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Best Practices

Going Upstream: Addressing Fall-Related Medicare Costs

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Philip Oravetz, MD, MPH, MBA, Chief Population Health Officer, Ochsner Health

Steven Castle, MD, Clinical Director of Geriatrics, Professor of Geriatric Medicine, VA Greater Los Angeles & UCLA

Pete Fronte, MBA, Founder and CEO, Altura

Mark Schafer, MD, Senior Medical Advisor, Altura

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— **Pete Fronte, MBA, Altura**

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Multiple trends are converging in senior care. As the population of patients age 65 and older grows, so does the number of falls busy care teams must treat—along with all the medications, labs, and scans that often come with caring for this age group and their chronic conditions.

"There just isn't enough time during a clinic visit to address all these health problems," said Mark Schafer, MD, with Altura, which delivers age-friendly technology, resources, and support so that healthcare organizations (HCOs) of all types can build or expand older adult active aging programs. Exasperating the trend of rising utilization is an ongoing shortage of doctors, RNs, and healthcare staff in general.

On the business side, HCOs face rising prices and changing reimbursement models, including a shift to more risk sharing. With more and more patients in value-based plans that focus on quality and cost utilization, reimbursement is a looming problem.

"Our value-based care models, they are not really built to handle this," Schafer said. Philip Oravetz, MD, MPH, MBA, chief population health officer for Ochsner Health, noted that there is not even a code for tracking falls.

This webinar explored fall prevention as "low-hanging fruit" for HCOs right now, for both patient outcomes and cost of care.

The Vicious Cycle Impacting Value-Based Care

When factoring in hospitalization, surgery, rehabilitation, and long-term care, falls account for nearly 20% of seniors' healthcare costs. For the patients themselves, falls often lead to severe injuries such as fractures (including most hip fractures), along with head trauma, reduced mobility, and decline in overall health.

"Falling once doubles a chance of falling again," said Pete Fronte, MBA, Altura founder and CEO. "With the over-85 cohort nine times more likely to have a hip fracture than the 65-to-74 cohort, this group needs consistent and intentional outreach and support."

"You have inactivity that leads to weakness and then fear of falling. And then falling leads to increasing fear and lower activity. And then you see physical decline and depression, and that leads to worsening of those chronic conditions," Schafer said of the vicious cycle that a single fall or fear of falling can unleash.

"A quarter of the patients die within six months," Oravetz noted. "A quarter of the patients never get back to their previous level of function. A quarter of them never get out of a skilled nursing facility or a nursing home."

These impacts extend to reimbursements as well. "For an elective joint replacement, you can be pretty efficient and get great outcomes," said Oravetz. "But what you don't have control over are ambulances bringing fracture patients to nearby emergency rooms." He pointed out that these fracture patients can dilute the shared savings generated by the joint replacements. "This represents a hidden cost in all of your value-based programs."

Hip and femur fractures impact value-based programs such as:

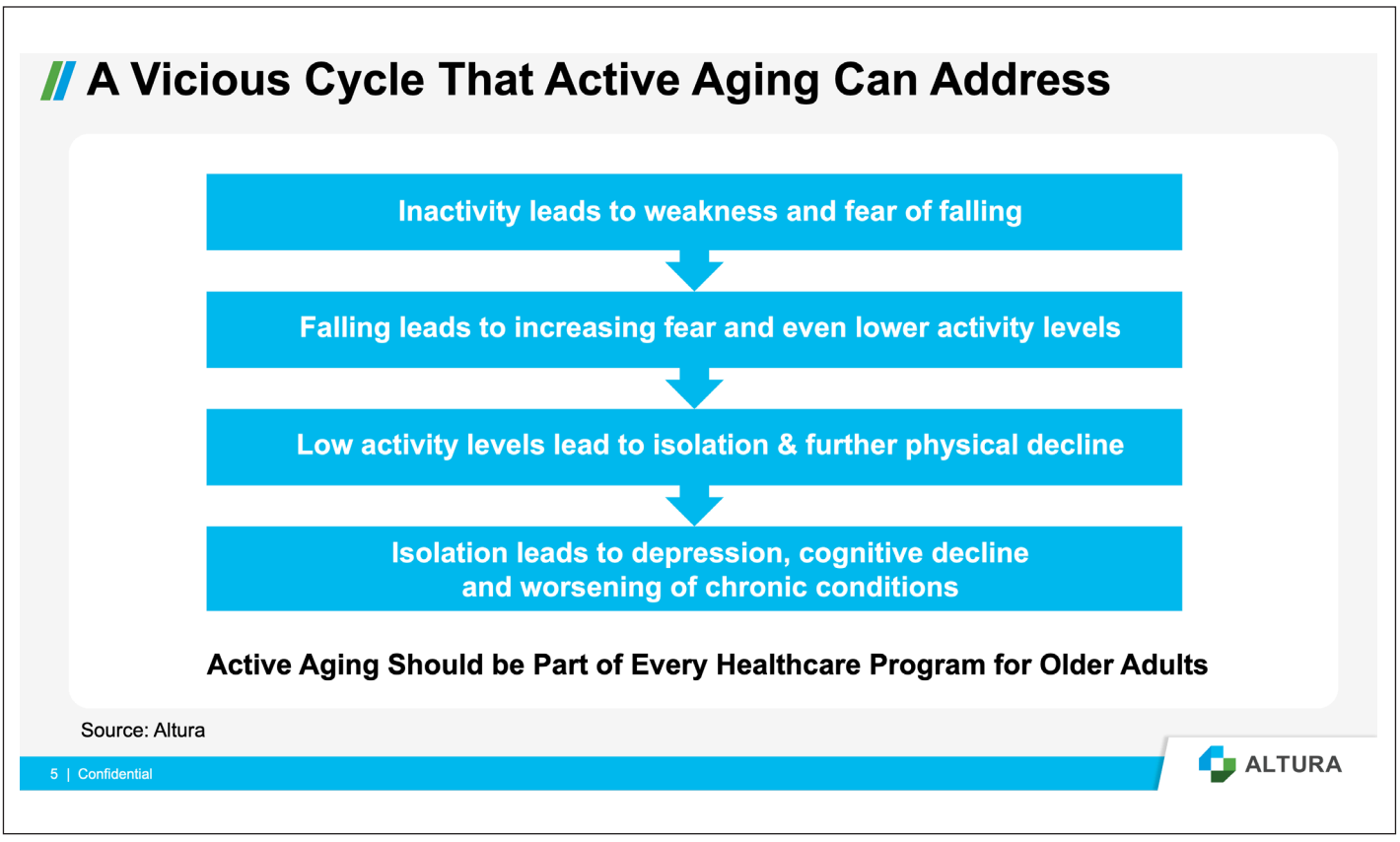
- *Comprehensive Joint Replacement (CJR)*
- *Bundle Payment Care Initiative-Advanced (BPCI-A)*
- *Transforming Episode Accountability Model (TEAM)*
- *Medical Advantage (MA)*
- *Medicare Shared Saving Program (MSSP)*

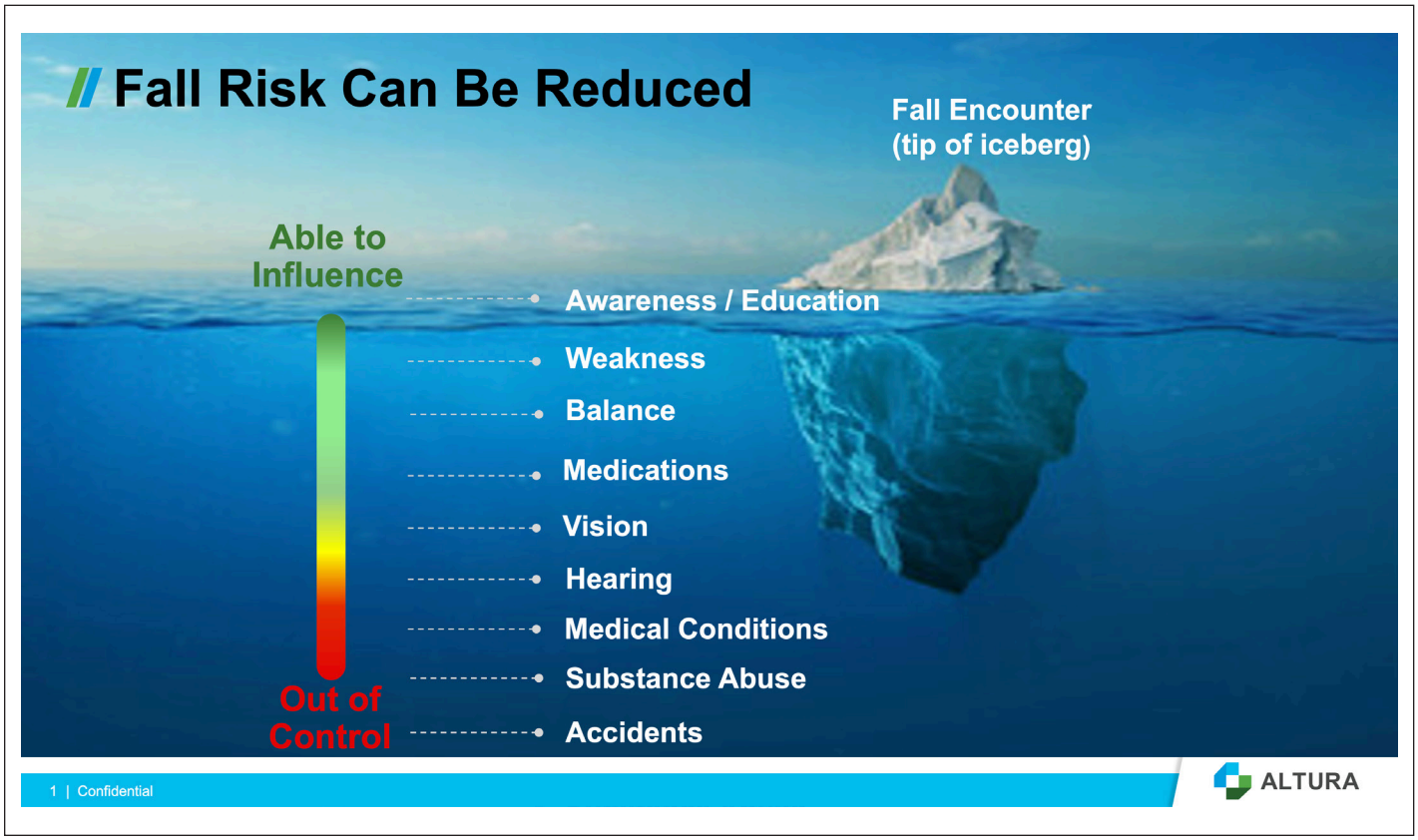
Fall Prevention's Underutilized Potential

"Fall prevention is not new," Schafer pointed out, noting there have been "a lot of programs around the concept since the 1980s."

Yet despite their prevalence and impact, falls and fall prevention too often rank below other priorities on an HCO's list of things to tackle, like chronic conditions on the care side and risk-adjusted coding on the business and administrative end. Falls are not typically tracked. And they may not be among the multiple conditions that come up in conversation during a busy visit with a provider.

That's where fall prevention comes in. "Falls happen. We can't avoid that, but they can be reduced," Fronte said.





"One way to look at it is to ask: What can we control and what can we influence?" Fronte said, citing influenceable factors like education, weakness, balance, medications, vision, and hearing, both at and outside of the point of care.

And this latter part is particularly important. "What can we do away from the clinic, mobilizing other people in the healthcare continuum like caregivers and patients themselves?"

Meeting Older Patients' Varied Needs and Preferences

Though grouped under the category of "seniors," this patient population is far from a homogenous monolith. Through work with the Michael J. Fox Foundation for Parkinson's Research and various full-risk HCOs over the years, Altura has "learned a lot about older adults and how they are not only consuming healthcare, but what they're doing outside of the healthcare system," Fronte said. "What's important to them is maintaining or improving their mobility and fitness. People want to keep doing things they love for as long as possible, and remaining mobile also reduces isolation "

Getting to such a goal isn't a one-size-fits-all solution. Older populations are complex, Fronte pointed out, with wide-ranging health conditions, comfort with technology, and wants and needs.

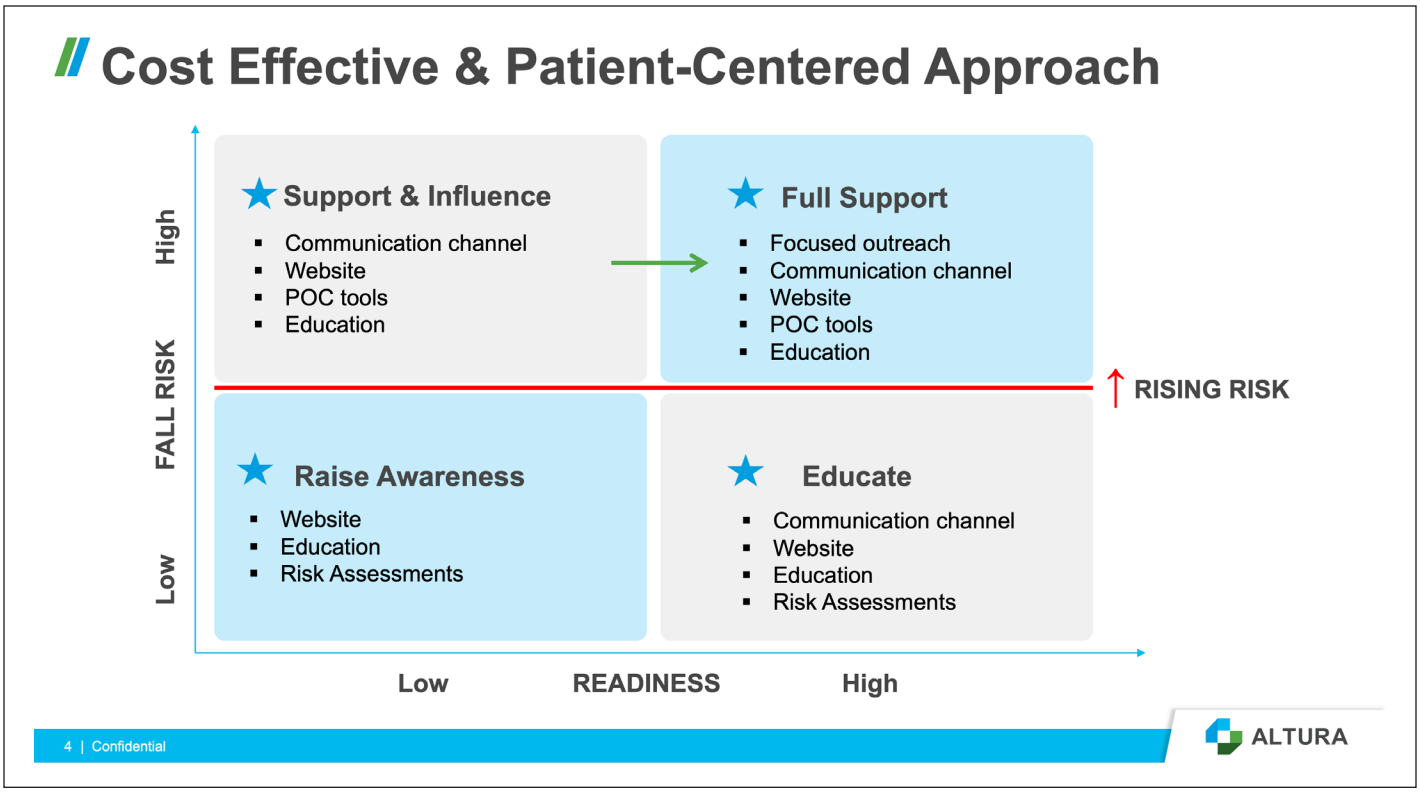
"There is a pretty big difference between the baby boomers in their sixties and seventies who may certainly benefit from a free gym membership and those in their eighties and nineties," Schafer said. "Eighty-five-year-olds typically are not going to the gym or using apps, so we need different techniques, different ways of approaching these older populations."

"Baby boomers are more likely to use tech. They are more involved with their care, whereas the silent generation still wants that personal touch, that phone call and printed material," said Fronte, citing a hotline, focused outreach, education via email or text, website content, online courses, local activities, and point-of-care tools.

"Patients still want phone calls, especially the Spanish-speaking population, and they want information and prevention resources at home," Fronte said.

For low-risk patients, Fronte said, the goal is to educate and raise awareness, focusing more resources on those at higher risk (e.g., history of a fall, assessment rating).

How does an HCO determine a patient's risk classification? One simple but useful method is assessing a person's level of activity based on an Altura visual model that any team member can use. Level one is a person who is mostly sedentary and chair bound and needs caregiver assistance to get around. But they're



not the only group who needs attention. “The level twos should be using a walker or some type of mobility device,” Fronte said. “They are a rising risk cohort because they’re still getting around on their own but their strength and balance is declining.” Level three are active people at risk of physical decline, while level four are very active and are low risk.

For this reason, it’s important to look beyond “just giving a handout of random exercises” and provide exercises “that help them do what they want to do or address their specific problems”—if, for example, they are struggling with stairs and steps. Fronte also emphasized the importance of looking beyond traditional services to “what happens when patients are away from the clinic.”

The Many Facets of an Aging-Friendly Health System

Fronte and Schafer walked through the components of such a multifaceted aging-friendly health system.[1]

Where traditional approaches to fall prevention focus on balance, strength, home safety, and education, newer initiatives expand this lens to “active aging,” encouraging and assisting patients to be physically active as they get older.

From longevity in the “blue zone” of Sardinia[2] to the daily steps encouraged today, lifestyle has long been connected to better health in seniors. Steven Castle, MD, a specialist in geriatric medicine, delved into the research and rationale.

Castle has published extensively in the areas of exercise and fall risk and prevention for older adults.[3] For the webinar, he extended this discussion more broadly, where falls contribute to overall health outcomes and better health can help lower fall risk. Castle mentioned more than a hundred papers he and the Altura team have reviewed in the past few years connecting increased physical activity such as steps per day to better sleep, lower blood pressure, and decreased risk of stroke, heart failure, and cancer.

The connection between physical activity and brain health is particularly strong. The U.S. POINTER Study randomized clinical trial studied structured and self-guided approaches that included physical exercise,

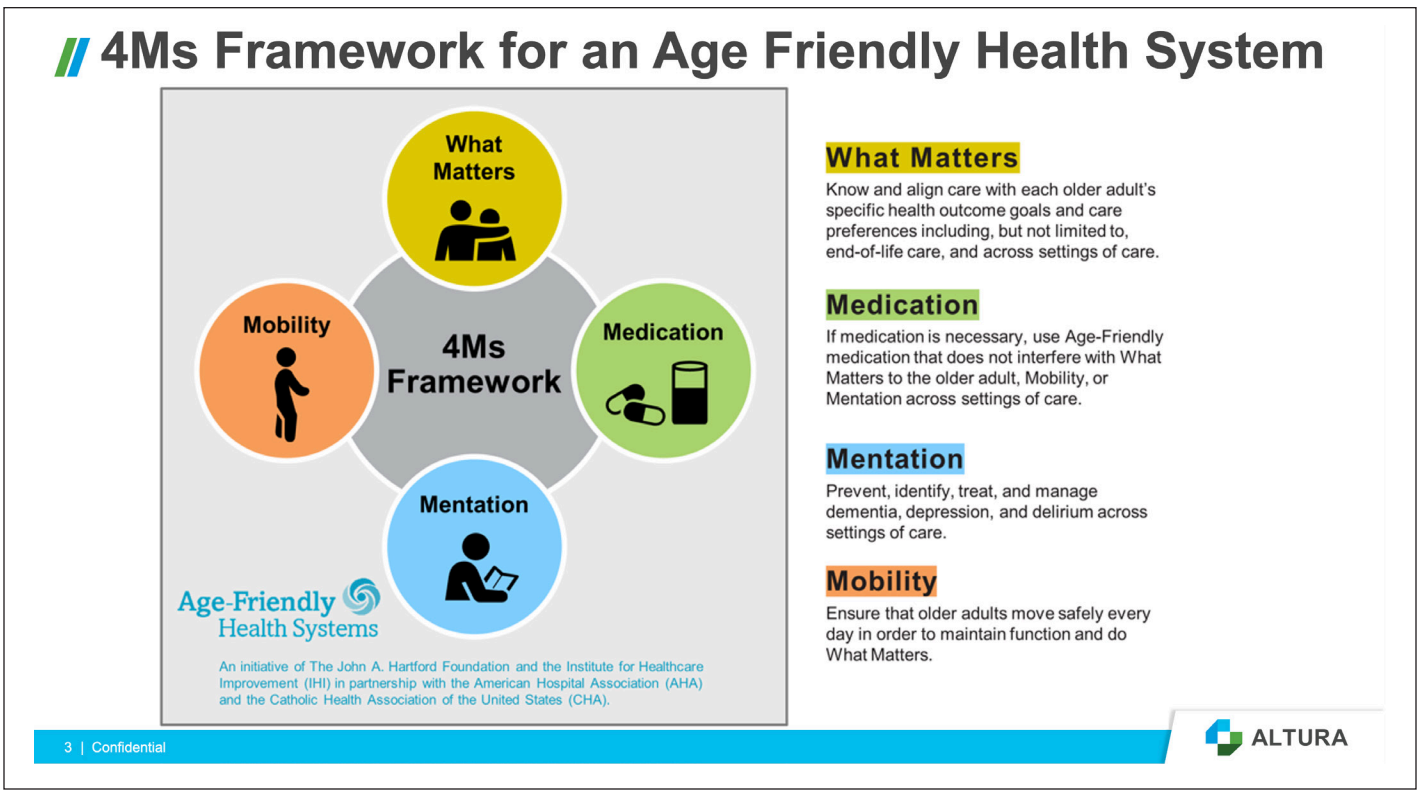
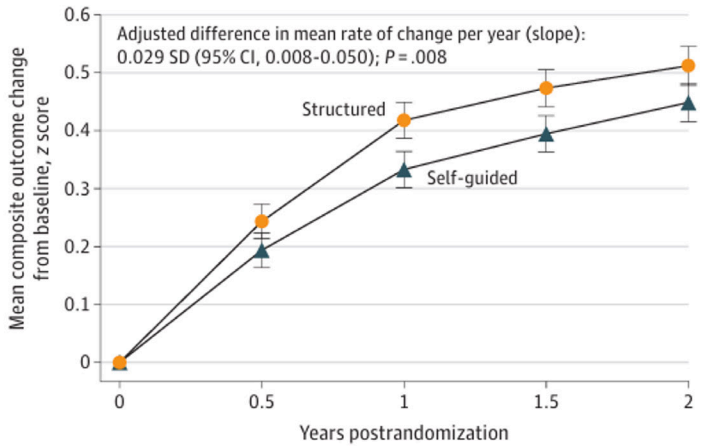


Figure 3. Change From Baseline in Global Cognitive Function Composite Score (Primary Outcome) by Structured vs Self-Guided Lifestyle Interventions



Total No.					
Structured	1056	965	949	918	923
Self-guided	1055	976	949	929	956

ALTURA

adherence to the MIND diet, cognitive challenges, social engagement, and cardiovascular health monitoring.[4] Older adults in both groups showed a marked improvement in cognitive functioning over two years.

"A lot of our older adults are spending hundreds of dollars a month on supplements," Castle said. "Instead, we could engage them to increase their physical activity. Remaining active improves health quality and lowers healthcare costs."

Schafer connected these findings to what he's been seeing in his own work, including a significant decrease in emergency department and urgent care visits. "Just a little amount of activity—even a couple thousand steps a day—has been shown to reduce the impact on chronic disease," he said.

Upstream Efforts at Ochsner Health

At Ochsner Health, which serves patients across Louisiana, Mississippi, and the Gulf South, each day brings five or more seniors into the system with a hip or femur fracture, according to Oravetz. "Five a day," he emphasized. In addition, falls are the top complaint for seniors visiting Ochsner's emergency departments.

The organization has made many efforts to address this "multifactorial" situation, including establishing a fracture liaison service.

"We're creating pathways where patients who fall are getting directly referred into therapy from the emergency department," Oravetz said. "But that's too little, too late. So we're going upstream to get to the patients before they fall."

He talked about Ochsner Health's many screening efforts across emergency departments, inpatient settings, clinics, and well patient visits for those age 65 plus. "We don't lack for our ability to screen. However, I think we have opportunities to better coordinate prevention efforts based on results."

"Osteoporosis is part of the equation," he said, noting Ochsner Health's participation in the AMGA Osteoporosis Collaborative and new United States Preventative Task Force recommendations to screen

all women age 65 and up for osteoporosis, along with younger women with high risk.[5]

Also part of the equation: extending the reach of the fracture liaison service to prevent repeat falls. "We're taking those high-risk patients we identify in the ED," Oravetz said, "and we're putting them into our collaborative with multidisciplinary clinics."

These clinics include a fracture liaison service with orthopedics and endocrinology, in three locations. Other interventions include partnering with pharmacy departments to accelerate therapeutic interventions and updates to Epic, which are currently in development.

"Our primary care doctors have asked for a SmartSet on how we make sure we're doing the appropriate workup and getting patients on the appropriate treatment," Oravetz said.

Q&A

Q: ***For daily activity metrics like steps per day, what's important? What's a minimum?***

A: "It depends on where you're starting and your mobility level," said Castle, emphasizing the importance of steady progression from this baseline.

Q: ***What intake metrics does a SmartSet include, and do clinic nurses or medical assistants ask these questions?***

A: At Ochsner Health, SmartSets guide physicians and physician assistants toward a comprehensive workup (e.g., have metrics like calcium and thyroid levels been measured?) "to make sure that we're covering all our bases," Oravetz said. "What's really nice in the era of AI that's coming in, we can look at the chart and see if those things have been done."

Q: ***How can HCOs get insurance to pay for longer physical therapy sessions?***

A: "Physical therapists are busy, with a three- to four-week wait for appointments and limits on how many sessions you can actually have," Fronte said, citing the obstacles.

Then the discussion turned to what kind of treatment these patients need in the first place, exploring the example of a female in her eighties with osteoporosis who has probably experienced a fall already. More sessions of physical therapy typically won't help this patient as much as home safety evaluations and modifications, like grab bars in bathrooms.

For patients at a lower risk level, the transition from physical therapy to daily physical activity is the treatment opportunity.

"For something like fall prevention and active aging, it really needs to be a longer-term chronic type of program where you're really teaching the patient to become active, teaching them to move and doing it in a way that is cognizant of their abilities and their age," said Schafer.

Q: *How can organizations moving into accountable value-based care start preparing for the uptake in older patients?*

A: "Get a screening tool," Oravetz advised. "Sort that list and really work that list to get to the highest-risk people with a variety of interventions."

Ochsner Health is currently exploring virtual therapy as a way to engage patients and avoid the vicious cycle of isolation and inactivity, especially during the hot Louisiana summers. "You know, it's hard to be outside when it's 100 degrees out."

Fronte cited the reverse situation—with a similar result—with an HCO in Pennsylvania. "Once the ice and snow comes, people don't want to go outside because of the risk of falls and slips, nor is outdoor physical activity encouraged due to the risks. Our experience with need-driven, phone-based fall prevention support has been very positive. Video-based calls can be an obstacle, but the phone always works for the 80 plus population," he said.

Q: *How can HCOs manage their resources to prioritize fall prevention?*

A: Among "the 10 top things that we worry about in our system," falls generally gravitate to the bottom of the list, Oravetz replied.

"Unless leadership realizes the tip of the iceberg and the size of that iceberg, it's really hard," Fronte said. "I see HCOs struggle because providers have so much on their plate."

"If we can show that there are some great solutions out there, that we can actually do something about it, I think that will help to move people in that direction," Schafer said. "Raise awareness, point out the magnitude of the problem and that there are solutions, and you'll see improvement."

"Don't wait to build something," Fronte advised. "Take a small step and then keep building on it. Creating a fall registry or implementing a risk-stratified fall assessment are good starts, but ultimately a basic level of support is needed for the high-risk cohort."

For more information, visit www.altura.health or email info@altura.health.

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One Prince Street
Alexandria, VA 22314-3318

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