Coordinated Post-ED Care for Senior Frequent Fallers
Colleen M. Casey

In 2015 and 2016, over 6,500 older patients have been seen in Providence-Oregon's 8 EDs for a fall. Most worrisome are the ~500 patients who present to the ED for 2 falls; and the ~170 patients who were seen 3 or more times for a fall in a year. The focus of this initiative is to develop a tailored-intervention care pathway for seniors who present 2 or more times a year to the ED for a fall. For these frequent fallers seeking care, the falls may well be a proxy that they need a higher level of care; need a referral to palliative care; have a diagnosis of unrecognized geriatric syndromes, polypharmacy, or cognitive impairment; and/or have high unmet psychosocial needs. Currently these patients are underserved, and are vulnerable to fragmented, episodic, and unproductive care despite their high utilization and high cost.

The project's goal is to increase coordinated services delivered to this marginalized population and decrease hospital/ED use. Data will characterize and identify these patients and a team-based approach will focus on better meeting their needs, even if we cannot prevent all of their falls. Data from claims and the electronic health record (EHR), as well as interviews, will characterize these patients in terms of age, gender, living environment, chronic diseases, payor, history of community supports, and hospitalization patterns. Invested representatives include the disciplines of care management, geriatrics, social work, rehabilitation, pharmacy, primary care, palliative care, home health, ED, hospital administration, community-based organization leadership, and health plan leadership. Tailored interventions will leverage existing community-based resources and health system infrastructure (including targeted case management, ED social work). Additional interventions will include, but not be limited to, physical (PT)/ occupational (OT) therapy, home health, social work, palliative care, paramedicine visits, home safety evaluations, or high-risk medication review, depending on the needs of the patient. The PCL grant affords an opportunity to better understand this group of at-risk patients and ultimately deliver better, more coordinated care to them by developing a tailored-intervention pathway for seniors who fall 2 or more times in a year, with a resultant trip to the ED.