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Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

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MARYLOU SUDDERS
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MONICA BHAREL, MD, MPH
Commissioner

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October 4, 2016

Steven T. James
House Clerk
State House Room 145
Boston, MA 02133

William F. Welch
Senate Clerk
State House Room 335
Boston, MA 02133

Dear Mr. Clerk,

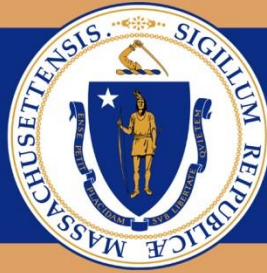
Pursuant to Section 224 of Chapter 111 of the Massachusetts General Laws, please find enclosed the Massachusetts Commission on Falls Prevention 2016 Annual Report.

Sincerely,

Monica Bharel, MD, MPH
Commissioner
Department of Public Health

Charles D. Baker
Governor

Karyn Polito
Lieutenant Governor



Marylou Sudders
Secretary

Monica Bharel, MD, MPH
Commissioner

Massachusetts Commission on Falls Prevention

2016 Annual Report

(Reporting Period: 9/2015-9/2016)

October 2016

Massachusetts Department of Public Health



LEGISLATIVE MANDATE

The following report is hereby issued pursuant to Section 224 of Chapter 111, Massachusetts General Laws.

Section 224 of Chapter 111 of the Massachusetts General Laws reads, in relevant part, as follows:

There shall be a commission on falls preventions within the department. The commission shall consist of the commissioner of public health or the commissioner's designee, who shall chair the commission; the secretary of elder affairs or the secretary's designee; the director of MassHealth or the director's designee; and 8 members to be appointed by the governor, 1 of whom shall be a member of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a member of the AARP, 1 of whom shall be a member of the Massachusetts Senior Care Association, Inc., 1 of whom shall be a member of the Massachusetts Association of Councils on Aging, Inc. 1 of whom shall be a member of the Massachusetts Medical Society Alliance, Inc., 1 of whom shall be a member of the Massachusetts Assisted Living Facilities Association, 1 of whom shall be a member of Mass Home Care and 1 of whom shall be a member of the Massachusetts Pharmacists Association Foundation, Inc.

The commission on falls prevention shall make an investigation and comprehensive study of the effects of falls on older adults and the potential for reducing the number of falls by older adults. The commission shall monitor the effects of falls by older adults on health care costs, the potential for reducing the number of falls by older adults and the most effective strategies for reducing falls and health care costs associated with falls. The commission shall:

- (1) consider strategies to improve data collection and analysis to identify fall risk, health care cost data and protective factors;*
- (2) consider strategies to improve the identification of older adults who have a high risk of falling;*
- (3) consider strategies to maximize the dissemination of proven, effective fall prevention interventions and identify barriers to those interventions;*
- (4) assess the risk and measure the incidence of falls occurring in various settings;*
- (5) identify evidence-based strategies used by long-term care providers to reduce the rate of falls among older adults and reduce the rate of hospitalizations related to such falls;*

(6) identify evidence-based community programs designed to prevent falls among older adults;

(7) review falls prevention initiatives for community-based settings; and

(8) examine the components and key elements of the above falls prevention initiatives, consider their applicability in the commonwealth and develop strategies for pilot testing, implementation and evaluation.

The commission on falls prevention shall submit to the secretary of health and human services and the joint committee on health care financing, not later than September 22, annually, a report that includes findings from the commission's review along with recommendations and any suggested legislation to implement those recommendations. The report shall include recommendations for:

(1) intervention approaches, including physical activity, medication assessment and reduction of medication when possible, vision enhancement and home-modification strategies;

(2) strategies that promote collaboration between the medical community, including physicians, long-term care providers and pharmacists to reduce the rate of falls among their patients;

(3) programs that are targeted to fall victims who are at a high risk for second falls and that are designed to maximize independence and quality of life for older adults, particularly those older adults with functional limitations;

(4) programs that encourage partnerships to prevent falls among older adults and prevent or reduce injuries when falls occur; and

(5) programs to encourage long-term care providers to implement falls- prevention strategies which use specific interventions to help all patients avoid the risks for falling in an effort to reduce hospitalizations and prolong a high quality of life.

I. INTRODUCTION AND BACKGROUND

According to the Centers for Disease Control and Prevention (CDC), every year in the United States, one third of people age 65 years or older experiences at least one fall. In 2010, the Massachusetts Legislature acknowledged the need for the Commonwealth to more fully address the serious public health problem of older adult (age 65 +) falls and the escalating health care costs associated with fall-related injuries, by passing legislation (Section 9 of Chapter 288, Acts of 2010) establishing the Massachusetts Commission on Falls Prevention. At that time, total hospital charges in Massachusetts associated with older adult fall-related injuries (e.g., bone fractures, traumatic brain injuries) exceeded \$630 million with unintentional falls the principal reason older adults received treatment in acute care hospitals (61,466 nonfatal older adult fall-related injuries were treated with 35% of those cases requiring hospitalization). Tragically, falls were also cited as the main underlying cause in the deaths of 434 older adults in the Commonwealth.¹

The Massachusetts Commission on Falls Prevention (“the Commission”) is a public body of thirteen members convened under the aegis of the Massachusetts Department of Public Health (DPH), with the Commissioner of Public Health or their designee serving as Chair (see Appendix A for a list of current Commission members and representation). The ten stakeholder organization members are appointed by the Governor; there are also three state agency members on the Commission. The Commission first began meeting in August, 2012.

The Commission’s statutory mandate is to:

“...make an investigation and comprehensive study of the effects of falls on older adults and the potential for reducing the number of falls by older adults. The commission shall monitor the effects of falls by older adults on health care costs, the potential for reducing the number of falls by older adults and the most effective strategies for reducing falls and health care costs associated with falls.”

In fulfillment of this mission, the Commission members organized their work into two phases. DPH, as the lead state agency, contracted with JSI Training & Research, Inc., to provide professional staff to coordinate and facilitate this work that included the formation of Task Groups (Data and Surveillance (Phase 1 only), Community-Based Falls Prevention, Providers and the Clinical Environment, Public Education and Communication) and recruitment of additional falls subject matter experts and advisors. In Phase 1 (2012-2013) the Commission explored the present landscape in Massachusetts relative to older adult falls, gathering information to further their understanding of, for example: available fall-related data and data sources, ongoing

¹“Fall-Related Injuries and Deaths Among Older MA Adults: 2002-2010, August 2013,” Injury Surveillance Program, Bureau of Health Information, Statistics, Research, and Evaluation, DPH.

prevention initiatives including the delivery of evidence-based programming in the state and uncovering key issues such the impact of the built environment/community structuring (e.g. condition of main walkways; lack of signage, etc.) on the occurrence of falls on the older adult population. In September 2013, the Commission issued their initial report, *Phase 1 Report: The Current Landscape*:

<http://www.mass.gov/eohhs/docs/dph/injury-surveillance/falls-prevention-phase-1-report.pdf>

During Phase 2 (2013-2015) the overall goal for the Commission was to compile what was learned about older adult falls and falls prevention from Phase 1, seek out more information where there were gaps and finally, assemble a set of consensus recommendations highlighting best strategies for reducing falls in Massachusetts and the costly consequences of falls injuries on health care delivery system resources and quality of life of our older adult citizens. The end product of this focused investigation period was the falls prevention blueprint report entitled, *Phase 2 Report: Recommendations of the Massachusetts Commission on Falls Prevention*.

<http://www.mass.gov/eohhs/docs/dph/com-health/injury/falls-prevention-phase-2-report.pdf>

Some dominant themes stand out within the Phase 2 recommendations, including the critical role primary care providers have in the prevention of falls and management of falls risks for patients 65 years and older. During these times of ongoing reform in both the delivery and payment of health care services, e.g., emergence of Accountable Care Organizations (ACOs), the Commission places strong emphasis on the importance of standardizing falls risk screening of older adult patients within primary care practices both as a falls prevention strategy as well as a health care cost reduction approach. Another key component to this recommendation is for primary care physicians (PCPs) to begin regularly referring their older adult patients identified “at risk” for falls, for appropriate interventions that could include, for example, a home safety assessment or participation in an evidence-based falls-related program offered through a community-based organization such as a Council on Aging/local Senior Center, YMCA, etc. Types of programming referrals could include evidence-based Tai Chi (to build muscle strength, improve balance) and *A Matter of Balance* (to address the fear of falling and promote self efficacy).

With the completion of their main statutory task – issuance of consensus recommendations in the “Phase 2” report in September 2015, the Massachusetts Commission on Falls Prevention provided guidance to state policymakers and stakeholders on optimum ways the Commonwealth of Massachusetts can actively try to reduce older adult falls and related injury rates and promote the adoption of healthy aging lifestyle practices.

The following MDPH summary provides an update of the Commission's activities during the reporting period of 9/2015 - 9/2016.

II. SUMMARY OF ACTIVITIES

The Chair and the MA Commission on Falls Prevention convened four open meetings:

- November 2, 2015
- January 25, 2016
- May 2, 2016
- July 20, 2016

Meeting minutes that have been formally accepted by the Commission membership can be found in Appendix B (note: 7/20/2016 minutes are not included; review and acceptance are still pending per the next scheduled open meeting in late fall 2016).

These meetings included featured speakers, covering various fall-related topics.

- During the November, Commission members heard from Patrick Dempsey, a Project Coordinator from the Brigham and Women's Hospital Team involved in a national randomized falls prevention trial (funded by the Patient-Centered Outcomes research Institute (PCORI) and the National Institute on Aging (NIH)) known as STRIDE (Strategies to Reduce Injuries and Develop Confidence in Elders); the 5 year study, initiated in June 2014 has 10 clinical sites across the country including Partners Healthcare system in Boston. In short, the trial is focused on testing a redesigned medical model that would utilize a Falls Care Manager (RN) within medical practices to engage older adult patients more pro-actively in their own individual falls prevention plans.
- In January, Commission members received a status report from injury prevention evaluator Jonathan Howland, PhD, MPH, the Executive Director from the Boston Medical Injury Prevention Center on a key project that he is overseeing that was undertaken on the Commission's behalf. Through funding support received under a CDC injury prevention grant and federal Preventive Health and Health Services Block Grant, MDPH contracted with Dr. Howland to develop a Primary Care Physician (PCP) Falls Prevention survey that will be performed to capture baseline data from Massachusetts PCPs to: 1) gauge their awareness and knowledge levels of falls prevention and importance of older adult fall risk screening/assessment; and; 2) understand what they are doing within their own medical practices to address falls with their older adult patients. Dr. Howland worked for over a year on refining the survey tool with input from local and national subject matter experts –and also received useful feedback from Commission members during a lengthy discussion at the January meeting. At this time, the survey tool has been finalized and Dr. Howland and his team plan to begin the survey process some time in Autumn 2016. The results of the survey should help inform the work of the Commission as well as other primary state partners, such as the MA Executive Office of Elder Affairs in making policies and implementing strategies to address the prevention of older adult falls in the Commonwealth.

- During the May meeting, Mary Sullivan, PharmD, a Commission member representing the MA Pharmacists Association Foundation, presented on medication safety and increased falls risks for older adults, who are commonly taking multiple prescription drugs (4 or more) and/or over the counter medications, with varying side effects; e.g. causing dizziness or drowsiness-that can lead to falls.

Finally, since the completion of the Phase 2 report and recommendations, a frequent focus for Commission members' open meeting discussions has been the challenge of engaging key stakeholders to undertake some of the Commission's recommendations. For example, what are effective methods the Commission can use to promote commitments from Accountable Care Organizations, Health Plans/Insurers, and primary care providers to standardize older adult fall risk assessments and support fall prevention interventions, all within the backdrop of an ever changing health care delivery and payment model environment? Given the complexity of these matters, the Commission members agreed to form a small "Stakeholder Engagement Workgroup" comprised of a few volunteer Commission members, to tease out most significant issues and pinpoint options (see Appendix A). The Workgroup met only once during this reporting period on April 11, 2016. The Workgroup identified one ongoing development in Massachusetts that the Commission will need to track: the potential impact that a forthcoming restructuring plan for MassHealth could have in advancing the falls prevention agenda.

III. NEXT STEPS

During the coming year the MA Commission on Falls Prevention plans to:

- Hold quarterly meetings (provided an Open Meeting Law quorum of members can be achieved) and invite relevant speakers/experts to present and inform the Commission on current initiatives, etc. and participate in pertinent discussions on reduction of older adult falls and fall-related health care costs;
- Continue the dialogue on identifying ways to engage key stakeholders/partners in adopting and committing to Phase 2 Commission Report recommendations.
- Review most currently available older adult falls/falls injury data in Massachusetts through a public presentation by DPH injury prevention epidemiologists.

APPENDIX A

Members of the Massachusetts Commission on Falls Prevention

Member Name/Title	Organization Representing:
<ul style="list-style-type: none"> ▪ Carlene Pavlos (Commission Chair) Director, DPH Bureau of Community Health and Prevention and Director, Division of Violence and Injury Prevention 	MA Department of Public Health (state agency)
<ul style="list-style-type: none"> ▪ Almas Dossa, Program Manager, Home Health, Hospice, and Independent Nurse Providers Office of Long Term Care Services & Supports 	MassHealth (state agency)
<ul style="list-style-type: none"> ▪ Annette Peele, Director of Information Services 	MA Exec. Office of Elder Affairs (state agency)
<ul style="list-style-type: none"> ▪ Colleen Bayard, Director of Regulatory and Clinical Affairs 	Home Care Alliance of MA
<ul style="list-style-type: none"> ▪ Ish Gupta, Assistant Professor of Internal Medicine, University of MA Medical School 	MA Medical Society
<ul style="list-style-type: none"> ▪ Melissa Jones, Practicing PT 	American Physical Therapy Association of MA
<ul style="list-style-type: none"> ▪ Jennifer Kaldenberg, Clinical Asst. Professor, BU, College of Health and Rehab. Sciences: Sargent College 	MA Association for Occupational Therapy
<ul style="list-style-type: none"> ▪ Helen Magliozzi, Director of Regulatory Affairs 	MA Senior Care Assn.
<ul style="list-style-type: none"> ▪ Joanne Moore, Director, Duxbury Council on Aging 	MA Assn. of Councils on Aging
<ul style="list-style-type: none"> ▪ Emily Shea, Commissioner, Commission on Affairs of the Elderly (City of Boston) 	Mass Home Care
<ul style="list-style-type: none"> ▪ Mary Sullivan, Pharmacy Manager, Senior Whole Health 	MA Pharmacists Assn. Foundation
<ul style="list-style-type: none"> ▪ <i>Vacancy as of April, 2014; approval pending*</i> 	American Assn. of Retired Persons (AARP)-MA Chapter
<ul style="list-style-type: none"> ▪ <i>Vacancy as of Dec., 2014; approval pending*</i> 	MA Assisted Living Facilities Assn. (Mass-ALFA)

*Pending Member Appointments:

-Richard T. Moore, MA Assisted Living Facilities Assn. (Mass-ALFA)

-Deborah Washington, AARP

Members of the Stakeholder Engagement Workgroup
(Massachusetts Commission on Falls Prevention)

Member Name/Title	Organization Representing:
<ul style="list-style-type: none"> ▪ Carlene Pavlos (Commission Chair) Director, DPH Bureau of Community Health and Prevention and Director, Division of Violence and Injury Prevention 	MA Department of Public Health
<ul style="list-style-type: none"> ▪ Almas Dossa, Program Manager, Home Health, Hospice, and Independent Nurse Providers Office of Long Term Care Services & Supports 	MassHealth
<ul style="list-style-type: none"> ▪ Colleen Bayard, Director of Regulatory and Clinical Affairs 	Home Care Alliance of MA
<ul style="list-style-type: none"> ▪ Ish Gupta, Assistant Professor of Internal Medicine, University of MA Medical School 	MA Medical Society

**MA Commission on Falls Prevention Meeting
MA Department of Public Health (DPH)
Lobby 1 Conference Room
250 Washington St., Boston**

November 2, 2015; 11:00 AM–1:00 PM
Meeting Minutes (*accepted 1-25-16*)

Members Attending: Carlene Pavlos (Chair), Colleen Bayard, Almas Dossa, Ish Gupta, Melissa Jones, Jennifer Kaldenberg, Joanne Moore, Annette Peele, Emily Shea

Others Attending: Carla Cicerchia, DPH-Div. of Violence and Injury Prevention (DVIP); Julie Kautz Mills, DPH-DVIP; Santhi Hariprasad, DPH-Prevention and Wellness Trust Fund team; Patrick Dempsey, Brigham and Women's Hospital-STRIDE; Kety Vanda Silva, Brigham and Women's Hospital-STRIDE; Ridha Abidshah, MA Exec. Office of Elder Affairs (Intern); Torey Tokarski, MA Exec. Office of Elder Affairs (Intern)

1) Welcome/Introductions/Commission Business (Carlene Pavlos, Department of Public Health (DPH), Commission Chair)

- Commission Chair, Carlene Pavlos greeted Commission members and other attendees present at the meeting; all individuals were requested by the chair to introduce to introduce themselves and their affiliations.
- Minutes: Following introductions, members reviewed draft minutes of the last meeting on 6-30-15. The Chair made a motion to approve the meeting minutes, which was seconded; the minutes were then unanimously accepted.
- Carlene announced that the Commission's Phase 2 Report had been officially submitted to the Legislature (Joint Committee on Health Care Financing) and Sec. Sudders (EOHHS) by the 9/22/15 deadline. She thanked the members again for their contributions during the development process and for the final preparation of the report as facilitated by the public health consulting team from JSI Research and Training, Inc.

2) Presentation: *STRIDE (Strategies to Reduce Injuries and Develop Confidence in Elders). A Randomized Trial of a Multifactorial Fall Injury Prevention Strategy* (Patrick Dempsey, STRIDE Project Coordinator, Brigham and Women's Hospital) *PPT slides*

- Project Coordinator, Patrick Dempsey provided an overview of STRIDE-the landmark national randomized falls prevention trial that has 10 clinical trial sites participating throughout the country including Partners Healthcare System in

Boston. The Patient-Centered Outcomes Research Institute (PCORI) and the National Institute on Aging (NIA) awarded the funding (\$30 million) for the 5 year study, which began in June 2014. Patrick introduced Kety Vanda Sylva, who also attended the meeting; she is a research assistant working with the Falls Care Manager (Yvette Wells, RN) on the Boston area project.

- The Partners Healthcare System Trial Site Team members include: Patricia Dykes, RN, PhD from Partners HC as the Principal Investigator; Alejandra Salazar, Pharm. D a pharmacist consultant and co-investigator; Jeffrey Linder, MD, MPH, the Clinical Site Director and 9 others. The Joint Principal Investigators for the STRIDE national study include: Shalender Bhasin, MD from Partners, Brigham and Women’s Hospital; Thomas Gill, MD from the Yale School of Medicine; and David Reuben, MD from the University of California Medical School in LA. Yale University serves as the data coordinating and recruitment site for the STRIDE study.
- The overall research question or premise on which the clinical trial is based is *“Can redesigning medical practices and engaging patients reduce serious falls-related injuries?”*
- During the presentation, Patrick outlined the design of the study (nationally, 6000 community dwelling older adults 75 years or older with one or more fall risk factors are being recruited), the two phases of the study (year 1 has focused on protocol development/refinement, pilot-testing, and training, e.g. the Falls Care Manager; years 2 thru 5 will involve the actual implementation of the trial) and details about the intervention and co-management model being tested; there are 6 control site and 6 intervention site clinical practices participating.
- Patrick provided some description of the process in place for engaging patients when an RN Falls Care Manager (FCM) is utilized. Each patient undergoes a pre-visit telephone call with the FCM, is asked to fill out a pre-visit questionnaire that includes a home safety checklist that is discussed at the initial visit, and an initial visit with the FCM (lasting approximately 60 minutes). The role of the FCM includes: conducting a fall risk assessment , engaging the patient in self-management to identify and reduce fall risk factors and develop an individualized falls care plan that is approved by the patient’s primary care provider, directly implementing some recommendations like referrals to evidence-based programs in the community such as Tai Chi or A Matter of Balance, monitoring the patient for 2 ½ years (through June 2018) while providing periodic phone support and assistance with any barriers to following

the plan, e.g. transportation, etc. Patrick said that together the FCM and patient jointly prioritize the selection of interventions and the falls care plan that develops is essentially an individualized algorithm for fall risk management.

- The STRIDE study has been working with consultants like Dr. Pam Duncan (APTA) in the development of a home-based exercise program that can be offered to certain patients.
- Home safety assessment is provided free of charge-although participation, for example at a YMCA Tai Chi class is not. The FCM will assist in locating falls-related community-based programs that are available for the individual patient.
- Patrick also reviewed the training that is in place for all Falls Care Managers (includes 23 on-line modules established through the Institute for Johns Hopkins Nursing) and efforts to maintain fidelity-including establishment of on-site Fidelity Working Groups.
- The study has included the formation of a National Patient and Stakeholder Council as well as a local Patient and Stakeholder Council facilitated by Partners HC. Older adults are members of the Councils.
- *Discussion/Questions*-Following Patrick's presentation – several Commission members and attendees asked questions about the study. These included:
 - Is the cost of using a Falls Care Manager within a practice part of the study? Not at this point.
 - What's the difference between the control and intervention clinical sites? Control site patients receive fall risk assessment by the PCP; the Intervention sites offer the addition of the co-management model involving the Falls Care Manager.
 - What tests are used in the patient assessment? Strength, balance and gait tests, medication reviews, vision checks, etc.
 - How are medication reviews performed by the FCM and medication reconciliation with the PCP handled? The PCP is involved but this process is not always integrated at the same time as the patient's PCP visit.
 - Are all 10 Stride sites in urban areas only? No-Minnesota and Iowa are more rural.
 - When a patient in the study falls-are you capturing incidence information about that fall? Yes.

3) Discussion: Future Work Plans for the Commission –Post Phase 2 Report (Carlene Pavlos/All)

- Carlene led the group in a discussion on future work plans using the Phase 2 Report and recommendations as the framework. The first two recommendations really focus on stakeholder engagement and how to encourage best practices to be broadly disseminated and adopted. (Recommendation 1: “the MA Commission on Falls Prevention will convene stakeholders, including Accountable Care Organizations,and other health care provider groups, to support the dissemination of the consensus on provider practice regarding falls risk screening and interventions in primary care settings for older adults” and Recommendation 2: “will collaborate with key stakeholders in the planning and distribution and promotion systems for community-based falls prevention programs....”).
- Commission members talked about various ways stakeholders could be asked to participate in a broader public dialogue about the importance of falls prevention, etc. and moving the Commission’s recommendations forward. Ideas included providing stakeholders with the issues and information ahead of time and inviting them to come prepared to comment at a public meeting or informational hearing. Carlene asked members to identify some of the stakeholders and state leaders that should be potentially invited to such an event, which included: the Sec. of Elder Affairs, Commissioner of DPH, Assist. Sec. of MassHealth, MA Medical Society, various Health Plans such as Blue Cross, Blue Shield, Tufts, and Harvard Pilgrim, MA Hospital Association, Mass-ALFA, Partners Health Care, the Healthy Living Center of Excellence, etc. It was suggested that Dr. Holly Hackman, DPH injury prevention epidemiologist and Dr. Jonathan Howland, from the Boston Medical Center Injury Prevention Center be asked to present an overview of current data and background issues at the beginning of the meeting. One Commission member (Colleen Bayard) suggested forming a working group to develop a Power Point presentation on the promotion of falls prevention and implications for cost savings that could be used at the stakeholder meeting and to educate other potential partners.
- For Recommendation 4, relative to making statutory changes to the Commission’s membership and revision of the Commission’s reporting obligations to the legislature, members expressed their interest in adding an expert in vision care, a health insurance/third party payer representative, and falls research expert. Carlene offered to explore these matters further by seeking input from the Legislative Director at DPH. She asked for a voice vote from members present on their support for her to carry this out on the Commission’s behalf (which was received).
- Finally, the members briefly discussed the scheduling of meetings for the coming year. Carlene suggested that the members try to schedule four meetings: in January, April, July and October. She also recommended that a standing day and time be considered-possibly on Wednesdays or Thursdays (?). Members will be contacted about this via Doodle poll and asked about days of the week that would be problematic. The next scheduled meeting will be in January.

4) Closing Remarks (Carlene Pavlos)

- Carlene thanked the members and other attendees for their participation during the meeting.
- Meeting was adjourned.

**MA Commission on Falls Prevention Meeting
MA Department of Public Health (DPH)
Lobby 1 Conference Room
250 Washington St., Boston**

January 25, 2016; 10:00 AM–12:00 PM
Meeting Minutes (*accepted 5/2/16*)

Members Attending: Carlene Pavlos (Chair), Colleen Bayard, Ish Gupta, Melissa Jones, Jennifer Kaldenberg, Helen Magliozzi, Joanne Moore, Annette Peele, Emily Shea; Deborah Washington, Mary Sullivan (via conference line)

Pending Members Attending: Richard Moore, Deborah Washington

Others Attending: Carla Cicerchia, DPH-Div. of Violence and Injury Prevention (DVIP); Santhi Hariprasad, DPH-Prevention and Wellness Trust Fund team; Jonathan Howland (Boston Medical Center Injury Prevention Center)

2) Welcome/Introductions/Commission Business (Carlene Pavlos, Department of Public Health (DPH), Commission Chair)

- Commission Chair, Carlene Pavlos greeted members and other attendees present at the meeting; all individuals were requested to introduce themselves and their affiliations. Richard Moore was also welcomed to the Commission, as the new representative for the MA Assisted Living Facilities Association (Mass-ALFA)-pending official Gubernatorial appointment.
- Minutes: Following introductions, members reviewed draft minutes of the last meeting on 11-2-15. Commission staff, Carla Cicerchia identified a correction that was needed - Melissa Jones had inadvertently been left off of the attendance list in the draft. The Chair made a motion to approve the meeting minutes with said correction, which was seconded; the minutes were then unanimously accepted.
- Carlene announced that the Commission's Phase 2 Report had been officially submitted to the Legislature (Joint Committee on Health Care Financing) and Sec. Sudders (EOHHS) by the 9/22/15 deadline. She thanked the members and other advisors for their contributions during the development process of the report and the JSI Research and Training, Inc. consultant team for facilitating that process and preparing the final draft.

3) Presentation/Discussion: Survey of Massachusetts Primary Care Physicians on Older Adult Fall Risk Assessment & Intervention (Jonathan Howland, PhD, MPH-Professor of Emergency Medicine, Boston University School of Medicine; Executive Director, Boston Medical Center Injury Prevention

- Dr. Jonathan Howland provided some background on a project that is being performed on behalf of the Commission, which will survey Massachusetts Primary Care Physicians (PCPs) on their understanding/awareness of the importance of fall risk assessment of older adult patients, e.g. CDC STEADI toolkit, and their current practices and attitudes around this topic. Jonathan identified the main sources used as models for formulating questions for the developing survey tool (i.e. surveys from the National Council on Aging, Centers for Disease Control and Prevention and a University of North Carolina graduate student dissertation on fall risk assessment within assisted living facilities).
- He explained that there had been ten draft versions of the tool along the way-as input was gathered from multiple experts including Commission member Ish Gupta, DPH injury prevention epidemiologist, Holly Hackman, Executive Office of Elder Affairs Secretary Alice Bonner, and others. The first version of the survey had 100 questions, which were eventually whittled down to 30 questions in the current version that was circulated to the Commission members for feedback during the meeting.
- The 30 questions have been organized to capture the following about a PCP's falls-related practices with older adult patients "65 and older and living independently"-and appear as topical headings on the survey draft: *Screening Questions, Attitudes, Beliefs, Knowledge, Behavioral Control, Behaviors, Subjective Norms, Intentions, Respondent Characteristics*. Jonathan indicated that the headings on the survey would be removed once it's prepared for web-based access. Jonathan noted that methods used to deliver the former Inventory of falls prevention programs survey are being planned for this survey, whereby a letter signed by agency leads from DPH and EOEA would be sent to the CEOs/ Directors of certain health care organizations (e.g., Managed Care Organizations, Accountable Care organizations, Community Health Centers) via e-mail to encourage buy-in and participation in the survey by their PCP members. Although PCPs that agree to participate will be identified through their e-mail addresses-all of the data collected will be aggregated.

- *Member suggestions:* - As the members reviewed the survey together the following questions and issues were raised for Jonathan to consider as the final version of the tool is developed:
 - Could the Board of Registration in Medicine be engaged for assistance with this project including possibly reaching out to health care agency/organization leads?
 - Would there be any value in contacting the Centers for Medicaid and Medicare Services (CMS) for input given that there is no professional association for just PCPs? One member recommended looking at PECOS (Provider Enrollment, Chain and Ownership System)-the electronic Medicare enrollment system that providers can use to submit applications, etc.
 - There could be some confusion with the meaning of patients who are “living independently”. It’s important to clarify this, especially for patients residing in an assisted living facility.
 - Does Primary Care Physician/PCP need to be defined?
 - There should be a question that directly asks if the PCP regularly refers patients to community-based programs, etc. Should the survey also ask if the PCP regularly makes referrals to other providers such as occupational therapists and physical therapists?
 - Would the Massachusetts Medical Society be a useful partner for this project?
 - Should the survey ask about a PCP’s EHR/clinical decision supports relative to falls risk assessment?

- In addition to the review and discussion about the survey questions, etc. Commission members also talked about other areas associated with the issue of engaging PCPs in fall risk assessment and intervention referral as standard practice. One topic that garnered a lot of conversation was whether reduction of falls could be best addressed using high risk strategies applying interventions that help individuals at high risk for falls or population health management strategies (behavioral approach) that could involve interventions for older adult populations at low or moderate risk for falls. The Chair, Carlene Pavlos recommended that Commission members take a look at the published work of Epidemiologist, Geoffrey Rose in this area. She noted that the trend right now is to find ways to control health care costs-looking at those medical conditions that are the most expensive to treat-which is not primary prevention. Ish Gupta commented that physicians have been encouraged to practice medicine this way because high risk patients utilize the most resources. Jennifer Kaldenberg pointed out that the prevention of falls and associated interventions offers health improvement, e.g., cardiac health and social benefits, e.g., taking A Matter of Balance workshop, which is good for all older adults.

Most members were in general agreement around this philosophy even though it's still a challenge to bring payors/insurers to the table on this.

- Carlene added how looking at the social determinants of health is another public health focus that is getting a lot of traction these days. Deborah Washington noted a report released by the Institute of Medicine (IOM) in partnership with the Robert Wood Johnson Foundation that focused on the challenges of health care delivery and the nursing profession in meeting the future demands of aging and diverse populations in the U.S. Carlene suggested that members might be interested in reading the latest cost trend report from the state's Health Policy Commission:
<http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/>
- Finally, the group also touched on the subject of older adult medication use/substance misuse and the management and screening role of physicians especially where increased fall risk of patients is concerned. Carlene suggested that this topic be examined further at a future meeting.

4) Discussion: Commission's Work Plans for 2016 (Carlene Pavlos/All)

- With limited meeting time left Carlene led the group in a brief discussion of future work plans. The following points were highlighted:
 - Carlene informed the members that since the Phase 2 Report and recommendations had been fulfilled as the Commission's statutory obligation – for 2016 DPH would be submitting a "Progress Report" to the Legislature/EOHHS Secretary in September focusing on the Commission's meetings and activities.
 - Carlene has been meeting with DPH's Legislative Director for guidance on making recommended changes to the Falls Commission's statute (e.g., adding new members, reporting requirements). She will continue to find out more about this process and possibilities and report back to the Commission at a future meeting.
 - The members discussed best times for meeting in the future-with Wednesdays a strong preference. Commission staff will attempt to schedule meetings for the remainder of the year in April, July, and October. No meetings will be held before 10:30 AM.
 - A Stakeholder Engagement Workgroup will be formed to consider options for engaging key stakeholders in buying into and partnering on some of the Commission's Phase 2 recommendations, e.g. Health Care Providers' focus on older adult falls risk assessment; deploying falls prevention programming and ensuring access across the state, etc. Carlene will Chair the Workgroup. Colleen Bayard, Ish Gupta volunteered to participate. Almas Dossa, who represents MassHealth on the

Commission, will also be asked to participate. Carlene would like the workgroup to try and convene at least once before the next Commission meeting in the spring.

4) Closing Remarks (Carlene Pavlos)

- Carlene thanked the members and other attendees for their participation during the meeting.
- Meeting was adjourned.

**MA Commission on Falls Prevention Meeting
MA Department of Public Health (DPH)
Lobby 1 Conference Room
250 Washington St., Boston**

May 2, 2016; 10:30 AM–12:30 PM
Meeting Minutes (*accepted 7-20-16*)

Members Attending: Carlene Pavlos (Chair), Almas Dossa, Melissa Jones, Helen Magliozzi, Joanne Moore, Annette Peele, Emily Shea; Mary Sullivan

Pending Members Attending: Richard Moore

Others Attending: Carla Cicerchia, DPH-Div. of Violence and Injury Prevention (DVIP); Julie Kautz Mills (DPH-DVIP); Santhi Hariprasad, DPH-Prevention and Wellness Trust Fund Team

5) Welcome/Introductions/Commission Business/Updates(Carlene Pavlos, Department of Public Health (DPH), Commission Chair)

- Commission Chair, Carlene Pavlos opened the meeting by welcoming members and other attendees present; each person introduced them self and their affiliation.
- Minutes: Following introductions, members reviewed draft minutes of the last meeting on 1-25-16. The Chair made a motion to approve the meeting minutes which was seconded; the minutes were then unanimously accepted.

6) Presentation: *Medication Related Fall Risk* (Mary Sullivan, PharmD, Pharmacy Manager of Compliance, Senior Whole Health/Commission member representing the MA Pharmacists Association Foundation); *PowerPoint presentation has been provided.*

- As a subject matter expert and representative of the pharmacy profession on the Commission, Mary Sullivan presented a comprehensive overview of issues concerning the role that medications, both prescription and over the counter (OTC) can have in increasing fall risks in older adults and the need for improved medication safety awareness in consumers and health care prescribers. Mary brought her own “library” of articles on this topic –placed in a large binder that she circulated for members to peruse during the meeting. The following bullets capture some of the key points of the presentation.
- Mary stressed how older adults (and their caregivers) need to be better informed about the medications they are taking and be pro-active by carrying

an updated list of their medications with them at all times. This can be critical information that is needed if someone is suddenly taken to an emergency room.

- She cited the work of the American Geriatric Society (AGS) in highlighting concerns with older adult medication use and risk for falls and other complications. In 2015, the *AGS Beers Criteria* was updated; this is a list of medications that older adults should avoid or use with caution. More detailed information and consumer hand-outs can be found here:

<http://www.healthinaging.org/medications-older-adults/>.

- She spent some time talking about polypharmacy (taking 4 or more medications or psychotropic medications) and the dangers that can arise when an older adult is taking medications prescribed by multiple providers (including specialists), using multiple pharmacies and adding in OTC medications and vitamin/herbal supplements concurrently. She said that electronic health records though valuable have limitations; given the fragmentation of the vast health care delivery system; Primary Care Physicians and other specialists who may be prescribing for older adults don't always see "the whole picture". Transitions of care when a patient is transferring from one setting to another can also pose communication breakdowns in this area, e.g., home to hospital to LTC facility.
- She explained how age-related changes of the body can impact how an older adult metabolizes or absorbs certain medications causing enhanced side effects such as syncope (fainting), balance impairment, cognitive issues etc., and consequently raising the risk for falls. She also mentioned how common it is for older adults to be receiving treatment for multiple chronic conditions such as osteoporosis, cardiovascular issues, etc. that can increase their risk of a medication related fall. Some medications can cause Vitamin D deficiency in older adults leading to muscle weakness (increasing fall risk), which is why these levels need to be closely monitored.
- Finally, she talked about the Medicare Part D – [Medication Therapy Management Program](#)- consumers should be advised to check their plan to see if they are eligible for this type of medication review. The regular review and modification of an older adult's medication regimen is an important falls prevention intervention.
- Brief follow-up discussion comments:
 - What kinds of services do ASAPs (Aging Services Access Points) offer in terms of medication reviews? Annette Peele (EOEA) can look into this.
 - Are there any evidence-based programs involving medication reviews? Emily Shea mentioned *HomeMeds* –a home care-related program.

http://www.acl.gov/Programs/CPE/OPE/docs/HomeMeds_InterventionSummary.pdf

- Action item: Joanne Moore said that local newspapers and newsletters might be a good place to remind older adults about medication safety. She proposed drafting a piece from the Commission about this topic that could be put in the MA Councils on Aging newsletter for September (recognizing Falls Prevention Awareness Day). Joanne will connect with Mary Sullivan and work with staff on this.

7) Discussion: Updates from the Stakeholder Engagement Workgroup (Carlene Pavlos/All)

- Carlene Pavlos reported that she and other members of the Stakeholder Engagement Workgroup (includes Almas Dossa, Colleen Bayard, Ish Gupta) held a first meeting on April 11th. The workgroup was formed to discuss various options and opportunities the Commission might have to engage key stakeholders in adopting the Phase 2 Report recommendations –especially health care providers’ focus on fall risk screening/assessment and promotion of prevention interventions, e.g. evidence-based programs. Carlene shared some notes from the meeting.
- Carlene acknowledged the current health care delivery system transformations taking place; she said that a state plan from the Executive Office of Health and Human Services (EOHHS) to restructure the MassHealth delivery system and adopt Accountable Care Organization models (ACOs) was recently released in mid-April and is under review. She showed the slides that accompanied the proposal. She highlighted some of the features of the plan, which includes incentivizing ACOs to establish linkages with community-based partners, and addressing social determinants of health. There is also a proposed 1115 waiver to CMS to establish a 5 year Delivery System Reform Investment Program (DSRIP) to support these initiatives.
The slides are posted here:
<http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/mass-health-restructuring-overview-document.pdf>
- The question for the Commission is how do we engage stakeholders as this new world of health care delivery is emerging? What are clinical practice organizations like ACOs doing to prevent older adult falls? Carlene suggested that certain knowledgeable speakers be invited to discuss this topic area at a future meeting, including: Sec. Alice Bonner and Robin Lipson from EOEA, Dr. Robert Schreiber from Hebrew Senior Life/Healthy Living Center of Excellence, and a representative from Atrius Health.
- The Commission will continue to monitor latest state developments in this restructuring process.

4) Closing Remarks (Carlene Pavlos)

- Carlene expressed her appreciation to Mary Sullivan for her presentation and all the members and other attendees for their active participation during the meeting. The Commission will convene again July 20, 2016.
- Meeting was adjourned.