding falls for research, reimbursement of service, and policy development.
5. Improve surveillance and data collection on falls. Many falls currently go unreported, which causes difficulty in conducting falls research.
6. Improve surveillance on intervention outcomes.
7. Improve reporting issues:
   a. Define what constitutes a fall;
   b. Develop fall prevention criteria;
   c. Develop state descriptors for fall prevention.
8. Develop guidelines for public funding of fall prevention programs; limit funding to evidence-based programs.
9. Fund professionally led, multidisciplinary evidence- and community-based programs that include all disciplines including psychiatric and other mental health providers, and follow patients into nursing homes and hospitals.
10. Promote optimum use of professional registered nurses, OTs and PTs in community programs demonstrating evidence of need for these professionals.
11. Conduct large professional and public education programs.
12. Raise public and professional awareness about complexity of falls.
13. Demonstrate that fall prevention creates savings for the health care system, and plow savings back into fall prevention.
14. Focus evaluation of fall prevention programs on percentages of the elderly for whom health and wellness was improved rather than the number of fall prevention programs conducted.
15. Create demonstration programs to provide complete understanding of what is medically necessary, including attention to factors such as depression and social isolation, and the broad range of services needed to achieve full knowledge of actual cost savings.

**SPECIFIC SPECIALTIES**

1. **Occupational therapy**: Increase role for occupational therapists to:
   a. Conduct in-home assessments;
   b. Watch patients do daily activities to understand how they function at home;
   c. Help patients appreciate and manage their own capacities;
   d. Demonstrate that equipment is medically necessary;
   e. Train patient aides and families on proper use and maintenance of equipment;
   f. Open in-home health cases without delays that currently exist;
   g. Better understand existing reimbursement policies, measures, and opportunities in providing home health care;
   h. Link patients to information and local community resources
   i. Explore opportunities for state Medicaid waivers that allow reimbursement for T and PT that is not otherwise reimbursable.

2. **Physical Therapy**:
   a. Allow reimbursement for patients to get direct access to physical therapy without delay or a physician order.
   b. Reimburse PT for falls screening, and for evaluation and care after screening
   c. Allow for preventive PT therapy for at risk patients.
   d. Address caps, which affect all Medicare patients.

3. **Vision Care**:
   a. Integrate eye health into all programs and policies that affect health and make it part of any health prevention activity, as eye problems are one major cause of falls.
   b. Reimburse for attention to asymptomatic eye disease, to allow intervention at the optimum time for correction.

4. **Pharmacology**
   a. Eliminate differences between pharmacist definition of Medication Therapy Management and the legislative definition.
b. Conduct research on medications suitable for frail elderly

c. Reimburse pharmacists for conducting medication reviews and providing other education that can help prevent falls.

5. **Family Physicians and Geriatricians**
   - a. Educate physicians about community programs.
   - b. Provide education opportunities about falls, including evidence-based information, to improve identification of falls risk and falls interventions.

**LOCAL/COMMUNITY**

1. Examine causative factors for falls in the community, including street, sidewalks, walking paths, pedestrian intersections and lighting design.

2. Involve the whole communities in making environment safe.

3. Examine building codes and zoning requirements and other restrictions that are barriers for establishing community exercise activities and promoting mobility.

4. Set policies that encourage universal design.

5. Examine transportation needs and alternatives.

**FUNDING AND RESEARCH ISSUES**

**FUNDING**

1. Consider and reimburse for fall risk as a chronic disease to be addressed over the lifetime, rather than an acute incident.
   - a. Provide a continuum of care for maintenance after a patient plateaus for fulfilling active life;
   - b. Revise “improvement standard” that stops reimbursement when patient plateaus;
   - c. Promote ways to enhance quality of life.

2. Address Medicare therapy caps, which affect all patients including those who have fallen.

3. Reimburse for fall prevention screening at annual medical visit. (Note: This issue was addressed in recent health care reform law PPACA which added an annual wellness visit to Medicare benefits.)

4. Monitor research and evidence that provision of patient education as well as sufficient amounts of physical therapy, occupational therapy or other services provided for certain individuals provides benefits to warrant reimbursement for these services at appropriate interims even after the patient is no longer improving under the current coverage guideline.
5. Align payment policy with evidence-based home care services to promote more uniform interventions to promote long-term affect on incidence of falls.

6. Discontinue limitations on use of physical therapy (PT)/occupational therapy (OT) staff for home safety evaluations recommending equipment that is not paid for by Medicare.

7. Reimburse for all durable equipment needed at discharge from nursing homes, including ramps, bath chairs, etc.

8. Ensure that wheelchairs provided actually fit personal physical capability of patient and residence requirements.

9. Provide coverage for evaluating need for as well as buying and installing needed safety equipment of patient, including needs of bariatric-sized patients.

10. Enact policies to reflect family and caregiver needs to better understand and manage cognitive issues as they affect safety.

11. Remove home-bound status criteria limit in Medicare home health benefit so that people with chronic disease who still participate in the community can obtain appropriate services.

12. Create multifactorial policy that broadly expects all providers to work together seamlessly, including physicians, therapists, psychiatrists, eye care specialists, pharmacists, etc.

13. Reimburse for preventive eye care to allow identification of problems at the asymptomatic stage, the optimum time for correction.

14. Reimburse for continuing services that would benefit patients after they leave a fall prevention program to sustain function.

15. Reimburse for patient education about provider recommendations related to fall prevention (e.g., exercise programs, referral to community programs).

16. Create consistent incentives for providers to conduct fall prevention assessments and develop and implement a plan of care.

17. Balance pay-for-performance approach which encourages aggressive control of a specific disease but may also contribute to falls; for example, medication used for aggressive blood pressure control may contribute to falls.

18. Create incentives for postural blood pressure checks.

19. Improve provider understanding and competence about reimbursable services and how to accurately document for those services.
20. Reimburse for training caregivers about how to better protect patients from fall risks.

21. Cover home modification for both medical and quality of life enhancement.

22. Better educate public and caregivers about how to appeal a denial of Medicare coverage.

23. Eliminate inconsistencies among states in Medicaid reimbursements related to fall prevention (i.e., reimbursement for in-home safety equipment.)

24. Educate providers about community-based fall prevention options, especially in relation to fulfilling falls items under PQRI.

RESEARCH AND DATA COLLECTION NEEDS

1. Analyze and publicize home health OASIS assessment data to provide a baseline as to any emergency room visits or inpatient hospitalization related to falls.

2. Collect data on if and how providers are proactively using V codes.

3. Collect data on use of PQRI fall prevention measures.

4. Determine cost effectiveness of fall prevention activities.

5. Develop tracking mechanism for collecting data on Medicaid’s share of the cost of falls.

6. Determine length of stay due to fall-related injury and in-hospital falls.

7. Study fear of fall programs to determine impact on reducing the rate of falls.

8. Fund initial studies and clinical trials that take place in setting in which they would ultimately be deployed, for example, in patient homes, assisted living facilities, and nursing homes; collaborate with various settings to improve translation opportunities.

9. Study frail population that has sustained multiple falls in a controlled trial to determine what is effective in preventing further falls and to improve cost savings and health and wellness.

10. Study how intervening earlier with ambulatory individuals living in the community might help prevent later injuries and associated costs.

11. Conduct research on medications suitable for frail elderly.
6. Enable people to use support services for accessing and using health care that address issues such as transportation, literacy, cognitive barriers, language translations, and cultural competencies.