Emergency Department Trauma Discharge Fall Follow-Up Program

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Purpose: Three million older adults are treated for a fall injury each year and falls are the number one cause of death from injury. Older adult falls is the leading cause of injury for the Trauma Service. According to the Center for Disease Control, once the individual falls (injury or not), the chances of falling again doubles (2018). The aim of the Emergency Department Trauma Discharge Fall Follow-Up Program is to reduce the recidivism risk of low altitude (defined as less than six (6) feet) falls for patients who have been examined by the Trauma Service and discharged home from the Emergency Department (ED). The program was formed based on a need for secondary fall prevention with our target population (older adults) within our surrounding community who are discharged home after sustaining a fall. The program provides the patient with a follow-up phone call after their discharge from the ED. The injury prevention coordinator provides the patient with a chance to ask questions, provide feedback on the care they received and provide fall prevention education, as well as local resources.

Resources: Resources needed to accomplish the project include:
1. Access to electronic medical records
2. Discharge list of ED Trauma Patients
3. Telephone
4. Envelopes
5. Letterhead
6. Postage
7. Fall Prevention Education: Center for Disease Control STEADI brochures, local fall prevention class dates, local fall prevention resources

Description: Patients are identified by utilizing the Trauma Service Activation Log, chart review via electronic medical record, & inclusion criteria. Inclusion Criteria: >60 years, sustained a low altitude fall outside of the hospital, evaluated by the Trauma Service with discharge home from the ED, resides at home with minimal assistance, functionally independent & not cognitively impaired. Exclusion Criteria: < 60 years sustained a high-altitude fall, not evaluated by the Trauma Service, admission to hospital, reside outside of a private residence, a medical history of cognitive impairment, ETOH involvement or those who left against medical advice. Follow-up phone calls are performed by the IPC within 72 hours of discharge, utilizing an interview tool, patient specific questions & phone discussion. Informational materials are mailed to the address on record for all included patients. Materials include: fall prevention education from the CDC, local resources, local fall prevention classes & contact information for the Trauma Service. Return fall-related ED visits, placement in observation, or admission to the hospital due to a fall are monitored for 1 year after initial date of service.

Effectiveness: The EMR is used to identify the recidivism rate for the patients included in the program at 30-60-90 day, 6 month, and 1 year intervals. Two-hundred and three (n=203) patients were included within the program & two-hundred and thirty six (n=236) were excluded from the program. One-hundred and thirty-six (136) or sixty-seven percent (67%) of patients, 136/203 (67%) were contacted by the IPC for a follow-up phone call. Thirty (30) days Included: Four (4) or two percent (2%) of patients, 4/203 (2%) had either a return ED visit or admission for a fall-related event. Sixty (60) days Included: Two (2) or one percent (1%) of patients, 2/203 (1%) had either a return ED visit or admission for a fall-related event. Thirty (30) days Excluded: Twenty-four (24) or ten percent (10%) of patients, 24/236 (10%) had either a return ED visit or admission for a fall-related event. Sixty (60) days Excluded: Twenty-one (21) or nine percent (9%) of patients had either a return ED visit or admission.

Lessons Learned: Phone-to-phone conversations appear to be contributing to the preliminary success of the program. A level of customer satisfaction is shared with the IPC during the phone calls & patients appreciate the “check-in” after discharge. Approximately, half of the patients discharged from the ED were excluded. These patients have higher rates of return, making it more challenging to provide successful fall prevention strategies. The program does not consider included patients who fall again & seek treatment at another healthcare institution. Attempts to contact included

patients are made twice, with 67/203 or (33%) that could not be reached. While all included patients are sent the same educational materials, it appears that the personal conversations are more effective. Contact information must be correct to effectively provide necessary information to the patient. We are currently unable to evaluate the accuracy of the phone or mailing information making it difficult to track delivery.

Conclusions: Recidivism for fall-related ED visits, placement in observation or admission to HFMH because of a low altitude fall is being monitored for a period of 1 year after the initial date of service at 30-60-90 day, 6 month and 1 year intervals. Data collection continues for the 90-day, 6 month and 1 year intervals. Data is reported quarterly at Trauma Operations Committee. The ED Trauma Discharge Fall Follow-Up Program will continue thru 2020, with ongoing data collection and analysis. Additional fall prevention resources will be shared with the patients as they become available. The program will be shared with local, regional and state Injury Prevention groups.