

## Geriatric Hip Fracture Management: PBL

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## Robin Cornell Creamer, DO, FAAFP

Assistant Director, Florida Hospital Family Medicine Residency, Winter Park; Assistant Director, Geriatric Medicine Fellowship Program, Florida Hospital, Orlando; Associate Professor, Florida State University College of Medicine, Tallahassee; Assistant Professor, University of Central Florida College of Medicine, Orlando.

Dr. Creamer is a graduate of the Chicago College of Osteopathic Medicine, Downers Grove, Illinois, and completed her family medicine residency at Florida Hospital in Orlando. She also recently completed a fellowship in geriatric medicine at Winter Park Memorial Hospital, Florida. Dr. Creamer has been practicing and teaching family medicine for more than 20 years. Following her passion for osteoporosis prevention, she leads a National Osteoporosis Foundation (NOF) support group called Central Florida Healthy Bones and has earned her NOF fracture liaison service certificate. She believes one of family medicine's critical challenges is to motivate patients to be as physically active as possible.

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## Nathan Falk, MD, FAAFP

Assistant Director, Sports and Family Medicine Faculty, Florida Hospital Family Medicine Residency, Winter Park, Florida.

Dr. Falk is a graduate of the University of Nebraska College of Medicine. He completed his family medicine residency at Offutt Air Force Base (AFB). He served as residency faculty and director of sports medicine at Offutt AFB/University of Nebraska where he was the 2012 Faculty of the Year. Dr. Falk specializes in advanced non-surgical care for musculoskeletal conditions, including evaluation, ultrasound, and injections, as well as medical care of the athlete, ranging from asthma to concussions. Additionally, he has interest in faculty development and teaching residents to teach. He has published numerous chapters, books, and articles on sports and family medicine topics, as well as serving as an expert lecturer from Florida to China.

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## David Lee, MPA

Executive Director, National Bone Health Alliance.

Lee is a graduate of the University of Nebraska in Lincoln and American University in Washington D.C. He joined the National Bone Health (NBHA) as executive director in March 2011. NBHA is a public-private partnership launched in late 2010 that bring together the expertise and resources of 50 organizational participants from private, non-profit, and government sectors to promote bone health and prevent disease; improve diagnosis and treatment of bone disease; and enhance bone research, surveillance, and evaluation. Among NBHA's signature initiatives include efforts to drive the widespread implementation of post-fracture liaison service care coordination programs; the 2Million2Many public and health care professional awareness campaign; and a variety of projects aimed at standardizing the use of bone turnover markers. Lee has more than 25 years of non-profit and for-profit health care expertise and executive leadership.

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## Learning Objectives

1. Practice applying new knowledge and competencies gained from geriatric hip fracture management sessions, and receive feedback from expert faculty.
2. Interact collaboratively with peers to solve complex and challenging case-study scenarios.
3. Develop problem-solving skills that promote effective reasoning to manage geriatric hip fractures within the context of professional practice.

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## Audience Engagement System



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## Recommended Practice Changes

1. Review available resources for physicians to improve care of patients post-hip fracture.
2. Review and practice fall prevention screening tests and therapy exercises.
3. Discuss barriers and recommendations for improving care coordination for post-fracture care

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## Outline of the Session

- Review available physician resources
- Review screening for fall risk and practice exercises for fall prevention
- Introduce and discuss chronic care coordination as part of secondary fracture prevention
- Session breakout and discussion of ideas

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## Case

- 72 yo female presents to office after fall
- Had cough and URI
- Fell and broke her Right Hip
- Fixed by ortho and was in SNF for 2 wks
- Discharged yesterday

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## Case

- PMHx
  - HTN, CAD s/p PCI in 2010
- Meds
  - Lisinopril 20 mg daily, metoprolol 25 mg BID, ASA 81 mg daily

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## Case

- Vitals and Exam
  - BP 150/85, HR 85, RR 16
  - RRR, Lungs CTA
  - Walking with walker
  - Mild edema in both ankles

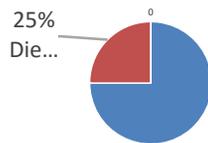
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## Case

- Visit Plan
  - HTN and edema – add HCTZ
  - CAD – discussed statin, on ACE and B-Blocker
  - Face/Face form filled out and home PT ordered

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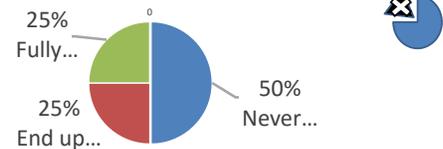
## Hip Fracture a Threat to Independence One year after a Hip Fracture



<sup>1</sup>U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Bone Health and Osteoporosis: A Report of the Surgeon General. Washington, DC, 2004.  
<sup>2</sup>Burge R, Dawson-Hughes DH, Wong JB, King A, Tosteson A. "Incidence and Economic Burden of Osteoporosis-Related Fractures in the United States, 2005-2025." JBM 2007; 22:465-475.

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## Hip Fracture a Threat to Independence Of the 75% who survive 1<sup>st</sup> year...



<sup>1</sup>U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Bone Health and Osteoporosis: A Report of the Surgeon General. Washington, DC, 2004.  
<sup>2</sup>Burge R, Dawson-Hughes DH, Wong JB, King A, Tosteson A. "Incidence and Economic Burden of Osteoporosis-Related Fractures in the United States, 2005-2025." JBM 2007; 22:465-475.

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## Prevent a Second Fracture: Performance Measure

- National Committee for Quality Assurance (NCQA) HEDIS measure: the number of women age 65-85 who suffered a fracture who had either BMD or a prescription for an anti-osteoporosis medication is less than 25%.
- Average cost of hospital episode of hip fracture is \$42,000
- Current system leads to maximized charges
- Bundled care may provide better incentives to improve care and decrease cost

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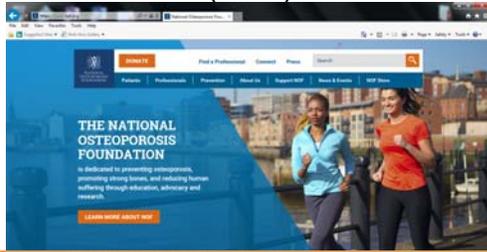
## Available Resources

- National Osteoporosis Foundation
- National Bone Health Alliance
- CDC.gov

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# National Osteoporosis Foundation (NOF)

<https://www.nof.org/>



# Fall Prevention Resources

- Screening Tests
  - Timed Up and Go (TUG) Test
  - 30-second Chair Stand Test
  - 4-stage Balance Test
- CDC - Stopping Elderly Accidents, Deaths & Injuries (STEADI)
- CDC - A CDC Compendium of Effective Fall Interventions: What Works for Community-Dwelling Older Adults
- National Council on Aging National Falls Prevention Resource Center

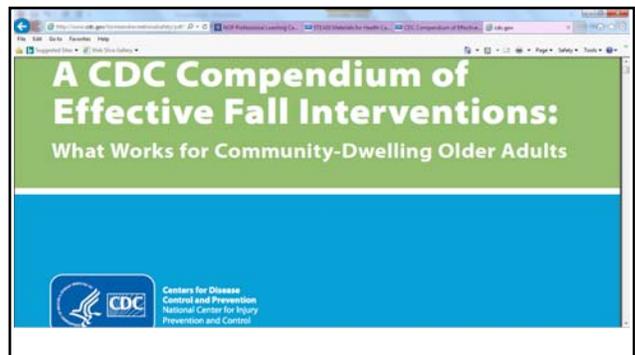
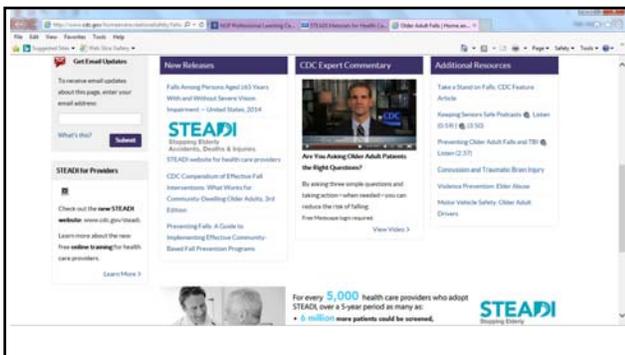
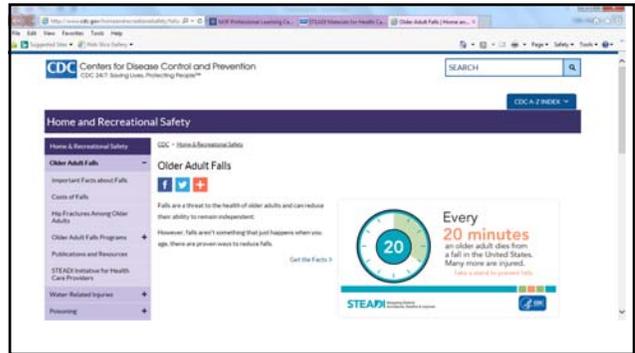


**Integrating Fall Prevention into Practice**

Intervention	How to integrate	Resources
Screening for fall risk	Use a validated fall risk assessment tool (e.g., Timed Up and Go, 30-second Chair Stand Test, 4-stage Balance Test) during routine visits.	See the STEADI algorithm for fall risk assessment.
Addressing identified deficits	Develop a care plan for each patient with identified deficits. Address deficits through referrals to physical therapy, occupational therapy, vision care, etc.	See the STEADI algorithm for fall risk assessment.
Conducting focused physical exams	Perform a focused physical exam to identify deficits such as gait, strength, balance, and vision.	See the STEADI algorithm for fall risk assessment.
Addressing medication-related risks	Review and manage medications to reduce fall risk. Consider deprescribing unnecessary medications and tapering high-risk drugs.	See the STEADI algorithm for fall risk assessment.
Addressing footwear risks	Advise patients on proper footwear: well-fitting, non-slip soles, closed-toe shoes.	See the STEADI algorithm for fall risk assessment.
Addressing home safety	Conduct a home safety assessment to identify and address hazards like clutter, poor lighting, and loose rugs.	See the STEADI algorithm for fall risk assessment.
Addressing caregiver needs	Identify and train caregivers on fall prevention strategies.	See the STEADI algorithm for fall risk assessment.
Addressing patient education	Provide patient education on fall prevention through brochures, videos, and group sessions.	See the STEADI algorithm for fall risk assessment.

Assessment and/or intervention	Identify when to practice use in the	What it involves
Screen all older patients for falls		<ul style="list-style-type: none"> <li>Have each patient complete the Stey Independent Brochure—only if necessary.</li> <li>Review Stey Independent Brochure &amp; take a falls history.</li> </ul>
Identify modifiable fall risk factors		<ul style="list-style-type: none"> <li>Additional one or more gait, strength &amp; balance tests:                             <ul style="list-style-type: none"> <li>Timed Up &amp; Go Test (Recommended)</li> <li>Chair Rise Test: NOF Protocol Statement</li> <li>Observe &amp; record patient's postural stability, gait, reach length &amp; turn.</li> <li>30-Second Chair Stand Test (Optional)</li> <li>4-Stage Balance Test (Optional)</li> </ul> </li> <li>As needed, refer to physical therapist or recommend community exercise or fall prevention program.</li> <li>PTs can assess gait &amp; balance, provide one-on-one program gait &amp; balance retraining, strengthening exercises, &amp; recommend &amp; teach correct use of assistive devices.</li> </ul>
Conduct focused physical exam		<ul style="list-style-type: none"> <li>In addition to a customary medical exam:                             <ul style="list-style-type: none"> <li>Assess muscle tone, look for increased tone, hypertonia (spasticity).</li> <li>Examine feet &amp; ankle/footwear: look for structural abnormalities, deficits in sensation &amp; proprioception.</li> <li>Screen for cognitive impairment &amp; depression.</li> <li>If needed, refer to podiatrist or podiatrist.</li> <li>These conditions can identify &amp; treat foot problems &amp; can prescribe corrective footwear &amp; orthotics.</li> </ul> </li> </ul>
Assess for & manage postural hypertension		<ul style="list-style-type: none"> <li>Check sitting &amp; standing blood pressure using 1-puff protocol, Measuring Orthostatic Blood Pressure.</li> <li>Recommend medication changes to reduce hypertension.</li> <li>Monitor patient as he/she makes recommended changes.</li> <li>Consult patient &amp; give the brochure, Postural Hypertension, What It Is and How to Manage It.</li> </ul>
Review & manage medications		<ul style="list-style-type: none"> <li>Taper &amp; stop psychoactive medications if there are no other indications. Try to reduce doses of necessary psychoactive medications.</li> <li>Recommend changes to reduce psychoactive medications.</li> <li>Monitor patient as he/she makes recommended changes.</li> </ul>

<b>Hypertension</b>	<ul style="list-style-type: none"> <li>• <b>Medication:</b> Measure Diastolic Blood Pressure <ul style="list-style-type: none"> <li>• Recommended medication changes to reduce hypertension.</li> <li>• Monitor patient as he/she makes recommended changes.</li> <li>• Counsel patient to gain the benefits, reduce hypertension, what it is and how to manage it.</li> </ul> </li> </ul>
<b>Review &amp; manage medications</b>	<ul style="list-style-type: none"> <li>• Taper &amp; stop psychotropic medications if there are no other indications. Try to reduce doses of necessary psychotropic medications.</li> <li>• Recommended changes to reduce psychotropic medications.</li> <li>• Monitor patient as he/she makes recommended changes.</li> </ul>
<b>Increase vitamin D</b>	<ul style="list-style-type: none"> <li>• Recommendation of at least 800 IU vitamin D supplement.</li> </ul>
<b>Assess visual acuity &amp; optimize vision</b>	<ul style="list-style-type: none"> <li>• Referral to ophthalmologist or optometrist.</li> <li>• These specialists can identify &amp; treat medical conditions contributing to vision problems &amp; address problems with visual acuity &amp; contrast sensitivity.</li> </ul>
<b>Address home safety &amp; how to reduce fall hazards</b>	<ul style="list-style-type: none"> <li>• Counsel patient about reducing fall hazards. Use CDC brochures. Check for Safety.</li> <li>• Refer to OTC to assess safety &amp; patient's ability to function in the home.</li> </ul>
<b>Educate about what causes falls &amp; how to prevent them</b>	<ul style="list-style-type: none"> <li>• Educate patient about fall prevention strategies.</li> <li>• Use CDC brochures, What You Can Do to Prevent Falls.</li> <li>• Recommend exercise or community fall prevention programs.</li> </ul>
<b>Identify community exercise &amp; fall prevention programs</b>	<ul style="list-style-type: none"> <li>• Contact senior services providers &amp; community organizations that provide exercise &amp; fall prevention programs for seniors.</li> <li>• Compile a resource list of available programs.</li> </ul>



## Screening Tests for Fall Risk

- 30-second chair stand test
- Timed get up and go (TUG)
- 4-stage balance test

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Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: AM/PM

### The 30-Second Chair Stand Test

**Purpose:** To test leg strength and endurance.

**Equipment:**  
 • A chair with a straight back without arm rests (at least 17" high)  
 • A stopwatch

**Instructions to the patient:**

- Sit in the middle of the chair.
- Place your hands on the opposite shoulder (rested on the arms).
- Keep your feet flat on the floor.
- Keep your back straight and keep your arms against your chest.
- On "Go," rise to a full standing position and then sit back down again.

Repeat this for 30 seconds.

**On "Go," begin timing.**  
 If the patient must use his/her arms to stand, stop the test. Record "0" for the number and note.

Count the number of times the patient comes to a full standing position in 30 seconds.

If the patient is unable to rise halfway to a standing position within 30 seconds have stopped, count it as a stand.

Record the number of times the patient stands in 30 seconds.  
 Number: \_\_\_\_\_ Score: \_\_\_\_\_ See next page.

A score average score indicates a high risk for falls.

Notes: \_\_\_\_\_

For relevant articles, go to: [www.ohi.gov/agency/STEAD](http://www.ohi.gov/agency/STEAD)




Chair Stand--Below Average Scores

Age	Female	Male
60-64	< 10	< 10
65-69	< 12	< 11
70-74	< 12	< 10
75-79	< 11	< 10
80-84	< 10	< 9
85-89	< 8	< 8
90-94	< 7	< 8

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: AM/PM

### The Timed Up and Go (TUG) Test

**Purpose:** To assess mobility.

**Equipment:** A stopwatch.

**Directions:** Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit on a standard arm chair and identify a line 2 centimeters or 10 feet away on the floor.

**Instructions to the patient:**

When I say "Go," I want you to:

- Stand up from the chair.
- Walk to the line on the floor at your normal pace.
- Turn.
- Walk back to the chair at your normal pace.
- Sit down again.

**On the word "Go" begin timing.**  
 Stop timing the patient once he or she sits back down and record.

Time: \_\_\_\_\_ seconds

An older adult who takes 12 seconds to complete the TUG is at high risk for falling.

Choose the patient's postural stability, gait, stride length, and weight. Circle all that apply. (Use tentative pace.)  
 • Loss of balance • Short stride • Slow or no arm swing • Stumbling or tripping • Shuffling • In-line turning • Not using assistive device properly

Notes: \_\_\_\_\_

For relevant articles, go to: [www.ohi.gov/agency/STEAD](http://www.ohi.gov/agency/STEAD)




Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: AM/PM

### The 4-Stage Balance Test

**Purpose:** To assess static balance.

**Equipment:** A stopwatch.

**Directions:** Place one foot progressively more challenging positions. Patients should not use an assistive device (cane or walker) and keep their arms open.

Describe and demonstrate each position. Stand next to the patient, hold their arm and help them assume the correct foot position. When the patient is steady, let go, but remain ready to catch the patient if he or she should lose their balance.

If the patient can hold a position for 10 seconds without moving their feet or reaching to support, go on to the next position. If not, stop the test.

**Instructions to the patient:** I'm going to show you four positions. Try to stand in each position for 10 seconds. You can hold your arms out or move your feet to help keep your balance but don't move your feet. Hold this position until I tell you to stop.

For each stage, say "Ready, begin" and begin timing. After 10 seconds, say "Stop."

See next page for detailed patient instructions and directions of the four positions.

For relevant articles, go to: [www.ohi.gov/agency/STEAD](http://www.ohi.gov/agency/STEAD)




**Instructions to the patient:**

- Stand with your feet side by side. Time: \_\_\_\_\_ seconds
- Place the heel of one foot on it to touching the big toe of the other foot. Time: \_\_\_\_\_ seconds
- Place one foot in front of the other, heel touching toe. Time: \_\_\_\_\_ seconds
- Stand on one foot. Time: \_\_\_\_\_ seconds

An older adult who cannot hold the position shown for at least 10 seconds is at an increased risk of falling.

Notes: \_\_\_\_\_

## Available Options if Positive Screening

- Formal PT referral (home vs outpatient)
- Home exercises



## Otago Exercise Program

- 17 strength and balance exercises
- Developed in New Zealand
- 35-40% reduction in falls in frail elderly over 6-12 month period
- Improvement may start in as little as 8 weeks
- Promoted by:
  - Centers for Disease Control
  - Patient Centered Outcomes Research Project
  - Administration for Community Living

Shubert, TE, Smith, MJ, Jiang, L, Ory, M. Perceived and Actual Physical Performance Improvements From an In-Home Evidence-Based Fall Prevention Program for Older Adults in Press for The Gerontologist



## Otago Exercise Program – 3 Main Components

- Strengthening
  - 5 muscle strengthening exercises
  - 2 sets of each exercise
  - 3 times each week
- Balance Retraining
  - 12 balance retraining exercises
  - 1 set each – progress from supported to unsupported
  - 3 times each week
- Walking
  - Advice and assistance
  - 2 times each week

[http://www.hfwcn.org/Tools/BroadCaster/Upload/Project13/Docs/Otago\\_Exercise\\_Programme.pdf](http://www.hfwcn.org/Tools/BroadCaster/Upload/Project13/Docs/Otago_Exercise_Programme.pdf)



# Practice Time!

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## Head movements

- Stand up tall and look ahead
- Slowly turn your head as far as you can to the right
- Slowly turn your head as far as you can to the left
- Repeat five times to each side



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## Back extension

- Stand up tall with the feet shoulder-width apart
- Place the hands on the small of the back
- Gently arch back
- Repeat five times



## Side hip strengthening exercise

- Strap the weight on to your ankle
- Stand up tall beside the bench
- Hold on to the bench
- Keep the exercising leg straight and the foot straight forward
- Lift the leg out to the side and return
- Repeat  times
- Strap the weight on to the other ankle
- Turn around
- Repeat this exercise  times



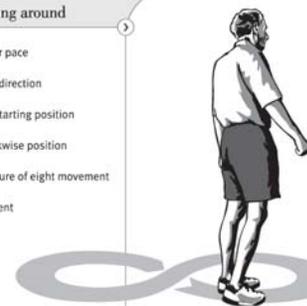
## Knee bends – hold support

- Stand up tall facing the bench with both hands on the bench
- Place your feet shoulder-width apart
- Squat down half way, bending your knees
- The knees go over the toes
- When you feel your heels start to lift, straighten up
- Repeat  times



## Walking and turning around

- Walk at your regular pace
- Turn in a clockwise direction
- Walk back to your starting position
- Turn in an anti-clockwise position
- The exercise is a figure of eight movement
- Repeat this movement



## Prevent a Second Fracture

- Greatest Risk for Hip Fracture is a Previous Hip Fracture!
- Patients with hip fractures are at an increased risk for a second fracture.
- Secondary fracture prevention has been proven to decrease recurrent fracture rates, yet less than 30% of patients hospitalized with a hip fracture receive proper evaluation and care for osteoporosis.
- National Committee for Quality Assurance (NCQA) HEDIS measure: the number of women age 65-85 who suffered a fracture who had either BMD or a prescription for an anti-osteoporosis medication is less than 25%.

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## Dual-energy X-ray Absorptiometry (DXA)

- How do I get it covered?
- AKA – I'm tired of resubmitting!!!

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## Great for Patient It's Ordered...

- But reimbursement has really gone down. What's being done to address this?!?!?

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## National Bone Health Alliance Overview

- Launched in late 2010 as a public-private partnership that brings together the expertise/resources of its public, private and non-profit sector partners
  - co-convened by the National Osteoporosis Foundation and American Society for Bone and Mineral Research
  - working toward the goals and recommendations of the U.S. Surgeon General's Report on Osteoporosis and National Action Plan on Bone Health
- **55 organizational participants**
  - 30 non-profit members
  - 20 private sector members
  - 5 government agency liaisons (CDC, CMS, FDA, NASA, NIH)
- **Collective reach: over 100,000 health care professionals and 10 million consumers**
- Uses its collective voice and diverse membership base to:
  - weigh in on subjects important to bone health
  - foster ongoing communication among individuals and organizations interested in bone health
  - identify shared priorities/projects that can become reality through pooled funding

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STRONG BONES AMERICA

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## Major NBHA Initiatives (1)

- Driving the widespread adoption of **Fracture Liaison Service (FLS) care coordination programs**, led by NP/PA/RN care coordinators that collaborate with the patient's PCP to ensure individuals who fracture receive appropriate screening, diagnosis, treatment (if needed) and support
  - **Fracture Prevention CENTRAL** ([www.FracturePreventionCENTRAL.org](http://www.FracturePreventionCENTRAL.org)): an online portal on FLS programs, was launched in March 2013 - over 3,600 registered users
    - resources include over 30 archived webinars, business plans, case studies (all available free of charge)
  - Developed and piloted **FLS cloud-based IT/registry tools** that enable sites to quickly establish FLS programs and move the needle on major quality measures/improve care coordination (available through [www.ostonics.com](http://www.ostonics.com))
  - **NBHA/NOF Osteoporosis Qualified Clinical Data Registry** ([www.medconcert.com/FractureQDR](http://www.medconcert.com/FractureQDR)): only osteoporosis-focused QCDR which enables HCPs to report on osteoporosis and other quality measures
  - Testing use of **CMS Chronic Care Management CPT code (99490)** which provides ~\$40/member/month to physicians/other qualified HCPs that perform at least 20 minutes of clinical staff time per calendar month in non-face-to-face care coordination for patients with 2 or more chronic conditions
    - this CPT code has been underutilized (only ~100,000 patients billed to date)
    - major new incentive that can provide greatly needed reimbursement for the FLS Coordinator function/chronic disease care coordination in the primary care setting

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## Major NBHA Initiatives (2)

- **2Million2Many Awareness Campaign:** In 2012, NBHA launched the 2Million2Many campaign, which focuses on the connection between bone breaks and osteoporosis and the 2 million fractures that occur each year
  - the campaign centers around "Cast Mountain", an installation that represents the 5,500 bone breaks that occur each day in the U.S. (2 million per year)
  - there is a variety of free print, video and other materials at [www.2Million2Many.org](http://www.2Million2Many.org)



- **Payer Summit/Reimbursement Dossier:** NBHA intends to develop a reimbursement dossier (to be published in 2017) around the cost effectiveness of the variety of bone health prevention, detection and treatment interventions, which would include:
  - a summary of the clinical, economic, and humanistic value and supporting evidence for prevention, detection and treatment interventions
  - background information on osteoporosis and post-fracture care (disease prevalence, burden of illness, epidemiology, etc.)

Before developing the dossier, NBHA will convene a **payer summit** to obtain feedback on what evidence would be needed for payers to consider updating their reimbursement guidance and decisions around these bone health interventions (target date: October 2016)

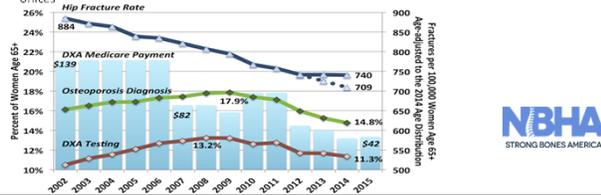
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## Major NBHA Initiatives (3)

**DXA Bone Density Payment Reform:** Since 2012, due to a drastic cut in the reimbursement rate for DXAs performed in physician offices (from a high of ~\$140 in 2006 to \$42 in 2015), over 2 million fewer DXAs have been performed which has led to a decrease in DXA testing and diagnosis rates (as well as an increase in hip fractures after over a decade of steady decline)

- NBHA is championing a bill in the U.S. House of Representatives, HR 2461 (to be introduced in the Senate shortly) that would set a floor of \$98 for Medicare reimbursement rates for DXA performed in physician's offices



## Care Coordination

- 3 questions?
  - What are barriers to meeting recommended guidelines for post-hip fracture care within your current practice?
  - What resources would be helpful to overcome these barriers?
  - How could you incorporate osteoporosis and post-osteoporotic fracture care into practice using chronic disease model/CPT?



## Care Coordination

- Idea Sharing



## Outline of the Session

- Review available physician resources
- Review screening for fall risk and practice exercises for fall prevention
- Introduce and discuss chronic care coordination as part of secondary fracture prevention
- Session breakout and discussion of ideas



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## References and Resources

- [www.nof.org](http://www.nof.org)
- [www.nbha.org](http://www.nbha.org)
- [www.cdc.gov/steady/materials.html](http://www.cdc.gov/steady/materials.html)
- [www.med.unc.edu/aging/cqec/exercise-program](http://www.med.unc.edu/aging/cqec/exercise-program)
- [www.cdc.gov/homeandrecreationalafety/falls/compendium.html](http://www.cdc.gov/homeandrecreationalafety/falls/compendium.html)
- [http://www.hfwcn.org/Tools/BroadCaster/Upload/Project13/Docs/Otago\\_Exercise\\_Programme.pdf](http://www.hfwcn.org/Tools/BroadCaster/Upload/Project13/Docs/Otago_Exercise_Programme.pdf)



## Associated Session

- Geriatric Hip Fracture Management: A Threat to Independence

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