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December 13, 2022

Dear Mr. Clerk,

Pursuant to Section 224 of Chapter 111 of the Massachusetts General Laws, please find enclosed a report from the Department of Public Health titled "*Massachusetts Commission on Falls Prevention Phase 4 Report: Strengthening Systems and Building Local Capacity to Address the Devastating Impact of Older Adult Falls.*"

Sincerely,

Margret R. Cooke
Commissioner
Department of Public Health

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CHARLES D. BAKER
GOVERNOR

KARYN POLITO
LT. GOVERNOR



MARYLOU SUDDERS
SECRETARY

MARGRET R. COOKE
COMMISSIONER

Massachusetts Commission on Falls Prevention

Phase 4 Report: Strengthening Systems and Building Local Capacity to Address the Devastating Impact of Older Adult Falls

December 2022



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Legislative Mandate

Pursuant to Massachusetts General Law Chapter 111, Section 224:

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 statute further requires that the Commission submit:

biennially, 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.

The Commission respectfully submits the below report in compliance with these requirements.

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Acknowledgments

This report was prepared by Beth Hume, Alexandria Papadimoulis, Max Rasbold-Gabbard, Sam Riley, and Bekah Thomas. Special thanks to Joanne Moore and Annette Peele for their guidance in shaping the report. Additional thanks to all Commission members for their thoughtful input and to our key informants for their insights.

Executive Summary

Falls and fall-related injuries are a growing public health problem that affect Massachusetts' older residents and the systems of care that support them. From 2010-2020 the rate of fall-related deaths in Massachusetts increased by 61%. The urgency of making systemic changes to address older adult falls is underscored by the growing share of the Massachusetts population age 65 and older, which will increase to 22% by 2030, up from about 14% in 2010. Without investment in falls prevention services, the rate of fall-related fatalities will continue to grow alongside the older adult population.

The Massachusetts Commission of Falls Prevention issues this report with the following recommendations to strengthen local capacity for falls prevention efforts, integrate age-friendly strategies into statewide planning efforts, and improve data collection around non-fatal falls:

- The Commission recommends that the Commonwealth allocate resources to support regional approaches to implementation of evidence-based falls prevention practices by local boards of health and partner agencies.
- The Commission recommends that the Commonwealth support the development of a pilot program that pairs home safety assessments—including fall risk assessments supported by occupational therapists—with subsidized home modifications to mitigate injury risk.
- The Commission recommends that the Commonwealth catalog local, regional, and statewide planning processes that affect older adult falls hazards; embed falls prevention considerations and age-friendly strategies into those efforts; and collaborate with stakeholders to assure falls are specifically and explicitly addressed through state-promoted assessments and planning processes.
- The Commission recommends that the Commonwealth work with stakeholders to develop and implement strategies that improve the completion of relevant injury codes, where feasible. Specific strategies could include providing guidance to hospitals and medical coders around coding of activity and location of injury; providing hospitals and coders with feedback on the quality and completeness of data coming from their institution; and developing a scheme for reimbursing providers for using such codes.

Introduction

Falls and fall-related injuries are a major and growing public health problem that affect Massachusetts' older residents and the systems of care that support them. From 2010-2020 the rate of fall-related deaths increased by 61% (77.7 per 100,000 in 2020).¹ For older adults—those age 65 and over—falls happen in the home, in public, or in care facilities, and can have serious consequences, like broken bones, head injuries, and death.^{2,3} After a fall, older adults can become afraid of falling again, leading to a decrease in everyday activities, which can lead to declines in physical strength and mental health; those outcomes can even further increase the risk for a fall.⁴

Despite the imposing threat they present, falls and fall-related injuries are largely preventable and are not an inevitable part of aging. A broad range of interventions can protect against a wide array of risk factors linked to falls. For example:

- Evidence-based exercise classes can help older adults build and maintain strength.
- Proper vision care can help people see their environment and better maintain their balance.
- Medication management can help adults safely use or avoid drugs that may cause dizziness, blood pressure issues, and cognition issues that can increase fall risk.
- Home modifications, like installing grab bars in bathrooms or removing tripping hazards, can make it safer for people to move around where they live.
- Age-friendly local and regional planning and development can make it easier and safer for people to get around in their communities.⁵

The risks of falls and how to prevent them is well-worn territory in the landscape of public health literature. Yet fully confronting the issue of older adult falls in Massachusetts requires overcoming significant barriers.

The state's fragmented local public health system has left local boards of health (LBOHs) overburdened and underequipped to support, coordinate, or gather data about falls prevention activities. Additionally, the Commonwealth lacks a statewide mechanism to provide older adults with in-home modifications that can reduce fall risks and save lives. Furthermore, some of the methods by which data on falls are collected make it difficult to know which environments—at home, for example, or out in the community—are most closely linked to non-fatal falls. Using the Healthy People 2030 Framework for

About the Massachusetts Commission on Falls Prevention

Formed in 2011, the Massachusetts Commission on Falls Prevention is a [statutory body](#) charged with investigating the serious public health issue of older adult falls in Massachusetts and recommending best strategies to reduce falls, fall-related injuries, and the health care costs associated with them. The Commission meets regularly to study issues related to its charge, develop recommendations, and draft reports, which are issued every two years.

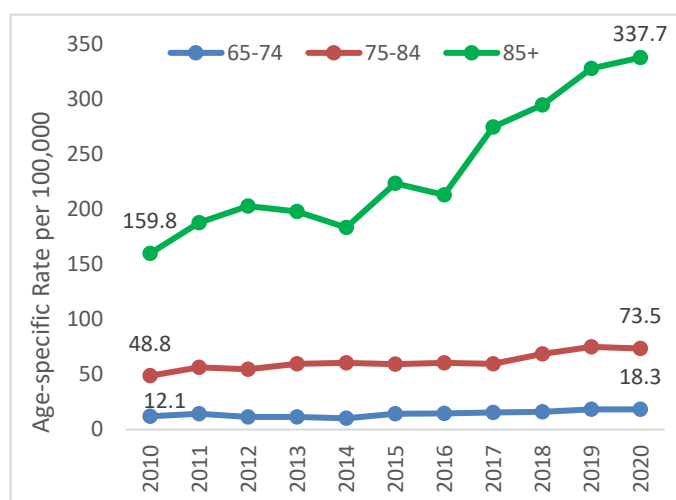
Local Public Health Infrastructure, the Falls Commission explored opportunities for strengthening local prevention activities and improving data collection to better support and protect Massachusetts' growing older adult population.⁶

The Devastating Impact of Older Adult Falls

Unintentional falls among older adults are a leading cause of fatal and nonfatal injury in the U.S. and Massachusetts (MA).⁷ In Massachusetts in particular, the rate of these injuries is skyrocketing. The rate of fall deaths for older adults in MA increased 61%, from 48.1 per 100,000 in 2010 to 77.7 per 100,000 in 2020.¹

Figure 1: Rate of Fall Deaths among Massachusetts Residents by Age Group, Ages 65 and Older

Fall death rates in MA increased most dramatically among those ages 85 and older, with rates for that group increasing 111%, from 159.8 per 100,000 to 337.7 per 100,000 from 2010 to 2020. (See Figure 1).¹ Among fall death rates in MA, American Indian/Alaska Native, non-Hispanic residents had the highest rate (99.4 per 100,000)^a followed by White, non-Hispanic, (71.7 per 100,000,) and Asian, Non-Hispanic residents (56.8 per 100,000). Males had a higher rate of fall deaths than females in MA (83.5 per 100,000 and 73.2 per 100,000 respectively). Inequities in fall deaths rates between MA counties exist, with a range of 48.3 per 100,000 in Franklin County compared to 74.8 per 100,000 in Berkshire County.



Beyond the physical toll of falls, the financial costs associated with fall-related injuries sustained by older adults are substantial. Projected lifetime costs associated with fatal fall injuries in 2019 among Massachusetts residents ages 65 and older are estimated at \$2.43 billion.⁷ Fall-related injury hospital charges for older adults submitted in FY2019 were approximately \$864.4 million.⁹

The urgency of making systemic changes to address older adult falls is underscored by the rapid growth of the Massachusetts population that is age 65 and older. Population projections suggest that the proportion of Massachusetts residents who are older adults will grow from about 14% in 2010 to 22% by 2030.^{10,11} Without significant and dedicated focus on falls prevention services, the rate of fall-related fatalities will continue to rise alongside the older adult population.

^a Rates are based on counts less than 20 and may be unstable.

Focusing Locally to Prevent Falls

Since issuing its 2020 report, the Commission has identified numerous challenges around falls prevention service delivery to older adults, especially during the COVID-19 pandemic. The Commission has previously observed that Massachusetts has a vast network of organizations that offer evidence-based programs designed to serve older adults.¹² However, at the beginning of 2020, referrals, screenings, and programs were not widely accessible. With the arrival of the COVID-19 pandemic, the availability of these interventions was further limited by public health orders that restricted public gatherings and in-person services. Even as it limited access to services, the pandemic has brought considerable public attention to the functions and capacity of the local public health system overall, its assets, and needs. With that attention has come widespread interest in strengthening local public health infrastructure through systemic changes and investment. In the last year, increased funding has become available to address local needs. For example:

- The Administration for Community Living under the U.S. Department of Health and Human Services has provided grants aimed at building expertise around aging and disability in the public health workforce.¹³
- The federal Bipartisan Infrastructure Law contains provisions that support municipalities in building healthy streets and improving transit access.¹⁴
- The Commonwealth's allocation of funds from the federal American Rescue Plan Act provides professional development for local health officials, improves local data collection and sharing, and encourages collaboration between local boards of health.¹⁵

Public health experts and scholars have highlighted the role of public health infrastructure as a critical component in efforts to address this growing problem. In its Healthy People 2030 framework, the Centers for Disease Control and Prevention note that “[p]ublic health infrastructure provides the necessary foundation for all public health services [and] includes a capable and qualified workforce, up-to-date data and information systems, and agencies that can assess and respond to public health needs.”⁶ Scholarship on falls prevention argues that the Healthy People framework for local public health infrastructure encompasses not only local boards of health, but also Area Agencies on Aging/Aging Services Access Points, health care providers, first responders, and other community organizations.^{6,16} In reviewing this framework, the Commission considered which entities provided local public health services related to falls prevention, including screening, referrals, provision of evidence-based programs, professional development, surveillance, and advocacy. Commission members identified over 30 organizations and organization types that engage in such activities (See Appendix B: Elements of Public Health Infrastructure Relevant to Local Falls Prevention Services).

The Commission engaged stakeholders and experts from across the array of organization types identified (See Appendix C: Commission Key Informants on Local Public Health Infrastructure). Organization representatives expressed high confidence in

the current evidence-based interventions around older adult falls, which include exercise, nutrition, medication reviews, and home safety modifications.¹⁶ In its work on the topic, the Commission has identified the following issues and related recommendations as central to reversing the upwards trend in older adult falls.

Issue 1: The capacity of local boards of health and partner organizations is limited by funding, staffing, and statutory obligations.

As municipal agencies that are deeply involved throughout communities, local boards of health (LBOHs) appear to be situated in an ideal position to support and implement community-based falls prevention activities. However, LBOHs face a host of challenges that make it difficult to pursue such work.

The statutory obligations of LBOHs are manifold. Among many other responsibilities, LBOHs:

- Investigate and report on cases of infectious diseases and outbreaks of foodborne illnesses
- Inspect and permit restaurants, camps, pools, septic systems, and beaches
- Respond to complaints about unsanitary residential properties
- Provide information on radon and lead exposure
- Conduct disaster planning
- Track animal-borne diseases
- Safeguard wells

These local public health duties are carried out by 351 individual local boards of health, one for each of Massachusetts' municipalities. As municipal agencies are largely funded by local tax revenue, LBOHs have highly variable access to funding and staff, making it difficult for many of these agencies to meet their obligations. Because of the overwhelming burden facing under-resourced agencies, many LBOHs have little or no available capacity to undertake falls prevention activities and similar programs that are not mandatory.¹⁷

One hundred and seventeen municipalities participate in a public health district or shared service arrangement, approaches that allow LBOHs to centralize some services.¹⁸ In some instances, LBOHs collaborate to tackle specific public health issues, like air quality or hazardous waste management. Other approaches involve communities within a region sharing public health services, like public health nursing services, inspectional services, or animal control services.¹⁹ These cross-jurisdictional arrangements generally have more capacity than individual LBOHs to administer voluntary programs. However, like their municipal counterparts, these collective

arrangements face limitations and inconsistencies in funding and remain unprepared to address the impending challenges of addressing older adult falls.

The challenges in capacity for fall-related work are further ameliorated in some communities by the responsibility for activities being shared across a wider range of organizations than a sole LBOH. Through initiatives like the Community Emergency Medical Services (CEMS) program, EMS providers in a given community can offer high-value, low-risk prevention services like falls screenings and simple home modifications.²⁰ Area Agencies on Aging and Aging Service Access Points, other community-based organizations like YMCAs and senior centers, and hospitals all frequently offer falls prevention screenings, evidence-based programs like Matter of Balance and Tai Chi, and referrals to those programs. Still, as with local boards of health, the availability of fall-related programming through these and similar agencies is dependent on their capacity and funding, which similarly varies across the state.

Finally, workforce shortages—particularly among community health workers, home health aides, and case managers—restrict the ability of organizations to implement falls prevention activities. This issue has received extensive attention by the [Special Commission on Local and Regional Public Health](#), which noted that workforce challenges in local boards of health are particularly vexing:

“The local public health workforce is a grab bag of trained and experienced staff, untrained and inexperienced staff, contractors, volunteers, and board members who, regardless of professional background, may fill in as needed.... The personnel crisis tends to be even worse in small towns and rural areas, hamstrung by small budgets, geographic isolation, and a lack of infrastructure.”¹⁷

The early stages of the COVID-19 pandemic have exacerbated staffing shortages throughout public health infrastructure and allied health professions, with personal care attendants and home health aides being particularly affected by the risk of exposure and limited public transportation.^{21,22}

Ultimately, a robust, locally-informed approach to falls prevention requires improved financial support for LBOHs and community-based organizations to support collaboration both within and across municipalities. LBOHs that can both work with partners in their municipalities and harness the economy of regional cooperation will be better positioned to improve the availability, effectiveness, and efficiency of falls prevention activities: education of residents about fall risk factors; coordination or provision of direct services to older adults; and collaboration with planning entities, public works departments, and other stakeholders to improve the built environment.

The Commission recommends that the Commonwealth allocate resources to support regional approaches to implementation of evidence-based falls prevention practices by local boards of health and partner agencies.

Issue 2: An effective systemic approach to falls prevention requires sustained, long-term investments in the built environment.

The built environment plays a major role in the occurrence of older adult falls. Fall risks are influenced both by how homes and public spaces are designed and used.

Sixty percent of fatal falls occur in the home.⁸ When older adults fall, the injury is frequently attributable to the interaction between factors in the environment—such as tripping hazards or a lack of grab bars—and other factors like dizziness from medications or reduced physical strength. Strong evidence supports home modifications that address environmental factors as an effective approach to preventing falls.²³ Although some minimal modifications can be accomplished in some communities through interventions like the Community Emergency Medical Services program, there is no statewide program that can support residents in making a wider range of home modifications to reduce injury risk.

In the energy conservation space, the MassSAVE program offers a promising model of a similar intervention. Through contractors, MassSAVE provides homeowners and landlords with no-cost home energy assessments. Homeowners are provided with simple energy-saving modifications during the assessment; they also become eligible to receive certain no-cost energy-saving products, rebates towards the purchase of energy-efficient appliances, and loans towards more expensive energy-saving home modifications. A comparable program aimed at addressing in-home injury risks—including fall risks—could greatly reduce the impact of older adult falls by removing hazards and serving as a point of referral to connect older adults with evidence-based programs in their communities. The program would engage occupational therapists around assessments for home modifications, coordinate and subsidize construction or installation services by third-party contractors, follow up with residents to ensure that modifications were performed correctly, and refer residents to other evidence-based programs as needed.²⁴ The economic benefit from such an intervention is significant: recent research estimates that “community-dwelling older adults who fall in a given year will have average health care costs \$1,500–\$2,500 higher than those who do not fall.” In contrast, research on interventions that have provided home modifications as a falls prevention strategy suggests that typically, home modifications—like installing raised toilet seats or grab bars—cost less than \$500 on average, including the cost of equipment and installation.²⁵ In addition to state funding, funding sources to support such a program could include federal grants aimed at reducing older adult falls and creating healthy housing, or expansion of the state’s Home and Community Based Services Medicaid waiver to include reimbursement for home modifications.

The Commission recommends that the Commonwealth support the development of a pilot program that pairs home safety assessments—including fall risk assessments supported by occupational therapists—with subsidized home modifications to mitigate injury risk.

Evidence also suggests that the built environment around a community—sidewalks, roads, and other public spaces—influences perceived fall risk and creates barriers to physical activity, which may, in turn, further increase fall risk.^{26,27} In this way, older adult falls risk may be reduced through land-use planning, like creating multi-use zones that facilitate walkable communities; infrastructure development, like building transportation systems and safe pedestrian networks that can reduce reliance on cars and improve access to community resources; and public works operations and maintenance, like thorough and timely clearing of snow and ice from sidewalks. Integrating falls prevention considerations into these processes requires surveying the processes in play and collaborating with stakeholders to make sure that relevant issues are brought to the fore. These processes include:

- Age- and dementia-friendly community assessments
- Community Health Assessments
- Community Needs Assessments
- Determinations of Need
- Municipal and regional master plans
- The State Highway Strategic Plan
- The Statewide Pedestrian Transportation Plan
- Racial Equity Municipal Action Plans
- Walkability assessments

The Commission recommends that the Commonwealth catalog local, regional, and statewide planning processes that affect older adult falls hazards; embed falls prevention considerations and age-friendly strategies into those efforts; and collaborate with stakeholders to assure falls are specifically and explicitly addressed through state-promoted assessments and planning processes.

Issue 3: Incomplete data on circumstances surrounding non-fatal falls constrain surveillance and prevention efforts.

Data on older adult falls and related health outcomes are collected in several ways.²⁸ For non-fatal falls, a major source is statewide acute care hospital billing data, known as Case Mix data, which offer insights into hospitalizations, observations, and emergency department visits and associated charges.⁹ Such information has long been instrumental to understanding the impact of injuries, including older adult falls.^{29–31} However, challenges around data collection prevent the public health community from realizing the full potential of these datasets.

Case Mix data include codes that detail the health condition for which a patient is treated and, sometimes, the circumstances that led to that health outcome. Conditions treated in health care settings in the U.S. are required to be coded using the International Classification of Diseases Tenth Revision-Clinical Modifications (ICD-10-CM).^{32,33} This coding scheme includes codes for a specific diagnosis (like a hip fracture). It also includes “external cause” codes to describe the cause and intent

associated with an injury (like an unintentional fall), the location where the event occurred, and the activity the patient was engaged in when the event occurred.³⁴

Although federal guidance encourages the reporting of external cause codes, there is no national requirement for providers to do so.³⁴ In the absence of a broader mandate, Massachusetts has implemented a number of state-level interventions to improve the collection of these data, including a 1994 requirement for hospitals in which a primary diagnosis code for an injury must be accompanied by an external cause-of-injury code, and the creation of dedicated fields in billing datasets to capture external cause codes. As a result, external codes indicated the cause of an injury in around 95% of billing data for injury-related hospitalizations and emergency department visits in Massachusetts.^{35,36}

While the codes that indicate a cause of injury are almost always submitted, medical coders and health care providers are less consistent in their use of codes that indicate the location where an injury occurred and the activity a patient was engaged in when injured. Barriers to more robust use of these codes persist. The completion of external cause codes is not reimbursed by insurers. Furthermore, determining the appropriate values for location and activity codes can be complicated by the quality of history that patients recite to providers and what other information providers have about an incident. While coding for diagnoses must be based on documentation from the patient's provider, coding for external causes may be based on any available documentation, assuming it does not contradict physician documentation.³⁴ Some coders must balance the time involved in reviewing additional documentation with quota systems that demand they complete coding at a certain pace, further disincentivizing the submission of voluntary codes.

Improving the completion rates for location and activity codes would help the public health community better understand the circumstances of older adult falls and design more appropriate falls prevention interventions that can, in turn, reduce disability and premature death from falls.

The Commission recommends that the Commonwealth work with stakeholders to develop and implement strategies that improve the completion of relevant injury codes, where feasible. Specific strategies could include providing guidance to hospitals and medical coders around coding of activity and location of injury; providing hospitals and coders with feedback on the quality and completeness of data coming from their institution; and developing a scheme for reimbursing providers for using such codes.

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Appendix A: Commission on Falls Prevention Membership

- **Bekah Thomas, Chair**
Director, Injury Prevention and Control Program
Massachusetts Department of Public Health
- **Almas Dossa**
Assistant Director, Fee-For-Service programs, Home Health, Hospice and Therapy Services, MassHealth Office of Long Term Care Services & Supports
MassHealth
- **Brian Doherty**
President and CEO
Massachusetts Assisted Living Association
- **Ish Gupta**
Medical Director, Team Health Hospitalist, Saint Vincent Hospital
Massachusetts Medical Society
- **Melissa Jones**
Quality Coordinator, Beth Israel Lahey Health at Home
American Physical Therapy Association of Massachusetts
- **Jennifer Kaldenberg**
Clinical Assistant Professor, BU, College of Health and Rehab. Sciences: Sargent College
Massachusetts Association for Occupational Therapy
- **Helen Magliozzi**
Director of Regulatory Affairs
Massachusetts Senior Care Association
- **Joanne Moore**
Director, Duxbury Senior Center
Massachusetts Association of Councils on Aging
- **Annette Peele**
Director of Community Programs
Massachusetts Executive Office of Elder Affairs
- **Colleen Pierro**
Director of Regulatory and Clinical Affairs
Home Care Alliance of Massachusetts
- **Emily Shea**
Commissioner, Commission on Affairs of the Elderly, City of Boston
Massachusetts Home Care
- **Mary Sullivan**
Pharmacy Manager, Senior Whole Health
Massachusetts Pharmacists Association Foundation
- **Deborah Washington**
Director of Diversity, Patient Care Services, MA General Hospital
American Association of Retired Persons

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Appendix B: Elements of Public Health Infrastructure Relevant to Local Falls Prevention Services

Types of Fall Prevention Services	Agencies Providing Services		Workforce Delivering Services	Indicators of Service Improvement
Screening	<ul style="list-style-type: none"> Community-based Organizations (CBOs) <ul style="list-style-type: none"> Gyms and YMCAs Councils on Aging (COA) Senior Centers Area Agencies on Aging/Aging Services Access Points Visiting Nurses Associations Local Boards of Health (LBOHs) Physician practices Pharmacies Pre-hospital provider agencies Occupational therapy (OT) and physical therapy (PT) practices Optometry practices/agencies Community health centers Adult day health programs Urgent Care Facilities 	<ul style="list-style-type: none"> Assisted living residences DHDC Housing for Senior Disability Community Independent living homes Continuing care retirement communities Community retirement homes 	<ul style="list-style-type: none"> CBO staff Evidence-based program (EBP) providers Certified Nursing Assistants (CNA) Community Health Workers (CHW) Physicians Nurses Pharmacists Pre-hospital providers Optometrists Emergency Department (ED) physicians Occupational therapists and physical therapists 	<ul style="list-style-type: none"> Number of screenings performed Number of cases of fall risks identified
Referral and Reverse Referral	<ul style="list-style-type: none"> Hospitals Community health centers Home health agencies Independent living agencies CBOs 		<ul style="list-style-type: none"> Clinicians CHWs CBO staff EBP providers 	<ul style="list-style-type: none"> Number of referrals made to service/ program Number of referrals made from source Number of programs completed based on referrals

Types of Fall Prevention Services	Agencies Providing Services	Workforce Delivering Services	Indicators of Service Improvement
Evidence Based Programs	<ul style="list-style-type: none"> ▪ CBOs ▪ Hospitals ▪ Public works departments ▪ Buildings departments ▪ Domestic violence (DV) homes/shelters ▪ OT and PT practices ▪ Municipal senior centers 	<ul style="list-style-type: none"> ▪ EBP staff ▪ CHWs ▪ CNAs ▪ Pre-hospital providers ▪ Building inspectors ▪ General contractors/home repair professionals ▪ PT and OT practitioners 	<ul style="list-style-type: none"> ▪ Numbers of individuals served
Professional Development	<ul style="list-style-type: none"> ▪ National Council on Aging ▪ Local COAs ▪ STEADI resources and training ▪ DV homes/shelters 	<ul style="list-style-type: none"> ▪ LBOHs ▪ State Department of Public Health (DPH) ▪ Clinicians ▪ Pharmacists 	
Surveillance	<ul style="list-style-type: none"> ▪ Hospitals ▪ Community health centers ▪ Pre-hospital provider agencies ▪ LBOHs ▪ State DPH 		<ul style="list-style-type: none"> ▪ Number of falls; associated ED visits, hospitalizations ▪ Risk and protective factors ▪ Monitoring cost of falls
Awareness/ Advocacy	<ul style="list-style-type: none"> ▪ Senior Citizen Clubs, advocacy organizations, community organizations 	<ul style="list-style-type: none"> ▪ CBO staff ▪ CHWs ▪ Advocates 	

Appendix C: Commission Key Informants on Local Public Health Infrastructure

In its deliberations and the process of drafting this report, the Commission and Commission staff consulted with the key informants listed below.

- **Meaghan Avery**
Healthy Living Program Director
Old Colony YMCA
- **Lauren Bartell**
Executive Director of Healthy Living
Old Colony YMCA
- **Charles Deutsch**
Former Director,
Population Health Research
Program
Harvard Catalyst
- **James Fuccione**
Senior Director
Massachusetts Healthy Aging
Collaborative
- **Lisa Gurgone**
Executive Director
Mass Home Care
- **Carlene Pavlos**
Executive Director
Massachusetts Public Health
Association
- **Jennifer Raymond**
Director, Healthy Living Center of
Excellence
AgeSpan
- **Kate-Marie Roycroft**
Director of Public Policy
Alliance of Massachusetts YMCAs
- **Sam Wong**
Director, Office of Local and
Regional Health
*Massachusetts Department of
Public Health*
- **Ted Zimmerman**
State Planner/
Legal Assistance Developer
*Massachusetts Executive Office of
Elder Affairs*

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