of LTSS program design and decision-making. This shows that "everyone can make a difference," she said.

Medicaid is the largest payer of LTSS in the United States, Ms. Kotzias emphasized. In 2013, Medicaid spending comprised 51% of total national LTSS spending, after other public sources (21%), out-of-pocket spending (19%), and private insurance (8%), according to a 2015 Kaiser Family Foundation report ("Medicaid and Long-Term Services and Supports: A Primer," available at https://kaiserf.am/2J1J2AM).

Medicaid LTSS spending has been slowly trending away from institutional care for decades; in 2012, the balance between institutional and HCBS expenditures as a percentage of total Medicaid LTSS spending finally shifted, with HCBS expenditures outpacing the institutional component. In 2015, HCBS spending made up about 55% of all Medicaid LTSS expenditures, according to a 2017 report commissioned by the Centers for Medicare & Medicaid Services (available at http://bit.ly/2sk4o1E).

The percentage of Medicaid LTSS expenditures for HCBS has continued to vary across states and population groups. HCBS accounted for 44% of spending in programs targeting older adults and people with disabilities, compared with 76% of spending in programs targeting people with developmental disabilities and 42% for behavioral health services for people with mental health and substance abuse disorders, according to the 2017 CMS report.

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EDITOR'S NOTE

In another arena, the Centers for Medicare & Medicaid Services has recently added the option for Medicare Advantage (MA) programs to provide non-medical supports to their enrollees.

Clearly, psychosocial and economic factors can play heavily into utilization of health care resources, and this seems a step in the right direction. Often, what starts as a pilot with MA eventually becomes Medicare policy. Blue Shield of California is an early adopter of this option, and *Caring* will keep readers updated as this gets rolled out. I am sure geriatrician and health care advocate and visionary Joanne Lynn, who has spoken at the Society Annual Conference on occasion, is most pleased at the movement in this direction.

Also related to Medicaid, some readers may have seen the news about the eviction notices to 37,000 long-term nursing home residents in Louisiana (https://cbsn.ws/2Kb7a03) in May. This situation related to their state budget deficits, and there was a last-minute fix to allow these people not to be put out on the street (or back to family situations without resources to look after them). But this may be a shape of things to come in our post-modern sociopolitical landscape.

My advice: If you possibly can, amass a lot of resources and have a lot of daughters, so you won't have to rely on Medicaid.

—Karl Steinberg, MD, CMD, HMDC
Editor in Chief

Reducing Polypharmacy to Reduce Fall Risk: It's Complicated

Randy Dotinga

It sounds like common sense: If you'd like to reduce the risk of falls in vulnerable populations, try weaning patients off drugs that boost the risk of falls. But an analysis of the existing research has suggested the true picture may be more complicated.

"When resources or time are limited, care providers who are specifically looking to prevent falls in older adults or developing fall prevention programs should focus first on implementing proven approaches that have shown to have the most benefit — exercise, vision assessment and treatment," said the review's lead author Justin Lee, MD, BScPhm, a geriatrician with the Department of Medicine at McMaster University in Hamilton, Ontario.

The findings of the review were released in a presentation at the World Congress of Gerontology & Geriatrics, presented by the International Association of Gerontology and Geriatrics, in San Francisco (https://academic.oup.com/innovateage/article/1/suppl_1/268/3902906).

Many drugs are linked to a higher risk of falls in the elderly. A 2009 meta-analysis of nine drug classes said three types of drugs show a "significant association" with falls in people older than 60: sedatives and hypnotics, antidepressants, and benzodiazepines (*Arch Intern Med* 2009;169:1952–1960).

But it's still debatable whether reducing the drug load is helpful. In 2015, a systematic review examined 19 studies to find a connection between polypharmacy and falls. Researchers found that only six of the studies reported an association between more medication use and more falls (*Eur J Clin Pharmacol* 2015; 71:1429–1440).

In an interview with *Caring*, Dr. Lee said current fall-prevention guidelines typically suggest reducing or eliminating use of the drugs thought to boost the risk of falls. But the guidelines fail to identify the most useful strategies, he said.

Dr. Lee and colleagues identified just five randomized controlled trials with 1,309 participants that evaluated the withdrawal of the drugs believed to boost the risk of falls.

The studies failed to show evidence of a decline in the rate of falls, the number of fallers, or the rate of fall-related injuries between intervention and control groups over a period of 6 to 12 months.

How is it possible that falls don't decline when at-risk patients take fewer of the drugs linked to falls? One possibility is that reducing polypharmacy actually does work, but the five studies were insufficient to detect an effect. This could be because it was difficult to wean patients off the mediations, Dr. Lee said.

It's also hard to understand the role played by the drugs in boosting the fall risk, Dr. Lee said. "It's unclear whether the associated increased risk of falls is truly caused by the use of these drugs, the underlying conditions that the drugs are treating, or some other patient-related factor that is common in those who receive these drugs," he said. "It is likely that the risk of falls varies with different fall-risk-increasing drugs (e.g., opioids vs. antipsychotics vs. antihypertensives) and the patient circumstances under which the drug is being used (e.g., osteoarthritis vs. Alzheimer's dementia vs. orthostatic hypotension)."

According to Dr. Lee, none of the studies measured the adverse effects of withdrawing from the drugs, and only one looked at fall-related injuries. None examined any effect on fall-related fractures or fall-related hospitalization, even though "these are arguably the outcomes that matter most to patients, health care providers, and our health systems," he said. He cautioned that providers shouldn't simply assume that there's no fall-prevention benefit to reducing polypharmacy. "There are potentially several other reasons to review, reduce, and optimize medications in older adults, such as prevention of other adverse drug events including cognitive impairment and delirium," he said.

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