# Introduction

* Summary of data and recommendations

# The Burden of Older Adults Falls(Data to be imported from Older Adult Falls Special Emphasis Report)

* 1. Mortality
* Number and share of fall deaths among older adults
* Estimate of weekly fatal fall injuries among older adults
* Location of deaths where reported, home versus residential facilities
* 2015-2020 trend in age-adjusted rate of fall deaths for all MA residents ages 65 and older
* Include comparisons to national data where relevant
	1. Morbidity
* Number and share of nonfatal fall-related hospitalizations and ED visits among older adults
* Estimate of weekly nonfatal fall injuries among older adults resulting in hospital stays or ED visits
* Share of older adults reporting falls and fall-related injuries
* Leading injury types resulting from falls, and share discharged to SNFs, rehabilitation facilities, and home
* Years of Life Lost
* Sequelae
* Impacts on mental health, quality of life
* Include comparisons to national data where relevant
	+ 1. United States
	1. Economic cost
* Projected lifetime costs associated with fall injuries in a single year among MA residents ages 65 and older; stratification by medical costs and lost productivity costs, and by deaths, hospital stays and ED visits
* “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 (Carroll et al., 2005; Shumway-Cook et al., 2009; Stevens et al., 2006). The cost to Medicare for treating fall-related injuries in 2015 totaled more than $31 billion (Burns et al., 2016).”1
	1. Inequities
* Stratification of fall-related hospitalizations, ED visits by sex and race
* Stratification of reported falls and fall-related injurie by sex, age, and disability
* Stratification of fatal and nonfatal fall injury rate by age, race, and sex, relative risk
	1. Forecasted demographic shifts

# Older Adult Falls and Local Public Health Infrastructure

## Commission process for issues identification and recommendation development

* Commission identified theme; staff and commission developed framework; staff spoke with informants; commission workgroup developed report; revised by commission and submitted.

## Conceptual framework

* “Public health infrastructure provides the necessary foundation for all public health services—from vaccinations to chronic disease prevention programs to emergency preparedness efforts…. A strong public health infrastructure includes a capable and qualified workforce, up-to-date data and information systems, and agencies that can assess and respond to public health needs.”2
* Viewed in the context of falls prevention by Gagen and Bulzacchelli, the Healthy People framework encompasses not only local health departments, but also AAA/ASAPs, health care providers, first responders, and other community organizations.
* In reviewing the 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.

## Context and constraints

* High confidence in interventions around older adult falls
	+ “Abundant research shows that exercise, nutrition, and home safety assessment and modification are all effective in reducing rates of falls among older adults in community settings.”1
	+ “Group and home‐based exercise programms, and home safety interventions reduce rate of falls and risk of falling.”3
	+ “Massachusetts has a vast network of organizations that offer such services, and older adults should be referred to them.”4
* Workforce shortages—particularly among community health workers, home health aides, and case managers—restrict the ability of organizations to implement falls-prevention activities.
	+ “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.”5
	+ The early stages of the COVID-19 pandemic exacerbated staffing shortages, with PCAs and HHAs being particularly affected by the risk of exposure, limited public transportation, and enhanced unemployment benefits that exceeded low wages in the field.6,7
* Awareness—of falls as a public health problem and of available interventions—is growing but remains lower than ideal
* Approaches for implementing evidence-based interventions—for example, CEMS, YMCA/AAA/ASAP offerings—are highly dependent on local resources, both financial and organizational.

## Issues and recommendations

* Incomplete data hamper falls surveillance efforts
	+ Effective injury surveillance is reliant on providers’ coding of injury-related care in the billing process. When treating someone who has suffered a fall-related injury, providers should ideally use the relevant ICD-10-CM codes to indicate both that the injury resulted from a fall and the place where the injury occurred.
	+ As indicated above, review of recent nonfatal injury data revealed a large share of records missing coding for the location of a fall injury.
	+ Furthermore, some Commission informants indicated concern that fall injuries were not always coded as such.
	+ **Recommendation:** The Commission should work with the DPH Bureau of Health Care Safety and Quality to understand the barriers to using these codes and develop interventions that improve relevant injury code use where appropriate.
* Local organizational capacity is constrained by various factors
	+ Municipal agencies ability to undertake falls prevention activities is limited by funding as well as the availability and capacity of partner organizations.
	+ In particular, local health department capacity is severely constrained by funding, staffing, statutory obligations1,5
	+ **Recommendation**: Increased statewide financial support for regional approaches to implementation of evidence-based falls-prevention practices by local public health departments
* An effective systemic approach to falls prevention requires sustained, long-term investments in the built environment
	+ 60% of fatal falls are in the home
	+ Home modifications are supported by strong evidence3
	+ Evidence also suggests that the built environment influences perceived fall risk and creates barriers to physical activity8,9
	+ **Recommendation**: EOEA and DPH should work to embed falls prevention considerations and aging-friending strategies into regional and statewide planning efforts
	+ **Recommendation**: Development of a pilot program that pairs statewide home assessments for hazards with subsidized home modifications to mitigate injury risk
		- Modeled on MassSAVE

# References

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9. Rosenberg DE, Huang DL, Simonovich SD, Belza B. Outdoor built environment barriers and facilitators to activity among midlife and older adults with mobility disabilities. *Gerontologist*. 2013;53(2):268-279. doi:10.1093/geront/gns119